

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/18/2021
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NAME OF PROVIDER OR SUPPLIER VILLAGE RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 365 MARION BLVD MARION, IA 52302
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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: 32 Number of tenants with cognitive disorder: 2 Memory Care Unit Number of tenants without cognitive disorder: 5 Number of tenants with cognitive disorder: 13 Total Census: 52 There were no regulatory insufficiencies cited during the onsite infection control survey. A comment was made to the Program regarding the recommendations for eye protection for staff. The investigation of Complaints #97032-C and #97225-C and the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program were completed. The following regulatory insufficiencies were identified:	A 000		
A 335	481-67.9(3) Staffing 67.9(3) Training documentation. The program shall have training records and staffing schedules on file and shall maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 335	Reviewed regulation 481.679(3)- Staffing-training documentation. Staff files have been reviewed for training, documentation, nurse delegation on certified and noncertified staff this was completed by 12-31-2021. All staff files have been updated to reflect training and documented by Director of Healthcare. Human Resources and Executive Director (or designee) random audit on staff files 30day, 90day and 120 day to ensure compliance of regulation. The competency skills check list added colostomy care to the form for training documentation for nurse delegation that the program provides. Staff B, re-educated by D.O.H on colostomy care- competency task sheet has been updated and documented and completed. Staff C-Not employed as of 11-24-21 Staff D- Not employed as of 02-03-21	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 335	Continued From page 1 Program failed to provide training documentation for all nurse delegated tasks, including colostomy care for 3 of 6 staff reviewed (Staff B, C and D). Findings follow: 1. Record review on 11-15-21 and 11-16-21 of Staff B's training documents revealed a hire date of 12-5-20. Staff B had nurse delegated training document on tasks dated 12-12-20, including catheter care; however, did not have any documented training on colostomy care. 2. Record review on 11-15-21 and 11-16-21 of Staff C's training documents revealed a hire date 9-2-21. Staff C had nurse delegated training on tasks dated 9-8-21, including catheter care; however, did not have any documented training on colostomy care. 3. Record review on 11-15-21 and 11-16-21 of Staff D's training documents revealed a hire date of 9-30-21. Staff D had nurse delegated training on tasks dated 10-6-21, including catheter care; however, did not have any documented training on colostomy care. 4. When interviewed on 11-18-21 at 2:44 p.m. the Director of Healthcare confirmed Staff B and Staff D assisted with colostomy care. There were two tenants who received staff assistance with colostomy care. She said she covered training of colostomy care with staff.	A 335			
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		Reviewed regulation 67.9(4) Nurse delegation procedures. Staff files have been reviewed for nurse delegation procedures on certified and noncertified delegation 12-31-2021. Human resources and Director of Healthcare or designee will randomly review files 30day, 90day and 120day to ensure compliance of regulation. Director of Healthcare training on nurse delegation procedures will be completed by 1-16-2022. Staff A -re-educated on policy and procedure of insulin administration same day as surveyor observed medication pass completed 11-17-2021. All staff re-educated who administers insulin medication received training by the Director of Healthcare completed 11-23-2021. Training of insulin policy and procedure on current delegation task sheet.		

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A 361	Continued From page 2 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 their for 1 of 1 tenants observed receiving insulin (Tenant #4). Findings follow: 1. When observed on 11-16-21 at approximately 10:55 a.m. Staff A administered medications to four tenants including Tenant #4. Tenant #4 independently took her blood glucose, which was 133. She was prescribed sliding scale insulin. Staff A asked if she wanted to inject her insulin or if she wanted Staff A to administer it. Tenant #4 elected for Staff A to administer the insulin. Staff A injected the insulin in Tenant #4's abdomen without donning gloves. 2. When interviewed on 11-17-21 at approximately 1:33 p.m. Staff A said Tenant #4 always took her own blood glucose and it was up to her if she would administer her own insulin or if she wanted staff to do it. Staff A confirmed she was not wearing gloves when Tenant #4's insulin was administered during the observed medication pass. She said she typically wore gloves when insulin was administered. 3. Review of Staff A's training documents revealed the most recent nurse delegation training was completed in April of 2021, which included training on insulin administration. 4. Review of a Program training document	A 361		

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A 361	Continued From page 3 reflected staff were to wear gloves when administering insulin. 5. On 11-18-21 at 2:44 p.m. the Director of Healthcare confirmed staff were to wear gloves when insulin was administered. 6. On 11-17-21 at 3:46 p.m. the Executive Director confirmed Staff A had received training on insulin administration and staff were to wear gloves when insulin was administered.	A 361			
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have ensure dependent adult abuse training was completed within six months of employment for 1 of 1 staff reviewed employed greater than six months (Staff B). Findings follow: Record review on 11-15-21 and 11-16-21 of Staff B's training records revealed a hire date of 12-5-20. Staff B had certificate for completion of the Dependent Adult Abuse Mandatory Reporter Training dated 11-16-21. There was no additional dependent adult abuse training provided completed before 11-16-21 or within six months of Staff B's hire. When interviewed on 11-17-21 at 3:46 p.m. the	A 380	Reviewed 481-67.9(6) Staffing Dependent adult abuse training. Staff files have been reviewed for training on Dependent adult abuse training. Dependent Adult Abuse training has been added to the orientation process for new employees. Human Resource or designee will track and audit current employees files for training on Dependent adult abuse to ensure compliance of regulation. Staff B- Dependent Adult Abuse Training completed 11-16-2021		

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A 380	Continued From page 4 Executive Director confirmed no additional dependent adult abuse training was found for Staff B.	A 380			
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed with significant change and failed to have significant change evaluations completed by registered nurse or human service professional. This pertained to of 2 of 3 current tenants reviewed (Tenants #1 and #2) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: 1. Review of Tenant #1's file on 11-16-21 and 11-17-21 revealed a Clinical Update Summary was completed by Staff E, a licensed practical nurse (LPN), on 10-29-21. The Clinical Update Summary indicated a change of condition, hospice services and a nurse review. A Cognitive	A 145	481-69.22(3) Evaluation annually and with significant change To ensure compliance the Director of Healthcare, Nurse Coordinator have reviewed regulations, evaluation annually and with significant change with the Executive Director. The Executive Director will attend the Director of Healthcare and Nurse Coordinator meetings bi-weekly . Then review the nurse who is responsible for completing the evaluation. The Executive Director or Corporate Nurse will either review the completed assigned review or will delegate it to another nurse. Review of current tenants charts on evaluation annually and with significant change completed by 12-31-2021. Director of Healthcare and Nurse Coordinator or designee will do random chart audits 30, 90, 120 day to ensure compliance with regulation. Staff E-Nurse Coordinator (LPN) has been reeducated on regulation which was completed day of surveyor exit, along with 481 Table A. Tenant 1-Chart has been reviewed and updated by RN Completed by 12-31-2021 Tenant 2- Tenant discharged 11-19-2021 prior survey. Tenant C2-Tenant record was closed record. Tenant C2 was discharge 04-21-021 The nurse who was responsible for the oversight Tenant C2 during this timeframe no longer works at the program (terminated)		

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A 145	Continued From page 5 Ability Assessment was also completed by Staff E, dated 10-29-21. Continued review revealed the Service Agreement AL dated 10-29-21 indicated Tenant #1 had level 3 care package. The previous Service Agreement AL dated 5-7-21 indicated Tenant #1 had a level 2 care package. A Nurse's Note dated 10-23-21 Indicated Tenant #1 was admitted to hospice services. Tenant #1 had a change of condition, including the addition of hospice services and an increased level of care. Evaluations were completed with the change of condition; however, the evaluations were completed by an LPN, when a significant change occurred. 2. Review of Tenant #2's file on 11-16-21 and 11-17-21 revealed a Clinical Update Summary was completed by Staff E, on 7-8-21. The Clinical Update Summary indicated a change of condition. A Cognitive Ability Assessment was also completed by Staff E, dated 7-8-21. Continued record review revealed the Master Care Plan dated 7-8-21 indicated the review was prompted by a change in condition. Tenant #2 was seen for a placement of an indwelling Foley catheter. Catheter care would be provided by staff. Tenant #2 had a change of condition, including the placement of an indwelling Foley catheter and staff assistance with catheter care. Evaluations were completed with the change of condition; however, the evaluations were completed by an LPN, when a significant change occurred.	A 145		

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A 145	Continued From page 6 3. Review of Tenant C2's file on 11-16-21 and 11-17-21 revealed Tenant C2 had a diagnosis of dementia and was staged at a 5.8 on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant C2 was discharged to a higher level of care on 4-21-21. Resident Notes indicated the following: - On 2-3-21 it was noted Tenant C2 had a witnessed fall. Staff could not intervene due to Tenant C2 striking out at staff. The primary care provider (PCP) was notified of the fall and given an update regarding increased aggression, exit seeking and tearful behaviors since the discontinuation of Seroquel on 12-24-20. - On 3-3-21 it was noted Tenant C2 was observed on the floor on 2-25-21. There was a red mark on her cheek and her right eyebrow was swollen. - On 3-30-21 it was noted Tenant C2 had an unwitnessed fall on 3-27-21. Staff noted a large bump on her forehead and an abrasion near the left eyebrow. Tenant C2's family took her to the emergency room (ER) and she returned with traumatic injury of the head. - On 3-30-21 it was noted Tenant C2 had a skin tear to her left hand. Staff went to her apartment as Tenant C2 did not want to get up and she began hitting staff. Staff held her arms to prevent her from hitting staff and to assist her to her feet. A skin tear was noted and the area was washed with soap and water. - On 4-6-21 Tenant C2 had a unwitnessed fall and staff observed her on the floor. - On 4-12-21 it was noted Tenant C2 had an unwitnessed fall in another tenant's apartment on 4-11-21. - On 4-12-21 it was noted Tenant C2 was not able to be redirected by staff. She was unsteady when ambulating with her walker, and was going into other tenants' apartments. Tenant C2 had	A 145		

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A 145	Continued From page 7 been hitting staff with her fists when they tried to redirect her. She yelled that she needed to go to Cedar Rapids and to let her out. The PCP Indicated Tenant C2 needed to go to the ER for a direct admit to the behavioral unit. A fax to the PCP dated 4-2-21 indicated Tenant C2 continued to hit, strike out and kick staff, mostly at night, but at times during the day. Tenant C2 had become more confused and occasionally tried to open the memory care door. Staff provided interventions; however, the interventions were not successful lately. Further record review revealed the most recent evaluations were dated 11-17-20, which was for the annual assessment and nurse review. No change of condition evaluations for falls, behaviors and unsuccessful interventions and increased confusion could be located. 4. When interviewed on 11-18-21 at approximately 3:55 p.m. the Director of Healthcare confirmed Staff E (an LPN) completed the evaluations for Tenant #2. In addition, no change of condition evaluations for Tenant C2 were in the tenant's file.	A 145			
A 350	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 350	481-69.26(1) Service Plans Review of the regulation Service Plans with Director of Healthcare, Nurse Coordinator and Executive Director. Review of current tenant's charts on service plans will be completed by 12-31-2021. Director of Healthcare, Nurse Coordinator or designee will review random chart audits randomly at 60 day and 120 day to ensure compliance. This information on service plans will also include the Executive Director and or Corporate Nurse for review for compliance. Tenant 2- Tenant discharged 11-19 -2021 Tenant 3- Service Plan was updated by Director of Healthcare to reflect tenant current status completed 12-05-2021 Tenant C2 Tenant record closed discharged 04-21-2021 prior to survey.		

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A 350	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed for 2 of 3 current tenants (Tenants #2 and #3) and 1 of 2 discharged tenants (Tenant C2). Findings follow: 1. Review of Tenant #2's file on 11-16-21 and 11-17-21 revealed a Resident Note dated 8-3-21 indicating Tenant #2 had excoriated areas on his groin and testicles. Tenant #2 had a indwelling catheter and staff provided assistance with the care. A fax was sent to the primary care provider (PCP) on 8-2-21 to request a treatment order. Continued record review revealed a fax to the PCP indicated an order was received to wash with soap and water, pat dry and apply a light "dusting" of Nystatin powder topically to the affected areas twice daily. The treatment could be repeated up to 2 more times a day as needed. The order was noted on 8-3-21. Tenant #2's Master Care Plan was dated 7-8-21. The service plan did not reflect the excoriated areas and treatment. 2. Review of Tenant #3's file on 11-16-21 and 11-17-21 revealed Resident Notes indicated the following: - On 8-19-21 it was noted Tenant #3 had a fall in the bathroom on 8-18-21. Tenant #3 was taken to the emergency room (ER) and was seen for a fall, scalp hematoma and urinary tract infection (UTI) without hematuria. Tenant #3 returned to the Program with an order for Ciprofloxacin 250 milligram (mg), one tablet twice daily for five days. - On 8-26-21 it was noted the antibiotic therapy	A 350		

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A 350	Continued From page 9 was completed for the UTI. On 8-21-21 an order was received to change the antibiotic from Ciprofloxacin 250 mg, twice daily for five days to Cephalexin 500 mg, twice daily for five days (positive urine culture). It was noted Tenant #3 had a history of UTIs. - On 10-7-21 it was noted on 10-5-21 an order was received to begin antibiotic therapy for recurring UTIs. An order was received for Cephalexin 500 mg, by mouth, four times per day for 10 days and Macrochantin 100 mg, daily for 60 days. - On 10-15-21 It was noted Tenant #3 had completed the Cephalexin antibiotic and would continue Macrochantin as ordered. Tenant #3's Master Care Plan dated 2-8-21 reflected a history of UTIs in the Client History section. The service plan did not reflect anything additional regarding UTIs, including increased urination, falls or other changes when Tenant #3 presented with a UTI. The plan did not address the treatment of the UTIs both acute and recurring. 3. Review of Tenant C2's file on 11-16-21 and 11-17-21 revealed Tenant C2 had a diagnosis of dementia and was staged at a 5.8 on the Global Deterioration Scale, which indicated moderately severe cognitive decline. Tenant C2 was discharged to a higher level of care on 4-21-21. Resident Notes indicated the following: - On 2-3-21 It was noted Tenant C2 had a witnessed fall. Staff could not intervene due to Tenant C2 striking out at staff. The primary care provider (PCP) was notified of the fall and given an update regarding increased aggression, exit seeking and tearful behaviors since the discontinuation of Seroquel on 12-24-20. - On 3-3-21 It was noted Tenant C2 was	A 350		

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A 350	Continued From page 10 observed on the floor on 2-25-21. There was a red mark on her cheek and her right eyebrow was swollen. - On 3-30-21 it was noted Tenant C2 had an unwitnessed fall on 3-27-21. Staff noted a large bump on her forehead and an abrasion near the left eyebrow. Tenant C2's family took her to the emergency room (ER) and she returned with traumatic injury of the head. - On 3-30-21 it was noted Tenant C2 had a skin tear to her left hand. Staff went to her apartment as Tenant C2 did not want to get up and she began hitting staff. Staff held her arms to prevent her from hitting staff and to assist her to her feet. A skin tear was noted and the area was washed with soap and water. - On 4-6-21 Tenant C2 had a unwitnessed fall and staff observed her on the floor. - On 4-12-21 it was noted Tenant C2 had an unwitnessed fall in another tenant's apartment on 4-11-21. - On 4-12-21 it was noted Tenant C2 was not able to be redirected by staff. She was unsteady when ambulating with her walker, and was going into other tenants' apartments. Tenant C2 had been hitting staff with her fists when they tried to redirect her. She yelled that she needed to go to Cedar Rapids and to let her out. The PCP indicated Tenant C2 needed to go to the ER for a direct admit to the behavioral unit. A fax to the PCP dated 4-2-21 indicated Tenant C2 continued to hit, strike out and kick staff, mostly at night, but at times during the day. Tenant C2 had become more confused and occasionally tried to open the memory care door. Staff provided interventions; however, the interventions were not successful lately. The tenant's service plan dated 11-17-20	A 350		

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A 350	Continued From page 11 reflected Tenant C2 occasionally would strike out or kick at staff and was occasionally up all night. The service plan reflected Tenant C2 had three falls in the previous 90 day period. The service plan also reflected Tenant C2 had a slow and steady gait. The service plan was not updated as needed to reflect Tenant C2's increased confusion, increased behaviors and falls and changes in gait. 4. When interviewed on 11-18-21 at 3:55 p.m. the Director of Healthcare confirmed these findings.	A 350		
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 nurse reviews every 90 days for tenants that received personal or health related care. This pertained to 1 of 3 current tenants reviewed (Tenant #3) and 2 of 2 discharged tenants reviewed (Tenants C1 and C2). Findings follow:	A 430	481-69.27(1)c Nurse Review To ensure compliance the Director of Healthcare and Nurse Coordinator has reviewed regulations. Director of Healthcare and Nurse Coordinator or designee will audit tenant files. Director of Healthcare, Nurse Coordinator or designee random chart audits in 30, 90, and 120 days to ensure compliance. Director of Healthcare and Nurse Coordinator re-educated on nurse reviews on tenant refusal of assessment. Tenant 3- Tenant file reviewed and updated to reflect tenants current status by Director Of Healthcare 12- 05-2021 Tenant- C1- Tenant record closed discharged 08-02-2021. Tenant C2-Tenant record closed discharged 04-21-2021 The nurse who was responsible for oversight of tenant C2 during Timeframe is no longer with the program.	

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/18/2021
NAME OF PROVIDER OR SUPPLIER VILLAGE RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 430	Continued From page 12 1. Review of Tenant #3's file on 11-16-21 and 11-17-21 revealed Clinical Update Summary dated 2-8-21. The summary indicated it was an annual assessment. The next Clinical Update Summary was dated 6-2-21, which was greater than 90 days from the previous evaluation. 2. Review of Tenant C1's file on 11-16-21 and 11-17-21 reflected a Clinical Update Summary dated 12-15-20. The summary indicated it was a discretionary change and nurse review. Nurse's Notes documented two refusals of assessments in March of 2021; however, no further attempts to complete the assessment were documented. Tenant C1 was discharged on 8-2-21. No additional 90 day reviews were completed between 12-15-20 and Tenant C1's discharge. 3. Review of Tenant C2's file on 11-16-21 and 11-17-21 reflected a Clinical Update Summary dated 11-17-20. The summary indicated it was an annual assessment. Tenant C2 was discharged on 4-21-21. No additional 90 day reviews were completed between 11-17-20 and Tenant C2's discharge. 4. When interviewed on 11-17-21 at approximately 1:40 p.m. the Executive Director confirmed there were no 90 days evaluations located in the time period requested for Tenant C2. 5. When interviewed on 11-18-21 at approximately 3:55 p.m. the Director of Healthcare said Tenant C1 was discharged in August; however, left on 6-29-21. There were no other 90 day reviews found for Tenant C1 from March 2021 to June 2021. There were no other 90 day reviews found from 11-17-20 to the time of	A 430		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2021
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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 430	Continued From page 13 Tenant C2's discharge. Regarding Tenant #3, there were no other 90 day nurse reviews from 2-8-21 to June 2021. She said there had been issues with computers in the spring of 2021.	A 430		