STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165396	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Hills Village IN Keokuk	20 Village Circle 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observation, interview, and record review the facility failed to ensure an insulin pen was primed prior to insulin administration for one of two residents reviewed for insulin during the medication administration task (Resident #26). The facility reported a census of 65 residents. Findings include: Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 4 out of 15 on a Brief Interview for Mental Status exam, which indicated severely impaired cognition. Per this assessment, the resident took insulin for seven of the last seven days. The Care Plan dated 8/22/23 revealed, Problem: [Resident #26] has diabetes. The intervention also dated 8/22/23 revealed, Approach: Administer insulin as ordered. Monitor for side effects. Observation conducted 9/11/24 at 11:20 AM revealed Staff A, Licensed Practical Nurse (LPN) prepared insulin via a Novalog Flexpen to administer to Resident #26. During preparation of the insulin pen to administer insulin to the resident, Staff A was not observed to prime the insulin pen prior to then administering insulin to the resident. On 9/11/24 at 11:30 AM when queried about priming, Staff A explained if the bubble was at specific place in the pen, it was sufficient. Staff A explained this was what she had been told. When queried who told her that, Staff A responded the Assistant Director of Nursing (ADON). On 9/12/24 at 9:57 AM during an interview with the ADON about how staff instructed to prime, the ADON responded that would be with [DON name redacted], and [DON name redacted] did clinical with all the nurses. When queried if she gave it what would do, the ADON responded prime. On 9/12/24 at 12:26 PM when queried about priming a Novalog Flexpen, the Director of Nursing (DON) explained to prime with two units, inject that, and dial the dose. The DON acknowledged from prior experience always had to inject 2 units. The Facility Policy titled Insulin Administration Procedure dated 2/04 did not address insulin administration via pen. (continued on next page)

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of additional documentation provided by the DON titled Novalog Flexpen (insulin apart injection) 100 units/mL (milliliter) revealed the following: Step 3 Perform An air shot. For each injection: 1. Select a dose of 2 units. 2. Take off the outer needle cap (save it) and inner needle cap (throw it away) 3. With the pen pointing up, tap the insulin to move the air bubbles to the top. 4. Press the button all the way in and make sure insulin comes out of the needle. a. Repeat up to two more times with the same needle if needed. b. If insulin does not come out after three times, change the needle and try again. c. If insulin still does not come out after changing the needle, the pen may be broken.