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
	S0380	A. BUILDING: _____ B. WING _____	C 02/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER BEND RETIREMENT COMMUNITY ALP/I	813 TYLER STREET NE CASCADE, IA 52033

(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: 14 Total census: 14 An onsite infection control survey was completed and no regulatory insufficiencies were identified. The investigation of Complaint #97324-C was completed and the following regulatory insufficiencies were identified:	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 its policy regarding the completion of incident reports for 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Review of Tenant C1's file on 1-27-22 revealed diagnoses including falls, right leg plate, chronic difficulty weight bearing on the left leg, chronic left hip pain, gait instability and cognitive loss. Tenant C1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. A review of the tenant's Nurse's/Care Notes revealed the following: - On 1-29-19 a nurse reported Tenant C1 had a	A 150	Plan of Correction is attached	

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 150	Continued From page 1 bruise on his left side of his forehead. Tenant C1 said "the cops did it." - On 1-30-19 it was noted Tenant C1 had light "blue/brown" bruise, approximately 1 x 1, on the left side of his forehead. Tenant C1 said he did not know how it happened. - On 2-4-19 it was noted family was made aware Tenant C1 said a staff member hit him. An incident report related to Tenant C1's bruising of unknown etiology could not be located. Continued record review revealed a Resident Incident Report dated 5-3-19 indicated staff went to get Tenant C1 for breakfast and he needed assistance to get ready. It took two staff and a gait belt to get Tenant C1 up. He could not put any weight on his right ankle. The nurse was notified. An incident report was completed; however, there were no documented vital signs on the incident report. The Program's Incident Report policy indicated staff would notify the the nurse/manager of all accidents with possible injury or unusual occurrences. Staff would complete an incident report before the end of their shift. The incident report would be factual and include statements from anyone who witnessed the incident. When interviewed on 2-28-22 at 1:02 p.m. the Corporate Office Manager confirmed all incident reports for the tenants requested were provided.	A 150		
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 395		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 395	Continued From page 2 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 ensure service plans reflected the identified needs of 1 of 2 current (Tenant #1) and 2 of 2 former (Tenants C1 and C2) tenants reviewed. Findings follow: 1. Review of Tenant #1's file on 1-27-22 revealed a diagnosis of lewy body dementia with hallucinations. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Charting Notes indicated the following: - On 11-22-21 it was noted staff reported an incident on 11-18-21 when Tenant #1 tried to stand up on her own and staff attempted to tell her to rest. Tenant #1 became "increasingly agitated." Staff put a gait belt on Tenant #1 and she started screaming and tried to go out of the door. She then hit one of the staff in the face. - On 12-10-21 it was noted at approximately 4:00 a.m. Tenant #1 became agitated and wanted staff to leave the room. She tried to shut the door on staff and slammed the door. Tenant #1 grabbed staff around the back of the neck. Staff attempted redirection but Tenant #1 became more agitated. The family came in and she calmed down. An order was received for Seroquel 12.5 milligram, orally, every 12 hours as needed for agitation. The tenant's service plan was updated on 12-27-21 and reflected Tenant #1 was easy to redirect. If she was hallucinating staff were to	A 395		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 395	Continued From page 3	A 395		

change the subject. Staff were to offer her a doll to hold on to and it usually calmed her down. Staff could call family to come in if needed. The service plan did not reflect Tenant #1's physical behavior towards staff.

2. Review of Tenant C1's file on 1-27-22 revealed a diagnosis of cognitive loss. He was staged at four on the GDS, which indicated moderate cognitive decline. Tenant C1 was discharged on 5-3-19.

Nurse's/Care Notes indicated the following:
- On 1-29-19 it was noted Tenant C1 dressed and undressed several times yesterday. He came out at 11:00 p.m. last evening with a belt hanging around his neck, a protective undergarment on, two shoes and one sock. He had no other clothing on.
- On 2-1-19 it was noted the previous evening, Tenant C1 came out with his protective undergarment on over his pants. He flickered the kitchen light switch, thinking it was the call light.
- On 2-6-19 it was noted at 1:40 a.m. Tenant C1 came out of his apartment without anything on. Tenant C1 was incontinent of bowel movement.
- On 2-11-19 it was noted when "he gets onto something you can't get him off it." Tenant C1 made his bed over and over.
- On 2-26-19 it was noted Tenant C1 had his leg looped through his walker and he tried to get his sock on. Staff offered help and he kept removing the sock and trying to put it on again. Tenant C1 was easily agitated.

The tenant's service plan dated 3-31-19 reflected Tenant C1 had repetitive speech and went from subject to subject. The service plan did not reflect Tenant C1's behaviors as indicated above.

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 395	Continued From page 4 3. Review of Tenant C2's file on 1-31-22 revealed a diagnosis of late onset Alzheimer's without behavioral disturbance. Tenant C2 was staged at a six on the GDS, which indicated severe cognitive decline. Tenant C2 was discharged on 1-13-22. Charting Notes indicated the following: - On 10-29-21 it was noted Tenant C2 was going into other tenants' apartments and getting in their beds. - On 11-2-21 Tenant C2 hit staff with her purse, used profanity and screamed. - On 11-5-21 it was noted on 11-4-21 Tenant C2 tried to go in another tenant's apartment. She came out and hit staff on the head. Staff told her she could not hit people and she hit staff multiple times in the face. - On 11-29-21 Tenant C2 attempted to get into another tenant's apartment that was locked. When the door opened, Tenant C2 hit and kicked the other tenant until staff separated them. - On 12-1-21 three different incidents of aggressive behavior were noted. She grabbed another tenant's arm and when staff attempted to redirect her she yelled and scratched staff. She tried to go into the kitchen when staff were trying to do dishes and pushed and scratched staff. She also tried to push the kitchen door open, yelled and was angry. - On 12-6-21 Tenant C2 stood at another tenant's doorway and tried to push staff in to get into the apartment. She was asked to go back to her apartment. She grabbed at the other tenant's belongings and yelled at staff. She threw dishes from the counter to the sink. The day prior she tried to put her arms around another tenant and he tried to get away. She grabbed his wrists and would not let go. The other tenant was "very nervous and scared."	A 395		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 395	Continued From page 5 - On 12-11-21 Tenant C2 had a large bowel movement in another tenant's shower on the shower chair. - On 12-15-21 it was noted Tenant C2 stood in the hallway early that morning and screamed and used profanity at staff and other tenants. Staff tried to administer a PRN (as needed) medication but she would not take it. Tenant C2 "continued to threaten staff and other residents" and went into another tenant's apartment and would not come out. She scratched staff when they attempted again to administer a PRN medication. - On 12-16-21 it was noted there was discussion with Tenant C2's family as the Program did not feel they could keep her there due to her aggressive behavior. - On 12-20-21 it was noted on 12-17-21 Tenant C2 stood in the doorway of another tenant's apartment and would not come out. Staff tried to get her to come out and she pushed and hit staff and then lost her balance. Staff lowered her to the floor and tried to help her up but she kicked and said her legs hurt. On 12-18-21 it was noted Tenant C2 kept putting her arms around another tenant and would not leave him alone. He told her to leave him alone and she started yelling at him. - On 12-22-21 it was noted staff were not able to direct Tenant C2 to the toilet. Tenant C2 came out of her apartment and was found in the pet therapy area sitting on the couch with her pants down. She had defecated and urinated. Further record review revealed the December 2021 medication administration records (MARs) reflected medications were refused by Tenant C2 on nine different dates. The MARs also reflected lorazepam tablet 0.5 milligram (mg), one tablet every 8 hours as needed for anxiety, was administered over 50 times in December of 2021.	A 395		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 395	Continued From page 6 Tenant C2's service plan dated 11-11-21 reflected to redirect Tenant C2 if she went into other tenants' apartments or beds. If Tenant C2 became agitated staff were to back off, give her room and try again later. The service plan was updated on 11-29-21 to reflect staff were to observe for agitation and to separate Tenant C2 from other tenants. The service plan did not reflect the physical behaviors towards staff and other tenants, medication refusals, or defecating in places other than the bathroom. 4. When interviewed on 2-28-22 at 1:02 p.m. the Corporate Office Manager confirmed these findings.	A 395		
A 430	481-69.27(1)c 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: c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status; This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete a nurse review as needed for a change in health status for 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow:	A 430		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 430	Continued From page 7	A 430		

1. Review of Tenant C1's file on 1-27-22 revealed a Resident Incident Report dated 4-23-19 at 8:35 p.m. indicating Staff A found Tenant C1 laying in the doorway of his apartment. He was laying underneath his walker. Tenant C1 told staff that he fell by the television and he was light headed. Staff then noticed Tenant C1 had a "gash" on his forehead. The incident report indicated Tenant C1 hit his head. Staff called the Former Nurse Manager and ibuprofen was given for his fever. Tenant C1 was assisted off of the floor and into his chair. A band-aid was applied to his forehead. Tenant C1's reaction to the incident was that he laughed and said "it was just like it had happened before." Vital signs were recorded and indicated his temperature was 102.6, blood pressure was 155/85, pulse was 63 and respiration rate was 20. The incident report indicated Tenant C1's family and primary care provider (PCP) were notified.

Review of the Post Fall Follow up document revealed Tenant C1 fell on 4-23-19 at 8:45 p.m. The form indicated vitals and questions that were to be completed for three days following the fall. Staff were to notify the nurse on-call if the tenant responded "yes" to any of the questions asked. The Neurological Flow Sheet indicated on 4-24-19 at 12:35 p.m. Tenant C1's head felt very tender.

Tenant C1's file revealed diagnoses including falls, right leg plate, chronic difficulty weight bearing on the left leg, chronic left hip pain, gait instability and cognitive loss. Tenant C1 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. The service plan reflected he was independent with ambulation and transfers and used a walker. He also had a wheelchair that he

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A 430	Continued From page 8 could propel himself in for long distances if elected. Tenant C1 was discharged on 5-3-19. The tenant's Nurse's/Care Notes indicated the following: - On 4-23-19 Tenant C1 was found laying in the doorway of his apartment. His walker was on top of him. Tenant C1 reported he fell by the television and was light headed. Tenant C1 had a cut on this forehead. Tylenol was administered and a band-aid was placed. His family was notified and he did not have a fever through the night. On 4-24-19 Tenant C1 denied pain, headache, dizziness, visual disturbances or nausea and his gait was steady. Tenant C1 was reading the newspaper and it was noted "unable to tell if pupils reactive R/T fall." A bump with some bruising was noted above the right eye. A brown bruise was observed under the right eye. Tenant C1 said he had been walking over to put his eyeglasses in the enclosed area in the television stand (regarding the fall on 4-23-19). An eye glass case was found for Tenant C1, so he would not need to put the glasses in the television stand. - On 4-29-19 it was noted the area around the right eye, above and below, remained dark with a purple and blue bruise. Tenant C1 denied any pain. Further record review revealed there were no other documented nurse reviews completed related to Tenant C1's fall (on 4-23-19) between 4-24-19 to 4-29-19 despite Tenant C1 falling, hitting his head and having pain around his eye and tenderness on the bruise. Nurse reviews were not completed as needed to follow up related to the fall on 4-23-19. 2. A Resident Incident Report dated 5-3-19 at	A 430		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 430	Continued From page 9	A 430		

6:30 a.m. indicated Staff B went to get Tenant C1 for breakfast and he needed assistance to get ready. It took two staff and a gait belt "just to stand" Tenant C1. He could not bear weight on his right ankle. The Former Nurse Manager was notified. Staff B looked at his right ankle and noted it was bruised both under and above the ankle. Staff B went to get the Former Nurse Manager and she looked at it. Tenant C1 said he twisted his ankle on Wednesday and hit the door when out for an appointment, per staff. No vitals signs were documented. The family and the PCP were notified.

The tenant's Nurse's/Care Notes indicated the following

- On 5-1-19 at 9:00 a.m. it was noted Tenant C1 went to a medical appointment.
- On 5-1-19 at 3:15 p.m. it was noted Tenant C1 returned via family vehicle from his appointment with no new orders.
- On 5-3-19 Tenant C1 complained of right lower leg pain. Tenant C1 had usual swelling, however, there was bruising on the right lower leg on the outside near his right ankle. Tenant C1 complained of pain with palpitation of the bruise on the front of the leg but not the outer ankle. He required an assist of two staff to pivot transfer and did not bear any weight on his leg. The Former Nurse Manager was also told that on Thursday Tenant C1 mainly used his wheelchair but did walk a little bit. Family was notified but was not able to take him in for evaluation. The PCP's office was called to see if he wanted the tenant sent to the emergency room via ambulance or if staff should just monitor the leg.
- On 5-3-19 it was noted Tenant C1's family called and was aware he was going to the hospital. Tenant C1's family said it took the security guy and several others to get the tenant

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 430	Continued From page 10	A 430		

in an out of the truck on Wednesday (the appointment on 5/1/19). She said they carried him to get him out of the truck.
- On 5-3-19 family called and said Tenant C1 had a broken ankle and needed surgery.

Review of the hospital records revealed Tenant C1 was observed not bearing weight at the Program where he resided. Family was contacted and he was brought to the emergency room. Tenant C1 had "ecchymosis over the right ankle." X-rays indicated a bimalleolar ankle fracture. "Apparently, this patient had been walking on this for a few days." Tenant C1's family member said she had taken him to an appointment on Wednesday and he "could not really walk then, had to be helped in and out of a wheelchair." Tenant C1 fell about a week prior and when evaluated he did not complain of ankle pain at that time. He was not able to recall when the injury occurred and was not able to add any additional information. Tenant C1 had "ecchymosis over the lateral aspect of the ankle and foot, but it appeared to be old." There was a "very small medial malleolar component, which is a transverse and minimally for all displaced. He has an oblique fracture of the fibula with displacement some degree of shortening and translation." Tenant C1 "sustained a fracture, this is probably a subacute injury happened sometime within the last week." Tenant C1 elected for surgical repair and the procedure performed was a "right open reduction and internal fixation of ankle fracture."

A nurse review related to staff observing the tenant primarily using his wheelchair instead of walking could not be located. The service plan indicated Tenant C1 transferred and walked independently with his walker and used a

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 430	Continued From page 11 wheelchair for long distances if elected. This change occurred the day prior to Tenant C1 requiring the assistance of two staff and a gait belt to transfer and was non-weight bearing. Hospital records indicated Tenant C1 had a fractured ankle and the fracture had occurred in the last week before he was hospitalized. A nurse review was not completed as needed when staff noted a change with Tenant C1. 3. When interviewed on 2-28-22 at 1:02 p.m. the Corporate Office Manager confirmed these findings.	A 430		

Iowa Department of Inspections and Appeals

On behalf of River Bend I respectfully submit the following plan of correction for your approval. Our response is specific to complaint #97324-C that was investigated between 1/26/2022 and 2/28/2022.

Program Policy and Procedure

1. Incident reports will be completed as required by regulation and specified per policy. Program staff will be re-trained by RN or designee on incident report policy including needed documentation and incident reporting criteria
2. All new staff will be educated on Incident Report policy upon hire by DON or designee
3. Administrator to regularly review incident reports to ensure completion
4. The above will be completed and implemented no later than 05/06/2022

Service Plans

1. Service Plans will be developed as required by regulations and will identify tenant needs and preferences for assistance
2. All care staff and faculty will be re-educated to report new or changes in behaviors to RN for evaluation as well as where to find interventions for managing behaviors on the service plan
3. RN or designee will audit tenant service plans at least every 90 days to ensure service plans identify tenant needs and preferences for assistance
4. The above will be completed and implemented no later than 05/06/2022

Nurse Review

1. A nurse review will be completed when a tenant has a change in condition and/or is required by regulation
2. The RN was re-educated on regulatory requirement for completing a nurse review
3. RN or designee will review tenant charts at least two times per year to ensure regulatory compliance
4. The above will be completed and implemented no later than 05/06/2022

Jill Koopmans, manager 4/21/22

5/9/22