STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RISEN SON CHRISTIAN VILLAGE	**3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and clinical record review, the facility failed to adequately complete comprehensive care plans for two of four residents reviewed (Residents #1 & #3). The facility reported a census of 52 residents. 1. According to the Minimum Data Set (MDS) assessment tool, Resident #1 had [DIAGNOSES REDACTED]. The MDS documented the resident displayed severely impaired cognition, required extensive assist of two staff for bed mobility, transfers, and toilet use, and took an anticoagulant seven out of seven days a week. The physican order dated 6/18/20 directed staff to administer Xarelto 20 mg daily. , and an order dated 7/29/20 that directed staff to give [MEDICATION NAME] 500 mg 1 tablet each evening for three days for pneumonia. An additional order dated 7/29/20 directed staff to [MEDICATION NAME] mg, twice a day for 3 days for a urinary tract infection. Observation on 8/11/20, revealed the resident had multiple bruises on her chest, neck, right side, and left leg. Progress Notes revealed discovered the bruising on 8/1/20 and described it as deep purple in color and covering the resident's right breast, axilla, anterior and posterior right shoulder, top and bottom of right upper arm, left arm, and right inner thigh. A progress note on 8/2/20 revealed the bruising was consistent with the sling of mechanical lift. On 8/4/20 the resident transferred to the hospital. The hospital progress notes showed the resident had a hemoglobin of 5.1 and received blood [MEDICAL CONDITION]. Interview with the DON on 8/10/20 at 4:22 PM revealed she was made aware of the bruising on 8/1/20. She stated she asked her staff where it was likely the bruises came from and was told likely the hoyer lift. Resident #1's care plan did not contain any references to anticoagulation therapy. 2. The MDS for Resident #3 revealed the resident's [DIAGNOSES REDACTED]. The MDS revealed the required extensive assistance of one staff for bed mobility, transfers and toilet use and took an anticoagulant seven out of seven days a week. Resident #3's orders dated 12/14/19 documented an order for [REDACTED].#3's care plan failed to contain any information related to anticoagulant use.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, interviews, and clinical record review, the facility failed to provide adequate nursing supervision to prevent hazards for 1 of 3 residents reviewed (Resident #5). The facility reported a census of 52 residents. According to the quarterly MDS dated [DATE], Resident #5 had [DIAGNOSES REDACTED]. The MDS revealed the resident's demonstrated moderately impaired cognition and required limited assistance of 1 staff for bed mobility, transferring, and toilet use. The MDS documented the resident experienced falls. Observation on 8/10/20 at 4:00 PM revealed an an entrance to the COVID unit and exit to the COVID unit. The entrance and the exit both had two sets of doors. The door to the outside was unlocked and unalarmed, and the door on the inside of the vestibule was locked from the outside. This required staff to unlock and deactivate the alarm from the inside of the COVID unit so they could pass through the door without activating the alarm. Further observation revealed the keys to the inside of the vestibule were located on a hook that had been installed next to the door on a hook at eye level. On 8/11/20 the facility reported Resident #5 left the facility and staff found her outside the COVID unit doors. An observation on 8/12/20 at 4:00 PM revealed the locked COVID doors with no keys are no longer on the hook by the doors. An incident report dated 8/11/20 at 9:30 AM revealed the resident was found outside the COVID unit with the outside door ajar. The door alarm was inactivated on inspection and the key which had been hanging by the door was found in use in the door. The resident denied pain or discomfort and an assessment revealed no injuries. The resident stated she had been looking for her son. The resident performed range of motion for the staff. A head to toe was performed on the resident with no injuries noted. Resident stated she was looking for her son. Staff were told to put the key behind the nurses station. An audit was conducted for alarmed doors with no findings of concerns. Staff education provided to staff. The incident reported the Staff E, LPN, stated the resident was last seen 15 to 20 minutes previously in her room eating breakfast. Progress Notes showed the resident resided in the COVID unit at the time of the incident. In a progress note on 8/8/20, showed the resident found beating on the COVID unit door close to room C-22. Staff able to redirect resident at the time. A progress note for 8/11/20 showed resident was found outside sitting on the ground. The assessment showed to be within normal limits for the resident and the resident brought back inside. The note stated the keys to the door will now be placed at the nurses station. A social service note dated 6/18/20 showed resident had a BIMS of 3. Resident #5's care plan revealed the resident is at risk for elopement. Resident has wandergaurd on. Resident's care plan also revealed the resident is at high risk for falls. The resident's elopement risk assessment dated [DATE] showed the resident score as 7.5 and is a risk for elopment. The resident's fall risk assessment dated [DATE] showed the resident's score as 7.0 However, the fall risk assessment dated [DATE] showed the resident for a score of 15 which is a high risk for falls. A thirty day look back for Resident #5's behaviors showed the resident wandered 7/25, 7/29, 7/31, 8/4, & 8/5. During an interview on 8/13/20 a 10:40 AM, the administrator reported the resident was seen by a resident from the indepdent living who found her and helped her. The administrator stated the resident was wearing shirt, pants and shoes at the time of the incident. The administrator stated the COVID unit does not have wanderguards by the emergency exits but the resident does have a wanderguard on. During an interview on 8/13/20, the resident from indepedent living stated he was coming home, when he noticed his neighbor pointing up at the facility. He stated he looked up and saw the resident outside the facility, trying to open the door to go in. He stated he went up to her and couldn't understand her mumbling but assisted her. He reported he saw there was a wheelchair on the other side of the first set of doors and the second door on the outside was open a little. He stated she leaned back but he caught her before she fell and helped sit her on the ground. He stated his neighbor called the facility to notify them of the resident outside. He stated staff came around the outside and assessed the resident and helped her back inside through the door. He reported the event occured between 9:30 AM and 10 AM. During an interview on 8/13/20 at 11 AM, the DON stated there are two members back in the COVID unit at all times. She stated some days she allows another staff member depending on acuity. She stated the emergency exit doors are alarmed at all times unless someone is passing through for their shift or for room trays. She stated the door alarms when the door the key is turned so the door is alarmed. An interview on 8/13/20 at 12:45 PM, Staff D, CNA reported the door is always alarmed. She stated once you turn the alarm on, the door chirps to let you know it is locked. When you turn the key to shut the alarm off, the door will alarm will alarm if you hold it. An interview on 8/13/20 at 12:55 PM, the administrator reported the door alarm will not go off if the key is in the door and turned for the alarm to go off, but if you hold the door open for 15 seconds, it will alarm. He stated the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) door will alarm when the door is turned to alarm witht he key. Review of the elopement policy revised 8/23/13, which revealed staff are to do a visual check of residents if a door alarm is found to be inactivated, before alarmimg the door again. Also, if for any reason doors alarms are turned off, staff will continually visually monitor the doors. Lastly, the DON or Administrator will question staff to determin who de-activated the door alarm and the reason for doing so. During an interview on 8/13/20 at 2:12 PM, the administrator stated the resident has moments of being coherent and it was likely she was able to unlock or disalarm the door and elope. During an observation on 8/13/20 at 2:20 PM, the COVID unit emergency exit doors were found to be locked and the keys were not hanging on the hooks by the doors.