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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>165049 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>08/08/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Ridgecrest Village |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>4130 Northwest Boulevard<br>Davenport, IA 52806 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>26529</p> <p>Based on observations, clinical record review, and resident and staff interviews the facility failed to identify and respond to an elopement in a timely manner for 1 of 1 residents reviewed for elopement (Resident #1). Resident #1 eloped from the facility on 7/20/24 at approximately 3:00 a.m., was found at 7:20 a.m. by facility staff on a neighboring business property approximately 100 yards from the facility. Facility staff initially identified the resident was missing at 6:50 a.m., notified management staff at 7:08 a.m., and staff went outside and looked for the resident at 7:15 a.m. The facility failed to follow appropriate precautions when a door alarm sounded on 7/20/24, they did not assess the area around the door for residents and did not take action to ensure that all residents were accounted for that resulted in a resident's elopement and fall with injuries. Residents that were cognitively impaired but independently mobile could potentially have been impacted by the facility's failure. The facility reported a census of 51 residents.</p> <p>The State Agency informed the facility of the Immediate Jeopardy (IJ) on 8/6/24 at 2:00 p.m. The IJ began on 7/20/24. The facility staff removed the IJ on 8/6/24 by implementing the following actions:</p> <ol style="list-style-type: none"> <li>1. Staff educated to account for all residents when a door alarm is sounded, effective 2:00 p.m. on 7/20/24. All door alarms were checked for correct operation; concerns were identified on the Station 2 door and beauty shop door, and a staff member was positioned by the doors and designated as a door watch until the security alarm company arrived on 7/22/24 and assessed alarm functions on all exit doors. Adjustments to the alarm sensitivity were made at that time, replacement parts ordered, the company returned on 7/24/24 and completed repairs on the effected exit doors. The door watch was discontinued after alarm functions were verified on all WanderGuard alarmed doors.</li> <li>2. Staff educated on 7/22/24, 7/23/24, 7/24/24, 7/25/24, 7/26/24 and 7/30/24 regarding proper head counts of residents when the door alarm sounds, including visual confirmation that they are present in the facility. Additionally, staff were educated to respond to every door alarm. If there is an unwitnessed alarm activation staff have been educated to check the area around the door on both sides of the door and surrounding areas within proximity of the door that alarmed, and initiate an immediate headcount if the resident is not found near the door and completed prior to deactivating the alarm.</li> <li>3. Nursing staff were educated that all residents should be accounted for, including visual verification, on the change of shift rounds at every shift change</li> </ol> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>4. Responsible staff have been educated to complete door alarm checks every shift.</p> <p>5. Nursing staff educated they are required to verify placement of the WanderGuard bracelet on each of the resident's that have them, on every shift, and document on the resident's Treatment Administration Record (TAR). The WanderGuard alarm bracelets are also checked to ensure proper working order daily on the night shift using the remote checking device, also documented on the TAR.</p> <p>The IJ was removed on 8/6/24 at 5:30 p.m., the scope was lowered from a J to a G verified by onsite survey.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) Assessment tool dated 6/4/24 revealed Resident #1 had short and long term memory deficits and severe cognitive impairment, had a diagnosis of non-Alzheimer's dementia, was able to make himself understood and understood others, able to ambulate independently and required staff supervision to maintain his safety.</p> <p>A Wandering Risk Scale assessment form completed 6/6/24 revealed the resident scored between 0 and 8 points, in the low risk category for wandering. A score of 9-10 indicated the resident was at risk for wandering, and a score of 11 or greater indicated the resident was at high risk for wandering.</p> <p>A Risk for Wandering/Elopement problem initiated 6/15/23 on the resident's Nursing Care Plan directed staff:</p> <ol style="list-style-type: none"> <li>Engage resident in purposeful activity, initiated 7/15/23.</li> <li>Identify if there is a certain time of day when wandering/elopement attempts occur, initiated 6/15/23.</li> <li>Resident wears a WanderGuard bracelet (a device that activates an audible alarm when it is near an exit door). Staff to check placement every shift and 3rd shift to check if working properly, initiated 6/11/24.</li> <li>Clearly identify resident's room and bathroom, initiated 6/15/23.</li> </ol> <p>The resident's July, 2024 Treatment Administration Record (TAR) revealed staff were directed to check for placement/confirmation that the WanderGuard bracelet was on the resident every shift (3 times a day, on the day shift, evening shift and night shift). Staff were also directed to check the functioning of the resident's WanderGuard bracelet daily on the night shift. The July, 2024 TAR revealed staff did not check for placement of the WanderGuard bracelet on the evening shift on 7/19/24, and the night shift on 7/20/24, and staff did not check the functioning of the WanderGuard bracelet on the night shift on 7/20/24.</p> <p>The posted daily schedule for 7/19/24 revealed scheduled employees on the night shift that started at 10 p.m. , and ended at 6 p.m. on 7/20/24 included Staff D, CNA, Staff E, CNA, Staff F, LPN (Licensed Practical Nurse) through a staffing agency, and Staff G, LPN, also through a staffing agency.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>The posted daily schedule for the 6 a.m. to 2 p.m. day shift on 7/20/24 revealed Staff J, CNA, assigned to the resident, Staff A, CNA, also assigned to the resident's station, Station 3, and Staff C, RN assigned to Station 2.</p> <p>A Nursing Progress Note transcribed by Staff C, Registered Nurse (RN) on 7/20/24 at 1:33 p.m. stated: Alerted by staff that the resident was not in his room and staff unable to find the resident. All the CNA's (Certified Nursing Assistants) went around the facility to look for the resident, this nurse went around the health center looking for the resident door to door, at 7:08 a.m. notified the manager on call that the resident was missing and was advised to call the police if the resident could not be located. This nurse took their car and drove around the facility campus looking for the resident, while driving staff called and notified this nurse the resident was located by staff (Staff A, CNA and Staff B, CNA) at 7:20 a.m. at an adjacent property. This employee notified the manager on call the resident was located and drove to the resident's location. The 2 CNA's were with the resident, reported they found him face down on the pavement facing the direction of the facility. Staff A said the resident was bleeding; this employee knelt down and assessed the resident, his eyes were open, he was breathing, his pulse was racing, blood was on the pavement approximately 12 inches away from where he was laying. The resident was able to move, turned him over to his back for comfort and let him rest his head on the employee's leg. The resident did not cry or yell out in pain, appeared anxious and his hands were shaking. His forehead had a laceration, nose had dried blood and had debris covering his face. This nurse asked the resident if he was okay, the resident kept looking at this employee and did not respond (the resident's normal status due to his dementia) and called EMS right away (Emergency Medical Services). The 3 staff remained with the resident until EMS arrived at 7:37 a.m. and transported the resident to hospital.</p> <p>A hospital Discharge Summary report dated 7/22/24 revealed the resident presented to the Emergency Department on 7/20/24 after a fall that resulted in:</p> <ol style="list-style-type: none"> <li>1. A right sided triquetral fracture (bone in the wrist) that required application of a splint to be worn at all times, and follow-up with an orthopedic physician.</li> <li>2. Forehead and facial abrasions from fall.</li> </ol> <p>The facility's Wandering and Elopement policy, dated as last revised March, 2019 directed staff:</p> <ol style="list-style-type: none"> <li>1. The facility will identify residents who are at risk of unsafe wandering.</li> <li>2. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety plan.</li> <li>3. If an employee observes a resident leaving the premises, he/she should: <ol style="list-style-type: none"> <li>a. attempt to prevent the resident from leaving in a courteous manner,</li> <li>b. get help from other staff members in the immediate vicinity, if necessary; and</li> <li>c. instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises.</li> </ol> </li> </ol> <p>(continued on next page)</p> |  |  |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>4. If a resident is missing, initiate the elopement/missing resident emergency procedure:</p> <ul style="list-style-type: none"> <li>a. Determine if the resident is out on an authorized leave or pass;</li> <li>b. If the resident was not authorized to leave, initiate a search of the building(s) and premises; and</li> <li>c. If the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement officials, and (as necessary) volunteer agencies.</li> </ul> <p>5. When the resident returns to the facility, the director of nursing services or charge nurse shall:</p> <ul style="list-style-type: none"> <li>a. examine the resident for injuries;</li> <li>b. contact the attending physician and report findings and conditions of the resident;</li> <li>c. notify the resident's legal representative;</li> <li>d. notify search teams that the resident has been located;</li> <li>e. complete and file an incident report; and</li> <li>f. document relevant information in the resident's medical record.</li> </ul> <p>Observations revealed:</p> <p>8/1/24 at 3:15 p.m. revealed Staff H, Support Services Coordinator had a WanderGuard testing device by the Station 2 exit doors, the first set of exit doors alarmed when the device was near the door, and allowed the doors to open, as intended. The alarm continued to sound until a passcode was entered by staff. The second set of doors were equipped with magnetic locks, when the WanderGuard device activated the door alarm, the door became locked and required continuous pressure applied to the bar for 15 seconds in order for the door to open, also as intended. The alarm continued to sound until a passcode was entered by staff. The second set of doors opened to a hall that led directly to an unalarmed exit door. Staff H stated at that time she checked all door alarms daily from Monday through Friday, the doors alarmed with the device she used to check the alarms, but they found the alarms didn't always work with a resident that wore a WanderGuard bracelet.</p> <p>8/1/24 at 3:24 p.m. the first set of exit doors by Station 1 alarmed when a WanderGuard device was near it, and continued to sound until a passcode was entered by staff. The second set of exit doors had a magnetic lock activated when a WanderGuard device was near, and required 15 seconds of continuous pressure on the bar for the door to open, as intended. The alarm continued to sound until reset by staff. The 2nd set of exit doors led to an area between administrative offices and an attached independent living facility, both areas led to unalarmed exit doors to the outside.</p> <p>8/2/24 at 11:41 a.m., Resident #1 ambulated independently in the hall with regular gait, had shoes on and wore a splint on the right lower arm.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Staff interviews revealed:</p> <p>8/1/24 at 2:56 p.m., Staff D, CNA, stated he worked the night shift that started at 10 p.m. on 7/19/24 and ended at 6 a.m. on 7/20/24, there was usually 3 CNA's on the night shift but that night 1 of them had called in, and the other one (Staff E) arrived late, around 10:45 p.m. Staff D stated he was the only aide there for the night shift until Staff E arrived, he took report on all residents and saw Resident #1 laying down in his bed around 10:30 p.m. Once Staff E arrived, she had the Station 3 residents (the resident's area), Staff D had Station 2 residents, and the 2 aides split the Station 1 residents. The resident was still in his bed between 10:50 p.m. and 11 p.m. when he gave report to Staff E, CNA and rounded with her. He went past his room around 12 a.m. and the resident was still in bed. Between 2 a.m. and 2:30 a.m., he heard water running in the sink in the resident's bathroom and the resident was in there. Around 3 a.m. he went to Station 3 to assist Staff E, saw Staff G, LPN (Licensed Practical Nurse) as she came back from break and the door alarm at Station 1 was going off. Prior to that time that night, Resident #3 was up in her wheelchair, self-propelled and wandered throughout the facility, a usual activity for her, and activated the WanderGuard alarms at both Station 1 and Station 2 as she wandered. He followed Staff G, LPN to Station 1, Resident #3 self-propelled her wheelchair away from the exit door area and towards Station 2, Staff G told him to turn the door alarm off because she didn't know how to. Staff D stated he went out the first set of exit doors to turn the alarm off, the alarm on the 2nd set of doors was not activated, he didn't know the code to reset the alarm and silenced the alarm by inserting an ink pen into a hole located on the bottom of the alarm box, that was the only way he knew to silence the alarm. Staff D stated he thought Resident #3 had activated the door alarm because she was moving away from the door as they came down the hall from the Station 3 area. Staff D stated he had not seen Resident #1 out of his room that night.</p> <p>8/1/24 at 3:44 p.m., Staff E, CNA, stated when she worked the night shift on 7/19/24 to 7/20/24, she saw the resident in bed in his room around 2 a.m. The resident will get up by himself and use the bathroom, she thought she saw the bathroom light on with the bathroom door shut around 4:30 a.m. and thought the resident was in the bathroom. Resident #3 was up in her wheelchair that night, she goes around in her wheelchair and sets the door alarms off and had been doing that on that night. When she made rounds with the day shift that morning, she thought the resident was in the bathroom because the bathroom door was shut, the bathroom light was on, and did not see the resident at that time. She did not see the resident out of his room that night, and did not know the resident got out of the facility until she got a call that day about it.</p> <p>8/2/24 at 9:36 a.m., Staff F, LPN from a staffing agency, stated when she worked on the 7/19/24-7/20/24 night shift the resident was assigned to her, she saw him around 2 a.m., he was lying in his bed. She didn't see him in the halls that night.</p> <p>8/1/24 at 5:06 p.m., Staff G, LPN from a staffing agency, stated the door alarm at Station 1 was going off that night (7/20/24), as she returned from break at approximately 3:00 a.m. There was a resident that self-propels in her wheelchair throughout the night and had set door alarms off earlier that shift, she was going towards Station 2 from Station 1 at the time (Resident #3). The agency staff received little instruction on specifics to the facility, she did not know the passcode or how to reset the door alarm, Staff D knew how to reset the alarm and did. Staff G stated she wasn't assigned to the resident that night, had no observations of him and had not seen him in the hall that night.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>8/2/24 at 5:42 a.m., Staff I, CNA, stated she had worked on the night shift for several years, knew Resident #1 well, he didn't sleep very good and was up and down at night. He usually came out of his room, sat in a recliner across from the Nurse's Station, he ate a snack and has something to drink, then goes back to bed. He always puts his shoes on or had his shoes on when he came out of his room, she has seen him wander towards Station 2 and will get to the door if staff don't intervene and redirect him back to Station 3. She had not seen him go towards Station 1.</p> <p>8/2/24 at 3:40 p.m., Staff J, CNA, stated he worked the day shift on 7/20/24. When he got report from the night shift, the resident wasn't in his bed, the bathroom door was shut, the light was on in the bathroom, and the staff that gave report to him said he was in the bathroom. As he assisted his residents that morning he could not find the resident in his room, he wasn't in the bathroom and he couldn't find him in the area, so he asked his coworker if she had seen him, she had not, and everyone started looking for him.</p> <p>8/6/24 at 11:32 a.m., Staff A, CNA, stated she worked the day shift on 7/20/24, around 6:50 a.m. Staff J came to her and asked if she had seen the resident, she had not, she told him they needed to alert all staff and she notified staff at Station 2, then went to Station 1 and alerted them. Staff looked from room to room and she even went to the attached Assisted Living facility and did not see the resident. She went outside, saw 1 of the other aides outside looking for the resident (Staff B, CNA) who said she hadn't found him in the area, they went to the road that went around the facility, the gate on the fence line by the road was open so they went through it, she thought she saw someone in the distance on the ground, moved toward them and as she got closer she knew it was the resident. He was on the pavement, face down, he had dried blood on his face and on the ground by him, he was awake, his eyes were open, and she called the facility to tell them where he was. They stayed with the resident, the nurse, Staff C, RN, came in her car, she assessed him and called 911. Staff A stated she knew the resident well, he had walked towards Station 1 a couple of times but was easy to redirect.</p> <p>8/5/24 at 11:34 a.m., Staff C, RN, stated she worked the day shift on 7/20/24, around 7 a.m. that day staff said they couldn't find the resident and they all started looking for him. They didn't find him in the facility, she called the manager on call to notify her, and got in her car to drive around the property to see if she could find him. She got a call that he was found in a business parking lot and drove there. The aides that found him were with him, he was laying on the ground face down, there was dried blood on his face and on the ground near him. He was awake, his eyes were open, she tried to talk to him, he didn't respond but that was normal for him. He could move everything and didn't act like he was in pain so they turned him to his back so he would be more comfortable, she didn't see injuries other than cuts/abrasions on his face. She called 911 and the manager on call. Prior to that day, she had seen the resident walk to Station 2 a couple of times in the last year, and when he was first in the facility he had gone to the Station 1 door. He was always easy to redirect.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>8/2/24 at 2:20 p.m., the Director of Nursing (DON) stated staff called her on the morning of 7/20/24, notified her the resident had eloped, she went to the facility immediately, spoke with staff and implemented education that day on the expectations of what staff were supposed to do when a door alarm went off. They also assigned a staff member to each of the exit doors to monitor the doors in case there was an alarm malfunction until their service provider could inspect the alarm system. The facility was equipped with several surveillance security cameras and she thought she could review how the resident exited and the time, however, it was right after the computer software crash on 7/19/24, and their security cameras did not function because of that. One of the employee's there had connections to a neighboring business and how the facility had access to their security surveillance videos, that showed the resident walked across the parking lot at 3:13 a.m., headed south, to the corner of a business, then he turned, walked towards the facility, walked along a fence line that separated the parking lot from a business, the resident fell where staff found him that morning. The DON didn't know if the time on the video was correct, but she didn't think the resident was in the bathroom or in the building when staff said he was at 4:30 a.m., she thought the resident left through the Station 1 door when it alarmed at 3 a.m. and staff didn't check to see if anyone had gone out the door, or check for missing residents when the door alarmed and staff should have done that. All staff were educated to look on both sides of the door and around the area when a door alarm sounded, to make sure a resident hadn't left, do a headcount and make sure all residents were accounted for before the door alarm was reset. Staff were also educated to account for all residents, visually see each one when they gave the shift to shift report, and staff had not done this on that day.</p> <p>8/2/24 at 10:33 a.m., a representative from the facilities contracted WanderGuard service provider was interviewed and stated they were at the facility on 7/23/24 to assess the system. They found all door alarms functioned but had to adjust the sensitivity of the signal on 1 of the doors due to electrical interference in the area. He stated the doors/alarms were normally set to alarm when a WanderGuard was within 6 feet of the door, but due to the interference at that door, it was sensitive and alerted when the WanderGuard was within 2 feet of the door. They returned on 7/25/24 and made additional adjustments to the sensitivity settings for the alarms, all alarms worked.</p> |  |  |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>26529</p> <p>Based on observation, record review, and resident and staff interviews, the facility failed to provide appropriate urinary catheter care, and failed to follow standard infection control practices during 2 of 2 observations of urinary catheter care, for 2 of 2 resident's reviewed for catheter care (Resident #5 and Resident #7). The facility reported a census of 51 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The Minimum Data Set (MDS) Assessment tool dated 4/30/24 revealed Resident #5 had diagnoses that included anxiety and generalized weakness, scored 15 out of 15 points on the Brief Interview for Mental Status (BIMS) cognitive assessment, that indicated no cognitive impairment or symptoms of delirium present, and required extensive support of staff for transfers to and from chair and bed, dressing, toileting, a urinary catheter used and the resident was unable to ambulate.</li> <li>A Physician Order date 5/19/23 directed staff to change the resident's urinary catheter monthly and as needed (PRN).</li> <li>An Indwelling Catheter problem initiated 6/1/23 on the resident's Nursing Care Plan directed staff: <ol style="list-style-type: none"> <li>1. Catheter care per facility protocol. Be sure catheter is placed below bladder, initiated 2/8/24.</li> <li>2. Check tubing for kinks each shift, initiated 6/1/23.</li> <li>3. Monitor and document intake and output as per facility policy, initiated 6/1/23.</li> <li>4. Monitor for signs or symptoms of discomfort on urination and frequency, initiated 6/1/23.</li> <li>5. Monitor/record/report to MD signs or symptoms of Urinary Tract Infection (UTI) that include pain, burning, blood tinged urine, cloudiness, no output, increased pulse, increased temperature, foul smelling urine, chills, altered mental status, change in behavior.</li> </ol> </li> </ol> <p>Observation on 8/8/24 at 5:51 a.m. revealed a sign on the resident's door that directed staff to follow Enhanced Barrier Precautions isolation practices, that included gown and gloves required when staff provided catheter care or had close physical contact with the resident.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Observation on 8/8/24 at 6:25 a.m. revealed Staff K, Certified Nursing Assistant (CNA) entered the resident's room without a gown on, applied gloves, uncovered the resident, unsecured the incontinence brief, pushed the front portion of the brief down between the resident's legs, grabbed a wet wash cloth that was folded in fourths and used the taco method with the cloth, wiped from front to back to the left groin, right groin, middle twice, placed the wash cloth in a bag and continued to wear the same gloves as he used the bed controls to lower the head of the bed. Staff K then rolled the resident to her right side that revealed the resident had a dressing on the sacral area and another dressing on the lower buttocks/thigh area. Staff K used another folded wet washcloth, the taco method used, wiped from front to back on the resident's buttocks, 4 passes, and placed the washcloth in a bag. He continued to wear the same gloves, positioned a new brief behind the resident, assisted the resident to roll to her left side, pulled the brief through that side, then assisted the resident to her back and pulled the brief up between the residents legs, secured the new brief and covered the resident. Staff K removed the gloves at that time.</p> <p>The facility's Urinary Catheter Care policy dated as revised August, 2022, directed staff:</p> <ol style="list-style-type: none"> <li>1. Place the clean equipment on the bedside stand or over-bed table. Arrange the supplies so they can be easily reached.</li> <li>2. Wash and dry hands thoroughly.</li> <li>3. Fill the wash basin 1/2 full with warm water, or use bathing wipes. Place basin or bathing wipes on the bedside stand within easy reach.</li> <li>4. Apply gloves.</li> <li>5. Place bed protector under resident.</li> <li>6. Cover the resident with a sheet or towel, exposing only the perineal area.</li> <li>7. Remove catheter from securement device on leg if used.</li> <li>8. With non-dominant hand separate the labia of the female resident, maintain the position of this hand throughout the procedure.</li> <li>9. Use a washcloth with warm water and soap, or bathing wipe to cleanse the labia. Use one area of the washcloth or wipe for each downward, cleansing stroke.</li> <li>10. Change the position of the washcloth or wipe and cleanse around the urethral meatus. Do not allow the washcloth/wipe to drag on the resident's skin or bed linen.</li> <li>11. With a clean washcloth or wipe, rinse using the same procedure.</li> <li>12. Use a clean washcloth with warm water and soap or bathing wipe to cleanse and rinse the catheter from insertion site to approximately four inches outward.</li> <li>13. Secure catheter with catheter securement device.</li> </ol> <p>(continued on next page)</p> |  |  |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>The facility's Enhanced Barrier Precautions policy, dated July 27, 2022 directed staff:</p> <ol style="list-style-type: none"> <li>Enhanced Barrier Precautions, in addition to Standard and Contact Precautions will be implemented during high-contact resident care activities when caring for residents that have an increased risk for acquiring a multi-drug-resistant organism, such as with indwelling medical devices.</li> <li>High-Contact resident care activities include bathing/showering, providing hygiene, changing briefs and device care use that included urinary catheter, and require application of gown and gloves.</li> <li>Provide isolation cart with Personal Protective Equipment immediately outside resident room.</li> </ol> <p>2. The MDS Assessment tool dated 5/7/24 revealed Resident #7 had diagnoses that included obstructive uropathy and non-Alzheimer's dementia, the resident scored 8 out of 15 points possible on the BIMS cognitive assessment that indicated moderate cognitive impairment, without symptoms of delirium, required moderate staff assistance to reposition in bed or transfer to and from bed, dressing, toileting, and bathing, and urinary catheter used.</p> <p>A Physician Order dated 2/27/24 directed staff to change the urinary catheter monthly.</p> <p>An Indwelling 16 French Foley Catheter, 10 milliliter balloon related to Obstructive Uropathy problem initiated 2/15/24 on the resident's Nursing Care Plan directed staff:</p> <ol style="list-style-type: none"> <li>Be sure resident has a leg bag when not in bed, initiated 2/15/24.</li> <li>Catheter care per facility protocol. Be sure catheter is placed below bladder, initiated 2/15/24.</li> <li>Monitor and document intake and output as per facility policy, initiated 2/15/24.</li> <li>Monitor for signs or symptoms of discomfort on urination and frequency, initiated 2/15/24.</li> <li>Monitor/document for pain/discomfort due to catheter, initiated 2/15/24.</li> <li>Monitor/record/report to MD signs or symptoms of Urinary Tract Infection (UTI) that include pain, burning, blood tinged urine, cloudiness, no output, increased pulse, increased temperature, foul smelling urine, chills, altered mental status, change in behavior, initiated 2/15/24.</li> <li>Position catheter bag and tubing below the level of the bladder and away from entrance room door, initiated 2/15/24.</li> </ol> <p>Observation on 8/8/24 at 6:48 a.m. revealed no Enhanced Barrier Precaution sign posted on the resident's door, and no isolation cart near the resident's room.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Observation on 8/8/24 at 6:55 a.m. revealed Staff L brought a bag that contained green washcloths and white washcloths and placed the bag on the over-bed table by the bed. Staff L did not have a gown on, applied gloves, obtained a brief from a package and placed it on the same table, used the bed controls and elevated the bed, uncovered the resident, unsecured the incontinence brief, pushed the front of the brief down and between the resident's legs, and assisted the resident to turn to her left side. From behind the resident, Staff L continued to wear the same gloves as she used a green washcloth that she explained had soap and water on it, cleansed the resident's buttocks area from front to back, made 1 pass, turned the cloth, then made at least 2 passes without changing the surface of the cloth, and placed the cloth in the bag with the other washcloths that had not been used as of that time. Staff L used a white wash cloth from the bag, she stated had only water on it, wiped the buttocks area and did not change the surface of the cloth. Staff L placed that cloth in the bag with the other washcloths, used a towel to pat the area dry, then squeezed barrier cream from a tube onto her finger and applied to the buttocks area. Staff L continued to wear the same gloves and assisted the resident to turn to her back. Staff L used a green cloth, wiped down the left groin twice without changing the surface of the cloth, changed the surface and wiped again, changed the surface of the cloth and wiped down between the labia twice without changing the surface of the cloth and placed the cloth in the same bag. Staff L used a white washcloth and wiped down the right groin, changed the surface of the washcloth and wiped again, and placed the washcloth in the bag, used a towel and patted the area dry, then applied barrier cream to her gloved finger and applied to the resident's frontal groin area. Staff L assisted the resident to roll to her left side, pulled the brief out from under the resident and positioned a new brief behind the resident as she continued to wear the same gloves. Staff L assisted the resident to turn to her right side, pulled the brief through, positioned the resident on her back and pulled the brief up between her legs, secured the brief, covered the resident and removed her gloves.</p> <p>During an interview on 8/8/24 at 8:21 a.m., the Director of Nursing (DON) stated staff should follow Enhanced Barrier Precautions, apply clean gloves after the resident is uncovered and brief removed, should always change the surface of the cloth with every pass, should change the gloves if they are soiled and before a new brief was applied, and start personal hygiene care from the front and not the back.</p> |  |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>26529</p> <p>Based on record review, and staff and resident interviews, the facility failed to ensure that residents received medications as ordered and directed by the physician, and resulted in a resident's transfer to a hospital Emergency Department for treatment of symptoms associated to medication withdrawal for 1 of 9 resident's reviewed (Resident #5). The facility reported a census of 51 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS) Assessment tool dated 4/30/24 revealed Resident #5 had diagnoses that included anxiety and bipolar disorder, scored 15 out of 15 points on the Brief Interview for Mental Status (BIMS) cognitive assessment, that indicated no cognitive impairment or symptoms of delirium present, and required extensive support of staff for transfers to and from chair and bed, dressing, toileting, and unable to ambulate.</p> <p>Physician Orders directed staff to administer medications that included:</p> <ol style="list-style-type: none"> <li>1. Chlorpromazine (an antipsychotic medication) 220 milligrams (mg) administered oral daily, ordered 3/17/24.</li> <li>2. Ingrezza 40 mg administered oral daily, ordered 5/14/23. Ingrezza is a medication used to treat tardive dyskinesia, that are a variety of repetitive, involuntary muscle movements caused by the long-term use of antipsychotic, antianxiety and selected antidepressant medications.</li> </ol> <p>A Psychotropic Medication Use related to Bipolar Disease Process problem, initiated 6/1/23 on the Nursing Care Plan had a goal that the resident would remain free of psychotropic drug related complications, including movement disorder, and directed staff:</p> <ol style="list-style-type: none"> <li>1. Administer psychotropic medications as ordered by the physician. Monitor for side effects and effectiveness, initiated 6/1/23.</li> </ol> <p>The resident's May, 2024 Medication Administration Record (MAR) revealed Ingrezza was not administered on 5/1/24, 5/2/24, 5/3/24, 5/6/24, and 5/7/24.</p> <p>The Hospital Emergency Department physician Progress Note dated 8/8/24 revealed the resident presented with symptoms that included involuntary head movements (tardive dyskinesia) that was relieved by the administration of benztropine medication (an anticholinergic medication used to treat tremors).</p> <p>An invoice from the facility's pharmacy dated 5/8/24 revealed 30 Ingrezza 40 mg tablets were dispensed to the facility, for Resident #5.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During an interview 8/7/24 at 2:33 p.m., Resident #5 stated the facility didn't have her Ingrezza medication, she didn't have it for about a week and had to go to the emergency room because she had continuous movements of her head and neck that made her uncomfortable. She got medicine in the emergency room that made it stop.</p> <p>During an interview 8/5/24 at 3:13 p.m., the resident's Power of Attorney (POA) stated she got a call on 5/8/24, they said the resident had stroke-like symptoms and they had to send her to the hospital, it was quite upsetting. Once at the hospital they determined she didn't have a stroke, it was all because they hadn't given her the medication that was ordered, for almost a month, had symptoms caused by the withdrawal of the medication and had to have an extra medication as a result. The Director of Nursing (DON) told them the resident hadn't received the medication.</p> <p>During an interview 8/5/24 at 4:05 p.m., the DON stated the facility changed pharmacies on 5/1/24, and the new pharmacy overlooked the order for the resident's Ingrezza. The nursing staff did send requests to the pharmacy daily, that said they didn't have her Ingrezza, and the staff had not reported the issue to her. Pharmacy wouldn't send the medication due to the medication cost and without special authorization, from the facility, and once she was involved the pharmacy sent the medication. The DON stated the resident did not have the medication for 7 days because it was not delivered by the pharmacy, and it was not available in their Emergency Medication supply. The DON stated she spoke to the resident's POA about the over-site with her sincere apologies, and the POA remained upset about the situation.</p> |  |  |