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 _____	04/22/2024

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	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: 32 Number of tenants with cognitive impairment: 13 Total census: 45 The following regulatory insufficiencies were cited the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	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 established policy and procedure related to medication administration and documentation of medication regarding 2 of 4 tenants reviewed (Tenant #2 and Tenant #3). Findings follow: 1. Review of Tenant #2's file on 4/18/24 revealed the February 2024 medication administration record (MAR) reflected the following orders: a. Ertapenen injection 1 gram (GM), add 3.2 milliters (ml) of Lidocaine to 1 GM vial of Invanz, mix thoroughly and inject intramuscular (IM) daily for seven days. It had a start date of 2/20/24 and	A 150	481-67.2(3) Review of the regulation of Policies and Procedures with the Executive Director (RN), Director of Healthcare, and nurse coordinators for AL/MC. Education/training provided to Executive Director, Director of Healthcare, and Nurse coordinators for AL/MC. Education/training provided to Executive Direct, Director of Healthcare, and nurse coordinators regarding medication management policies and procedures, and documentation by date of state surveyor exit 4/22/2024 and again on 5/10/2024 in nursing meeting. Program nurses were specifically educated on the process of reviewing/noting orders, ensuring that all components including, but not limited to, the ability to enter units of insulin/injectable given, and/or specific nursing instructions are able to be documented/appear on the MAR/service plan if indicated. It should be noted that this deficiency was identified and corrected on 3/1/2024 prior to state surveyor arrival on 4/18/2024. Future medication orders, but not limited to, will be co-reviewed by another nurse within the facility for all components of the order. MARs of all tenants who currently are administered injectables have been reviewed and updated. Nurse coordinators for both AL/MC will meet weekly for the next 30 days to review noted orders and that all components of an order have been met. Random chart audits will be conducted by DOH/designee during the next 60 days to 120 days to ensure future compliance with all new orders.	

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

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 _____	04/22/2024

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 150	Continued From page 1 stop date of 2/27/24. The scheduled time was between 10:00 a.m. to 1:00 p.m. The MAR reflected the initials of three staff for the administration of the medication: Staff A, Staff B and Nurse Coordinator #1. b. Lidocaine injection 1%, add 3.2 ml of Lidocaine to 1 GM vial of Invanz, mix thoroughly, inject IM daily for seven days. The scheduled time was 9:00 a.m. to 1:00 p.m. The MAR reflected the initials of three staff for the administration of the medication: Staff A, Staff B and Nurse Coordinator #1. 2. When interviewed on 4/22/24 at 10:30 a.m. Staff A said did not administer Tenant #2 an injectable medication. Regarding her initials on the MAR, she said she probably just signed it after the nurse gave the medication. She confirmed she had not administered an IM medication. On 4/22/24 at 10:55 a.m. Staff B said she not administer an IM injection to Tenant #2. She assumed she was logged in and one of the nurses gave the injection and clicked it, regarding her initials on the MAR. She was not aware of any non-licensed staff who had administered an IM injection. When interviewed on 4/22/24 Nurse Coordinator #1 said he and the Director of Health administered the IM medications to Tenant #2. He was not aware of any non-licensed staff who administered them. On 4/22/24 at 11:34 a.m. the Director of Health said she had staff pull out the supplies for two doses. She drew it up and administered it and it was clicked off on the MAR system. She should have had staff log out and she should have	A 150		

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 _____	04/22/2024

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 150	Continued From page 2 logged in. She confirmed non-licensed staff did not give the IM injections. 3. Review of Tenant #3's file on 4/18/24 and 4/22/24 revealed the January and February 2024 MARs reflected an order for Insulin Glar injection 100 units/ml, inject subcutaneously (SQ), every morning. A sliding scale was included of how many units of insulin were to be administered based on blood glucose readings. The tenant's January and February 2024 MARs reflected the staffs' initials, the site and the blood glucose reading; however, the number of units administered per the sliding scale were not documented. The tenant's March 2024 MAR reflected the same Insulin Glar order as noted above. The sliding scale was as follows: - if blood glucose readings were below 100, 0 units were to be given; - if blood glucose readings were between 101-150 then 14 units were to be given; - if blood glucose readings were between 151-200 then 20 units were to be given; - if blood glucose readings were between 201-250 then 26 units were to be given; - if blood glucose readings were between 251-300 then 28 units were to be given - if blood glucose readings were between 301-350 then 32 units were to be given. The insulin was not administered per the sliding scale order on the following dates: 3/4/24, 3/7/24, 3/14/24, 3/16/24, 3/21/24 and 3/22/24. The tenant's April 2024 MAR reflected an order for Lantus SoloStar injection 100 units/ml, inject subcutaneously (SQ), every morning. The order utilized the same sliding scale as noted above. The insulin was not administered per the sliding	A 150		

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 _____	04/22/2024

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 150	Continued From page 3 scale order on the following dates: 4/5/24, 4/13/24, 4/15/24, 4/16/24. The MARs reflected Pass Notes dated 3/4/24, 3/7/24, 3/14/24, 3/18/24, 3/22/24, 4/5/24, 4/11/24, 4/12/24, 4/14/24, 4/15/24 and 4/16/24 that reflected staff documented different units were administered than ordered per the direction of tenant's daughter-in-law (DIL). Documentation in Tenant #3's file reflected an order was received from a licensed practitioner dated 12/19/23 reflecting it was okay to call the DIL for questions and recommendations regarding Tenant #3's sliding scale insulin doses. Further record review revealed the MARs did not reflect the instructions (order) to contact the DIL for recommendations regarding Tenant #3's sliding scale insulin doses. When interviewed on 4/22/24 at 12:15 p.m. and 1:04 p.m. the Director of Health confirmed no sliding scale insulin units were documented for January or February 2024. She said the DIL used to managed Tenant #3's insulin when he lived with her. An order was received related to the DIL's involvement with his insulin. 4. Review of the Program's policies and procedures regarding Medication Administration and Medication Administration Record reflected any special instructions would be included on the MAR. Regarding the administration of medications, after the observation each dose would be documented by initials on the correct date and time on the MAR. 5. In summary, Tenant #2's IM injection was documented twice by non-licensed staff, Staff A and Staff B. The Director of Health confirmed she	A 150		

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 _____	04/22/2024

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 150	Continued From page 4 administered the doses. The MAR did not reflect the Director of Health's initials for the administration of the medication. The medication was not documented per policy and procedure. Tenant #3 had sliding scale insulin ordered and in January and February 2024, staff initialed they administered the insulin and the blood glucose reading; however, did not record the units of insulin administered. Additionally, the MAR lacked special instructions (order) related to the DIL's involvement and recommendations related to Tenant #3's sliding scale insulin.	A 150		
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 for two of four tenants reviewed (Tenant #2 and Tenant #3). Findings follow:	A 145	**481-69.22 (3) Evaluation annually and with significant change. Review of the regulation and policies and procedures with the Executive Director, Director of Healthcare, and the Nurse Coordinators for AL/MC. Education/training provided to the Executive Director, Director of Healthcare, and Care Coordinators regarding the evaluation of a tenant annually and with a change of condition. The director of healthcare/designee will then review the completed assessment and complete change of condition as indicated. The service plan/Master Care Plan for tenant #1, #2 and tenant #3 chart's have been reviewed and updated to reflect current status. Education with executive director, director of healthcare, and nurse coordinators for MC/AL reviewed upon state surveyor exit on 4/22/2022 and again on 5/10/2024. Director of healthcare will review these updated charts by 7/1/2024 during the nurses meeting. Tenant #3 has since passed away on hospice care and his record was closed. The Director of Healthcare/Executive Director will meet weekly with nurse coordinators for the next 30 days to evaluate the tenant's service plans and individual needs. Director of healthcare/designee will complete random chart audits 30 days, 90 days, 120 days to ensure future compliance with regulation.**	

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 _____	04/22/2024

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 145	Continued From page 5 1. Review of Tenant #2's file on 4/18/23 revealed Nurse's Notes dated 2/4/24 indicating Tenant #2 moved from the general population to the memory care unit. A Nurse Review was completed 2/22/24, for a review of her functional, health and cognitive status following a move to the memory care unit. There was some concern for potential lewy body related to her sudden and quick decline in function. A Clinical Summary Update was completed on 12/8/23 and entered on 12/26/23; however, an evaluation was not completed with the sudden decline noted with Tenant #2 and the move to the memory care unit. 2. Review of Tenant #3's file on 4/18/24 and 4/22/24 revealed an order was provided dated 12/8/23 to evaluate him for hospice care. Continued record review revealed a typed note dated 12/15/24 (sic) indicating Tenant #3 moved to memory care on 12/7/24 (sic) and was admitted to hospice services on 12/11/24 (sic). The record contained an evaluation dated 11/8/23 that was noted as an Admission Assessment and then a handwritten note indicated for a change to hospice, memory care and falls. The Nurse Assessment indicated the plan would be to move Tenant #3 to the memory care unit in December with a date to be determined. It was also noted they were awaiting a possible hospice admission. An evaluation was not completed at the time Tenant #3 moved from the general population to memory care and was admitted to hospice services. 3. When interviewed on 4/22/24 at 11:34 a.m. the Director of Health confirmed all evaluations were provided for the tenants reviewed.	A 145		

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 _____	04/22/2024

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 350	Continued From page 6	A 350		
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed for 3 of 4 tenants reviewed (Tenants #1, #2, #3). Findings follow: 1. Review of Tenant #1's file on 4/18/24 revealed a Risk of Concern document dated 4/2/24 indicating Tenant #1 was at increased risk for falling or placing herself on the floor. She had a strong and steady gait and ambulated with a two wheeled walker. The document indicated she had attention seeking behavior including putting herself on the floor, unplugging her television, hiding her remote and spilling her drinks. She had used her pull cord so frequently she had almost pulled it out of the wall. She would tell staff she put herself on the floor and she wanted their attention. This occurred with certain staff. After each fall Tenant #1 was up and ambulated without difficulty. Tenant #1 had falls but none with significant injury. Her family confirmed she had a history of manipulative and attention seeking behavior. The Risk of Concern was	A 350	**481-69.26(1) Review of the regulation and programs policies and procedures with the Executive Director, Director of Healthcare, and nurse coordinators for AL/MC regarding tenant service plans. Service plans for tenant #1, #2, and #3 will be reviewed and updated for specific needs of tenant's by 7/1/2024. Director of Healthcare/Executive Director will attend weekly meetings with AL/MC nurse coordinators to review tenant's service plans. Future service plans will be reviewed upon admission, 30 days after admission, quarterly, annually, and with changes of condition, but not limited to, as indicated. Random chart audits will be completed at 60 days and 120 days to ensure compliance.**	

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 _____	04/22/2024

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 350	Continued From page 7 signed by Tenant #1's primary care provider (PCP), the Director of Health and Tenant #1. Tenant #1 resided in the memory care unit and was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. Continued record review revealed the April 2024 ADL Log reflected staff completed checks (visual) every shift for Tenant #1. The tenant's Master Care Plan updated 4/4/24 reflected the Risk of Concern and that she unplugged her television, threw things on the floor and asked staff to pick them and placed herself on the floor. It indicated falls were to be expected and were no longer an unusual occurrence. It was noted Tenant #1 had four falls in the past 30 days. The service plan reflected staff reminded Tenant #1 to use her two two wheeled walker and staff remained in her apartment during her shower due to frequent falls during shower times. The service plan did not reflect interventions related to her behaviors including placing herself on the ground, visual checks as indicated on the ADL Log, and additional interventions related to her frequent falls. 2. Review of Tenant #2's file on 4/18/23 revealed Nurse's Notes dated 2/4/24 indicating Tenant #2 moved from the general population to the memory care unit. A Nurse Review dated 2/22/24 was completed for a review of her functional, health and cognitive status following a move to the memory care unit. There was some concern for potential lewy body related to her sudden and quick decline in function.	A 350		

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 _____	04/22/2024

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 350	Continued From page 8 March and April treatment administration records (TARs) reflected staff applied and removed anti-embolism hose daily. Nurse-Post Fall Assessments and a Resident Note revealed Tenant #2 had falls on 1/15/24, 1/23/24, 2/6/24, 3/31/24, 4/2/24 and 4/4/24. Tenant #2's Master Care Plan was completed on 12/8/23 and entered on 12/26/23 was not updated with the sudden decline noted with Tenant #2 and the move to the memory care unit. The service plan also did not reflect the staff assistance daily with applying and removing the anti-embolism hose or falls and interventions. 3. Review of Tenant #3's file on 4/18/24 and 4/22/24 revealed an order was provided dated 12/8/23 to evaluate him for hospice care. The file contained a typed note dated 12/15/24 (sic) indicating Tenant #3 moved to memory care on 12/7/24 (sic) and was admitted to hospice services on 12/11/24 (sic). The PCP was aware the the daughter in law (DIL) had been adjusting insulin based on blood glucose readings for years. Staff would call the DIL with questions and she would give permission to give units of insulin outside of current orders, based on what he ate. Tenant #3's March and April 2024 medication administration records (MARs) reflected Pass Notes dated 3/4/24, 3/7/24, 3/14/24, 3/18/24, 3/22/24, 4/5/24, 4/11/24, 4/12/24, 4/14/24, 4/15/24 and 4/16/24 documenting different units of sliding scale insulin were administered than ordered per the direction of the DIL. An order was received dated 12/19/23 reflecting it was okay to call the DIL for questions and recommendations for Tenant #3's sliding scale insulin doses. It was signed by a licensed practitioner.	A 350		

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 _____	04/22/2024

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 350	Continued From page 9 A Nurse's Note dated 1/11/24 indicated Tenant #3 had five areas and one open area on his buttocks. A fax was sent to the PCP regarding Calmoseptine as needed. A fax to the PCP dated 3/20/24 noted an open sore with light red discoloration on Tenant #3's buttocks. An order was requested for Calmoseptine. Further record review revealed the Master Care Plan was not updated at the time when Tenant #3 moved from the general population to memory care and was admitted to hospice services. The service plan also did not reflect the order regarding the DIL's involvement with insulin dosages and his sliding scale insulin. The service plan also did not reflect the areas on Tenant #3's buttocks and treatment. 4. When interviewed on 4/22/24 at 11:34 a.m. the Director of Health confirmed all service plans for the tenants reviewed were provided.	A 350	✓ 6/6/24	