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 06/20/2023

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 impairment: 1 Number of tenants with cognitive impairment: 15 Total census: 16 No regulatory insufficiencies were cited regarding Complaint #108794-C. The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	A 000	The Plan of Correction is attached	
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure staff provided services in accordance with the training provided. This pertained 1 of 5 tenants observed on a medication pass (Tenant #5). Findings follow: 1. When observed on 6/14/23 at the lunch medication pass Staff A administered medications	A 361		

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A 361	Continued From page 1 to five tenants including Tenant #5. Staff A prepared Tenant #5's medication and put the pills in a medication cup. One of the pills was dropped on the floor. When observed, Staff A picked up the dropped medication from the floor with a bare hand, put it in the medication cup and handed it to Tenant #5 who consumed the medication. Staff A signed the off the medications administered. 2. Record review on 6/14/24 revealed Staff A had nurse delegations, most recently completed on 1/31/23, that included medication administration. Staff A also had completed a medication managers course on 5/26/22. The Director of Nursing (DON) had signed Staff A's Student Practicum Certification dated 5/24/22, which included the preparation of oral mediations. The Medication Managers Skills Checklists document indicated if a medication was dropped, including during administration, staff were to dispose of the medication and remove another tablet either from the spare in the cassette or bubble pack or the bottle. It indicated to document a spare was used as a med was dropped and to notify the nurse. 3. When interviewed on 6/20/23 at 2:41 p.m. the DON said if a medication was dropped, it should be disposed of and the next one should be used.	A 361		
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 for assistance	A 395		

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A 395	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans that reflected the identified needs of the tenants for 3 of 4 current tenants reviewed (Tenants #1, #2 and #4). Findings follow: 1. Record review on 6/19/23 of Tenant #1's file reviewed Charting Notes indicating the following: a. On 3/21/23 Tenant #1 became irritable with staff trying to assist her and she raised her feet into staff's chest and pushed her away. Staff reported Tenant #1 had been up and down all night until 4:00 a.m. and then she was up and dressed. b. On 3/24/23 it was noted staff called last evening and reported Tenant #1 had squeezed out toothpaste all over. Staff found Tenant #1 by her dresser and she tried to hit staff. Staff reported at 1:20 a.m. that Tenant #1 was very upset, angry and crying. Tenant #1 said she was attacked by a man and staff reassured her. c. On 3/25/23 Tenant #1 became verbally aggressive towards other tenants at a meal. d. On 3/27/23 it was noted staff reported last evening that Tenant #1 smeared stool in her apartment and smeared toothpaste on her dresser. e. On 3/31/23 Tenant #1 attempted to use the chair next to her bed as a toilet. Staff attempted to redirect to her toilet and she hit staff. f. On 4/3/23 it was noted last evening staff reported Tenant #1 became agitated, grabbed a staff's wrist and tried to hit her. g. On 5/12/23 staff offered assistance to toilet and she swatted away the staff's hand and became mad. When in the bathroom Tenant #1 tried to use the shower chair as a toilet. Staff	A 395		

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went into the kitchen and as the door closed Tenant #1 grabbed the handle and held it so staff could not re-open it.
h. On 5/15/23 Tenant #1 hit at a staff member when she was cleaning the chairs in the common areas.
i. On 5/17/23 the primary care provider was made aware of Tenant #1's nighttime behaviors
j. On 5/23/23 staff reported Tenant #1 was awake and active every hour on third shift. Tenant #1 threatened to kick staff when she was found trying to use her chair as a toilet.
k. On 6/16/23 Tenant #1 kept coming out in a t-shirt and underwear and had put toothpaste on like lotion.

Tenant #1's service plan dated 4/19/23 reflected required frequent redirection and the tenant had hallucinations. The service plan indicated to notify a nurse if she became agitated or combative. The service plan did not reflect the extent of Tenant #1's behaviors as noted above and interventions related to the behavior.

2. Record review on 6/19/23 of Tenant #2's file reviewed Charting Notes indicating the following:
a. On 5/16/23 Tenant #2 asked staff twice explicitly if they wanted to touch his genitals. It was noted those behaviors had occurred in the past but had been managed recently.
b. On 5/24/23 Tenant #2 would not allow staff to leave until they tucked him in. Staff reported he stood between her and the door. Tenant #1 did not touch her but was saying inappropriate sexual things.
c. On 5/30/23 it was noted that on 5/27/23 Tenant #2 walked behind a female tenant still seated at the table and put his hands under arms from the back, reached around and put his hands over her breast area. The tenant was fully

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clothed. Staff immediately redirected.
d. On 6/5/23 Tenant #2 was in the dining room and had his hands out in front of him like he was going to touch a female tenant's breast. He was a foot away and no contact was made.

Continued record review revealed the Health and Functional Assessment dated 5/24/23 indicated Tenant #2 made self deprecating remarks about his abilities.

When interviewed on 6/19/23 Staff F said Tenant #2 verbally called staff names (inappropriate) daily on second shift. She said staff ignored it or had another staff step in. She also said Tenant #2 made comments daily regarding not knowing what he was doing and wanted to be shot in the head.

When interviewed on 6/19/23 at 10:39 a.m. Staff G said Tenant #2 came towards staff with his hands making a grabbing motion and staff redirected. It happened weekly.

The tenant's service plan dated 5/24/23 reflected he made inappropriate comments to staff, especially during showers. He also touched himself inappropriately and was to be directed to his apartment for privacy. It also reflected Tenant #2 called staff provocative names and sexually inappropriate behavior might be caused with over stimulating activity in the unit. The service plan did not reflect Tenant #2's behavior towards other tenants or physically sexually inappropriate behaviors as noted above. It also did not reflect comments made by Tenant #2 as noted above regarding shooting himself.

3. Record review on 6/20/23 of Tenant #4's file revealed the service plan dated 6/1/23 reflected

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A 395	Continued From page 5 Tenant #4 required the assistance of one to two people for transfers and once up, the assistance of one person was needed. When interviewed on 6/20/23 at 2:41 p.m. the Director of Nursing (DON) revealed Tenant #4 was a two assist for transfers and he had declined in the past two weeks. Continued record review revealed Tenant #4's service plan did not reflect the recent decline and consistent use of two people for transfers. 4. When interviewed on 6/20/23 at 1:55 p.m. the Healthcare Coordinator confirmed all service plans for the tenants reviewed were provided. When interviewed on 6/20/23 at 2:41 p.m. the DON confirmed all service plans for the tenants reviewed were provided.	A 395		

River Bend
ASSISTED LIVING & MEMORY CARE
813 TYLER ST NE, CASCADE, IA 52033 - (563) 852-5081

On behalf of River Bend Retirement Community in Cascade, I'm submitting our Plan of Correction for your approval. Our response is specific to the onsite visit which ended on June 20, 2023 Assisted Living Program with Dementia (ALPD). Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of state law.

ALPD Plan of Correction

Staffing
Staff will administer medications as delegated by the RN and in accordance with River Bend policies and procedures. All staff responsible for medication administration will be retrained by the Director of Nursing. Training will review all steps with medication administration including infection control and drug disposal. The RN or designee will observe staff with medication administration at least two times per year to ensure compliance.

Service Plans
The RN will update service plans for Tenants #1 and #2. Tenant #4 no longer resides at the Program. All tenants will have a service plan that identifies tenant needs and requests for assistance. The RN and nurse designee will be re-educated on regulatory requirements for service plan development. The RN and/or designee will review service plans at least every 90 days when completing a 90 day nurse review to ensure service plans are accurate and identify tenant needs and requests for assistance.

Sincerely,

Jill Koopmann

Jill Koopmann,
Manager

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