STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING KK on 9/22/14	C 08/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 9/1/14 Investigation of complaint # 49206-C resulted in the following deficiency.	F 000		

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

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.

POC accepted 9/22/14 VS minutes

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0580	A. BUILDING: _____ B. WING _____	C 08/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503

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N 101	50.7(1) 481- 50.7 (10A,135C) Additional notification. 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(1) Of any accident causing major injury. a. " Major injury " shall be defined as any injury which: (1) Results in death; or (2) Requires admission to a higher level of care for treatment, other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a " major injury " based upon the circumstances of the accident, the previous functional ability of the resident, and the resident ' s prognosis. b. The following are not reportable accidents: (1) An ambulatory resident, as defined in rules 481-57.1(135C), 481-58.1(135C), and 481-63.1(135C), who falls when neither the facility nor its employees have culpability related to the fall, even if the resident sustains a major injury; or (2) Spontaneous fractures; or (3) Hairline fractures. This Statute is not met as evidenced by: Based on record review and staff and family interviews, the facility failed to notify the Iowa Department of Inspections and Appeals of an	N 101		

DEPARTMENT OF INSPECTIONS AND APPEALS

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	IA0580	A. BUILDING: _____ B. WING _____	C 08/12/2014

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N 101	Continued From page 1 accident causing major injury which required hospitalization and a higher level of care for treatment (Resident #4). The facility identified a census of 94 residents. Findings include: 1. Resident #4 had a Minimum Data Set (MDS) assessment, with a reference date of 7/20/14. The MDS identified Resident #4 had diagnoses that included non-Alzheimer ' s dementia, glaucoma, arthritis, osteoporosis and lumbago (pain in the lower back). The assessment revealed the Resident did not have a BIMS (brief interview for mental status) due to cognitive deficits. The MDS reflected the resident used a walker and wheelchair for mobility and required one staff person to supervise the resident when ambulating in the resident ' s room, corridor or on and off of the unit. The resident required limited assistance of 1 staff person for transferring. The Care Plan, initiated on 5/2/14 identified the resident had impaired cognitive function/dementia or impaired thought processes in regards to dementia. The approach interventions directed staff that the resident needed supervision. The Care Plan identified a problem with activities of daily living related to impaired mobility and incontinence and hard of hearing. The problem was initiated on 4/29/14. The approach interventions reflected the resident could ambulate with a walker and 1-2 staff to assist the resident and used a wheelchair with staff assistance to propel. The Progress Notes dated 7/20/14 at 2:32 p.m. reflected Resident #4 ' s Wanderguard was located on the resident ' s walker. An alarm sounded and staff responded at the time of the accident. Resident #4 laid on the street side of the side walk. The resident had 2 wheels of the walker on the sidewalk. The vehicle van began to back up and the van hit the side of the resident ' s	N 101		

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 101	Continued From page 2 walker with the sliding door. The resident went down to the ground and hit the back of head and right walker on the cement. A staff person applied pressure to the back of the head until an ambulance arrived. The resident was transferred to the emergency room and due to head trauma was later sent to another hospital for evaluation and treatment. The Iowa Department of Transportation Investigation Report revealed the van was backing up in a parking lot at slow speed and struck a pedestrian. As a result of the impact, the pedestrian fell down and struck her/his head on the pavement. The pedestrian was walking, utilizing a walker, next to the side walk on the parking lot side of the curb. The hospital emergency room report dated 7/20/14 at 2:20 p.m. revealed upon arrival to the hospital, the resident was semi-alert and noted to have a laceration to the posterior [back] of the head. The resident vomited copious amounts. The resident voiced non-descriptive neck pain and bleeding from the right elbow laceration. The physician admitted the resident into the intensive care unit for neurological monitoring. The resident wore a C collar brace for the neck area. The Progress Notes dated 7/23/14 at 10:41 p.m. reflected the resident was readmitted into the facility on 3:30 p.m. from the hospital with a diagnosis of a T-12 (Thoracic Vertebra) fracture. On 8/11/14 at 2:23 PM, Staff AA, certified nursing assistant (CNA) was interviewed and confirmed Resident #4 did not have a Wanderguard on and stated "oh no that's very bad." Staff AA stated Resident #4 got outside unattended and was backed into by a car. On 8/11/14 at 2:25 PM the facility Director of Nursing (DON) confirmed Resident #4 wandered outside the facility unattended by staff and a van backed into him/her. The DON stated Resident	N 101		

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 101	Continued From page 3 #4 was transported to an area hospital and admitted to the ICU (Intensive Care Unit). On 8/11/14 at 4:20 p.m. the DON stated the facility did not report the incident to the Department of Inspections and Appeals because the patient could ambulate independently. On 8/11/14 at 4:22 PM the facility Administrator confirmed the facility did not report the incident to the Department of Inspections and Appeals because the resident ambulated independently outside and the van that struck Resident #4 was not owned by the facility so they [the facility] determined the facility was not culpable.	N 101		

Risen Son Christian Village
3000 Risen Son Boulevard
Council Bluffs, IA

28 August 2014

Please accept this Plan of Correction as our Credible Allegation of Compliance with the state deficiency issued in conjunction with a complaint survey conducted July 31 and August 11-12, 2014; the Deficiency Statement (A13R11) was received August 26, 2014. The deficiency cited will be corrected by September 1, 2014.

Plan of Correction

Deficiency cited will be corrected by September 1, 2014.

N101 50.7(1): Additional Notification

Correct the deficiency as it relates to the individual
Resident #4 moved from the Long Term Care section of the facility to the Assisted Living Wing 8-23-14.

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How we will act to protect residents in similar situations
Facility will continue to follow its practice of reviewing each resident incident as it occurs to determine if it meets the reporting criteria of 50.7(1) and reporting those incidents meeting the criteria.

Measures to be taken or systems to be altered to ensure that the problem does not recur
Facility will continue to follow its practice of reviewing each resident incident as it occurs to determine if it meets the reporting criteria of 50.7(1) and reporting those incidents meeting the criteria. In any situation in which it is unclear whether or not the criteria of 50.7(1) apply, we will err on the side of over-reporting.

How to monitor performance to make sure solutions are permanent
Resident incidents, including those that are reportable, will continue to be reviewed as they occur and monthly in the facility QA meetings.

Greg E. Witte, Administrator
Risen Son Christian Village
8-28-14