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
	S0053	A. BUILDING: _____ B. WING _____	03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HILLS VILLAGE	20 VILLAGE CIRCLE KEOKUK, IA 52632

(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	481-69 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. General Population Program Number of tenants without cognitive disorder: 26 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 26 TOTAL census of Assisted Living Program: 26 The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000	Preparation and/or execution of this Plan of Correction do not constitute admission or agreement by the provider to the allegations or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required under federal or state law. Plan of Correction next page.	
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: Based on interview and record review the Program failed to develop service plans that indicated tenants' identified needs for 3 of 3 tenant files reviewed (Tenants #1, #2 and #3). Findings follow: 1. Record review of Tenant #1's file revealed a	A 089		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather M Ballew — TITLE: Administrator — (X6) DATE: 4-3-17

4/6/17

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
	S0053	A. BUILDING: _____ B. WING _____	03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HILLS VILLAGE	20 VILLAGE CIRCLE KEOKUK, IA 52632

(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 1 fax indicating the temamt had a pressure area to the right buttock that measured 1.5 x 1.7 centimeters (cm) and was a stage II wound. A stage II pressure area to the left buttock measuring 0.5 x 0.5 cm was also noted. Staff were to continue the Calazime treatment and a pressure relieving cushion was ordered. An interview with the AL Director on 3-22-17 at 12:59 p.m. revealed the treatment for Tenant #1's wounds was Calazime three times daily and the gel cushion. One time per week the wounds were measured. Further record review revealed Tenant #1's service plan reflected a stage II wound on the right and left buttock, Calazime and the gel cushion. The service plan did not reflect the size of the wounds, treatment frequency and monitoring frequency of the size of the wounds. The service plan did not reflect the identified needs of Tenant #1. 2. Record review of Tenant #2's file revealed Tenant #2 had diagnoses including history of left hip fracture (12-2016) and osteoporosis. Progress Notes dated 2-22-17 indicated Tenant #2 complained of increased pain and swelling to the left hip/knee. According to Progress Notes dated 3-3-17 Tenant #2 was prescribed diclofenac 1% gel to the left hip and knee four times per day. An interview with the AL Director on 3-22-17 at 12:59 p.m. revealed Tenant #2 had the topical treatment prescribed for left hip and knee pain; however, Tenant #2 did not use it for the hip. Tenant #2's knee pain was a new onset and the topical gel was effective.	A 089	A089 Service Plans River Hills Village Assisted Living Staff was educated on 04/03/2017 the importance of a resident's service plan being individualized and indicate specific needs and/or preferences for assistance. Educational emphasis was placed on resident's who may need topical treatments for wounds and/or pain or have chronic conditions such as a UTI/low hemoglobin/blood pressure. Resident Service Plans were updated on 03/22/2017 to reflect individual needs/preferences and history of conditions/symptoms to alert staff to watch and report resident changes in condition to the Nurse. The Assisted Living Director and Administrator will audit 3 charts per week for 6 weeks and ongoing randomly to ensure compliance with service plans requirements.	

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
	S0053	A. BUILDING: _____ B. WING _____	03/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HILLS VILLAGE	20 VILLAGE CIRCLE KEOKUK, IA 52632

(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 2 Further record review revealed Tenant #2's service plan did not reflect the knee pain and the topical treatment. The service plan did not reflect the identified needs of Tenant #2. 3. Record review of Tenant #3's file revealed Tenant #3 had a diagnosis of anemia. Progress Notes dated 1-12-17 indicated Tenant #3 complained of urinary frequency but was unable to urinate. An order was received for a urinalysis with culture and sensitivity if indicated. Macrobid 100 milligrams, one tablet, by mouth, twice daily for five days and pyridium 200 mg, one tablet, by mouth three times daily for one day was ordered. Progress Notes dated 1-31-17 indicated Tenant #3 was out of the building for a blood transfusion and returned after supper. Progress Notes dated 2-27-17 indicated Tenant #3 was admitted with a low hemoglobin and had a blood transfusion. An interview with the AL Director on 3-22-17 at 12:59 p.m. revealed Tenant #3 had approximately three urinary tract infections (UTIs) in 15 months. Tenant #3 had two to three blood transfusions since she was the AL Director. Further record review revealed Tenant #3's service plan did not reflect the history of UTIs and antibiotic treatment or the blood transfusions and low hemoglobin. The service plan did not reflect the identified needs of Tenant #3.	A 089		