IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
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RODNEY A. ROBERTS, DIRECTOR

August 7, 2015

Ms. Diana Niemeier, Executive Director
Village Ridge
365 Marion Blvd.
Marion, IA 52302

RE: Final Recertification Monitoring Evaluation Report – Village Ridge, Marion, IA

Dear Ms. Niemeier:

Enclosed is the **Final Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following a survey by DIA on **July 29 and 30, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Service Plans and Nurse Review.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference or a contested case hearing must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

If you have any questions in regard to this report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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
	S0026	A. BUILDING _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE RIDGE	365 MARION BLVD MARION, IA 52302

(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	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 28 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 30 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 12 Total Population of Program at time of on-site: 12 TOTAL census of Assisted Living Program: 42 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program:	A 000		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.	A 083		

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

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A 083	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of tenant files and Program documents the Program failed to develop service plans to meet the specific service needs of the tenants and to update the service plans at least annually and whenever changes were needed for five of five tenant files reviewed (Tenants #1, #2, #3, #4 and #5). Service plans were not updated as needed and did not reflect the service needs for five tenants. 1. Tenant #1, a 94 year old, was admitted on 9-11-14 and diagnoses included: aortic stenosis, spinal stenosis, macular degeneration, shortness of breath and hypertension (HTN). According to a Clinic Referral document dated 5-4-15, an order was received for a hospital bed dated 5-7-15. According to Resident Note dated 5-29-15, Tenant #1's bilateral lower legs, feet and toes had 4+ pitting edema and areas were weeping Areas were covered with telfa and wrapped with Kerlix due to weeping. According to a Resident Note dated 7-9-15 (Quarterly Assessment), Tenant #1 had a history of lower extremity bilateral edema. According to a Resident Note dated 7-9-15 (Quarterly Assessment), on 6-11-15 Tenant #1 was sent to the emergency room (ER) regarding a fall with facial contusion, subluxation of teeth, multiple skin tears and contusion of vermillion border of lower lip On 6-15-15 Tenant #1 went to the dentist and received new orders for warm salt rinses three to four times per day, to hold over tender tissue two minutes each time and repeat for five days. On 6-18-15 Tenant #1 complained of leg cramps. On 6-24-15 an order was received	A 083		

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A 083	Continued From page 2 to start Magnesium 400 milligram (mg) one tablet by mouth at bedtime. The service plan updated on 6-4-15 reflected Tenant #1 had bilateral compression hose; however, did not reflect Tenant #1's edema. The service plan did not reflect Tenant #1's leg cramps or the use of a hospital bed. The service plan did not reflect the orders for a warm salt rinse. The service plan did not reflect the service needs of Tenant #1. 2. Tenant #2, a 90 year old, was admitted on 6-22-02 and diagnoses included: atrial fibrillation, HTN, chronic obstructive pulmonary disease, anemia, pneumonia, kidney failure and cardiomyopathy. Tenant #2 received Hospice services. According to a Resident Note dated 7-10-15, Tenant #2 had 1-2+ bilateral edema in the lower extremities, Tenant #2's appetite at supper was diminished and Tenant #2 had a nutritional supplement. The Resident Note indicated staff dialed up the amount of insulin required and injected for Tenant #2 including the scheduled dose and sliding scale dose if needed. The service plan updated on 6-18-15 reflected staff administered Tenant #2's medications and assisted with blood glucose; however, did not reflect staff dialed up and injected scheduled doses of insulin and sliding scale doses as needed for Tenant #2. The service plan reflected Tenant #2 had a regular diet and was independent with cutting food. The service plan did not reflect Tenant #2's diminished appetite at supper or the nutritional supplement. The service plan did not reflect the service needs of Tenant #2.	A 083		

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A 083	Continued From page 3 3. Tenant #3, an 83 year old, was admitted on 8-18-12 and diagnoses included: seborrheic keratosis, memory loss and osteoarthritis. Tenant #3 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #3 resided in the dementia unit. Tenant #3 received Hospice services. According to a Resident Note dated 7-17-15, Tenant #3 wore long sleeves, long pants, tennis shoes, heel protectors and elbow protectors. The Resident Note indicated Tenant #3 had an air mattress. The service plan updated on 6-24-15 reflected Tenant #3 had a hospital bed; however, did not identify the air mattress. The service plan reflected staff assisted with dressing and undressing; however, did not identify Tenant #3 wore long sleeves, long pants, tennis shoes and had heel and elbow protectors. The service plan did not reflect the service needs of Tenant #3 4. Tenant #4, a 93 year old, was admitted on 11-8-13 and diagnoses included: macular degeneration, anxiety, hypothyroidism and arrhythmia and urinary tract infection (UTI). According to a Resident Note dated 6-24-15 (Quarterly Assessment), on 5-20-15 Tenant #4 was sent to the emergency room (ER) and returned with orders for Cephalexin 500 mg one capsule by mouth four times daily for seven days for a UTI. It was noted Tenant #4 had a history of UTIs. According to a Resident Note dated 7-1-15, on 6-29-15 Tenant #4 had an emesis during breakfast. A fax was sent to the doctor regarding the episode of emesis, dates of last	A 083		

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A 083	Continued From page 4 antibiotic therapy and requested a clean catch urinalysis. The doctor agreed and ordered Keflex 500 mg by mouth four times daily for 10 days. The note indicated it was a recurrent issue. According to a Resident Note dated 7-20-15, a nurse review was prompted by Tenant #4's request to go the ER for complaints of nausea. Tenant #4 returned from the ER with diagnoses of nausea and UTI. On 7-18-15 Tenant #4 went to the ER and returned with orders for Cipro 500 mg one tablet twice daily for seven days and Ondansetron 4 mg disintegrating tablet take one tablet by mouth every eight hours as needed for nausea. There was also a hand written note regarding Levaquin 500 mg once on 7-19-15 at 2:00 p.m. According to a Resident Note dated 6-24-15, Tenant #4 had 1-2+ edema noted in the lower extremities and had a history of edema. According to a Resident Note dated 7-20-15, Tenant #4 had a difficult time swallowing medications; crushed or whole in pudding. The service plan updated 6-9-15 reflected staff administered medications; however, did not reflect Tenant #4's difficulty swallowing medications. The service plan reflected Tenant #4 had compression stockings; however, did not reflect a history of edema. The service plan reflected to encourage fluids; however, did not reflect a history of UTIs. The service plan did not reflect the service needs of Tenant #4. 5. Tenant #5, an 85 year old, was admitted on 10-3-12 and diagnoses included: dementia with behavior, depression, HTN, depressive disorder, anxiety disorder and hyperlipidemia. Tenant #5 was staged at a 5.5 on the GDS, which indicated moderately severe cognitive decline. Tenant #5	A 083		

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A 083	Continued From page 5 resided in the dementia unit. According to a Resident Note dated 4-3-15, Tenant #5 was admitted to the geriatric psych unit for aggression on 3-18-15 (Nurse's Notes indicated Tenant #5 returned to the Program on 4-6-15). The Resident Note indicated staff was instructed to allow Tenant #5 time to perform Tenant #5's tasks as Tenant #5 liked to do things independently and on Tenant #5's own time. Tenant #5 could become frustrated and irritable when rushed. Staff had been instructed to leave the room for a short time if Tenant #5 was irritable and then return to Tenant #5's apartment to remind Tenant #5 of what was to be completed. Nurse's Notes dated 4-16-15 indicated Tenant #5 was admitted to the geriatric psych unit. Nurse's Notes dated 4-28-15 indicated Tenant #5 returned to the Program. According to Nurse's Notes dated 5-12-15, staff wanted to check Tenant #5's protective undergarment and Tenant #5 grabbed staff by the shirt and swore at staff. Tenant #5 also tried to bite staff. According to a Resident Note dated 5-15-15, Tenant #5 used a hospital bed. According to a fax to Tenant #5' doctor, Tenant #5 was refusing medications and at times staff would give verbal cues three times for Tenant #5 to take medications. According to a Resident Note dated 7-6-15, Tenant #5 had an order for calmoseptine to the coccyx and the skin remained pink and non-tender to touch. The service plan updated 7-23-15 did not reflect Tenant #5's aggressive behavior and interventions related to the behavior The service plan reflected staff administered Tenant #5's medications; however, did not reflect Tenant #5 refused medications and interventions related to	A 083		

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A 083	Continued From page 6 the refusals. The service plan did not reflect the hospital bed or the skin issue and treatment. The service plan did not reflect the service needs of Tenant #5. 6. According to the Program's policy regarding service plans, the purpose of the policy was to provide guidelines for the development of the service plans to meet the specific service needs of the tenant.	A 083		
A 087	481-69.26(3)b Service Plans 481-69 26(231C) 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. b. If a significant change does not exist, the program may, after nurse review, add minor discretionary changes to the service plan without a comprehensive evaluation and without obtaining signatures on the service plan. This REQUIREMENT is not met as evidenced by: Three tenant files reviewed reflected minor and discretionary changes were made to the service plan; however, nurse reviews completed by a licensed practical nurse (LPN) or registered nurse (RN) were not completed related to the changes. 1. Tenant #1, a 94 year old, was admitted on 9-11-14 and diagnoses included: aortic stenosis, spinal stenosis, shortness of breath and hypertension (HTN).	A 087		

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A 087	Continued From page 7 The service plan was updated on 6-4-15 and reflected therapy was discontinued. Nurse's Notes dated 6-4-15 indicated notes were received from physical therapy (PT)/occupational therapy (OT) and Tenant #1 was discharged. The entry in Nurse's Notes was charted by an unlicensed staff. A nurse review was not completed by a LPN or RN related to discharge from therapy and when a minor discretionary change was made to the service plan. A nurse review was not completed as needed. 2. Tenant #4, a 93 year old, was admitted on 11-8-13 and diagnoses included: macular degeneration, anxiety, hypothyroidism and arrhythmia. The service plan was updated on 6-9-15 and reflected therapies were completed. Nurse's Notes dated 6-12-15 indicated therapy notes received for Tenant #4's discharge from PT/OT. The entry in Nurse's Notes was charted by an unlicensed staff and was completed after the change was made to the service plan A nurse review was not completed by a LPN or RN related to Tenant #4's discharge from therapy and when a minor and discretionary change was made to the service plan. A nurse review was not completed as needed. 3. Tenant #5, an 85 year old, was admitted on 10-3-12 and diagnoses included: dementia with behavior, depression, HTN, depressive disorder, anxiety disorder and hyperlipidemia. Tenant #5 was staged at a 5.5 on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant #5 resided in the dementia unit. The service plan was updated on 7-23-15 and	A 087		

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A 087	Continued From page 8 reflected Tenant #5 was discharged from PT. A nurse review was not completed related to Tenant #5's discharge from PT and when a minor and discretionary change was made to the service plan. A nurse review was not completed as needed.	A 087		
A 094	481-69.27(1) Nurse Review 481-69.27(231C) Nurse review. 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 or a licensed practical nurse via nurse delegation: 69.27(1) To monitor, at least every 90 days, or after a significant change in the tenant ' s condition, any tenant who receives program-administered 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 review of tenant files and Program documents the Program failed to complete nurse reviews to monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders were current and that the prescription medications were	A 094		

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A 094	Continued From page 9 administered consistent with such orders for two of five tenant files reviewed (Tenants #1 and #2). Nurse reviews were not completed by a licensed practical nurse (LPN) or registered nurse (RN) when there were changes and new physician orders were received for medications or treatments for two tenants. 1. Tenant #1, a 94 year old, was admitted on 9-11-14 and diagnoses included: aortic stenosis, spinal stenosis, shortness of breath and hypertension (HTN). According to Nurse's Notes dated 5-29-15, an order was received regarding the right leg skin tears to cover areas with telfa and wrap with Kerlix until clear. The entry was completed by an unlicensed staff; however, a licensed staff completed a nurse review on 5-29-15. Nurse's Notes dated 6-4-15 indicated a fax was received from the doctor to discontinue the telfa and wrap with Kerlix every day to the right leg. The entry was completed by a unlicensed staff and no nurse review was found. Nurse's Notes dated 6-15-15 indicated Tenant #1 returned from the dentist. Warm salt rinses three to four times per day, hold over tender teeth tissue, for two minutes each time for five days was ordered. The entry was charted by an unlicensed staff. According to Nurse's Notes dated 6-18-15, a fax was sent to the doctor due to Tenant #1 complaining of leg cramps at all times of the day making it difficult to walk. According to Nurse's Notes dated 6-24-15 an order for Magnesium Oxide 400 milligram one tablet by mouth at bedtime for leg cramps was ordered. The doctor also ordered to re-check the magnesium level in one week. The entries on 6-18-15 and 6-24-15 were completed by	A 094		

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A 094	Continued From page 10 unlicensed staff. Nurse reviews were not completed by either an LPN or RN related to changes and new medication orders for Tenant #1. Nurse reviews were not completed as needed. 2. Tenant #2, a 90 year old, was admitted on 6-22-02 and diagnoses included: atrial fibrillation, HTN, chronic obstructive pulmonary disease, anemia, pneumonia, kidney failure and cardiomyopathy. Tenant #2 received Hospice services. Nurse's Notes dated 5-19-15 indicated a fax was sent to Tenant #2's doctor to request an order for Miralax 17 gram (gm) in water every three days due to Tenant #2 having hard stool. Nurse's Notes dated 5-22-15 indicated a new order was received for Miralax 17 gm in water or juice every three days for constipation. The entries in Nurse's Notes on 5-19-15 and 5-22-15 regarding new medications orders and hard stools/constipation were completed by unlicensed staff. Nurse's Notes dated 6-8-15 indicated a new order was received to add Novolog five units before meals plus sliding scale. A Resident Note dated 6-18-15 indicated a change in Tenant #2's medication was noted after May's monthly blood glucose readings were reported. The entry in the Nurse's Notes regarding a new order for Tenant #2's insulin including sliding scale insulin was charted by unlicensed staff. Nurse's Notes dated 7-23-15 indicated Tenant #2 was having loose incontinent stools. Hospice was notified and a new order was received to discontinue Docusate twice daily and change to	A 094		

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A 094	Continued From page 11 twice daily as needed for constipation. The entry in notes regarding a new medication order for Tenant #2 was charted by unlicensed staff. Nurse reviews were not completed by either an LPN or RN related to changes and new medication and treatment orders for Tenant #2. Nurse reviews were not completed as needed. 3. According to the Program's policy and procedure regarding nurse review, all tenants who receive personal or health-related care would be reviewed by a RN or by a LPN via nurse delegation at least every 90 days, or after significant change in a tenant's condition. The nurse would monitor, at least every 90 days or after a significant change in the tenant's condition any tenant who received program administered prescription medications for adverse reactions to the medication and would make appropriate interventions and referrals. The nurse would ensure the prescription medication orders were current and the prescription medications were administered consistent with the health provider's orders.	A 094		

Tapestry Senior Living of Marion, LLC

DBA Village Ridge

July 29-30, 2015 Monitor's Visit

Plan of Correction

A. A083 481-69.26 (1) Service Plans

69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed

A 087 481-69.26(3) b Service Plans

481-69 26(231C) 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.

b. If a significant change does not exist, the program may, after nurse review, add minor discretionary changes to the service plan without a comprehensive evaluation and without obtaining signatures on the service plan.

481-69.26 (231C) Service Plans: Regulatory Insufficiency: **A083**

481-69 26(3) b Service Plans: Regulatory Insufficiency: **A087**

The regulations have been reviewed by the Executive Director, The Director of Healthcare and by the LPN.

The Service Plans for Residents 1, 2, 3, 4 and 5 were reviewed and updated by 8/12/15 and include all current physician orders, however Resident 4 died on 8/13/15. The Service Plans were reviewed by the Healthcare Services Coordinator.

All resident Service Plans will be reviewed by 9/30/15 and will be reviewed by the Director of Healthcare for accuracy.

The Healthcare Services coordinator will do quarterly reviews of the Service Plans for 10% of resident census.

B. AO94 481-69.27(1) Nurse Review

481-69.27 (231C) Nurse Review. 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 or a licensed practical nurse via nurse delegation:

69.27(1) To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medication 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.

The regulation and the facility policy have been reviewed by the Executive Director, the Director of Healthcare and the LPN. The Service Plans for Resident 1 and 2 have been updated and reviewed by the Healthcare Services Coordinator.

To ensure that nurse reviews are being completed and to ensure that the problem does not recur the RN and LPN will complete a nurse review with all physicians' orders. Beginning September 1, 2015 the unlicensed staff may continue to transcribe orders, but the licensed staff must complete a review, note the review in the medical record and update the service plan. The unlicensed staff will maintain a log of the orders received and licensed staff will check the log within 24 hours and initial the log when a review is complete. The log will be checked by the Healthcare Services Coordinator on a monthly basis. All nursing staff will be trained on new procedure prior to September 1, 2015.

The Executive Director, the Director of Healthcare and a LPN will be attending the seminar offered by ICAL on Thursday, August 20th in Des Moines.