IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
52148-I

April 2, 2015

Ms. Amanda Conway, AL Coordinator
Risen Son Christian Village
3000 Risen Son Blvd.
Council Bluffs, IA 51503

RE: Final Recertification & Complaint/Incident Investigation Report, Risen Son Christian Village, Council Bluffs, Iowa

Dear Ms. Conway:

Enclosed is the **Final Recertification & Complaint/Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following an investigation by DIA on **March 23 & 24, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Program policies and procedures, Staffing, Evaluation of Tenant, Service Plans, Dementia Specific Education for Personnel and Transportation.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

Enclosed you will find the Assisted Living Program Certificate **S0200** with effective dates of **November 12, 2014** through **November 11, 2016.**

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 5 Number of tenants with cognitive disorder: 18 Total Population of Program at time of on-site: 23 TOTAL census of Assisted Living Program: 23 The following regulatory insufficiencies were cited during the Recertification and investigation of Incident #52148-I.	A 000		
A 008	481-67.2(1)e Program Policies and Procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. 67.2(1) The program ' s policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program ' s building or on the premises that affect tenants shall be reported as incidents. This REQUIREMENT is not met as evidenced by: (Incident #52148-I)	A 008		

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
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 008	Continued From page 1 Based on tenant file reviews, an incident report was not completed for an unusual occurrence within the Program's premises. Per review of Tenant #1 and #2's files, an incident occurred and was reported by staff but an incident report was not completed. 1. Tenant #1, a 92 year old, was admitted on 1-8-15 and diagnoses included: hypothyroidism, hyperlipidemia, atrial fibrillation, mitral regurgitation, glaucoma, hard of hearing, congestive heart failure, hypertension, pain, constipation and history of falls. (The Program did not complete a Global Deterioration Scale (GDS) rating) According to Nurse's Notes dated 3-4-15 at 4:30 p.m., staff notified the nurse Tenant #1's door was locked and upon entering the room, Tenant #1 was standing in front of Tenant #2, who was sitting on the sofa. Tenant #1 had pants undone and belt was open. When asked what was going on, Tenant #1 stated they were just talking. When the nurse arrived in the room, Tenant #1 was sitting in a recliner, clearly winded with pants and belt fastened. Tenant #1 stated nothing sexual was going on and Tenant #1 and Tenant #2 were visiting. An investigation was started. The Program did not complete an incident report for the unusual occurrence within the Program. 2. Tenant #2, a 73 year old, was admitted on 7-1-14 and diagnoses included: benign essential hypertension, constipation, dementia and history of obstructive sleep apnea syndrome. (The Program did not complete a GDS rating) According to Tenant #2's Nurse's Notes dated 3-4-15 at 4:00 p.m., the nurse was notified by staff Tenant #2 had been found in Tenant #1's	A 008		

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
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 008	Continued From page 2 room. Tenant #2 was sitting on the sofa fully clothed and Tenant #1 was standing in front of Tenant #2 with belt undone, zipper and snap open. Tenant #2 was immediately removed from the room and taken to the nurses station. When Tenant #2 was asked what happened, Tenant #2 stated Tenant #1 asked Tenant #2 to "take a hold of it and go like this" as Tenant #2 made a jerking motion. The Program did not complete an incident report for the unusual occurrence within the Program.	A 008		
A 061	481-67.9(4)d Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants ' health, cognitive or functional status. This REQUIREMENT is not met as evidenced by: (Recertification) Based on review of tenant files, staff interview and nurse delegation documents, delegations were not completed for certified staff regarding training for different types of braces being utilized by tenants.	A 061		

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
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 061	Continued From page 3 Per review of Tenant #3 and Tenant #4's files, staff assisted Tenants #3 and #4 with braces without proper training for the devices used. 1. Tenant #3, an 84 year old, was admitted on 7-23-14 and diagnoses included: Alzheimer's, hypertension, gastric esophageal reflux disease, hyperlipidemia, benign prostatic hypertrophy, osteoarthritis, osteoporosis, angrodysplasia of colon, hypoxemia and osteopenia. (The Program did not complete a GDS rating) According to Physician's Orders dated 7-24-14, Tenant #3 may remove collar at night for sleeping, collar to be worn when up and ambulating. According to Tenant #3's service plan dated 7-23-14, Tenant #3 had limited range of motion due to recent fracture of C-1. Tenant #3 wore a C collar. 2. Tenant #4, a 92 year old, was admitted on 2-11-15 and diagnoses included: vertebrae fracture, anemia, hypertension, macular degeneration, osteoporosis, history of falls, Alzheimer's, hypothyroidism, glaucoma, urinary tract infection and osteoarthritis. (The Program did not complete a GDS rating) According to Physician's Orders dated 2-11-15, Tenant #4 was to wear a TLSO brace on at all times while ambulating due to fractured vertebrae. According to Tenant #4's service plan dated 2-11-15, Tenant #4 wore a soft back brace at all times while up. 3. On 3-24-15 at 3:30 p.m., the Assisted Living Coordinator (ALC) was interviewed and stated she had not delegated the use and application of the braces being used by Tenants #3 and #4. 4. A review of Certified Nurse Aide Documentation of Competency Assessment and Determination document did not reflect staff	A 061		

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
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 061	Continued From page 4 training for any types of braces.	A 061		
A 036	481-69.22(1) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant ' s functional, cognitive and health status prior to the tenant ' s signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant ' s eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant ' s mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional. This REQUIREMENT is not met as evidenced by: (Recertification) Based on review of tenant files, a cognitive evaluation was not completed using a scored objective tool. A GDS tool was not used at subsequent intervals when needed. Per review of Tenants #1 and #4s' files, the cognitive evaluation did not include a scored objective tool, nor was a GDS used when the cognitive evaluation indicated moderate cognitive	A 036		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 036	Continued From page 5 decline and risk. 1. Tenant #1, a 92 year old, was admitted on 1-8-15 and diagnoses included: hypothyroidism, hyperlipidemia, atrial fibrillation, mitral regurgitation, glaucoma, hard of hearing, congestive heart failure, hypertension, pain, constipation and history of falls. Prior to occupancy, functional, cognitive and health evaluations were completed on 1-7-15. A scored objective tool was not used as part of the cognitive evaluation, nor was a GDS tool completed when the cognitive evaluation indicated moderate cognitive decline and risk. 2. Tenant #4, a 92 year old, was admitted on 2-11-15 and diagnoses included: vertebrae fracture, anemia, hypertension, macular degeneration, osteoporosis, history of falls, Alzheimer's, hypothyroidism, glaucoma, urinary tract infection and osteoarthritis. Prior to occupancy, functional, cognitive and health evaluations were completed on 2-11-15. A scored objective tool was not used as part of the cognitive evaluation, nor was a GDS tool completed when the cognitive evaluation indicated moderate cognitive decline and risk.	A 036		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant ' s functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant ' s continued	A 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 037	Continued From page 6 eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: (Recertification) Based on review of tenant files, functional, cognitive and health evaluations were not completed with significant change. Per review of Tenant #1 and Tenant #4s' files, functional, cognitive and health evaluations were not completed for Tenant #1 and Tenant #4 when they experienced a significant change in condition. 1. Tenant #1, a 92 year old, was admitted on 1-8-15 and diagnoses included: hypothyroidism, hyperlipidemia, atrial fibrillation, mitral regurgitation, glaucoma, hard of hearing, congestive heart failure, hypertension, pain, constipation and history of falls. (The Program did not complete a GDS rating) According to Tenant #1's service plan dated 2-16-15, Tenant #1 had been agitated over the weekend and a current order for mixed drink was changed to one drink at 4:00 p.m. every day. An update to the service plan dated 2-28-15, indicated Tenant #1 at times, when in apartment, would have fly of pants open with genitals hanging out and at times even had removed bottom half of clothes. The service plan indicated on 2-28-15 a lock was	A 037		

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
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 037	Continued From page 7 placed on the apartment door and a key was given to Tenant #1 and to Tenant #1's family. Functional, cognitive and health evaluations were not completed with significant change. 2. Tenant #4, a 92 year old, was admitted on 2-11-15 and diagnoses included: vertebrae fracture, anemia, hypertension, macular degeneration, osteoporosis, history of falls, Alzheimer's, hypothyroidism, glaucoma, urinary tract infection and osteoarthritis. (The Program did not complete a GDS rating) According to a service plan update, dated 2-27-15, new orders were received for Ocuvite every morning, Aricept 5 mg every bedtime and one glass of wine per week and as needed. According to a service plan update, dated 3-9-15, Tenant #4 had an unwitnessed fall on 3-6-15. Skid socks to be on at bedtime and non-skid tape placed in front of toilet. According to a service plan update, dated 3-20-15, it indicated to discontinue the as needed Tramadol and start Tramadol 50 mg three times a day as scheduled. A new order was received on 3-23-15 to start Zofran for nausea and vomiting as needed. A 30 day update was completed on 3-11-15 ,with service plan notations as follows: Tenant #4 was oriented to self and at times, oriented to time; Tenant #4 had no complaints of pain or discomfort; Tenant #4 was to use a wheel chair for long distances; Tenant #4 was not independent in toileting and needed cues and reminders and Tenant #4 was not able to use the call light and needed cues and reminders. Functional, cognitive and health evaluations were not completed with significant change.	A 037		
A 086	481-69.26(3)a Service Plans 481-69.26(231C) Service plans.	A 086		

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
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 086	Continued From page 8 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant ' s occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: (Recertification) Based on review of tenant files, when a significant change occurred and the service plan was updated, the service plan was not signed and dated by all parties. Per review of Tenant #1 and Tenant #4s' files, significant changes occurred and were documented on the service plan. The service plan was signed by the nurse. The service plan was not signed by the tenant or the tenant's representative. 1. Tenant #1, a 92 year old, was admitted on 1-8-15 and diagnoses included: hypothyroidism, hyperlipidemia, atrial fibrillation, mitral regurgitation, glaucoma, hard of hearing, congestive heart failure, hypertension, pain, constipation and history of falls. According to Tenant #1's service plan dated 2-16-15, Tenant #1 had been agitated over the weekend and current order for mixed drink was changed to one drink at 4:00 p.m. every day. An update to the service plan dated 2-28-15, indicated Tenant #1, at times when in apartment, would have fly of	A 086		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0200	A. BUILDING _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 086	Continued From page 9 pants open with genitals hanging out and at times had removed bottom half of clothes. The service plan indicated on 2-28-15, a lock was placed on the apartment door and a key was given to Tenant #1 and to Tenant #1's family. A significant change triggered the review and update of the service plan. The service plan was signed by the nurse. The service plan was not signed and dated by Tenant #1 or Tenant #1's representative. 2. Tenant #4, a 92 year old, was admitted on 2-11-15 and diagnoses included: vertebrae fracture, anemia, hypertension, macular degeneration, osteoporosis, history of falls, Alzheimer's, hypothyroidism, glaucoma, urinary tract infection and osteoarthritis. (The Program did not complete a GDS rating) According to a service plan update, dated 2-27-15, new orders were received for Ocuvite every morning, Aricept 5 mg every bedtime and one glass of wine per week and as needed. According to a service plan update, dated 3-9-15, Tenant #4 had an unwitnessed fall on 3-6-15. Skid socks to be on at bedtime and non-skid tape placed in front of toilet. According to a service plan update, dated 3-20-15, indicated to discontinue the as needed Tramadol and start Tramadol 50 mg three times a day as scheduled. A new order was received on 3-23-15 to start Zofran for nausea and vomiting as needed. A 30 day update was completed on 3-11-15 with service plan notations as follows: Tenant #4 was oriented to self and at times, oriented to time; Tenant #4 had no complaints of pain or discomfort; Tenant #4 was to use a wheel chair for long distances; Tenant #4 was not independent in toileting and needed cues and reminders and Tenant #4 was not able to use the call light and needed cues and reminders. Significant changes triggered the review and update of the service plan. The nurse signed and	A 086		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 086	Continued From page 10 dated the service plan on 3-11-15, indicating it was a 30 day review. The service plan was not signed and dated by the tenant or the tenant's representative. Significant changes triggered the review and update of the service plan on 2-27-15, 3-9-15, 3-20-15 and 3-23-15 and were signed by the nurse. The service plan was not signed or dated by Tenant #4 or Tenant #4's representative.	A 086		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant ' s identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: (Recertification) Based on tenant file reviews, service plans were not individualized and did not indicated the tenant's identified needs and preferences for assistance. Per review of Tenant #3 and Tenant #4's service plans, the service plans did not include needs for placement of physician ordered braces and preferences for assistance with the braces. 1. Tenant #3, an 84 year old, was admitted on 7-23-14 and diagnoses included: Alzheimer's, hypertension, gastric esophageal reflux disease, hyperlipidemia, benign prostatic hypertrophy, osteoarthritis, osteoporosis, angrodysplasia of colon, hypoxemia and osteopenia. (The Program did not complete a GDS rating) According to	A 089		

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
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 089	Continued From page 11 Physician's Orders dated 7-24-14, Tenant #3 may remove collar at night for sleeping, collar to be worn when up and ambulating. According to Tenant #3's service plan dated 7-23-14, Tenant #3 had limited range of motion due to recent fracture of C-1. Tenant #3 wore a C collar. The service plan did not include directions on proper placement of the brace, how to remove the brace and care of the brace. 2. Tenant #4, a 92 year old, was admitted on 2-11-15 and diagnoses included: vertebrae fracture, anemia, hypertension, macular degeneration, osteoporosis, history of falls, Alzheimer's, hypothyroidism, glaucoma, urinary tract infection and osteoarthritis. (The Program did not complete a GDS rating) According to Physician's Orders dated 2-11-15, Tenant #4 was to wear a TLSO brace on at all times while ambulating due to fractured vertebrae. According to Tenant #4's service plan dated 2-11-15, Tenant #4 wore a soft back brace at all times while up. The service plan did not include directions on proper placement of the brace, how to remove the brace and care of the brace.	A 089		
A 092	481-69.26(4)d Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant ' s abilities and personal interests This REQUIREMENT is not met as evidenced by:	A 092		

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
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 092	Continued From page 12 (Recertification) Based on review of tenant files, the service plans were not individualized for tenants who were unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests. Per review of Tenants #1, #2, #3 and #4's service plans, the service plans were not individualized and tenants with dementia did not have planned and spontaneous activities based on their abilities and personal interest. 1. Tenant #1, a 92 year old, was admitted on 1-8-15 and diagnoses included: hypothyroidism, hyperlipidemia, atrial fibrillation, mitral regurgitation, glaucoma, hard of hearing, congestive heart failure, hypertension, pain, constipation and history of falls. According to Tenant #1's service plan dated 1-7-15, Tenant #1 liked all activities and liked music. The service plan was not individualized for Tenant #1 who could not plan own activities and did not include a listing of planned and spontaneous activities based on Tenant #1's abilities and personal interests. 2. Tenant #2, a 73 year old, was admitted on 7-1-14 and diagnoses included: benign essential hypertension, constipation, dementia and history of obstructive sleep apnea syndrome. According to Tenant #2's service plan dated 7-1-14, Tenant #2 enjoyed reading, car races and country music. The service plan was not individualized for Tenant #2 who could not plan own activities and did not include a listing of planned and spontaneous activities based on Tenant #2's abilities and personal interests.	A 092		

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
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 092	Continued From page 13 3. Tenant #3, an 84 year old, was admitted on 7-23-14 and diagnoses included: Alzheimer's, hypertension, gastric esophageal reflux disease, hyperlipidemia, benign prostatic hypertrophy, osteoarthritis, osteoporosis, angrodysplasia of colon, hypoxemia and osteopenia. According to Tenant #3's service plan dated 7-23-14, Tenant #3 like to watch golf and sports. The service plan was not individualized for Tenant #3 who could not plan own activities and did not include a listing of planned and spontaneous activities based on Tenant #3's abilities and personal interests. 4. Tenant #4, a 92 year old, was admitted on 2-11-15 and diagnoses included: vertebrae fracture, anemia, hypertension, macular degeneration, osteoporosis, history of falls, Alzheimer's, hypothyroidism, glaucoma, urinary tract infection and osteoarthritis. According to Tenant #4's service plan dated 2-11-15, Tenant #4 historically liked crossword puzzles and knitting. The service plan was not individualized for Tenant #4 who could not plan own activities and did not include a listing of planned and spontaneous activities based on Tenant #4's abilities and personal interests.	A 092		
A 093	481-69.26(4)e Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: e. Preferences, if any, of the tenant or the tenant ' s legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy.	A 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 093	Continued From page 14 This REQUIREMENT is not met as evidenced by: (Recertification) Based on review of tenant files, the service plans were not individualized to include preferences for nursing facility care, if the need for nursing facility care presented itself during the assisted living program occupancy. Per review of Tenants #1, #2, #3 and #4's files, services plans did not indicate Tenants #1, #2, #3 and #4s' choice of a nursing facility. 1. Tenant #1, a 92 year old, was admitted on 1-8-15 and diagnoses included: hypothyroidism, hyperlipidemia, atrial fibrillation, mitral regurgitation, glaucoma, hard of hearing, congestive heart failure, hypertension, pain, constipation and history of falls. According to Tenant #1's service plan dated 1-7-15, if Tenant #1 needed a higher level of care, Tenant #1 could transfer to the Program's nursing facility. Tenant #1 was not asked Tenant #1's choice of a nursing facility. 2. Tenant #2, a 73 year old, was admitted on 7-1-14 and diagnoses included: benign essential hypertension, constipation, dementia and history of obstructive sleep apnea syndrome. According to Tenant #2's service plan dated 7-1-14, if Tenant #2 needed a higher level of care, Tenant #2 could transfer to the Program's nursing facility. Tenant #2 was not asked Tenant #2's choice of a nursing facility. 3. Tenant #3, an 84 year old, was admitted on 7-23-14 and diagnoses included: Alzheimer's,	A 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 093	Continued From page 15 hypertension, gastric esophageal reflux disease, hyperlipidemia, benign prostatic hypertrophy, osteoarthritis, osteoporosis, angrodysplasia of colon, hypoxemia and osteopenia. According to Tenant #3's service plan dated 7-23-14, if Tenant #3 needed a higher level of care, Tenant #3 could transfer to the Program's nursing facility. Tenant #3 was not asked Tenant #3's choice of a nursing facility. 4. Tenant #4, a 92 year old, was admitted on 2-11-15 and diagnoses included: vertebrae fracture, anemia, hypertension, macular degeneration, osteoporosis, history of falls, Alzheimer's, hypothyroidism, glaucoma, urinary tract infection and osteoarthritis. According to Tenant #4's service plan dated 2-11-15, if Tenant #4 needed a higher level of care, Tenant #4 could transfer to the Program's nursing facility. Tenant #4 was not asked Tenant #4's choice of a nursing facility.	A 093		
A 121	481-69.30(1) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: (Recertification)	A 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 121	Continued From page 16 Based on review of staff files, Program personnel had not completed a minimum of eight hours of dementia-specific education and training within 30 days of employment or transfer to the Program. Per review of five staff files, Staffs A, B and C did not have a minimum of eight hours of dementia-specific education and training within 30 days of employment or transfer to the Program. Staff A, a CNA, transferred to the Program on 11-2-14. Staff A completed 1.5 hours of dementia-specific training on 11-4-14 and one hour of dementia -specific training on 11-5-14, for a total of 2.5 hours of training. Staff B, an LPN, transferred to the Program on 9-7-14. Staff B did not have any dementia-specific training within 30 days of transfer to the Program. Staff C, a CMA, transferred to the Program on 8-24-14. Staff C had 1.5 hours of dementia-specific training on 8-21-14 and one hour of dementia-specific training on 9-10-14, for a total of 2.5 hours of training. Staffs A, B and C did not have a minimum of eight hours of dementia-specific education and training within 30 days.	A 121		
A 147	481-69.33(6) Transportation 481-69.33(231C) Transportation. When transportation services are provided directly or under contract with the program: 69.33(6) The driver shall have a valid and	A 147		

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
	S0200	A. BUILDING: _____ B. WING _____	C 03/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE	3000 RISEN SON BOULEVARD CO 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) COMPLETE DATE
A 147	Continued From page 17 appropriate Iowa driver ' s license or commercial driver ' s license as required by law for the vehicle being utilized for transport. If the driver is licensed in another state, the license shall be valid and appropriate for the vehicle being utilized for transport. The driver shall meet any state or federal requirements for licensure or certification for the vehicle operated. This REQUIREMENT is not met as evidenced by: (Recertification) Based on review of transportation services, the Program's driver did not have a valid and appropriate Iowa driver's license or commercial license as required by law for the vehicle utilized for transport. Per review of Staff D's Iowa driver's license, Staff D did not possess the appropriate license as required by Iowa law. On 3-24-15, review of Staff D's driver's license indicated the license was a Class C, non-commercial license. The State of Iowa requires a Class D (Chauffeur's) license with endorsement 3, allowing non-commercial use of a vehicle when transporting less than 16 passengers.	A 147		

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

10 April 2015

This Plan of Correction is submitted as the facility's credible allegation of compliance with the statement of regulatory insufficiencies issued in conjunction with the Recertification survey of the Risen Son Assisted Living Program conducted March 23-24, 2015. The regulatory insufficiencies cited will be corrected by April 17, 2015.

Plan of Correction

A 008: Incident Report Not Completed

How the program will correct the insufficiency
Tenant #1 no longer resides at the facility.

Measures to be taken to ensure it does not recur
Incident reports will be completed on all accident/incidents as stated in the program's policies and procedures. Program Coordinator will review all unusual occurrences in the program to determine if an incident report needs to be completed

How we will monitor compliance
DON or designee will conduct random audits of occurrences to ensure that incident reports are completed as warranted. Any problems noted will be reported to facility Quality Assurance Committee for discussion and resolution.

Date completed
April 17, 2015.

A 061: Delegations Not Completed For Brace Training

How the program will correct the insufficiency
One-on-one training for braces with AL-DS staff will be provided by Program Coordinator. Coordinator will provide demonstration of how to apply and remove brace with return demonstration by staff required. Staff participating will sign a statement verifying their understanding of the instructions.

Measures to be taken to ensure it does not recur
Program Coordinator will review changes in equipment or other apparatus used by tenants to assure that delegation is completed for staff as warranted.

How we will monitor compliance
DON or designee will conduct random audits of tenant changes in equipment to assure that delegation is occurring appropriately. Any problems noted will be reported to facility Quality Assurance Committee for discussion and resolution.

Date completed
April 17, 2015.

A 036: Scored Objective Tool Not Used for Cognitive Evaluation

How the program will correct the insufficiency
Tenant #1 no longer resides at the facility. The Program will begin using the Standardized Mini-Mental State Examination (MMSE) in conjunction with the Global Deterioration Scale for tenants whose evaluation indicates moderate cognitive decline. Upon admission, the MMSE will be administered; the GDS will be administered at subsequent nurse reviews as warranted. For current tenants, the GDS will be done upon quarterly/annual nurse reviews or when a significant change occurs. For Tenant #4, the MMSE will be administered at next nurse review, with the GDS to follow as warranted at subsequent reviews.

Measures to be taken to ensure it does not recur
Program Coordinator will assure that appropriate objective tools are used for evaluating tenant cognitive status at admission, during regular nurse reviews and when a significant change occurs.

How we will monitor compliance
DON or designee will conduct random audits of tenant admissions and nurse reviews to assure that appropriate objective tools are being used for tenant cognitive evaluations. Any problems noted will be reported to facility Quality Assurance Committee for discussion and resolution.

Date completed
April 17, 2015.

A 037: Functional, Cognitive and Health Evaluations Not Completed with Significant Change

How the program will correct the insufficiency
Tenant #1 no longer resides at the facility. Functional, cognitive and health evaluations will be completed when a significant change occurs. For Tenant #4, a functional, cognitive and health evaluation will be completed if a significant change occurs.

Measures to be taken to ensure it does not recur
Change in condition schedule will be followed to assure all functional, cognitive and health evaluations are completed when a significant change occurs.

How we will monitor compliance
DON or designee will conduct random audits of tenant care documents to assure that the proper evaluations are being completed upon change of condition. Any problems noted will be reported to facility Quality Assurance Committee for discussion and resolution.

Date completed
April 17, 2015.

A 086: Service Plan Updates Not Signed and Dated by All Parties

How the program will correct the insufficiency
Tenant #1 no longer resides at the facility. The Service Plan of Tenant #4 will be signed by all parties at the next regular review.

Measures to be taken to ensure it does not recur
Program Coordinator will assure that Service Plan Updates are signed by all parties at 30-day and annual review, and when a significant change occurs.

How we will monitor compliance
DON or designee will conduct random audits of tenant service plan updates to assure that all parties have signed and dated them. Any problems noted will be reported to facility Quality Assurance Committee for discussion and resolution.

Date completed
April 17, 2015.

A 089: Service Plan Not Including Brace Care Directions

How the program will correct the insufficiency
The Service Plans of Tenants #3 and #4 were updated to include directions on proper placement, removal and care of the brace.

Measures to be taken to ensure it does not recur
Program Coordinator will review changes in equipment or other apparatus used by tenants to assure that service plans are updated as warranted to reflect the changes.

How we will monitor compliance
DON or designee will conduct random audits of tenant service plans to assure that appropriate updates are made when there are changes of equipment such as braces. Any problems noted will be reported to facility Quality Assurance Committee for discussion and resolution.

Date completed
April 17, 2015.

A 092: Service Plans Not Individualized for Activities

How the program will correct the insufficiency
Tenant # 1 no longer resides at the facility. The Service Plans of Tenants #2, 3, and 4 were updated to include a listing of planned and spontaneous activities based on their abilities and personal interests.

Measures to be taken to ensure it does not recur
Program Coordinator will review service plans of tenants who are unable to plan their own activities, to assure that the service plans are individualized based on abilities and personal interests.

How we will monitor compliance
DON or designee will conduct random audits of tenant service plans to assure that tenants who are unable to plan their own activities have service plans listing planned and spontaneous activities based on their abilities and personal interests. Any problems noted will be reported to facility Quality Assurance Committee for discussion and resolution.

Date completed
April 17, 2015.

A 093: Service Plans Not Noting Preference for Nursing Facility Care

How the program will correct the insufficiency
Tenant #1 no longer resides at the facility. The Service Plans of Tenants #2, 3, and 4 have been updated to include preference for nursing facility care.

Measures to be taken to ensure it does not recur
Tenant service plans will be updated quarterly and annually to include preference for nursing facility care. Upon admission, new tenants will have service plans that include preference for nursing facility care. Wording in the service plan template has been changed to reflect preference for nursing facility care.

How we will monitor compliance
DON or designee will conduct random audits of tenant service plans to assure that preference for nursing facility care is included. Any problems noted will be reported to facility Quality Assurance Committee for discussion and resolution.

Date completed
April 17, 2015.

A 121: Dementia Specific Education Not Completed Timely for Staff Working in the Program

How the program will correct the insufficiency
Since the recertification survey, Staff A, B and C have completed 6.5 hours of computer based training; one hour of hands-on training occurred in October of 2014, and another hour of hands-on training will take place 4-27-15.

Measures to be taken to ensure it does not recur
Program Coordinator will assure that 8 hours of Dementia Specific training is provided to employees within 30 days of hire or transfer to the Program.

How we will monitor compliance
Human Resources Director and DON or designee will conduct random audits of staff personnel files to assure that employees working in the Program or transferred to it have 8 hours of dementia specific training within 30 days. Any problems noted will be reported to facility Quality Assurance Committee for discussion and resolution.

Date completed
April 17, 2015.

A 147: Driver for Program Not Having Commercial License

How the program will correct the insufficiency
Program driver Staff D has obtained Class D (commercial) driver's license.

Measures to be taken to ensure it does not recur
Program Coordinator will ensure that any subsequent drivers employed by the Program have Class D license.

How we will monitor compliance
Facility Human Resources Director and Executive Director will assure that any future employees hired to work as drivers for the Program have the appropriate license.

Date completed
April 17, 2015.

Greg E. Witte, Administrator
Risen Son Christian Village
4-10-15