STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mississippi Valley	500 Messenger Road Keokuk, IA 52632

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policy review, resident and staff interviews, the facility failed to complete an informed consent prior to the administration of psychotropic medications for 5 of 5 (Resident #1, Resident #2, Resident #3, Resident #4 and Resident #7) residents reviewed for unnecessary medications. The facility reported a census of 54 residents. Findings include: 1. Review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE], revealed a list of diagnoses which included anxiety, depression, post-traumatic stress disorder (PTSD), tracheostomy status and dependence on a respirator status. The Medication section of the MDS indicated Resident #1 prescribed high-risk drug antipsychotic, antianxiety, and antidepressant medications. The MDS listed an admission date of 8/21/25. Review of the electronic health record (EHR) Physician Order Report revealed Resident #1 prescribed the following:a. Seroquel (an antipsychotic medication) prescribed daily for PTSD. Start Date: 1/26/26 for 100 mg (milligrams)/1 tab at bedtime; and 2/14/26 for 25 mg/1 tab twice daily.b. Buspirone (an antianxiety medication) prescribed daily for generalized anxiety disorder (GAD). Start Date: 10/2/25 for 15 mg/1 tab three times daily.c. Citalopram (antidepressant medication) prescribed daily for depression, unspecified. Start Date: 3/13/26 for 20 mg/1 tab daily.d. Lorazepam (antianxiety medication) prescribed as needed for anxiety. Start Date: 3/28/26 for 0.5 mg/1 tab every 6 hours as needed. End Date: 4/11/26.During an observation on 5/20/26 at 8:07 AM, Resident #1 in his room, laid on his left side resting in bed. No concerns noted.During an interview on 5/20/26 at 8:34 AM, the Director of Nursing (DON) stated Consent forms are located in the Resident Document section, under consents of the EHR. The DON stated Consent forms may also be on a written form. A review of the Resident #1's EHR Progress Note and Resident Document sections from the admission date of 8/21/25 to current resulted in no Consent forms related to the education of risks and benefits of psychotropic medications found. During an interview on 5/20/26 at 1:15 PM, Staff A, Registered Nurse (RN) stated when a provider ordered a resident new psychotropic medication (antidepressant, antianxiety, antipsychotic), the nurses typically provided education on the risks and benefits to the resident or the legal representative, then documented the education in the Progress Notes. During an interview on 5/20/26 at 1:30 PM, Staff B, Licensed Practical Nurse (LPN) reported nurses provided the education on psychotropic medication risks and side effects when a new order is given. Staff B stated sometimes the Administration or the Infection Preventionist has already provided the education, and they [nurses] just need to inform the resident of the new order. They document the education in the progress notes. During an interview on 5/20/6 at 1:35 PM, the Infection Preventionist (IP) stated that she generally checked the physician orders over for the correct time, medication, and diagnosis. The IP stated that she has done education with the resident/family on risks of psychotropic medications but not that often. She explained the education is documented in the progress notes. The IP stated a lot of times the Social Services Coordinator gets involved. During an interview on 5/20/26 at 1:50 PM, the Social Services Coordinator reported she is not involved in providing education on the benefits and risks of using psychotropic medications. During an interview on 5/20/26 at 2:15 PM, Staff C, LPN explained the nurse's provided education to the resident or the family on what medication the physician ordered, why the medication was ordered, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and answer any questions the family may have regarding the medication. Staff C added, the nurses do inform the resident/family if there are side effects and the conversation is documented in the Progress notes. 2. Review of Resident #2 MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The list of diagnoses included adjustment disorder with mixed disturbance of emotions. The Medication section of the MDS indicated Resident #2 prescribed high risk antianxiety and antidepressant medications. The MDS listed an admission date of 3/30/26.Review of the EHR Physician Order Report revealed Resident #2 prescribed the following: a. Clonazepam (antianxiety medication) prescribed daily for circadian rhythm sleep disorder. Start Date: 3/30/26 for 0.5 mg/1 tab at bedtimeb. Escitalopram oxalate (antidepressant medication) prescribed daily for adjustment disorder with mixed disturbance of emotions and conduct. Start Date: 3/30/36 for 10 mg/1 tab daily.c. Mirtazapine (antidepressant medication) prescribed daily for major depressive order. Start Date: 3/30/36 for 30 mg/1 tab at bedtime. During an observation on 5/20/26 at 8:19 AM, Resident #2 laid in bed resting on his right side. No concerns noted.A review of the Resident #2's EHR Progress Note and Resident Document sections from the admission date of 3/30/26 to current resulted in no Consent forms related to the education of risks and benefits of psychotropic medications found. 3. Review of Resident #3's MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating intact cognition. The list of diagnoses included anxiety and post-traumatic stress disorder (PTSD). The Medication section of the MDS indicated Resident #3 prescribed high risk antianxiety and antidepressant medications. The MDS listed an admission date of 11/14/23. Review of the EHR Physician Order Report revealed Resident #3 prescribed the following:a. Diazepam (an antianxiety medication) prescribed daily for obsessive compulsive disorder. Start Date: 2/8/25 for 5 mg/1/2 tab daily. Discontinue date: 4/6/26. Start Date: 4/6/26 for 5 mg/1/2 tab daily.b. Paroxetine Hydrochloride (an antidepressant medication) prescribed daily for obsessive compulsive disorder. Start Date: 12/6/24 for 10 mg/4 tabs daily. End Date: 4/6/26. Start date: 4/6/26 for 10 mg/4 tabs daily.During an observation on 5/20/26 at 2:10 PM, Resident #3 in her room with her privacy curtain pulled and stated she didn't want to talk or see anyone. A review of the Resident #3's EHR Progress Note and Resident Document sections from 8/1/25 to current resulted in no Consent forms related to the education of risks and benefits of psychotropic medications found. 4. Review of Resident #4's MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 indicating intact cognition. The list of diagnoses included respiratory failure, tracheostomy status, dependence on a ventilator status and dependence on supplemental oxygen. The MDS listed an admission date of 2/25/25.Review of the EHR Physician Order Report revealed Resident #4 prescribed the following:a. Buspirone (an antianxiety medication) prescribed daily for anxiety disorder. Start Date: 5/14/25 for 10 mg/1 tab three times daily.b. Citalopram (an antidepressant medication) prescribed daily for depression. Start Date: 5/14/25 for 10 mg/1 tab daily. c. Diphenhydramine Hydrochloride (commonly used as a sleep aide) prescribed as needed for anxiety. Start Date: 5/14/25 for 25 mg/1 tab every 6 hours as needed.d. Trazodone (an antidepressant medication) prescribed daily for depression. Start Date: 1/23/26 for 50 mg/1/2 tab at bedtime. A review of the Resident #4's EHR Progress Note and Resident Document sections from 8/1/25 to current resulted in no Consent forms related to the education of risks and benefits of psychotropic medications found. During an interview on 5/20/2026 at 2:11 PM, Resident #4 shared she didn't recall anyone talking to her about the risk or side effects of her antianxiety or antidepressant medications and she had taken the medications for a while. Resident #4 stated she gets pretty anxious and short of breath a lot. Resident #4 observed lying in bed on a mechanical ventilator with supplemental oxygen running. 5. Review of Resident #7's MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15 indicating severe cognitive impairment. The list of diagnoses included of acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), tracheostomy status, dependence on a ventilator status and dependence on supplemental oxygen. The MDS Medication section indicated Resident #7 prescribed high risk antianxiety and antidepressant medications. Review of the (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EHR Physician Order Report revealed Resident #7 prescribed the following:a. Venlafaxine (antidepressant medication) prescribed for generalized anxiety disorder, Start Date: 4/21/26 for 37.5 mg twice daily. b. Ativan (an antianxiety medication) prescribed for generalized anxiety disorder. The Start Date/Discontinue Dates for Ativan in April 2026 were for:1. 4/4/26 go 4/8/26 - 1 mg/1 tab every 6 hours as needed.2. 4/8/26 to 4/16/26 - 1 mg/1 tab every 6 hours as needed.3. 4/16/26 to 4/21/26 - 1 mg/1 tab every 6 hours as needed.4. 4/21/26 to 4/24/26 - 1 mg/1 tab every 6 hours as needed.5. 4/24/26 to 4/28/26, frequently changed to every 3 hours per 4/24/26 Progress noteDuring an observation on 5/20/26 at 8:06 AM, Resident #7 lying in bed resting. No concerns noted. A review of the Resident #7's EHR Progress Note and Resident Document sections from 8/1/25 to current resulted in no Consent forms related to the education of risks and benefits of psychotropic medications found. During an interview on 5/20/26 at 2:44 PM, the DON) reported she had looked in the Progress Notes for each resident (#1, #2, #3, #4 and #7) and had not found any documentation that psychotropic medication education for informed consent had been documented or completed. She explained she had even called the prior DON and wasn't able to find consent information and planned to work on that going forward. The Antipsychotic Medical Renewal Policy and the Psychotropic Drug use Policy, revised 2/2025 lacked direction to the nursing staff to provide education to the resident and/or legal representative regarding treatment, treatment options, benefits and risk factors of psychotropic medication treatment. The Residents' [NAME] of Right, revised 11/16, provided by the facility directed the resident has the right to be informed in advance, by the physician, other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives of treatment options and to choose the alternative or option he or she prefers.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, Center for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to code diagnoses used of psychotropic medications for 4 of 5 residents (Resident #2, Resident #3, Resident #4, and Resident #7) reviewed for unnecessary medications; and failed to accurately code restraint use for 2 of 2 residents (Resident #19 and Resident #51) reviewed for restraints. The facility identified a census of 54 residents.Findings include: 1. Resident #2's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) Score of 15 out of 15 indicating intact cognition. The list of diagnoses included adjustment disorder with mixed disturbance of emotions. The Medication section of the MDS indicated Resident #2 prescribed high risk antianxiety and antidepressant medications. Review of the EHR Physician Order Report revealed Resident #2 prescribed the following: a. Clonazepam (antianxiety medication) prescribed daily for circadian rhythm sleep disorder. Start Date: 3/30/26 for 0.5 mg/1 tab at bedtime b. Mirtazapine (antidepressant medication) prescribed daily for major depressive order. Start Date: 3/30/36 for 30 mg/1 tab at bedtime. A review of Resident #2's MDS revealed the lack of circadian rhythm sleep disorder and major depressive disorder diagnoses. During an interview on 5/21/26 at 8:40 AM, the MDS Coordinator reported she looked back at the most recent physician visit progress note and coded the diagnoses from the visit in Section I of the MDS. She reviewed Resident #2's MDS and verified the diagnoses were not on the MDS, then stated she would correct all the MDS assessments. When queried on what she used to code the MDS, the MDS Coordinator explained she coded based on how her prior preceptor trained her to code the MDS, but she had a copy of the RAI Manual in her office. 2. Review of Resident #3's MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, indicating intact cognition. The list of diagnoses included anxiety and post-traumatic stress disorder (PTSD). The Medication section of the MDS indicated Resident #3 prescribed high risk antianxiety and antidepressant medications. The MDS listed an admission date of 11/14/23. Review of the EHR Physician Order Report revealed Resident #3 prescribed the following: a. Diazepam (an antianxiety medication) prescribed daily for obsessive compulsive disorder. Start Date: 2/8/25 for 5 mg/1/2 tab daily. Discontinue date: 4/6/26. Start Date: 4/6/26 for 5 mg/1/2 tab daily. b. Paroxetine Hydrochloride (an antidepressant medication) prescribed daily for obsessive compulsive disorder. Start Date: 12/6/24 for 10 mg/4 tabs daily. End Date: 4/6/26. Start date: 4/6/26 for 10 mg/4 tabs daily. A review of Resident #3's MDS revealed the lack of an obsessive compulsive diagnosis. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #4's MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15 indicating intact cognition. The list of diagnoses included respiratory failure, tracheostomy status, dependence on a ventilator status and dependence on supplemental oxygen. The MDS listed an admission date of 2/25/25. Review of the EHR Physician Order Report revealed Resident #4 prescribed the following: a. Buspirone (an antianxiety medication) prescribed daily for anxiety disorder. Start Date: 5/14/25 for 10 mg/1 tab three times daily. b. Citalopram (an antidepressant medication) prescribed daily for depression. Start Date: 5/14/25 for 10 mg/1 tab daily. c. Diphenhydramine Hydrochloride (commonly used as a sleep aide) prescribed as needed for anxiety. Start Date: 5/14/25 for 25 mg/1 tab every 6 hours as needed. d. Trazodone (an antidepressant medication) prescribed daily for depression. Start Date: 1/23/26 for 50 mg/1/2 tab at bedtime. A review of Resident #4's MDS revealed the lack of anxiety and depression diagnoses. 4. Review of Resident #7's MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15 indicating severe cognitive impairment. The list of diagnoses included of acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), tracheostomy status, dependence on a ventilator status and dependence on supplemental oxygen. The MDS Medication section indicated Resident #7 prescribed high risk antianxiety and antidepressant medications. Review of the EHR Physician Order Report revealed Resident #7 prescribed the following: a. Venlafaxine (antidepressant medication) prescribed for generalized anxiety disorder, Start Date: 4/21/26 for 37.5 mg twice daily. b. Ativan (an antianxiety medication) prescribed for generalized anxiety disorder. The Start Date/Discontinue Dates for Ativan in April 2026 were for: 1. 4/4/26 go 4/8/26 – 1 mg/1 tab every 6 hours as needed. 2. 4/8/26 to 4/16/26 - 1 mg/1 tab every 6 hours as needed. 3. 4/16/26 to 4/21/26 - 1 mg/1 tab every 6 hours as needed. 4. 4/21/26 to 4/24/26 - 1 mg/1 tab every 6 hours as needed. A review of Resident #7's MDS revealed the lack of an anxiety diagnosis. During an interview on 5/21/26 at 11:20 AM, the Director of Nursing (DON) reported she didn't think the facility had a MDS RAI policy. The facility used the CMS RAI Manual to code the MDS. The CMS LTC RAI User's Manual, October 2025, Version 1.20.1, Page 1-4 documented the RAI process (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require the assessment accurately reflects the resident's status. The CMS RAI User Manual, Chapter 3, Page I-1 instructs to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status. Include active diagnosis in the last seven days in the look back period. 5. Review of the MDS assessment dated , 4/26/26, revealed Resident #51 had severely impaired cognitive skills for daily decision making and required dependence on staff assistance for all care tasks and mobility. The list of diagnoses included cerebral palsy, tracheostomy status, gastrostomy status, and dependence on ventilator (respirator). The MDS indicated that no restraints or alarms were used on the bed or on the chair/out of bed. Review of Resident #51's Care Plan, initiated 9/08/25, revealed the Focus area: I have an order for an abdominal binder to protect my P.E.G (Percutaneous Endoscopic Gastrostomy) tube with the goal to have intact skin with no signs of redness or irritation from wearing the binder. An intervention instructed staff to check skin integrity before applying and after removing device and skin checks every 2 hours while in place and as needed. Review of Resident #51's Medication and Treatment Administration Records (MAR/TAR), dated May 2026, revealed an order for: Abdominal binder to be applied to obscure PEG tube to avoid resident pulling on it for safety, start date 4/30/26. The order instructed to document every 2 hours if binder is on or off and perform a skin check every 2 hours when in place. Review of documentation between the dates of 5/01/26 and 5/19/26 revealed daily use of the abdominal binder. During an interview on 5/20/26 at 2:33 PM, Staff M, Certified Nursing Assistant (CNA), stated Resident #51 used the abdominal binder throughout the day shift. During an interview on 5/21/26 at 8:25 AM, Staff I, CNA, stated Resident #51 used the abdominal binder throughout the overnight shift. During an interview on 5/21/26 at 10:37 AM, the DON, stated Resident #51 had utilized the abdominal binder for months to help secure PEG tube and was unable to remove the binder independently. The DON identified Resident #51's abdominal binder as a physical restraint and expectation of assessments to reflect this. 6. Review of the MDS Assessment, dated 4/30/26, revealed Resident #19 had severely impaired cognitive skills for daily decision making and required dependence on staff assistance for all care tasks and mobility. The list of diagnoses included respiratory failure, heart failure, seizure disorder, tracheostomy status, gastrostomy status, dependance on ventilator (respiratory), and conjunctivitis (eye infection) of both eyes. The MDS indicated that no restraints or alarms were used on the bed or on the chair/out of bed. Review of the Care Plan, initiated 2/19/24, revealed the Focus area for Resident #19 behavioral symptoms, can become restless and agitated. Interventions instructed the following, in part: a. Arm immobilizers to bilateral upper extremities. Start date: 4/28/26. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Staff will monitor my mood if I seem agitated. Redirection will be attempted. Start date: 5/24/24. The Care Plan, additionally revealed the Focus area: I need to have padded hand mitt or sock as needed related to increased agitation, confusion, being fidgety and restless when in bed or chair. This is to keep me from pulling my ventilator circuit, feeding tube, and catheter and keep me from hitting myself. Interventions included the following, in part: a. Encourage participation of therapy department in assessing, re-assessing and determining the least restrictive/appropriate restraint to use. Start date: 5/24/24. b. Fully inform resident/family member of risks and benefits of all options being considered. Start date: 5/24/24. c. Mitts to be removed during periods of one on one. Start date: 5/24/24. d. Monitor, document, and report any negative outcome. Start date: 5/24/24. e. Remove mitts and complete hand hygiene. Range of Motion (ROM) and to check for redness, irritation, or breakdown. Start date: 5/24/24. f. Remove restraint to allow free time at meals or while attending activities (when staff is close by resident). Start date: 5/24/24. Review of Resident #19's MAR/TAR revealed an order, started on 4/15/26, for left and right arm immobilizers which instructed the following: Assess and remove restraint no less than every 2 hours to check resident tolerance and skin integrity; Denote nursing actions during release and reinstatement; Ensure side rail padding is in place over bed rail to prevent injury from resident banging hand on rail; Remove as needed while asleep. T Review of Resident #19's MAR/TARs, between the dates of 4/15/26 and 5/19/26, revealed that the left and right arm immobilizers were utilized daily. During an interview on 5/20/26 at 11:37 AM, Staff L, Registered Nurse (RN), stated that Resident #19 utilized arm immobilizers due to resident biting thumbs and scratching his eyes. Staff L explained that the immobilizers prevented Resident #19 from bending his elbows. Staff L reported that Resident #19 was unable to remove the immobilizers independently and stated that staff removed the immobilizers every 2 hours for skin check and ROM. During an interview on 5/21/26 at 8:45 AM, the MDS Coordinator, denied Resident #19's use of arm immobilizers during MDS assessment dated [DATE], but recalled that resident had an as needed order for hand mitts. During an interview on 5/21/26 at 10:37 AM, the DON stated Resident #19 had utilized arm immobilizers as ordered starting on 4/15/26 until discontinued on 5/21/26. The DON identified Resident #19's arm immobilizers as physical restraints and expectation of assessments to reflect this. Review of the CMS RAI User Manual, Chapter 3, Page P-1 instructed to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and the facility discharge to another facility checklist, the facility failed to complete a recapitulation of stay discharge summary for 1 of 1 residents reviewed for discharges (Resident #63). The facility reported a census of 54 residents. Findings include: The electronic health record (EHR) Census Records revealed Resident #63 discharged from the facility on 3/26/26. Review of a Social Services Note dated 3/5/26 at 8:58 AM, revealed SS (Social Services)-Discharge- Called [name redacted] @ [facility name redacted] She stated they have accepted resident. They are currently working on transportation and will let facility know an admit date . [Name redacted] was informed to call DON (Director of Nursing) [name redacted] with update on admit date . DON has been given this information. [name redacted] [facility name redacted] has informed Spouse of accepting resident and working on transportation. (email sent to DON, Admin (Administrator),MDS (Minimum Data Set) about discharge.)Review of a Nurse Note dated 3/26/26 at 1:04 PM, revealed [name redacted], RT (Respiratory Therapy) Director and [name redacted], Transport arrived at 11:34. They brought their own sling and reclining chair that had feces in the creases. Report given to [name redacted]. [Name redacted], RT at bedside along with [name redacted] to switch over to their vent. [Name redacted, Resident #63] will be leaving in their transport van. Vitals WNL (within normal limits) before leaving. Paperwork provided, left behind in room. [Name redacted, Resident #63] left our facility at 12:25. Report given to [name redacted], LPN (Licensed Practical Nurse). Faxed over all paperwork that should have been sent to [phone number redacted].Review of the EHR lacked a Discharge Summary for Resident #63During an interview on 5/21/26 at 8:31 AM, Staff E, Registered Nurse (RN), queried about Resident #63 discharge and she stated the nurses fill out a checklist for the discharge on the things the staff needed to complete for the discharge. Staff E asked if she completed a discharge summary with a recapitulation and Staff E stated from her standpoint Staff E printed off paperwork, completed vital signs, and gave report to the new facility. Staff E thought the recapitulation was completed by the management team. During an interview on 5/21/26 at 9:30 AM, Staff F, RN queried on a checklist for discharges to another facility and Staff F stated yes and pulled a copy out of the cabinet in the nurse's station. The Discharge to Another Facility Checklist provided revealed the following: complete discharge summary in Matrix under observations- discharge/transfer-discharge summary.During an interview on 5/21/26 at 9:54 AM, Director of Nursing (DON) queried about Resident #63 discharge summary and the she stated sometimes the records didn't get uploaded in the EHR and the DON would check medical records for the documentation. The DON confirmed she didn't see a discharge summary completed under the observations and a discharge summary should have probably been completed. During an interview on 5/21/26 at 11:20 AM, the DON reported she checked Resident #63's clinical record and there was no discharge summary completed. She stated it had probably been missed. The facility did not have a policy. They just developed a policy to work on it going forward. During an interview on 5/21/26 at 11:23 AM Staff G, Licensed Practical Nurse (LPN) queried about the process for residents discharging to another nursing facility and she stated she would first pull the policy and procedure book and the facility also had a checklist to complete. Staff G asked who completed the discharge summary and Staff G stated the floor nurses did unless they were busy and then the DON would help or other nursing staff. The Discharge to Home Policy dated 7/2025 revealed the following:Use the Discharge to Home Checklist with steps to follow upon day of discharge. The checklist is in the file cabinet at each nurse desk.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165151	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mississippi Valley	500 Messenger Road Keokuk, IA 52632

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews, the facility policy, and the manufacturer's insulin pen instructions, the facility failed to follow manufacturer instructions for administration of insulin and failed to administer an inhaler and nebulizer treatment at the physician prescribed time for 2 of 6 residents (Resident #22 and Resident #26) observed for medication administration causing a 10% medication error rate. The facility reported a census of 54 residents. Findings include: 1. The Minimum Data Set assessment dated [DATE] revealed Resident #26 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS revealed a diagnosis for diabetes mellitus (DM) and that resident received insulin 7 out of 7 days. Resident #26's Care Plan included a problem area dated 4/18/22 for the diagnosis of DM and use of an oral antidiabetic and insulin. The Intervention dated dated 7/12/24 directed staff to administer medications as ordered. Review of the electronic health record (EHR) revealed a Physician Order for Lantus U-100 Insulin solution; 100 units/ml (milliliter)- 35 units daily at 8:00 AM. During an observation on 5/20/26 at 7:38 AM, Staff C, Licensed Practical Nurse (LPN) prepared Resident #26 Lantus insulin pen. Without first priming the pen, Staff C turned the knob to 35 units and then administered the insulin into Resident #26 right abdomen and after the medication injected, kept the insulin pen in place for 2 seconds. During an interview on 5/20/26 at 1:45 PM, Staff C, LPN queried if the Lantus pen had any special instructions and Staff C stated not that she was aware of. Staff C asked about priming the insulin pen and she stated not that she was aware of. Staff C stated the insulin pen needed to be kept in place for at least 10 seconds after injected. Staff C informed the pen left in for only a few seconds, and Staff C stated it felt like 10 seconds. During an interview on 5/21/26 at 9:42 AM, the Director of Nursing (DON) queried on special instructions for the Lantus insulin pen and the DON stated nurses needed to push the air out and hold it in place for 15 seconds after injecting. The DON confirmed the nurse needed to prime the needle prior to administration. Review of the facility policy titled Insulin Preparation and Administration Policy and Procedures dated 4/2019 revealed: Prior to administering an insulin medication, the member of the professional nursing staff who prepared the insulin dose shall verify the insulin dose that was prepared is accurate/correct and is adherent to the Six (6) R's of medication administration. The administration of any insulin shall be done using an administration/injection needle that meets the manufacturer's recommended specifications for administration use.Review of the Lantus Solostar Pen manufacturer's instructions dated 8/2022 revealed: a. Perform a safety check: dial a test dose of 2 units, then hold the pen with the needle pointing up and lightly tap the insulin reservoir so that air bubbles rise to the top of the needle. This will help you get the most accurate dose. Then press the injection button all the way in and check to see that insulin comes out of the needle. b. Inject the dose.use your thumb to press the injection button all the way down. When the number in the dose window returns to zero as you inject slowly count to 10 before removing. (Counting to 10 will make sure you get your full insulin dose.)2. Review of Resident #22's MDS assessment dated [DATE] revealed a BIMS score of 11 out of 15, which indicated a moderate cognitive impairment. The MDS list of diagnoses included respiratory failure and asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease. The MDS indicated the resident received continuous oxygen therapy. Review of Resident #22's Care Plan revealed a problem area dated 10/10/22 for resident required oxygen. Interventions, dated 7/3/24 included breathing treatments/medications as ordered. The EMR revealed the following Physician Orders:a. Arnuity Ellipta (fluticasone furoate) blister with device 100 mcg/actuation- 1 puff once a day between 7 am- 10 am.b. Ipratropium-albuterol solution for nebulization; 0.5 mg (milligrams)- 3 ml- 1 vial inhalation four times a day (8 am, 12 pm, 4 pm, and 8 pm)During an observation on 5/20/26 at 7:48 AM, Staff H, Certified Medication Aide (CMA) prepared Resident #22 medications. Resident #22 ipratropium-albuterol foil packet did not have the date it was (continued on next page)

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	165151	A. Building B. Wing	05/21/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opened on it so Staff H stated she wouldn't administer it and reordered a new supply. Resident #22's Arnuity inhaler also did not have an open date on it, so Staff H did not administer the inhaler either. The inhaler had 21 doses left on it. Review of the May 2026 Medication Administration Record revealed:a. Arnuity Ellipta not administered: drug/item unavailable on 5/20/26 between 7:00 am -10:00 AM.b. Ipratropium-albuterol solution not administered: drug/item unavailable on 5/20/26 at 8:00 am and 12:00 PMDuring an interview on 5/20/26 at 9:05 AM, Staff H, CMA stated she reordered Resident #22 medications and the pharmacy would send out today and the facility should receive Resident #22 medications around 2:30 PM. Staff H stated Resident #22 inhaler was scheduled daily and his nebulizer treatments were scheduled 4 times a day. Staff H stated Resident #22 would also miss the 12 PM nebulizer treatment, but Resident #22 had a PRN (as needed) albuterol nebulizer treatment the facility could use. Staff H stated if a medication was not labeled with a date it was opened, staff didn't know how long the medication had been used for, so Staff H didn't give it. During an interview on 5/21/26 at 9:42 AM, the DON queried on Resident #22 inhaler and nebulizer vials not being dated when opened and the DON stated the medications were usually labeled and Resident #22 always gets through his medications. The DON stated she wished Staff H would of asked questions before not giving Resident #22 his medications. The DON stated they could of contacted the pharmacy to see when the medications were sent rather than not giving Resident #22 his medication at all. Review of the Medication Administration revised 7/2024 revealed, in part: Unless otherwise specified by the prescriber, medications are to be administered within one hour of the prescribed time of administration.