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
	930028	A. BUILDING: _____ B. WING _____	09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE RIDGE	305 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	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. General Population Number of tenants without cognitive disorder: 34 Number of tenants with cognitive disorder: 1 Memory Care Unit Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 13 TOTAL Census of Assisted Living Program for People with Dementia: 50	A 000	A review of regulation 481.69.26(4) (231) To ensure compliance the Director of Healthcare and Nurse Coordinator have reviewed regulations, clinical updates/master care plan with Executive Director. Service Plans will be reviewed by Executive Director and Corporate Nurse through random chart audits in 60 days and 120 days to ensure compliance. The service plan/master care plan for tenants #1 and #2 have been reviewed and updated to reflect tenants current status by Director of Healthcare.	9/12/19
A 069	481-69.26(4)a Service Plans 481-69.26(231C) 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to develop service plans that reflected identified needs for 2 of 5 tenants reviewed (Tenants #1, #2). Findings follow: 1. On 9-10-19 review of Tenant #1's file revealed he was admitted to the Program on 7-8-19 and	A 069		

10/28/19

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	80026	A. BUILDING: _____ B. WING _____	09/11/2019

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 089	Continued From page 1	A 089		

resided in the general population of the building. He moved to the memory care unit on 8-30-19 following a hospitalization.

Tenant #1's Master Care Plans dated 8-1-19 and 9-5-19 reflected he smoked 5 to 10 cigarettes per day. Smoking materials were stored by the Program in the medication room with the tenant's permission. He had access to them 24/7. The plans identified Tenant #1 was able to smoke safely without intervention.

When interviewed on 9-10-19 at 3:45 p.m. the Director of Health (DOH) revealed since Tenant #1 moved to the dementia unit on 8-30-19 he had only requested a cigarette a couple of times. Staff went with Tenant #1 when he smoked. When Tenant #1 resided in the general population he would go out the front door to the smoking area without any staff supervision.

Tenant #1's service plan dated 9-5-19 was not revised to reflect what type of supervision was needed or provided when smoking.

2. Review of Tenant #2's file on 9-10-19 revealed a Progress Note from the tenant's Advanced Registered Nurse Practitioner dated 8-16-19 reflecting a medical visit to assess a wound on Tenant #2's heel. Staff reported she had developed a wound on the left heel that appeared to have caused pain. An area on the back of her left heel approximately one inch in diameter and erythematous was noted. There was an area in the center, approximately 1/4 inch in diameter that appeared to be slightly open. The diagnoses was a pressure injury of the left heel (staged at a 1). The orders indicated to float heels at night and apply Mepilex border to the area and change every three days and as needed until healed.

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	96026	A. BUILDING: _____ B. WING _____	09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE RIDGE	395 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 099	Continued From page 2	A 099		

A Fax Transmission document dated 8-21-19 indicated an order to discontinue petroleum jelly and Desitin and initiate A & D Ointment as a barrier three times daily and as needed to an area of excoriation on the buttocks.

The Master Care Plan dated 7-8-19 reflected Tenant #2's buttocks were excoriated and petroleum gel was applied per order. The service plan was not updated to reflect the change from petroleum jelly to A & D Ointment three times daily and as needed as a barrier. It also did not reflect the area on Tenant #2's heel and treatment including floating the heels and Mepilex every three days and as needed.

3. When interviewed on 9-11-19 at 12:50 p.m. the DOH revealed the current service plans were provided for Tenant #1 and Tenant #2.

A 138	481-69.32(2) Life Safety	A 138	A review of 481-69.32(2) Life Safety. Front exterior door remains alarmed 9/5/19. Review of the policy/procedures no current changes needed on door alarms. 9/17/19-Inservice provided for staff on exterior door alarms during facility monthly staff meeting. Staff educated on door alarms. Door alarms are on at all times, and continue to be checked randomly throughout the day on an in house log sheet.	9/5/19 9/12/19 9/30/19

481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements.

69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the Program failed to have an operating alarm system connected to each exit door in a dementia-specific program as required. Findings follow:

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

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A 138	Continued From page 3 Observation on 9-5-19 at approximately 11:20 a.m. revealed the front door was not alarmed. There was an alarm located on the top of the door; however, an alarm did not sound when opened. When interviewed on 9-5-19 at approximately 11:20 a.m. the Executive Director revealed the front door was not alarmed during the hours Staff C was at the front desk. All other exterior doors were alarmed. On 9-10-19 at 2:35 p.m. the Executive Director said previously the front door was unlocked from the exterior at 5:30 a.m. but was still alarmed until 8:00 a.m. when it was attended by Staff C at the front door. The alarm was turned back on between 5:15 p.m. and 5:30 p.m. This protocol was changed on 9-5-19 to have the front door locked from the exterior and alarmed. The Program was getting bids for a new alarm system. On 9-10-19 at 3:45 p.m. the Director of Health (DOH) revealed previously the front door was kept alarmed until Staff C arrived at approximately 8:00 a.m. and it was re-alarmed in the evening when front office staff left between 5:00 p.m. and 8:00 p.m. On the weekends, she believed it was alarmed.	A 138	During the review process of the exterior front door entrance, the facility has ordered a new door alarm through Hi-Tech Communications for front exterior entrance. Per Hi-Tech Communications this is a specialty order. Placement of this system is approximately 45 to 60 days out. Staff will be educated on new system along with tenants and their families. The current system is functioning with the alarm on at all times.	ordered 10/9/19 12/1/19