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
	S0280	A. BUILDING: _____ B. WING _____	C 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 impairment: 25 Number of tenants with cognitive impairment: 10 Total census: 35	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to follow established policy regarding door alarm response affecting 1 of 1 discharged tenants (Tenant C1). Findings follow: A review of incident witness statements revealed on 3/7/24 at 8:00 AM, Staff J went to Tenant C1's apartment to take his breakfast order. She did not see him in his apartment. Staff J visited with the Business Manager and Staff A and neither had seen him. Staff J checked for Tenant C1 outside and discovered Tenant C1's car was not in the parking lot. Tenant C1's walker was outside the building. On 5/20/24 at 1:10 PM, Staff B recalled she worked from 10:00 PM on 3/6/24 until 3/7/24 at	A 150	The 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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6:00 PM. Staff B assisted Tenant C1 following a slide from his chair on 3/6/24. Staff B checked on Tenant C1, called the nurse and Tenant C1 reported he did not want to go to the hospital. Tenant C1 did not have any injuries and his vitals were within normal limits. She checked on him again after 1-1.5 hours and he was fine. Staff B was distracted during the night helping another tenant who was sent to the emergency room. The paramedics came and took that tenant to the hospital. She reported prior to 3/6/24, the front door had a door bell, but it could not be heard unless staff were close to the door. A tenant could walk in and out of the doors if they had the code. Staff A worked with Staff H and they took another tenant's dog outside, when they noticed the front door was pushed off the track. She thought at the time the door was pushed by the paramedics, but perhaps it was Tenant C1.

On 5/20/24 at 1:45 PM, Staff A reported she worked the morning of 3/7/24. She remembered Staff J asking her if she had seen Tenant C1. They went to his room but did not see him. They informed the Licensed Practical Nurse (LPN) who said she would make some calls to determine his whereabouts. Staff A had some free time and looked at social media. She saw a report of a body found in a car at a park. She looked through the comments and learned the car was the same type as the one belonging to Tenant C1. Tenant C1 was the person in the car.

On 5/20/24 at 3:30 PM, Staff C reported before a fix was made to the front door, a person could only hear the alarm on the door if they were right by it. They did not know when someone went out of the door.

On 5/21/24 at 4:00 PM, the LPN confirmed prior

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A 150	Continued From page 2 to the incident a person could not hear the doorbell unless they were close to the door. The door alarm system did not send any type of notification to staff about who entered or left the building. The Environmental Technician reported the door alarm was updated on 3/22/24 to send notifications to staff when the front door was used. The program had a door alarm response protocol. If the alarm activation was not witnessed, the person identifying the activated alarm would take note of all tenants in the immediate area. The person finding the triggered event should begin searching the area outside the door which alarmed. All staff should account for the tenants. The program did not follow the door alarm response protocol because staff were unable to hear the alarm when a tenant left the building.	A 150		
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure 3 of 5 current tenants reviewed were treated with dignity and autonomy (Tenant #1, Tenant #3 and Tenant #5). Findings	A 155		

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include:

1) Record review on 5/20/24 revealed a notice of progressive coaching for Staff F, who was previously employed by the program. On 9/10/23, Staff F took a video on her personal cell phone of a tenant with dementia without written consent. Staff F failed to reach out to her supervisor for advisement on how to handle the situation. On 9/10/23 she spoke to co-workers about the video knowing it was against policy to have taken it.

On 5/22/24 at 11:04 AM, Staff E recalled Staff F had a habit of agitating tenants on purpose. Staff F would say or do things to upset the tenants. Staff E saw a video Staff F took involving Tenant #1. On one occasion, Tenant #1 refused her medication after Staff F agitated her. It was difficult to get Tenant #1 to take her medication. Tenant #1 refused to take her medication. Staff F put Tenant #1's medication into some chocolate pudding and then Tenant #1 agreed to take it. Staff F then told Tenant #1 she could not have the medication. Staff F put the medication on the counter out of the tenant's reach. Staff E recalled Staff F bragged to her about this interaction when showing her the video.

On 5/21/24 at 3:25 PM, Staff G stated a co-worker pulled up a social media app, Snapchat, and showed a video to Staff G and the former Director. The video involved Tenant C1 who was having a bad day. Staff F reportedly put the video on Snapchat and sent it to a variety of people. Tenant C2 was yelling and screaming in the video. Tenant C2 was shaking a newspaper at Staff F while Staff F recorded the tenant. She thinks the video was on Staff F's Snapchat story (making it available to others on the app) and

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also sent to co-workers. This was the first time Staff G saw proof of Staff F taking videos.

On 5/22/24 at 10:32 PM the former director stated she found out Staff F took a video of Tenant #1 in her apartment. Tenant #1 hadn't had a shower for a while and Staff F was trying to get her into the shower. Tenant #1 became upset and combative. Tenant #1 asked them to leave her apartment. In the video the former director was unable to see Tenant #1's face which was why she did not consider it to be dependent adult abuse. When the former director spoke with Staff F about the video, Staff F said Tenant #1 was slapping her and she wanted a video to cover herself from any negative accusations.

2) Record review of legal documents for Tenant #5 revealed a court order dated 2/8/24 appointing an attorney for Tenant #5. There was further documentation from the court dated 4/15/24 appointing Individual 1 as the temporary guardian, medical power of attorney and health care power of attorney for 30 days. There was a further court order dated 5/15/24 in which Individual 1 was appointed as the temporary guardian and conservator for Tenant #5 pending a further hearing. The guardian was authorized to determine whether visitation between Tenant #5 and two others was in his best interest and could limit contact if she deemed it necessary to do so.

On 5/23/24 at 1:20 PM Tenant #5's attorney wrote in an email she had conversations with Individual 1 informing her she did not have the right to restrict visitors (other than those identified in the 5/15/24 court order) from seeing Tenant #5. The attorney described Tenant #5 as a person suffering from dementia. The attorney wrote, it is

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my position Individual 1 does not understand or appreciate the fact that even though she feels she is doing what Tenant #5 wants as his guardian and representative by restricting access to Tenant #5, she is in opposition to her requirements under the guardianship code.

The program had a hand-written list provided to them by Individual 1 restricting seven specific people from seeing Tenant #5. She wrote the program could only allow visits and phone calls from Tenant #5's sister and brother-in-law as well as herself (Individual 1).

On 5/22/24 at 9:40 AM, Tenant #5 reported there are people who cannot visit him because they are busy, live out of town or have to work.

On 5/22/24 at 9:50 AM, Staff I stated there was one tenant at the program who could not receive visitors, Tenant #5. Staff I believed Individual 1 had restricted visitation.

On 5/22/24 at 10:45 AM, the Executive Director reported Individual 1 had restricted visitation for Tenant #5, only allowing two people to visit with him.

The program restricted Tenant #5's access to visitors at the direction of Individual 1 when she did not have the authority to put this restriction in place.

3) On 5/20/24 at 4:20 PM, Staff D stated she had concerns with the manner in which Staff H interacted with Tenant #3. Staff H had taken Tenant #3's pendant in the past. Staff D knew this occurred because she would find Tenant #3's pendant across the room from where she was sitting. Staff H told Staff D he would remove

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A 155	Continued From page 6 Tenant #3's pendant because she pressed it five times in an hour. Staff D recalled Tenant #3 would press the pendant because of pain and also because she did not like to be in her apartment alone. On 5/20/24 at 12:00 PM, Staff B reported Staff H took the pendant of Tenant #3 because she kept pressing it. Staff H could be nice to others but if the tenants aggravated him, he would lash out. Staff H had a tone and would talk to people in a way you shouldn't. Staff H got aggravated with Tenant #3 due to her pain. On 5/21/24 at 2:00 PM the Licensed Practical Nurse (LPN) said she did verbal coaching with Staff H after she learned he took Tenant #3's pendant. She only heard of this occurring one time. Staff H said he took the pendant because it was around the tenant's neck. She has not heard of other issues with Staff H's treatment of tenants. On 5/23/24 at 1:40 PM the LPN confirmed the above findings.	A 155		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall 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 eligibility for the program and to determine any changes to services needed. 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. A licensed practical nurse shall not complete the	A 145		

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A 145	Continued From page 7 evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program's Registered Nurse (RN) failed to evaluate the needs of 3 of 5 current tenants reviewed (Tenant #1, Tenant #2 and Tenant #3) and 1 of 1 discharged tenants reviewed (Tenant C1) when they experienced a significant change. Findings include: 1) Record review on 5/21/24 revealed Tenant C1's assessment and service plan dated 10/23/23. Tenant C1 received assistance with grooming as needed but was independent with mobility, showering, toileting and dressing. A review of charting notes for Tenant C1 identified his physical therapist reported to the Licensed Practical Nurse (LPN) on 2/19/24 he became short of breath during therapy. Tenant C1's oxygen saturation dropped to 71% on room air. Tenant C1 reported when this occurred, he would use his CPAP machine. Tenant C1 put on his CPAP machine and his oxygen saturations stayed in the 80's. The LPN checked on him later and his oxygen saturation was in the 90's. The LPN contacted Tenant C1's primary care provider (PCP) to request oxygen. The program obtained an order for supplemental oxygen as needed on 2/20/24. Tenant C1 received his oxygen on 2/20/24. The LPN also gave him a pulse oximeter to monitor his oxygen level.	A 145		

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A 145	Continued From page 8 On 2/23/24, Tenant C1 was straining to breathe and experienced auditory wheezing. Tenant C1's oxygen was at 95% on oxygen but would drop to 86% within 30 seconds of removing his oxygen. Tenant C1's face had a purple tint. Tenant C1 was transported to the hospital. He was admitted for reported pneumonia and fluid on the lungs. Tenant C1 returned to the program on 2/28/24. He experienced intermittent confusion. Tenant C1 required an assist of one staff to transfer to his chair. He had weakness in his right lower extremity. On 2/29/24, a care giver reported Tenant C1 was taking off his oxygen, walking unassisted and went into the hallway wearing only a shirt and incontinence brief. His gait was unsteady and he lost his balance. Tenant C1 experienced 2 falls on 2/29/24. The LPN documented Tenant C1 was confused and had no safety awareness. He was worried and scared. The LPN talked with Tenant C1 about the program administering his medication or a referral to hospice. Tenant C1 agreed with these options. Tenant C1 was more aware on 3/1/24 and reported he would continue to administer his own medication. Tenant C1, his son and the LPN discussed the tenant's needs on 3/4/24. They agreed he would require shower assistance. Tenant C1 was on continuous oxygen and his oxygen saturation dropped below 80% when he was not using it. Tenant C1 required assistance with all activities of daily living. He would continue with physical therapy to increase his strength. The LPN completed an assessment on 3/4/24 of Tenant C1's needs. A program RN did not evaluate Tenant C1's	A 145		

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needs when he began utilizing oxygen as needed and physical therapy on 2/20/24. The RN did not evaluate Tenant C1's needs again when he returned from the hospital on 2/28/24 requiring assistance with all activities of daily living, continuous oxygen and experiencing confusion. The LPN conducted a review of Tenant C1's needs on 3/4/24 after he experienced a change of condition rather than a Registered Nurse.

2) Tenant #1 had an assessment and service plan dated 9/11/23. Tenant #1 received assistance with bathing reminders, toileting and medication administration. The program LPN completed a new assessment and service plan on 3/27/24. The review identified Tenant #1 required assistance with assuring her clothing was clean and changed daily. She refused to change her clothing. Staff were to provide maximum assistance with showering as she did not like to take showers. Tenant #1 needed staff to prompt her to brush her hair. The assessment and service plan noted staff were to administer medication to Tenant #1 but did not identify she would refuse medication or list interventions to help staff encourage Tenant #1 to take her pills.

A review of monthly task sheets for Tenant #1 identified she took two showers in March, 2024 but refused six showers; in April, 2024 she took two showers and refused six. As of 5/21/24, Tenant #1 received one shower during the month.

Program staff documented when Tenant #1 took medication on the Medication Administration Record (MAR). Tenant #1 refused her medication on 13 days in March, 2024; 11 days in April, 2024 and on 18 days as of 5/21/24.

A program RN did not review evaluate Tenant

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A 145	Continued From page 10 #1's health, functional and cognitive needs when she experienced a significant change in her ability to complete activities of daily living. 3) Tenant #2 had an assessment and service plan dated 10/9/23. Tenant #2 received assistance with dressing, bathing, grooming and medication management. The assessment noted Tenant #2 required minimum assistance with toileting. She was only incontinent if she could not find a bathroom. The program LPN completed a new assessment and service plan on 3/27/24. The plan identified Tenant #2 required increased assistance with dressing. Tenant #2 needed staff to help cut up her food. The updated assessment noted Tenant #2 had aggressive tendencies in the past and would peek into other tenant's apartments. The program LPN again assessed Tenant #2 on 5/20/24. The LPN's assessment revealed Tenant #2 would urinate in her own apartment at times. Tenant #2 would unknowingly have urine and feces all over herself and her apartment. A review of the MAR for Tenant #2 noted she refused medication on 21 days in March, 2024; 13 days in April, 2024 and on 12 days through 5/21/24. On 5/20/24 at 1:15 PM, Staff B said Tenant #2 urinated on the floor, air conditioning unit and the bathroom floor. There were days she would find out Tenant #2 had urinated on the floor each time she entered the apartment and other days when it did not occur at all. On 5/20/24 at 3:40 PM, Staff C stated if staff did not take Tenant #2 to the bathroom every two hours she would urinate in places other than the	A 145		

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A 145	Continued From page 11 toilet. On 5/20/24 at 4:20 PM, Staff D reported Tenant #2 was known to walk into the dining room, pull down her pants, sit in a chair and try to urinate. A program RN did not evaluate Tenant #2's needs after she experienced significant changes related to her nutritional and toileting needs. It was not noted Tenant #2 refused her medication. 4) Tenant #3 had an assessment and service plan written on 3/27/24 by the LPN. As of 3/27/24, Tenant #3 required moderate assistance with dressing, grooming and bathing. Staff administered medication to Tenant #3. A review of progress notes revealed on 5/1/24, Tenant #3 was complaining of pain to her lower back to family members. Tenant #3 went to the emergency room and returned later in the evening. Tenant #3 saw her PCP on 5/2/24 and was put on hydrocodone, a medication to help with pain. The LPN documented on 5/3/24 and 5/8/24 Tenant #3 reported pain to her back. She called out "help me" repeatedly. On 5/9/24, the program received orders from Tenant #3's PCP for her to receive services through hospice. Hospice services were initiated on 5/10/24. No one assessed Tenant #3 when she started receiving hospice services. The LPN confirmed these findings on 5/22/24 at 2:30 PM. The LPN noted there were no evaluations of tenants' functional, cognitive or health status in the tenant records. The program had cognitive evaluations for some tenants which were completed by the tenants' PCP.	A 145		

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A 315	481-69.25(1)n Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: n. A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal representative This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to obtain legal documents for 1 of 5 tenants reviewed (Tenant #5). Findings follow: Record review of legal documents for Tenant #5 revealed a court order dated 2/8/24 appointing an attorney for Tenant #5. There was further documentation from the court dated 4/15/24 appointing Individual 1 as the temporary guardian for 30 days, medical power of attorney and health care power of attorney. A review of Tenant #5's record revealed no power of attorney documents. On 5/23/24 at 1:50 PM the Executive Director confirmed the program did not have a copy of the power of attorney documents for Tenant #5.	A 315		
A 360	481-69.26(3) 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 360		

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RIVER VALLEY PLACE OF FORT MADISON	5025 RIVER VALLEY ROAD FORT MADISON, IA 52627

(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 360	Continued From page 13	A 360		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the program failed to update service plans when 1 of 5 current tenants reviewed (Tenant #3) and 1 of 1 discharged tenants reviewed (Tenant C1) experienced a significant change. Findings include:

1) Record review on 5/21/24 revealed Tenant C1 had an assessment and service plan dated 10/23/23. Tenant C1 received assistance with grooming as needed but was independent with mobility, showering, toileting and dressing.

A review of charting notes for Tenant C1 identified his physical therapist reported to the Licensed Practical Nurse (LPN) on 2/19/24 he became short of breath during therapy. Tenant C1's oxygen saturation dropped to 71% on room air. Tenant C1 reported when this occurred, he would use his CPAP machine. They put on Tenant C1's CPAP machine and his oxygen saturations stayed in the 80s. The LPN checked on him later and his oxygen saturation was in the 90s. The LPN contacted Tenant C1's primary care provider (PCP) to request oxygen.

The program received an order for supplemental oxygen as needed on 2/20/24. Tenant C1 received his oxygen on 2/20/24. The LPN also gave him a pulse oximeter to monitor his oxygen level.

On 2/23/24, Tenant C1 was straining to breath and experienced auditory wheezing. Tenant C1's

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A 360	Continued From page 14	A 360		

oxygen was at 95% on oxygen but would drop to 86% within 30 seconds of removing his oxygen. Tenant C1's face had a purple tint. Tenant C1 was transported to the hospital. Tenant C1's friend told the LPN he was admitted to the hospital for reported pneumonia and fluid on the lungs (the program did not have any hospital notes).

Tenant C1 returned to the program on 2/28/24. He experienced intermittent confusion. Tenant C1 required an assist of one staff to transfer to his chair. He had weakness in his right lower extremity. On 2/29/24, a care giver reported Tenant C1 was taking off his oxygen, walking unassisted and went into the hallway wearing only a shirt and incontinence brief. His gait was unsteady and he lost his balance. Tenant C1 experienced 2 falls on 2/29/24. The LPN documented Tenant C1 was confused and had no safety awareness. He was worried and scared. The LPN talked with Tenant C1 about the program administering his medication or a referral to hospice. Tenant C1 agreed with these options. Tenant C1 was more aware on 3/1/24 and reported he would continue to administer his own medication.

Tenant C1, his son and the LPN discussed the tenant's needs on 3/4/24. They agreed he would require shower assistance. Tenant C1 was on continuous oxygen and his oxygen saturation dropped below 80% when he was not using it. Tenant C1 required assistance with all activities of daily living. He would continue with physical therapy to increase his strength. The LPN completed an assessment on 3/4/24 of Tenant C1's needs.

On 5/20/24 at 1:45 PM Staff A reported Tenant C1

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A 360	Continued From page 15	A 360		

was initially independent with completing his activities of daily living. A week or 2 prior to his death, his health started to decline. Tenant C1 started to need more assistance and this was hard for him. He was having a hard time walking and staff provided standby assistance when he ambulated. Tenant C1 couldn't make it to the toilet. He was getting meal trays because it was hard for him to walk to the dining room.

Tenant #1's service plan was not updated when he returned from the hospital on 2/28/24 requiring assistance with all activities of daily living, continuous oxygen and experiencing confusion. The LPN conducted a review of Tenant C1's needs on 3/4/24 after he experienced a change of condition.

2) Tenant #3 had an assessment and service plan written on 3/27/24 by the LPN. As of 3/27/24, Tenant #3 required moderate assistance with dressing, grooming and bathing. Staff administered medication to Tenant #3. Staff were to assist Tenant #3 to the toilet as needed. Tenant #3 receive minimum assistance with transfers and ambulation, which consisted of one staff providing hands on assist with transfers. Tenant #3 had chronic back pain. She required encouragement to accomplish tasks related to her cognitive decline.

A review of charting notes revealed on 5/1/24, Tenant #3 was complaining of pain to her lower back to family members. Tenant #3 went to the emergency room and returned later in the evening. Tenant #3 saw her PCP on 5/2/24 and was put on hydrocodone, a medication to help with pain. The LPN documented on 5/3/24 and 5/8/24 Tenant #3 reported pain to her back. She called out "help me" repeatedly. On 5/9/24, the

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A 360	Continued From page 16 program received orders from Tenant #3's PCP for her to receive services through hospice. Hospice services were initiated on 5/10/24. An observation of a medication pass on 5/20/24 at 4:40 PM found Tenant #3 in bed. Staff D was unable to rouse Tenant #3. Tenant #3's family reported she had taken a turn for the worse over the past few days. Tenant #3's service plan was not updated to reflect her admission into hospice and her increased service needs. On 5/20/24 at 1:15 PM, Staff B reported Tenant #3 had broken her back and was in a lot of pain. It would take two people to get her up and moving. As on 5/20/24, Tenant #3 did not get up and was bedbound. Tenant #3 was easy to take care of now because staff didn't have to get her out of bed. On 5/20/24, Staff C said Tenant #3 was bed bound at the time of the interview. On 5/20/24 at 4:20 PM, Staff D stated Tenant #3 required the assistance of two staff to transfer. She reported Tenant #3 received hospice services. The LPN confirmed these findings on 5/22/24 at 2:30 PM.	A 360		
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 17 for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to list the identified needs and services for 2 of 5 current tenants reviewed (Tenant #1 and Tenant #2). Findings include: 1) Tenant #1 had an assessment and service plan dated 3/27/24. The review identified staff were to administer medication to Tenant #1 but did not identify she would refuse medication. Program staff documented when Tenant #1 took medication on the Medication Administration Record (MAR). Tenant #1 refused her medication on 13 days in March, 2024; 11 days in April, 2024 and on 18 days in May as of 5/21/24. On 5/20/24 at 1:45 PM, Staff A reported it could be difficult to get Tenant #1 to take her medication. She would say, I don't take medication. On 5/22/24 at 1:04 PM, Staff E recalled it was difficult to get Tenant #1 to take her medication. Tenant #1's service plan did not address her refusal to take medication and the interventions staff should use when she would not take them. 2) Tenant #2 had an assessment and service plan dated 5/20/24. The service plan revealed Tenant #2 would urinate in her apartment at times. Tenant #2 would unknowingly have urine and feces all over herself and her apartment.	A 395		

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A 395	Continued From page 18 On 5/20/24 at 1:15 PM, Staff B said Tenant #2 urinated on the floor, air conditioning unit and the bathroom floor. There were days she would find out Tenant #2 had urinated on the floor each time she entered the apartment and other days when it did not occur at all. On 5/20/24 at 3:40 PM, Staff C stated if staff did not take Tenant #2 to the bathroom every two hours she would urinate in places other than the toilet. On 5/20/24 at 4:20 PM, Staff D reported Tenant #2 was known to walk into the dining room, pull down her pants, sit in a chair and try to urinate. Tenant #2's service plan did not address urinating in inappropriate places or the need for a toileting schedule. On 5/22/24 at 2:30 PM the LPN reported she was not aware until recently Tenant #2 had urinated in her apartment. The housekeeper reported finding urine which had not been cleaned by staff. The LPN confirmed the service plans did not address tenant's specific needs.	A 395		
A 420	481-69.27(1)a Nurse Review 69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: a. To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered	A 420		

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A 420	Continued From page 19	A 420		

prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the program's Registered Nurse (RN) failed to conduct nurse reviews as required for 3 of 5 current tenants reviewed (Tenant #1, Tenant #2 and Tenant #3) and 1 of 1 discharged tenants reviewed (Tenant C1). Findings include:

1) Record review on 5/21/24 revealed Tenant C1 had an assessment and service plan dated 10/23/23. The document identified the next review of the plan was due on 1/21/24. Tenant C1 received assistance with grooming as needed but was independent with mobility, showering, toileting and dressing. The document did not identified Tenant C1 received outside services, such as physical therapy. The program RN did not review Tenant C1's needs on 1/21/24.

Charting notes for Tenant C1 dated 2/19/24 identified his physical therapist reported to the Licensed Practical Nurse (LPN) he became short of breath during therapy. Tenant C1's oxygen saturation dropped to 71% on room air. Tenant C1 reported when this occurred, he would use his CPAP machine. They put on Tenant C1's CPAP and his oxygen saturations stayed in the 80's. The LPN checked on him later and his oxygen saturation level was in the 90's. The LPN contacted Tenant C1's primary care provider (PCP) to request oxygen.

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The program received an order for supplemental oxygen as needed on 2/20/24. Tenant C1 received his oxygen on 2/20/24. The LPN also gave him a pulse oximeter to monitor his oxygen level.

On 2/23/24, Tenant C1 was straining to breath and experienced auditory wheezing. Tenant C1's oxygen was at 95% on oxygen but would drop to 86% within 30 seconds of removing his oxygen. Tenant C1's face had a purple tint. Tenant C1 was transported to the hospital. He was admitted for reported pneumonia and fluid on the lungs.

Tenant C1 returned to the program on 2/28/24. He experienced intermittent confusion. Tenant C1 required an assist of one staff to transfer to his chair. He had weakness in his right lower extremity. On 2/29/24, a care giver reported Tenant C1 was taking off his oxygen, walking unassisted and went into the hallway wearing only a shirt and incontinence brief. His gait was unsteady and he lost his balance. Tenant C1 experienced 2 falls on 2/29/24. The LPN documented Tenant C1 was confused and had no safety awareness. He was worried and scared. The LPN talked with Tenant C1 about the program administering his medication or a referral to hospice. Tenant C1 agreed with these options. Tenant C1 was more aware on 3/1/24 and reported he would continue to administer his own medication.

Tenant C1, his son and the LPN discussed the tenant's needs on 3/4/24. They agreed he would require shower assistance. Tenant C1 was on continuous oxygen and his oxygen saturation dropped below 80% when he was not using it. Tenant C1 required assistance with all activities of daily living. He would continue with physical

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therapy to increase his strength. The LPN completed an assessment on 3/4/24 of Tenant C1's needs.

On 5/1/24 at 1:45 PM, Staff A stated initially Tenant C1 was very independent. She might clean his room but usually only saw him at meals. A week or two prior his death on 3/6/24, Tenant C1's health started to decline. He started to need more assistance which was hard for him. Tenant C1 was having a hard time walking and staff provided standby assistance. He couldn't make it to the toilet. Tenant C1 was getting meal trays because it was hard for him to walk to the dining room.

A program RN did not review Tenant C1's needs when he began utilizing oxygen as needed and physical therapy on 2/20/24. He was not further reviewed when he returned from the hospital on 2/28/24 requiring assistance with all activities of daily living, continuous oxygen and experiencing confusion. The LPN conducted a review of Tenant C1's needs on 3/4/24 after he experienced a change of condition rather than a Registered Nurse.

2) Tenant #1 had an assessment dated 9/11/23. The document noted the next review was due on 12/10/23. Tenant #1 received assistance with bathing reminders, toileting and medication administration. The program LPN completed a review on 3/27/24. The review identified as of 3/27/24, Tenant #1 required assistance with assuring her clothing was clean and changed daily. She refused to change her clothing. Staff were to provide maximum assistance with showering as she did not like to take showers. Tenant #1 needed staff to prompt her to brush her hair.

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A 420	Continued From page 22 A program RN did not review Tenant #1's needs for over six months. 3) Tenant #2 had an assessment and service plan dated 10/9/23. The form identified the next review was due on 1/7/24. Tenant #2 received assistance with dressing, bathing, grooming and medication management. The assessment noted Tenant #2 required minimum assistance with toileting. She was only incontinent if she could not find a bathroom. The program LPN completed a new assessment on 3/27/24. The plan identified Tenant #2 required increased assistance with dressing. Tenant #2 needed staff to help cut up her food. The updated assessment listed Tenant #2 had aggressive tendencies in the past and would peek into other tenant's apartments. The program LPN again assessed Tenant #2 on 5/20/24. The LPN's assessment revealed Tenant #2 would urinate in her own apartment at times. Tenant #2 would unknowingly have urine and feces all over herself and her apartment. A program RN did not review Tenant #2's needs between 10/9/23 and 3/27/24. Tenant #2 experienced significant changes related to her nutritional and toileting needs which were assessed by an LPN, not an RN. 4) Tenant #3 had an assessment and service plan written on 3/27/24 by the LPN. As of 3/27/24, Tenant #3 required moderate assistance with dressing, grooming and bathing. Staff administered medication to Tenant #3. A review of progress notes revealed on 5/1/24, Tenant #3 was complaining of pain to her lower back to family members. Tenant #3 went to the	A 420		

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emergency room and returned later in the evening. Tenant #3 saw her PCP on 5/2/24 and was put on hydrocodone, a medication to help with pain. The LPN documented on 5/3/24 and 5/8/24 Tenant #3 reported pain to her back. She called out "help me" repeatedly. On 5/9/24, the program received orders from Tenant #3's PCP for her to receive services through hospice. Hospice services were initiated on 5/10/24.

On 5/20/24 at 1:15 PM, Staff B reported Tenant #3 had broken her back and was in a lot of pain. It would take 2 people to get her up and moving. As on 5/20/24, Tenant #3 did not get up and was bedbound. Tenant #3 was easy to take care of now because staff didn't have to get her out of bed.

On 5/20/24, Staff C said Tenant #3 was bed bound at the time of the interview.

On 5/20/24 at 4:20 PM, Staff D stated Tenant #3 required the assistance of two staff to transfer and was on hospice.

No one assessed Tenant #3 when she started receiving hospice services.

The LPN confirmed these findings on 5/22/24 at 2:30 PM.

PLAN OF CORRECTION

Provider/Supplier Name:	River Valley Place of Fort Madison
Street Address, City, Zip:	5025 River Valley Road Fort Madison, IA 52627
Date of Survey:	5.23.2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0280

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A 150	The door alarm was corrected on 3/22/24 by rewiring the ceiling control box to make door alarm change setting in tablet. The door is now locked down and on Night Mode 24/7. The Environmental Technician has been doing routine door alarm checks to ensure proper working order since 3/22/2024. An in-service was completed on 8/9/2024 to include door alarm protocol and the staff will follow the program's policy and procedure. All new employees will be educated on policy and procedures on hire, annually and as needed.	08/27/2024
A 155	Staff F was not employed by the facility at the time of the survey. An in-service regarding tenant rights and Mandatory Reporting to re-educate our staff was included in an all staff meeting on 8/9/2024 by the Executive Director and the staff will follow the program's policies and procedures. Employees will be educated in policies and procedures, tenant rights, and mandatory reporting upon hire, annually and as needed. All tenant documents were audited on 8/16/2024 to ensure correct information on file for guardian and POA person/status. Tenant files will be updated immediately when/if person/status changes. The community will follow applicable rules and laws regarding visitor restrictions effective immediately.	08/16/2024
A 315	All tenant documents were audited on 8/16/2024 to ensure correct information on file for guardian and POA person/status. Tenant files will be updated immediately when/if person/status changes.	8/16/2024
A 145 A 360 A 420	The community will work with the RN of a sister community to oversee the program including the completion of required assessments, major service place revisions, change of condition monitoring, delegations, and supervision of staff and tenants. LPN will work in conjunction with RN for staff training /supervision and nurse reviews for medication managed residents if no change of condition exists. All resident ISPs will be audited to ensure reflection of current status and needs as well as staff assistance and interventions. Residents needing major changes to ISP (change of condition) will be assessed by RN by 9/12/2024 to evaluate functional, cognitive and health status.	9/12/2024

A 395	All resident ISPs will be audited to ensure reflection of status and needs as well as staff assistance and interventions. If the residents need a major change to ISP (change of condition) will be assessed by RN by 9/12/2024 to evaluate functional, cognitive and health status. Any consistent resident refusal of medications and/or care will be documented in the ISP during this update, with interventions implemented to support their right to refuse while aiming to reduce refusals where possible. Inservice to be held on 9/9/2024 to include staff education on tenants right to refuse, interventions aimed to reduce refusals and notification to supervisor for refusals.	9/12/2024
	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission admission that the findings constitute a deficiency cited are correctly applied. Any changes to the community policies and procedures should be considered subsequent remedial measures as the concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies.	