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	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Hills Village IN Keokuk	20 Village Circle 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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, clinical record review, facility policy review and staff interview, the facility failed to ensure dietary staff served the correct portion size to meet the nutritional needs of the 9 residents (Residents #2, #3, #13, #20, #28, #30, #36, #56, #62) with a mechanical soft or puree diet order for one of one meal service observation. The facility reported a census of 65 residentsFindings include: 1. During an observation on 9/16/2025 at 10:04 AM, observation of the lunch meal preparation for mechanical soft and pureed diets revealed the following: Staff N, Cook, placed eight servings, four ounces each serving, of beef pot roast into a machine that mechanically ground the meat and added beef broth. The total amount of ground meat measured seven cups. Staff N, Cook, then placed five servings, 4 ounces of beef pot roast per serving, plus five pieces of bread with butter into the Robot Coup. Staff N added an unmeasured amount of beef broth to the mixture. Staff N ground the meat, bread, butter and brother mixture to a pureed texture. Staff N measured the total amount of the pureed mixture to equal 5 cups. The Dietary Manager reviewed the food service diet portion size chart and reported Staff N should use two #8 scoops (for a total of 8 ounces). At 11:49 AM, Staff N, Cook, began food service in the memory care unit and then served the lunch meal in the main dining room. Staff N used one #8 white scoop (4 ounces) to serve each of the residents with a mechanical soft diet their meat. Staff N served a total of six residents a mechanical soft diet, Residents #2, #3, #13, #28, #36, and #62. Staff N used one #8 white scoop (4 ounces) to serve each of the residents with a pureed diet their meat, bread and butter. Staff N served a total of three residents with pureed diets, Resident #20, #30 and #56. Staff N, [NAME] completed the lunch meal service at 12:22 PM. During an interview at the conclusion of the meal, Staff N confirmed she should have used two #8 scoops to serve the pureed meat and a #8 scoop plus a #10 scoop to serve the mechanical ground meat.During an interview on 9/16/25 at 12:42 PM, the Dietary Manager reviewed the food service diet portion size chart, and based on the number of servings added to the food processer and the amount of food measured after the cook ground the meat, reported Staff N should use a #8 (4 ounces) scoop and a #10 (3 ounces) to serve the residents with a mechanical soft diet.2. The Minimum Data Set (MDS) assessment for Resident #2, dated 7/20/25, included the following documentation: the resident had diagnoses of dementia, dysphagia (difficulty swallowing), and malnutrition; the resident required supervision or touch assistance with eating; the resident had a Brief Interview for Mental Status (BIMS) score of 1 out of 15, which indicated a severe cognitive impairment.Review of the Electronic Health Record (EHR) revealed:a. A General Order, dated 6/14/23, with a physician's order for a mechanical soft diet.b. The Care Plan, last revised 9/15/25, identified Resident #2 at risk for malnutrition and weight loss.3. The MDS assessment for Resident #3, dated 8/13/25, included the following documentation: the resident had a diagnosis of dementia; the resident had difficulty swallowing; the resident required partial to moderate assistance with eating; the resident had a BIMS score of 1 out of 15, which indicated a severe cognitive impairment.Review of the EHR revealed:a. A General Order, dated 7/23/25, with a physician's order for a mechanical soft diet.4. The MDS assessment for Resident #13, dated 7/16/25, included the following documentation: the resident had diagnoses of dementia, dysphagia, and malnutrition; the resident required set up assistance with (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

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	165396	A. Building B. Wing	09/18/2025

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	eating; the resident had a BIMS score of 5 out of 15, which indicated a severe cognitive impairment.Review of the EHR revealed:a. A General Order, dated 3/5/25, with a physician's order for a mechanical soft diet.b. Care Plan, last revised 8/13/25, identified the resident at risk for choking and weight loss.5.The MDS assessment for Resident #20, dated 8/13/25, included the following documentation: the resident had a diagnosis of dementia; the resident had difficulty swallowing; the resident was dependent on staff for eating; the resident had a severe cognitive impairment.Review of the EHR revealed:a. A General Order, dated 4/19/22, with a physician's order for a pureed diet.b. Care Plan, last revised 8/19/25, identified the resident at risk for choking and included a goal for the resident to maintain her weight.6.The MDS assessment for Resident #28, dated 8/27/25, included the following documentation: the resident had a diagnosis of dementia; the resident had difficulty swallowing; the resident required set up assistance with eating; the resident had a BIMS score of 0 out of 15, which indicated a severe cognitive impairment.Review of the EHR revealed:a. A General Order, dated 10/18/23, with a physician's order for a mechanical soft diet.7.The MDS assessment for Resident #30, dated 6/18/25, included the following documentation: the resident had a diagnosis of dementia; the resident had difficulty swallowing; the resident required set up assistance with eating; the resident had a BIMS score of 6 out of 15, which indicated a severe cognitive impairment.Review of the EHR revealed:a. A General Order, dated 7/7/25, with a physician's order for a pureed diet.8.The MDS assessment for Resident #36, dated 8/6/25, included the following documentation: the resident had a diagnosis of dementia; the resident required set up assistance with eating; the resident had a BIMS score of 1 out of 15, which indicated a severe cognitive impairment.Review of the EHR revealed:a. A Dietary progress note, dated 9/12/25, revealed [Name redacted, Resident #36] will follow a mechanical soft diet with a plate guard at all meals.b. Care Plan, last revised 9/12/25, identified the resident at risk for choking and weight loss.9. The MDS assessment for Resident #56, dated 7/16/25, included the following documentation: the resident had a diagnosis of Alzheimer's dementia; the resident had difficulty swallowing; the resident was dependent on staff for eating; the resident had a severe cognitive impairment.Review of the EHR revealed:a. A General Order, dated 2/21/24, with a physician's order for a pureed diet.b. Care Plan, last revised 7/22/25, identified the resident at risk for choking and weight loss.10. The MDS assessment for Resident #62, dated 7/30/25, included the following documentation: the resident had a diagnosis of Alzheimer's dementia; the resident had difficulty swallowing; the resident was dependent on staff for eating; the resident had a severe cognitive impairment.Review of the EHR revealed:a. A General Order, dated 4/28/25, with a physician's order for a mechanical soft diet.b. Care Plan, last revised 8/5/25, identified the resident at risk for choking and weight loss.Review of the facility policy, titled Food Service, dated 9/2010, revealed the food service staff were responsible for serving the food as ordered.

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	165396	A. Building B. Wing	09/18/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on meal services observation, facility policy review, review of the Federal Food and Drug Administration Code, and staff interview, the facility failed to ensure dietary staff served food under sanitary conditions for one of one meal service observations. The facility reported a census of 65 residents.Findings include:During an observation on 9/16/25 at 11:49 AM, Staff N, Cook, uncovered the pans on the steam table in the memory care dining unit, gloved, uncovered plates, and served the lunch meal to residents in the memory care unit. At 12:02 PM, Staff N completed the lunch service in the memory care unit. While keeping the same pair of gloves on, Staff N covered all of the food pans with lids, unplugged the electric cord for the steam table cart, picked the electric cord off the floor, wound the cord the up and placed the cord on the bottom of the steam table. Staff N then pushed the steam table cart to the main dining room. Staff N kept the same pair of gloves on and served the lunch meal to residents in the main dining room. During the main dining service, Staff N was observed to touch her gloves with some of the food she scooped onto the plates and she was observed to place food on the areas of the plate wear her unclean gloves had touched. On 9/16/2025 at 12:42 PM, the Dietary Manager reported they served a total of 32 residents in the main dining room and confirmed Staff N, Cook, should have changed gloves and washed her hands prior to serving food in the main dining room. The facility policy, titled Food Service, dated 9/2010, identified the food service staff were responsible for serving the food. The Food and Drug Administration (FDA) Food Code, dated 2017, identified under section 2-301.14 the following: food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including, but not limited to, after handling soiled equipment or utensils; during food preparation; as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and, after engaging in other activities that contaminate the hands.

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	165396	A. Building B. Wing	09/18/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review, and staff interviews the facility failed to ensure staff transferred a resident in a dignified manner for 1 of 1 resident (Resident #18) reviewed for dignity. The facility reported a census of 65 residents.Findings include: Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 scored a 2 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated a severe cognitive impairment. The MDS indicated the resident had a bilateral lower extremity impairment and used a wheelchair. The MDS indicated the resident required partial/moderate assistance with sitting to standing; and dependent with chair/bed to chair transfer. The MDS list of diagnoses included non-Alzheimer's dementia and unspecified osteoarthritis, unspecified site.Review of Care Plan dated 8/19/25, revealed a Focus area of Resident Care Information. Interventions included Safe Resident Handling Procedures-Transfer method with assist x 1 manual stand aide for all transfers, date 5/13/24; and wheelchair for mobility, dated 4/21/25. The Care Plan also included a Focus area, dated 8/29/25, for resident being at risk for falling related to dementia, macular edema, atrial fibrillation, incontinence, unsteady gait, history of falling . Interventions included in part, assist x1 with manual stand aid for all transfers, dated 3/25/25 indicated assist x1 with manual stand aid for all transfers During an observation on 9/15/25 at 8:37 AM, Staff C, Certified Nurse Aide (CNA) transported Resident #18 in the non-mechanical stand aid from the dining room table to Resident #18's room. Resident #18 sat at the dining room table on the opposite side of Resident #18 room. During an observation on 9/15/25 at 12:50 PM, Staff C, CNA used the non-mechanical stand aid to transport Resident #18 to her room from the dining room. During an observation on 9/16/25 at approximately 8:30 AM, Staff C, CNA helped assist Resident #18 onto the non-mechanical stand aid and transported Resident #18 from the dining room to Resident #18 room. On 9/16/25 at 12:36 PM, Staff C, CNA assisted Resident #18 onto the non-mechanical stand aid. Staff C asked Resident #18 multiple times to stand, and eventually Resident #18 stood up. As Staff C transported Resident #18 to her room, Staff C told Resident #18, she couldn't be sleeping when Resident #18 was being pulled to her room, because Resident #18 needed to hold onto the bar. Staff C reminded Resident #18 a few times to stay awake and Staff C pulled her to her room. During an interview on 9/17/25 at 1:23 PM, Staff A, CNA queried on using the non-mechanical stand aid to transfer Resident #18 to her room, and Staff A stated she never saw anybody do it. Staff A asked why she wouldn't transfer Resident #18 from the dining room to Resident #18 room, and Staff A stated she thought it could be a dignity or safety concern. During an interview on 9/17/25 at 1:38 PM, Staff B, CNA queried if she ever transported Resident #18 from the dining room table to Resident #18 room using the non-mechanical stand aid and Staff B stated she did. Staff B asked the reasoning for it, and Staff B stated it had just become a pattern, and everyone did it. During an interview on 9/17/25 at 3:09 PM, Staff C, CNA queried if she used the non-mechanical stand aid to transport Resident #18 to her room and Staff C stated yes. Staff C asked the reason behind it and Staff C stated because the rooms were so close. Staff C stated when Staff C took Resident #18 to the shower, Staff C would put her in the wheelchair instead of using the non-mechanical stand aid. Staff C asked about the transfer yesterday after lunch and Staff C stated Resident #18 slept at the dining room table at times, and sometimes Resident #18 will close her eyes when Staff C transports Resident #18 to her room, but Resident #18 never let go of the bar.During an interview on 9/18/25 at 11:40 AM, Staff B, CNA queried if she had any dignity or safety concerns with transporting Resident #18 the non-mechanical stand aid and Staff B stated more of a dignity concern because having her on the stand while other residents and family can see Resident #18 transported across the room. During an interview on 9/18/25 at 12:43 PM, the Director of Nursing (DON) informed of Resident #18 being transferred to her room using the non-mechanical stand aid and the DON stated she thought Resident #18 should have been (continued on next page)

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	165396	A. Building B. Wing	09/18/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transported in Resident #18 wheelchair. The DON confirmed it was a dignity concern because with the distance, Resident #18 would be visible to the family and residents and it would stand out. The DON confirmed the non-mechanical stand aid needed to change position or for a short transfer, not wheeled across the room. Review of the undated facility policy, titled Resident Rights revealed the following statement: A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

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	165396	A. Building B. Wing	09/18/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on clinical record review, review of facility policy, staff, resident and resident representative interview, the facility failed to ensure the resident and the resident's representative were included in the care plan process for 1 of 1 resident sampled (Resident #4) for care plans. The facility reported a census of 65 residents. Findings include:The Minimum Data Set (MDS) assessment for Resident #4, dated 8/20/25, included the following documentation: the resident had diagnoses of heart failure, respiratory failure, cognitive communication deficit, and malnutrition; the resident had upper and lower body impairments bilaterally, utilized a wheelchair for mobility, and was dependent on staff for toileting hygiene and transfers; the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 (indicative of a moderate cognitive impairment). On 9/16/25 at 8:57 AM, Resident #4 reported not being aware of being involved in the care planning process and was not sure that his family was involved in the process. Resident #4 reported his upper dentures were wore out and in need of repair or replacement. Resident #4 explained the problem with his dentures made it difficulty to eat. The resident was unsure if the facility was aware. He was not sure who he said something to about his dentures, or what was being done about it. On 9/17/25, review of the clinical record for Resident #4 revealed the following: a. The MDS assessment list included documentation of an admission assessment, dated 11/15/24, three quarterly assessments, dated 2/15/25, 6/18/25 and 8/20/25, and one significant change in condition assessment, dated 4/22/25. b. The facility document, titled Care Conference Report (care plan meeting list), included documentation of two care conferences, dated 11/18/24 and 12/9/24. The care conference meetings included documentation that both the resident and the resident's family participated in the meetings. The clinical record lacked documentation of a care conference, resident or family participation in the care planning process for the quarterly MDS assessments and significant change in condition MDS assessment. The clinical record lacked documentation the resident and his family had been invited to any care plan meetings. c. A facility document, titled General Order, dated 4/4/25, included a signed physician order written by Staff E, Licensed Practical Nurse (LPN), for the facility staff to make an appointment for Resident #4's dentures. The clinical record lacked any other documentation in relation to Resident #4 needing an appointment for his dentures. d. The facility document for Resident #4, titled Care Plan, and last revised 9/15/25, included care plan concerns related to the resident being at risk for weight loss and at risk for choking due to dysphagia (difficulty swallowing). The care plan did not identify the resident's concern with needing his dentures fixed. On 9/17/25 at 10:31 AM, during an interview, the family member designated as a Power of Attorney (POA) for Healthcare decisions reported not getting invited to any care conferences for Resident #4 since December 2024. The POA reported that they would attend the care conference meetings if they had been invited. The POA was unaware that Resident #4 had reported problems with his dentures and reported relying on facility staff to talk care of the resident's dental and physical health appointments. On 9/17/25 at 11:04 AM, Staff E, LPN, thought the resident was having problems with his upper dentures, and she recalled Resident #4 wanted to get his dentures fixed. She recalled getting an order for the resident to get his dentures fixed. Staff E explained when the staff received a physician order to set up an appointment, they filled out a transportation form and sent the form to Staff H, Transportation Aide. Staff H made all the resident appointments outside of the facility and provided transportation. Staff E reported she filled out a request for Resident #4 for his dentures. On 9/17/25 at 11:28 AM, the Assistant Director of Nursing (ADON)/MDS Coordinator reported she was responsible for the completion of all MDS assessments and care plans. The ADON/MDS Coordinator reported being responsible for setting up the care conference meetings for residents and sending invitations to residents and their family members; she did not keep a copy of the invitations. The ADON/MDS Coordinator reported she put a note in the clinical record under progress notes if the resident or their family member chose not to (continued on next page)

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	165396	A. Building B. Wing	09/18/2025

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River Hills Village IN Keokuk	20 Village Circle Keokuk, IA 52632

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	participate in the meetings. The ADON/MDS Coordinator explained they held care conference meetings for residents with any MDS assessment, including a significant change in condition MDS and quarterly MDS assessments. The ADON/MDS Coordinator reviewed the clinical record for Resident #4 and confirmed the resident had not had a care conference meeting, did not have documentation of an invitation to a meeting, and did not have documentation of a refusal to attend a care conference meeting. The ADON/MDS Coordinator explained she did not know what happened. On 9/17/25 at 11:35 AM, the ADON/MDS Coordinator reported she would include any dental concerns a resident or family member identified in the resident's care plan if she was aware of the concern. The ADON/MDS Coordinator reported she had not been aware of the dental concern for Resident #4. On 9/17/2025 at 11:39 AM, Staff H, Transportation Aide, reported Resident #4 had been on the waiting list for the College of Dentistry to get his dentures fixed since April 2025. Review of the facility policy, titled Care Plan Policy, dated 6/1/2022, revealed the comprehensive care plan would be prepared by an interdisciplinary team, that included, but was not limited to the resident and the resident's representative. The care plan would include the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. On 9/18/25 at 2:30 PM, the Administrator reported being aware of Resident #4's denture concerns. The Administrator reported she had spoken with the resident's other POA/family member regarding the resident's dentures. The Administrator reported the POA/family member the Administrator spoke with was considered the person that the facility called and spoke with first regarding any concerns with the resident. The Administrator explained the primary POA took the resident out for lunch every week, and the Primary POA had reported the Resident voiced concerns regarding his dentures during the those weekly lunch visits. The Administrator further explained the lack of providers for denture care that took the resident's insurance.

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	165396	A. Building B. Wing	09/18/2025

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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. Based on clinical record review, resident interview, observation, staff interview and policy review, the facility failed to following professional standards of practice regarding the provision of wound care documentation and treatment for 1 of 1 residents sampled (Resident #4) with a pressure ulcer wound. The facility reported a census of 65. Findings include:Review of the Minimum Data Set (MDS) assessment for Resident #4, dated 8/20/25, revealed a list of diagnoses which included heart failure, respiratory failure, and malnutrition. The MDS identified the resident with bilateral upper and lower body impairments, utilized a wheelchair for mobility, and dependent on staff for toileting hygiene and transfers. The Brief Interview for Mental Status (BIMS) score of 12 out of 15 identified Resident #4 with a moderate cognitive impairment.Review of the Care Plan, last revised 9/15/25, identified Resident #4 at risk for pressure ulcers related to decreased mobility, generalized muscle weakness, chronic obstructive pulmonary disease, oxygen use, indwelling catheter, admitted with Stage 3 (wound with a full loss of skin layer with the layer of fat exposed) pressure injuries (wound resulting from pressure, friction and/or moisture) to the left buttock, chronic kidney disease, diabetes, and mild protein-calorie malnutrition. The Care Plan included interventions related to mitigating the risk of the development of pressure ulcers including pressure relieving devices, skin assessment and turning and repositioning the resident. The facility document, titled Prescription Order, dated 6/30/25, included a physician order for the topical application of Miconazole antifungal cream 2 percent mixed with Triad cream and applied daily to coccyx, buttock and right hip area daily until healed.Review of the September 2025 Treatment Administration History for the time period of 9/1/25 to 9/17/25, identified a scheduled treatment to apply a Miconazole and Triad cream mixture to the coccyx, buttock and right hip daily between 5:00 AM and 7:00 AM. The Treatment Administration History included documentation Staff D, Licensed Practical Nurse (LPN), applied the treatment on 9/15/25 and 9/16/25, and Staff I, Registered Nurse (RN) applied the treatment on 9/17/25. During an interview on 9/16/25 at 8:57 AM, Resident #4 reported he had a sore on his bottom. Resident #4 reported nursing staff were performing wound care on his sore bottom, and he had a lot of pain with the wound.During an observation on 9/17/25 at 7:19 AM Staff D, LPN, performed wound care on Resident #4's buttock and scrotum area. Staff D also assisted Staff J, Certified Nursing Aide (CNA) perform personal cares which included incontinence care during the observation. During the course of applying wound care treatment, Staff D, LPN, measured a total of 4 open wounds; one upper right outer buttock wound measured 2.6 centimeters (cm) in length by 1.6 cm in width, a second right upper buttock wound measured 0.5 cm in length and 0.5 cm in width, a mid-lower right buttock wound measured 2.5 cm in length and 1.5 cm in width, and a wound to the back side of the scrotum measured 1cm in length and 0.5 cm in width. Observation revealed all four wounds had a shallow depth measurement of 0.1 cm approximately. Staff D, LPN, reported the wounds had all opened today (9/17/25). Staff D, LPN, applied the Miconazole and Triad cream mixture to the wound areas. Review of the electronic health record (EHR) revealed the following:a. A Nursing note, entered on 9/8/25 at 12:56 PM, Treatment applied to buttocks, blanchable (a reddened area that turned white when pushed on and indicative of area that had blood flow) light pink erythema (redness).b. A Nursing note, entered on 9/10/25 at 5:28 PM, Treatment applied to buttocks, blanchable light pink erythema.c. A Nursing note, entered on 9/12/25 at 1:28 PM, Treatment applied to buttocks, blanchable light pink erythema.d. A Nursing note, entered on 9/14/25 at 9:48 PM, Treatment applied to bottom, blanchable . Review of the EHR revealed no further documentation related to the condition of Resident #4's buttocks.During an interview on 9/17/2025 at 8:55 AM, Staff D, LPN, reported Resident #4's wounds had all been reddened, a darker pink in color, blanchable and not open on 9/15/25 and 9/16/25. Staff D, LPN, explained nursing staff did not document wound measurements on wounds that were not open. During an interview on 9/17/2025 at 1:27 PM, Staff K, CNA, reported she did work on 9/16/25 with Resident #4 during the day shift (6:00 AM to 2:00 PM). Staff K reported she informed Staff D, LPN of open areas on Resident (continued on next page)

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	09/18/2025

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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	#4 right buttocks during the 9/16/25 shift. During an interview on 9/17/2025 at 2:05 PM, Staff L, CNA, confirmed she worked second shift on 9/16/25 (2:00 PM to 10:00 PM) and provided personal cares to Resident #4. Staff L reported Resident #4 had at least one open area on his buttocks that was leaking fluid. Staff L, CNA, reported she told Staff F, RN, about the wound. Staff L, CNA, explained Staff F, RN, gave her some white cream in a medicine cup to put on the buttock wound. Staff L, CNA, reported she applied the cream, but did not know what the cream was that she applied. During an interview on 9/17/25 at 2:20 PM, Staff F, RN, reported he had worked second shift on 9/16/25. Staff F, RN, reported the wounds on Resident #4 were not open until Staff D, LPN, discovered them today (9/17/25). When asked if Staff L, CNA, had told him that the resident had an open wound on the resident's buttock that was leaking on 9/16/25 during second shift, Staff F, RN, confirmed Staff L, CNA, had told him about the wound. Staff F, RN, reported he had assessed Resident #4's buttocks on 9/16/25. Staff F reported he found one open wound on the lower buttocks area, but did not see the wound leaking. Staff F, RN, reported none of the upper right buttock or scrotum wounds were open on 9/16/25. Staff F, RN, reported he put Triad cream in a cup and gave to Staff L, CNA, to apply to the wound on 9/16/25. During an interview on 9/17/2025 at 2:24 PM, the Director of Nursing (DON) reported Staff D, LPN, found the wounds on Resident #4 today (9/17/25). The DON was unaware Resident #4 had at least one open wound on 9/16/25 during first and second shift. The DON reported the nurse should have documented the open wound, physician notification and notification of the Resident's Power of Attorney (POA) when the nurse discovered the wound. The DON reported she was going to talk with her staff and find out what happened. Review of the EHR revealed a Resident Progress Note, date 9/16/25 8:31PM (Recorded as a Late Entry on 9/17/25 2:50 PM) Upon entering room CNA were changing resident. Noted small stage 2 pressure right lower buttock 0.5 (cm in length) x 0.5 (cm in width). Slight drainage noted serosangous (serosanguineous, a watery, blood-tinged fluid). Treatment applied as ordered to entire area. NP (nurse practitioner) and POA notified. During an interview on 9/17/2025 at 3:33 PM, Staff L, Advanced Registered Nurse Practitioner (ARNP) stated she had a message from a nurse last night (9/16/25) around 8:31 PM regarding Resident #4 with an open buttock pressure ulcer. Staff L reported she did not change wound care orders and planned on coming to the facility to assess the resident herself later in the evening on 9/17/25. During an interview on 9/18/2025 at 9:33 AM, the DON she expected nurses would apply physician ordered wound care treatments, not the CNAs. During an interview on 9/18/2025 at 10:40 AM Staff I, RN, confirmed she worked 6:00 PM on 9/16/25 to 6:00 AM on 9/17/25 and that she applied the morning Miconazole and Triad cream mixture to Resident #4's buttock. Staff I reported that when she assessed Resident #4's buttocks area on 9/17/25, there was a large effected area that appeared macerated (softened skin, wrinkly in appearance), sore, dark red in color. Staff I reported the resident did have open wounds. Staff I reported she did not document the wounds, and could not state why. Staff I explained that she should have documented the assessment of the wounds in a progress note, notified the physician and opened an event documentation to track the wound. Review of the facility policy, titled Pharmaceutical Procedures, dated 1/5/23, revealed nursing staff were responsible for administering medications as ordered by the physician. The facility policy, titled Wound Care, dated 10/16/24, included directions to staff to follow physician's orders for wound care, document wound care with each treatment and no less than daily, open an event in the electronic health record for documentation on the wound. Wound documentation should include any changes in wound and any other pertinent observations.