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 05/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RISEN SON CHRISTIAN VILLAGE ALP/D	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 type of 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: 23 Total census of Assisted Living Program for People with Dementia: 23 No regulatory insufficiencies were cited during the onsite infection control survey or during the investigations of Complaint #97087-C or Incident #97062-I. The following regulatory insufficiencies were cited during the investigations of Complaints #96874-C, #96682-C, #97064-C and Incident #97096-I.	A 000	√ 6/30/21	
A 105	481-67.2 Program Policies and Procedures 481-67.2 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. This REQUIREMENT is not met as evidenced by:	A 105	Plan of Correction is attached DD 6/24/21	

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

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A 105	Continued From page 1 Based on interview and record review the Program failed to develop an accident and emergency response policy that included provisions for head injuries affecting 1 of 1 tenants reviewed with a head injury (Tenant #1). Findings include: Record review of Nurses Notes on 5-12-21 revealed on 1-21-21 and 4-15-21 Tenant #1 suffered facial bruising and swollen eyes. Continued review revealed on 3-2-21 staff witnessed her hit the left side of her head on the wall resulting in a swollen area. No policy and/or procedure regarding responses to head injuries could be located. On 5-13-21 at 10:45 a.m. the Assisted Living Residential Services Director confirmed the Program failed to have a policy regarding head injuries.	A 105		
A 215	481-69.24(1)a Involuntary Transfer from Program 69.24(1) Program initiation of transfer. If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply: a. The program shall notify the tenant or tenant's legal representative, in accordance with the occupancy agreement, of the need to transfer the tenant and of the reason for the transfer and shall include the contact information for the office of long-term care ombudsman.	A 215		

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A 215	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to include the contact information for the office of the long-term care ombudsman when notifying the family of an involuntary discharge for 1 of 2 discharged tenants reviewed (Tenant #2). Findings follow: Record review of Tenant #2's Nurse's Notes revealed the following: *3-14-21 revealed he put his hands on another tenant's neck, gritted his teeth, and said "I am going to kill you". *3-25-21 revealed the Program notified the family he would not be accepted back due to safety issues. No documentation the Program provided the family with the contact information of the office of the long-term care ombudsman as required could be located. The Assisted Living Residential Services Director confirmed these findings on 5-13-21 at 10:02 a.m.	A 215		
A 220	481-69.24(1)b Involuntary Transfer from Program 69.24(1) Program initiation of transfer. If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply:	A 220		

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A 220	Continued From page 3 b. The program shall immediately provide to the office of long-term care ombudsman, by certified mail, a copy of the notification and notify the tenant's treating physician, if any. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to immediately provide to the office of long-term care ombudsman, by certified mail, a copy of the notification and notify the physician of an involuntary transfer for 1 of 2 discharged tenants reviewed (Tenant #2). Findings follow: Record review of Tenant #2's Nurse's Notes revealed the following: *3-14-21 revealed he put his hands on another tenant's neck, gritted his teeth, and said "I am going to kill you". *3-25-21 revealed the Program notified the family he would not be accepted back due to safety issues. No documentation the Program notified the office of long-term care ombudsman by certified mail or notified the physician of the involuntary discharge cold be located. The Assisted Living Residential Services Director confirmed these findings on 5-13-21 at 10:02 a.m	A 220		
A 395	481-69.26(4)a 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	A 395		

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A 395	Continued From page 4 for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record reviw the Program failed to ensure service plans wer based on the identified needs and preferences for assistance for 1 of 3 tenants reviewed (Tenant #1). Findings follow: Record review on 5-12-21 revealed Tenant #1's Service Plan dated 5-10-21 documented she had multiple falls in the last quarter and had a urinary tract infection (UTI) that correlated with the increased falls. Continued review revealed the service plan failed to be updated to include interventions to minimize the falls and UTI's. The Assisted Living Residential Services Director confirmed these findings on 5-12-21 at 11:17 a.m.	A 395		

A105-Policy and Procedure for Head Injuries was located on 6/7/21. Staff will be in-serviced on this policy by 7/6/21 and yearly thereafter. 2 interviews will be performed quarterly, by RN Manager, on Head Injury Policy and Procedure, to monitor compliance.

A125-RN ALDS Director was in-serviced on how contact State of Iowa Ombudsman. Further instances, if any, will show that facility contacted family with said number of State of Iowa Ombudsman, within 24 hours of discharge. Discharges will be monitored quarterly for 6 months to monitor compliance. Effective date of compliance is 7/6/21.

A220-RN ALDS Director was in-serviced on 6/17/21 of the statutory regulation regarding notifying the Ombudsman's Office via certified mail as well as the Physician (via phone conversation/message). Further instances, if any, will show that the facility contacted Ombudsman's Office via certified mail and initiated contact with the Physician. Discharges will be monitored quarterly for 6 months to monitor compliance.

A395-RN ALDS Director updated resident #1 service plan on 5/13/21 and instituted new interventions to increased falls. Service plans for Assisted Living Dementia Support are updated, by 7/13/21, fulfilling the quarterly requirement. Nurse consultant will audit 3 service plans, quarterly for the next year to monitor compliance.

6/30/21

6/21/21