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 02/10/2021

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	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 19 Total Census of Program: 19 No regulatory insufficiencies were cited during the investigation of Complaint 91842 or the onsite infection control survey. The following regulatory insufficiencies were cited during the investigation of Complaint #94609-C:	A 000	√ 4/14/21	
A 003	481-67.2 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. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.	A 003	Plan of Correction is attached	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure the policy for incident reports was followed for 1 of 3 tenants reviewed (Tenant #1). Finding follows: Record review on 1/21/21 revealed an unsigned Incident/Accident Report dated 11/17/20 for Tenant #1. According to the report the writer found Tenant #1 in her bedroom inside the door. On 1/25/21 the Program Registered Nurse (RN) confirmed Staff A filled out, but did not sign, the form. When interviewed on 2/2/21 at 1:35 p.m. Staff A said she found Tenant #1 on the floor in her room but the tenant could not tell her what had happened. Staff A said she filled out an incident report and placed it in the bin. Further review revealed a nurse's note dated 11/18/20. The note included a notation of a discussion between the Program's Registered Nurse (RN) and the Hospice nurse regarding new findings of bruising. According to the note the RN was not aware of any new falls at this time. Record review on 2/2/21 revealed the Program's Policy for Accidents/Incidents date dated 12/20/19. According to the policy the Program should have documented a descriptive summary of the incident/accident including what happened, tenant response, intervention, responsible party notification and physician notification. The policy indicated the Program should have reviewed the Tenant #1's vitals, pain, skin issues, interventions and tenant response for the next 72 hours. In addition, the Program should have an initiated accident/incident checklist, a 72 hour vital form,	A 003		

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A 003	Continued From page 2 completed the post fall investigation and review, and completed the medical director quality review. On 1/29/21 at 10:09 a.m. the RN confirmed she had no further documentation other than the original incident report.	A 003		
A 057	481-67.9(3) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(3) Training documentation. The program shall have training records and staffing schedules on file and shall maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures. This REQUIREMENT is not met as evidenced by: Based on record review the Program failed to maintain documentation of training of nurse-delegated procedures for 3 of 3 staff reviewed (Staff A, B, C). Finding follows: Record review on 2/9/21 revealed no documentation of nurse delegation training for Staff A, B or C. The Program failed to provide training records when requested.	A 057		
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. A program shall evaluate each tenant's functional, cognitive and health status	A 037		

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A 037	Continued From page 3 within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure functional, cognitive and health evaluations were completed with a significant change for 1 of 3 tenants reviewed (Tenant #1). Finding follows: Record review on 2/4/21 revealed Tenant #1's most recent evaluations were dated 10/7/20. Further review revealed a physician's order dated 11/6/20 for admission to hospice. Evaluations completed after admission to hospice could not be located. The Program's Nurse confirmed the evaluations dated 10/7/20 were Tenant 1's most recent evaluation.	A 037		
A 085	481-69.26(3) Service Plans 481-69.26(231C) Service plans. 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 085		

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A 085	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans were updated when a significant change occurred for 1 of 3 tenants reviewed (Tenant #1). Finding follows: Record review on 2/4/21 revealed Tenant #1's service plan dated 10/7/20. Further review revealed the Program failed to update Tenant #1's service plan when a change of condition occurred and hospice services were implemented in November 2020. The Program's Nurse confirmed the service plan was not updated as needed.	A 085		

A003

Tenant #1 discharged from the facility on November 14, 2020. RN program manager conducted accident/incident policy education with staff by April 24, 2021.

RN will complete this education with all new hires since March 25, 2021 by April 24, 2021. RN program manager will audit all incident reports weekly for 3 months to ensure compliance is reached with incident documentation, notifications, interventions and 72 hour observation following the incident. Results will be reported to the QAPI committee monthly for review and modifications as needed.

A057 Staffing

Nurse delegation training will be given by RN Program Manager on April 8, 2021 (4 hours). Training records will be updated and submitted as necessary. This will be monitored by the Program Manager monthly for 3 months.

A037

Resident #1 discharged on November 14, 2020. Service plans will be audited by Program Manager or nurse designee for change of conditions by April 24, 2021. The program will ensure timely evaluations or re-evaluations of tenants for functional, cognitive and health evaluation as indicated by audit findings. Program Manager will audit 5 service plans per month for 3 months. Findings will be reported to QAPI for 3 months.

A085

Resident #1 discharged on November 14, 2020. ED will in-service RN Program Manager on service plans pertaining to Assisted Living in Iowa. Service plans will be audited by Program Manager or nurse designee for documentation confirming updates to tenants' service plans for significant changes in condition. Based on audit findings, the program will ensure corresponding updates to tenants' service plans with significant changes in condition. The Program Manager will audit 5 service plans per month for 3 months. Audit finds and corresponding corrective actions will be reported to QAPI for 3 months for review and recommendations for additional actions.