STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Village	4130 Northwest Boulevard 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45338 Based on observation, interview, and record review the facility failed to ensure residents treated in a dignified manner for one of three residents reviewed for dignity (Resident #5). The facility reported a census of 51 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #5 revealed the resident was rarely to never understood and used a wheelchair and/or scooter. Review of Resident #5's Care Plan dated 9/20/23, revised 5/9/24, revealed, [Resident #5] has an ADL (activities of daily living) self-care performance deficit r/t (related to) dementia and impaired balance. An Intervention dated 9/26/23, revised 5/9/23, revealed Resident #5 utilizes a rolling Broda Chair (brand name of a type of chair that allows a resident to tilt or recline) for mobility. She is able to propel herself with her feet. During an observation on 9/24/24 at 12:11 PM Resident #5 pulled backwards down the hallway in a Broda chair with a staff member, Staff A, Certified Nursing Assistant (CNA) holding the resident's feet while the resident being transported backwards. The resident was being assisted rapidly backwards down the hallway. On 9/26/24 at 8:22 AM during an interview with Staff O, CNA, queried which way resident should be facing, backward or forward, when assisted in Broda chair and acknowledged forward. When queried about foot pedals. Staff O responded foot pedals should always be on when assisting/pushing a resident. On 9/26/24 at 10:49 AM, when queried what direction the resident should face when moving, the Assistant Director of Nursing (ADON) responded forward, and no back pulling of anyone. When queried about if it would be appropriate to hold the resident's feet, the DON acknowledged would not be. On 9/26/24 at 11:02 AM when queried about the above observation, the DON responded need foot pedals on, and to move forwards not backwards. The DON responded no pedal, no push. Review of the Facility Policy titled Dignity, dated 2001 and revised 2/21, revealed the following: Residents are treated with dignity and respect at all times.

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Ridgecrest Village		STREET ADDRESS, CITY, STATE, ZIP CODE 4130 Northwest Boulevard Davenport, IA 52806	

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 45338 Based on interview, clinical record review, and facility policy review the facility failed to ensure timely completion of an Admission Minimum Data Set (MDS) assessments for one of two residents reviewed for Resident Assessment Task (Resident #38). The facility reported a census of 51 residents. Findings include: Review of Resident #38's Electronic Health Record (EHR) revealed the resident admitted to the facility 1/16/24. Review of the resident's Admission Minimum Data Set (MDS) assessment with Assessment Reference Date 1/23/24 revealed the assessment completed on 2/16/24. On 9/26/24 at 10:30 AM, the MDS Coordinator confirmed the assessment was late. On 9/25/24 at 3:02 PM, a Facility Policy to address MDS completion requested. On 9/25/24 at 4:07 PM, the Administrator explained the facility did not have a policy.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on clinical record review and staff interview the facility failed to ensure timely completion of quarterly Minimum Data Set (MDS) assessments for two of two residents reviewed for Resident Assessment Task (Resident #13, Resident #38). The facility reported a census of 51 residents. Findings include: 1. Review of Resident #13's Quarterly MDS assessment with Assessment Reference Date (ARD) 6/25/24 completed on 7/11/24. 2. Review of Resident #38's Quarterly MDS assessment with ARD 4/23/24 completed on 5/9/24. On 9/26/24 at approximately 10:30 AM, the MDS Coordinator queried if there were issues completing quarterly assessments timely. Per the MDS Coordinator, it was pipped (part of Performance Improvement Project) for QAPI (Quality Assurance Performance Improvement). When queried about the specific MDS above, the MDS Coordinator explained for MDS 4/23/24 was waiting on other people to do their section, and for the MDS dated [DATE] MDS Coordinator had other matters she was attending to and there was not a back-up. On 9/25/24 at 3:02 PM, a Facility Policy to address MDS completion requested. On 9/25/24 at 4:07 PM, the Administrator explained the facility did not have a policy.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 45338 Based on clinical record review and staff interview the facility failed to ensure Minimum Data Set assessments submitted timely for one of two residents reviewed for Resident Assessment Task (Resident #13). The facility reported a census of 51 residents. Findings include: Review of Resident #13's Quarterly MDS assessment with Assessment Reference Date (ARD) 4/2/24 was completed 4/16/24. The assessment was submitted 5/16/24. On 9/26/24 at approximately 10:30 AM the MDS Coordinator explained they submitted every other week on Friday. When queried about Resident #13's MDS, the MDS Coordinator acknowledged it was late. A Facility Policy to address submitting MDS requested via email to the facility's Administrator. On 4/26/24 at 1:25 PM, the Administrator explained via email the facility did not have a policy.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on clinical record review and staff interview the facility failed to ensure accurate coding of medications on the Minimum Data Set (MDS) assessment for one of five residents reviewed for unnecessary medications (Resident #23). The facility reported a census of 51 residents. Findings include: Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #23 revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. Per this assessment, the resident took antianxiety, anticoagulant, opioid, and antiplatelet medication. Review of the resident's Medication Administration Record (MAR) dated August 2024 revealed the resident only took anticoagulant medication from the medication classes listed above. On 9/26/24 at 10:59 AM, the MDS Coordinator explained she looked at the wrong person, and acknowledged that was why the mistake occurred. On 9/25/24 at 3:02 PM, a Facility Policy to address MDS accuracy requested. On 9/25/24 at 4:07 PM, the Administrator explained the facility did not have a policy.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50874 Based on clinical record review, resident and staff interview, the facility failed to complete a Baseline Care Plan within 48 hours of admission for 2 of 2 newly admitted residents reviewed (Resident #32 and Resident #53). The facility reported a census of 51 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] identified Resident #32 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13. The MDS listed diagnoses included: acute chronic systolic heart failure (commonly called congestive heart failure), type 2 diabetes mellitus with unspecified complications. The MDS documented Resident #32 was admitted on [DATE]. A review of the Clinical Admission Assessment, dated 8/19/24, revealed the Care Planning section did not identify Focus Areas, Goals or Interventions for the risk factors, diagnoses or care needs for Resident # 32. During an interview on 9/25/24 10:22 AM, the MDS Coordinator reported she does not complete the Baseline Care Plans and these should be completed by the admitting nurse. During an interview on 9/25/24 at 3:38 PM, Staff J, RN disclosed she did not complete the Care Planning section of the Clinical Admission Assessment as this is completed by the MDS Coordinator. 25855 2. The MDS assessment, dated 9/1/24, identified Resident #53 with a moderate cognitive impairment as a result of a BIMS score of 9 out of 15. The MDS listed diagnoses included: atrial fibrillation (an abnormal heart rhythm), coronary artery disease and respiratory failure. The MDS documented Resident #53 admitted to the facility on [DATE]. A review of the N Adv- Skilled Evaluation, dated 8/26/24, revealed the Care Planning section did not identify revealed the Care Planning section did not identify Focus Areas, Goals or Interventions for the risk factors, diagnoses or care needs for Resident # 53. During an interview on 9/26/24 at 11:59 AM, the Director of Nursing (DON) reported she would expect the Nurses who took care of the Resident in the first 48 hours to develop the Baseline Care Plan within 48 hours. During an interview on 9/25/24 at 4:07 PM, the Administrator reported the facility did not have a policy on Baseline Care Plans.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on interview and record review the facility failed to update the resident's Care Plan following discontinuation of anticoagulant medication for one of seventeen residents reviewed for care plans (Resident #19). The facility reported a census of 51 residents. Findings include: Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #19 revealed the resident scored 13 out of 15 on a Brief Interview for Mental Status exam, which indicated intact cognition. Per this assessment, the resident did not take anticoagulant medication. On 9/24/24, review of the resident's Care Plan, revised date 7/18/23, revealed the resident is on anticoagulant therapy; Coumadin (brand name of blood thinner medication, commonly known as warfarin.) Review of Resident #19's Physician Orders for revealed Coumadin discontinued on 5/9/24. On 9/26/24 at 10:43 AM, the MDS Coordinator explained she had recently figured out how to use the review history in [electronic health record system brand name redacted]. The MDS Coordinator acknowledged when she looked at the resident's current Care Plan saw Coumadin still on there, realized yesterday, and explained would take it off. On 9/26/24 at 11:06 AM when queried if the MDS Coordinator did all the care plans, the Director of Nursing (DON) responded yes. When queried about Care Plan revision, the DON responded they should be revised any time a change, and definitely should be looked at quarterly. On 9/25/24 at 3:02 PM, a Facility Policy to address care plan revision requested. On 9/25/24 at 4:07 PM, the Administrator explained did not have a policy. 25855 2. The MDS assessment, dated 8/20/24, revealed a BIMS score of 15 out of 15 for Resident #23, indicating the resident cognitively intact. The MDS listed diagnoses included: spinal stenosis, paroxysmal atrial fibrillation (an abnormal heart rhythm) and left foot drop. The MDS assessed Resident #23 dependent on staff for assistance with oral hygiene, toileting hygiene, showering, lower body dressing and transfers. The MDS also identified Resident #23 as having an impairment to one side of his body. A review of the Physician Orders revealed an order dated 12/27/23 OT (Occupational Therapy) to evaluate for a left hand brace. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Care Plan, dated 11/29/23, included a Focus Area to address ADL (activities of daily living) self-care performance deficit r/t (related to) Impaired balance and limited mobility r/t spinal stenosis. Interventions included [resident name redacted] has left sided weakness of the upper and lower extremity. [Resident name redacted} is dominant on the right side. The Interventions did not address a brace for the left hand, including when to apply and remove. An observation on 9/25/24 at 12:48 PM revealed Resident #23 sat up in a wheelchair in his room eating lunch, and wore a brace on his left hand. Therapy evaluation and recommendation notes requested. The facility did not not produce the requested documentation. During an interview on 9/26/24 at 8:57 AM, Staff O, Certified Nursing Assistant (CNA) stated Resident #23 is to have his left hand brace put on when he gets up in the morning. Staff stated she did not recall when the brace should be removed. She also stated she did not know where to find information as to when the brace should be applied or removed. During an interview on 9/26/24 at 10:01 AM, Staff F, Registered Nurse stated Resident #23 is to have his left hand brace applied in the first part of the morning. Staff F stated the CNA's will usually remove the left hand brace at bedtime. She stated she could not explain why the left hand brace was not addressed on the Care Plan. Staff F explained the MDS Coordinator is primarily the one who makes changes to Care Plans, and she may not have been notified of the order for the brace. During an interview on 9/26/24 at 11:59 AM, the Director of Nursing (DON) stated Resident #23 is to have his left hand splint applied in the morning and removed at night. The DON stated she could not recall where the aides documented this as they are the ones who put it on and take it off. She stated she would expect the left hand brace to be addressed on the Care Plan. The DON stated any Nurse can update a Care Plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45338 Based on observation, staff interviews, and clinical record review the facility failed to ensure ongoing coordination of care between facility staff and hospice staff for one of one resident reviewed for hospice (Resident #19). The facility reported a census of 51 residents. Findings include: The Minimum Data Set (MDS) assessment, dated 8/6/24, revealed Resident #19 scored 13 out of 15 on a Brief Interview for Mental Status exam, which indicated intact cognition. Per the assessment the resident received hospice care while a resident. On 9/25/24, review of Resident #19's Physician Orders present in the electronic health record (EHR) lacked an order for when the resident admitted to hospice services. Review a Transfer to Hospital Summary Note, dated 6/9/24 at 11:00 PM, revealed Resident was found by this nurse calling out help. Resident was checked on previously five minutes prior, was stable, comfortable, expressed no needs. Resident was found on floor on right side with bump to head and bleeding from top right forehead. Oxygen saturation at 87% on 3L (3 Liters), medic came to evaluate resident, resident wanted to be evaluated at the hospital. Said I do not feel right. I . The Progress Note lacked documentation hospice staff were notified. Review of the resident's Hospice IDG (Interdisciplinary Group) Comprehensive Assessment and Plan of Care Update Report with SOC (Start of Care) date 5/2/24 revealed, At 2300 (11:00 PM) on 06/09/2024 pt (patient) had unwitnessed fall. The facility had difficulty getting the bleeding to stop, patient recently on Coumadin (anticoagulant medication), and she was severely dyspneic (short of breath) and hypoxic (having too little oxygen) saturating at 86% on 3L/min (liters per minute) continuous O2 (oxygen). The facility sent patient to [Hospital Name Redacted] at 2300 and did not inform hospice. Call from triage at 0249 (2:49 AM) from patient's daughter, [Name Redacted] to inform. Contacted [Hospital Name] ER (emergency room) PA (Physician Assistant), [Name Redacted] with update. Provided DNR (Do Not Resuscitate), med, and allergy list. Per [PA Name Redacted] the patient's head is fine, bleeding stopped, negative for fractures are the concern and she has agreed to IV (intravenous) Lasix (medication to treat fluid retention), DuoNebs (brand name for combination of two medications to open up the airways), labs and a chest X-ray. Review of the Hospice IDG Comprehensive Assessment and Plan of Care Update Report for IDG Meeting Date 6/21/24 revealed, Order date 6/17/24 Patient to discharge from hospice due to moved out of service territory. Patient admitted to non contracted facility for treatment. On 9/24/24 at 8:31 AM, Resident #19 observed in their room. The resident was wearing a nasal cannula with oxygen concentrator set to 4 Liters. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/24 at 10:55 AM during an interview with Staff N, Hospice Case Manager, explained the following when queried about sending the resident out of the facility and not calling hospice: Per Staff N, she thought it happened maybe one time, she knew the resident had gone to the hospital a couple of times, and it might have happened maybe once, she didn't specifically recall. Per Staff N, she was pretty sure the resident requested to go to the ER, the resident had fallen or rolled out of bed something maybe, the resident was sent to the hospital, hospice was unaware, and resident was admitted . Per Staff N, the resident came off services and had to admit to services. When queried what should happen when resident sent out, Staff N responded supposed to notify hospice, and if the patient competent and could make decisions and requested ER was their right. Staff N explained most of the time hospice tried to send a nurse out immediately to assess, and if could not manage, then would send the resident out. Staff N explained hospice asked facility notified them, hospice would give report to the hospital, so everyone was on the same page and hospice would have people follow up. On 9/26/24 at 11:09 AM when queried about a resident on hospice going to the hospital, the Director of Nursing (DON) explained staff should first call hospice, see what they say. Per the DON, the family would be called and let them know, and generally if the patient, family, wanted resident to go out and nursing would go out. Per the DON, if not, someone would come from hospice to see the resident. When queried if hospice should be notified if all parties in agreement to send the resident out, the DON responded yes, and if didn't, then missed it. When queried about hospice saying they were not notified, the DON responded that did happen, and there was serious re-education done about calling hospice with any condition change, concern, any falls, and any of those. A Facility Policy to address hospice requested via email to the facility's Administrator. On 4/26/24 at 1:25 PM, the Administrator explained via email the facility did not have a policy.

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on observation, interview, and record review the facility failed to hold warfarin, an anticoagulant medication (Coumadin, brand name for warfarin) following a documented International Normalized Ratio (INR) documented as 7.8 on 4/8/24 for one of one resident reviewed for warfarin administration (Resident #19). The resident received doses of warfarin on 4/8/24 and 4/9/24 when the medication was to be held. The resident's INR was documented as 9.3 on 4/10/24. The resident was found with blood on their arms and legs on 4/13/24. Resident sent to the hospital and admitted for INR of 8.2, Hemoglobin (Hgb) of 8.6, and treated with Vitamin K (antidote). This deficient practice resulted in an Immediate Jeopardy (IJ) to the health and safety of the resident. The facility reported a census of 51 residents. Findings include: The State Agency informed the facility of the Immediate Jeopardy (IJ) on 9/25/24 at 4:20 PM. The IJ began on 4/8/24, when warfare administered to the resident following an INR of 7.8. Facility staff removed the IJ on 9/25/24 at 11:36 AM through the following actions: 1. The identified resident's Coumadin/warfarin was discontinued on 5/9/24 2. All other residents with Coumadin/warfarin orders were reviewed for accuracy on 9/25/24. 3. Implemented new procedure regarding Coumadin/warfarin administration 9/25/24. 4. Coumadin/warfarin Procedure New orders or New Admit with orders for Coumadin/warfarin the Nurse will: 4a. Enter Coumadin/warfarin order into Electronic Health Record. 4b. Nurse will document order on Coumadin/warfarin log located at each station. 4c. DON (Director of Nursing)/Designee will check all new Coumadin/warfarin orders and the log within 24 hours to ensure dosing and follow-up labs are entered as ordered on the log and in Electronic Health Record. 5. The Nurse who took the order to hold Coumadin/warfarin on 4/8/24 is no longer employed at the facility. 6. All nurses will be educated on the new procedure on 9/26/24. Additionally, all nurses will be educated on how to properly enter orders in Electronic Health Records. 7. New employees and agency staff will be trained on how to complete this procedure including entering orders in Electronic Health Records during their orientation. 8. Audit tool implemented to ensure nurses are administering Coumadin/warfarin according to physician orders. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. Audits will be completed weekly for one month and then monthly ongoing as needed. 10. The audit results will be brought to the Quarterly QA (Quality Assurance) meeting. The scope and severity lowered from a J to a D during the survey. Review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #19 revealed the resident scored 14 out of 15 on a Brief Interview for Mental Status exam, which indicated intact cognition. Per this assessment, the resident took anticoagulant medication. On 9/24/24, review of the resident's Care Plan revised 7/18/23 revealed, The resident is on anticoagulant therapy; Coumadin. Review of the Intervention dated 7/18/24 revealed, Administer ANTICOAGULANT medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT (every shift). Review of Medical Diagnoses for Resident #19 revealed, in part, cardiac arrythmia. Review of the Health Status Note dated 4/1/24 at 4:16 PM revealed, Dr. [Name Redacted] aware of residents INR of 3.7 new orders given for Coumadin 3mg (milligram) on Thursday and Sundays and Coumadin 1.5mg on all other days, recheck INR on 4/8/24. The Physician Order present on Resident #19's MAR (Medication Administration Record) dated April 2024 revealed the following: a. (Start Date 4/1/24, with hold and discontinuation date 4/10/24): Coumadin Oral Tablet (warfarin sodium) Give 1.5 mg by mouth in the evening every Mon, Tue, Wed, Fri, Sat related to LONG TERM (CURRENT) USE OF ANTICOAGULANTS . 3mg on Thursday and Sundays recheck INR 4/8/24. The Orders-General Note from eRecord dated 4/8/24 at 3:03 PM authored by Staff L, Licensed Practical Nurse (LPN) revealed, [Lab Name Redacted] called with STAT lab results; Verbal report received from [Lab Name Redacted] staff [Name Redacted], PT (prothrombin, test for blood clotting): 73.4, INR: 7.8. Coumadin Clinic notified by this nurse. <sic>Comedian <sic> Clinc staff verbal response received from [Name Redacted]; Hold Coumadin for today and tomorrow. Check INR EARLY Wednesday. Watch out for bleeding. Any continuous bleeding, send resident out to the ER for further evaluation. Review of the fax sheet to Provider for Resident #19 dated 4/8/24 revealed, Please review labs. Coumadin clinic notified and gave orders to hold meds today & tomorrow. Draw labs early Wednesday send resident to ER if any continuous bleeding noticed. Review of the Lab Report for Resident #19 dated 4/8/24 revealed INR result 7.8 and Hgb 9.9. The Lab Report noted standard anticoagulant INR range 2.0-3.0 INR, and aggressive anticoagulant range 2.5-3.5 INR. Review of the Coumadin Dosage Schedule chart dated 4/8/24 from the clinic managing the resident's Coumadin revealed the resident not to receive Coumadin on 4/8/24 or 4/9/24. The Medication Administration Record (MAR) dated April 2024 revealed Resident #19 was administered Coumadin 1.5 mg on 4/8/24 and 4/9/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165049	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgecrest Village	4130 Northwest Boulevard Davenport, IA 52806

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Health Status Note dated 4/8/24 at 4:05 PM revealed, Response received from [Anticoagulation clinic name redacted] goes as follows: Continue same meds and follow up 4/30/24 as planned. Staff will continue to monitor. The Communication-with Physician note dated 4/10/24 at 10:59 AM revealed, Call received from [Name Redacted] at [Facility Redacted]/Coumadin clinic. Has concerns about Coumadin dosing/staff. Relayed to supervisor ([Name Redacted], ADON). The Lab Note dated 4/10/24 at 3:00 PM revealed, Call placed to Coumadin clinic RE: INR 9.3, PT 86.3. Spoke with [Name Redacted]. Has to speak to Dr. [Name Redacted] and will call back. The Order Note dated 4/10/24 at 3:30 PM revealed, ANY S/S (signs/symptoms) OF BLEEDING or FALLS - TO ER IMMEDIATELY. INR 9.3 PT 86.3 HOLD COUMADIN THROUGH SUNDAY RETEST INR 04/15/22. DO NOT GIVE COUMADIN UNTIL SPEAKING WITH CLINIC 04/15!!!!! every shift until 04/15/2024 18:00 (6:00 PM) Start Date: 4/10/2024 End Date: 4/15/2024 .Lab updated, wanted to d/c (discontinue) INR 04/11 and place the INR for 04/15. Pharmacy aware. The Health Status Note dated 4/13/24 at 5:25 AM revealed, Resident has a standing order to be sent to ED (emergency department) for eval (evaluation) if any bleeding. Resident found in bed with blood on her arms and legs. BP (blood pressure) 80/40. 02 (oxygen) sat 88% on room air. Placed on oxygen . Have standing order to be sent to ED for eval and treat for any bleeding. Left message with POA (Power of Attorney) daughter. Called medic for transport they are on their way. Paperwork prepared. Review of ED Admission Paperwork from Resident #19's Hospital Records dated 4/13/24 at 6:43 AM revealed the following per Chief Complaint: pt (patient) arrived from [Facility Name Redacted] d/t (due to) staff finding dry blood, skin tear on left forearm, and INR 9.3. has gallbladder infection. Review of the resident's vital signs revealed blood pressure documented as 102/50 mm hg. Review of the Physician Progress Note dated 4/14/24 revealed the following documented Hemoglobin levels of 8.6 on 4/13 and 4/14, with INR documented as 8.2 on 4/13 and 2.6 on 4/14. The Progress Note dated 4/13/24 at 11:40 AM revealed, Spoke to nurse [Name Redacted] at [Name Redacted] ER. admitted for an INR 8.2. Positive for blood in stool. Hemoglobin 8.6. Administered Vitamin K in ER. Bp (blood pressure) low, and not moving very well due to weakness. Coumadin clinic faxed, [Facility Name] on-call made aware. On 9/24/24 at 8:31 AM, Resident #19 observed in their room. The resident was wearing a nasal cannula, with oxygen concentrator set to 4 Liters. On 9/25/24 at 12:54 during an interview with Staff K, Medical Assistant from anticoagulation clinic, Staff K explained the following about Resident #19: Per Staff K, the resident's INR on 4/8 was 7.8, and at that point guidance was to hold the resident's warfarin on 4/8 and 4/9, and test on 4/10. Per Staff K, test on 4/10 revealed INR 9.3, and the resident ended up taking the warfarin on those nights when was supposed to be held. Per Staff K, Dr.[Name Redacted] said to hold Wednesday through Sunday (4/10-4/14), and test on Monday (4/15). Staff K explained the clinic did not get test on 4/15 because the resident was in the hospital. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff K further explained the clinic would call (facility) after every INR, every single one. When queried as to a set number for a critical value, Staff K responded it would depend on the person's range. Staff K explained for Resident #19, anything over 4.6 INR would hold the resident's warfarin. Staff K further explained she believed a lab would come in and draw the INR, and the clinic did not get it until the next day. Per Staff K, a schedule faxed with every INR which told whatever orders given. On 9/25/24 at 1:48 PM, interview conducted with Staff M, Licensed Practical Nurse (LPN). Staff M explained if INR was followed by the Coumadin clinic, the clinic would give the orders unless had an on-call for the weekend, but still should be the Coumadin clinic. Staff M explained the nurse would input the orders, usually would come with a print out and would have a calendar week with dosing and when to recheck. Per Staff M, the order would continue until the day of the INR, and would not give Coumadin that day until got orders. Staff M further explained needed to get the result (INR) to have orders, and not supposed to give Coumadin until go INR drawn. On 9/25/24 at 2:01 PM, the facility's Assistant Director of Nursing (ADON) queried about Resident #19's Progress Note which said the Coumadin clinic called with concerns, and phone call directed to the ADON. The ADON explained, in part, it was regarding the resident's high INR and she believed it was just an informative call. When queried if she was made aware of any Coumadin medication errors for Resident #19, the ADON responded no. When queried who would draw INRs at the facility, the ADON explained there was a lab, and that they would come in and draw. When queried how the Coumadin clinic communicated with the facility, the ADON responded sometimes sent a fax, and sometimes gave (facility) a call too. The ADON explained the following about critical lab values: The tab would call (facility), and a fax would come in from the lab after lab called. The ADON acknowledged staff should be on the phone and call any critical lab either to Coumadin clinic or PCP (Primary Care Physician). When queried how quickly INR results turned around to the facility, the ADON explained they had it now if the lab was not going to get back in a timely manner, the facility would take to a local lab. The ADON explained had not been doing too bad with INRs, and had not had to implement local lab process yet. The ADON explained INR supposed to be turned around and present before 3 PM because medication had to be given at 4 PM. The ADON explained unless result was critical, as would call immediately for those labs, and if not needed to be on the phone Dr, calling lab, and needed to be checking in on that. The ADON explained INRs were usually drawn about 5:00 AM/6:00 AM. When queried who would input the orders for Coumadin dosing, the ADON responded the nurses. Per the ADON, they would either get a fax back or if called, get a telephone order. The Coumadin clinic would give a telephone order and they would send a fax too. When queried about coordination between the Coumadin clinic and the provider, the ADON explained usually the nurses were the drivers, and they were going to make sure communication with the Coumadin clinic, info needed, and right dose. Per the ADON, they needed to make sure everything was in, everything on hold, and needed to be calling back, putting everything on hold, whatever the orders were. (continued on next page)

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	165049	A. Building B. Wing	09/26/2024

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When queried if staff would wait until had the INR result to give the drug that day, the ADON acknowledged they would. Per the ADON, on INR days would not give until get those results, and waited until got the results which is why wanted by 3 (PM) or would call the doctor. Per the ADON, she had never had a doctor say to give without results. The ADON was asked to pull up Resident #19's MAR for 4/8/24 and 4/9/24. When queried if she had been made aware of any errors, the ADON responded no. On 9/25/24 at 2:45 PM during an interview with Staff L, former Licensed Practical Nurse (LPN) at the facility (who had charted the note to hold the medication on 4/8/24 and 4/9/24), Staff L explained she hardly worked down the hall where resident resided. Staff L explained she could not enter labs because she did not have access to labs. Per Staff L, the she was never given access to labs, and the facility kept turning over directors. Staff L explained she went by word of mouth to get lab results. When queried if she was able to put in orders, Staff L expressed the following: Like meds and stuff like that, [Staff L] didn't ever do any of those things there (facility), [Staff L] couldn't do anything. Staff L explained they emailed human resources with concerns. Staff L expressed being able to do the bare minimum with the electronic health record system. Per Staff L, the former Director of Nursing (DON) was supposed to work on her computer access, and Staff L further explained she would show (facility) things she (Staff L) could not do, and (facility) said they would do it. Staff L explained she currently knew how to get into the computer system and put (order) on hold due to other employment, and then (prior) didn't know how to do those things and would pass information on to the ADON. Per Staff L, the ADON was aware Staff L could not access things. On 9/25/24 at 3:21 PM, interview conducted with the facility's DON. The DON explained she started in the position on 4/8/24. When queried if there were any concerns with Coumadin (warfarin) in April, the DON responded no. When queried if notified about blood on resident's arms/legs, the DON responded no. When queried if she was made aware of any concerns with Resident #19's Coumadin, the DON responded no. When queried about the situation, the DON acknowledged the following expectation: write the order to stop the Coumadin, stop the Coumadin, signs/symptoms of bleeding go the the ER (emergency department), watch for INR in 2 days, and make sure to discontinue on the MAR (Medication Administration Record), absolutely. When queried if she was aware of computer access concerns, the DON responded no, and the DON knew agency staff did not have access to lab. During the interview, the DON was made aware of the resident's INR of 7.8 followed by Coumadin administration, INR of 9, then hospitalization . The DON acknowledged the situation could have ended very poorly. When queried if the orders would be handled by the anticoagulation clinic if resident saw them, the DON acknowledged they would be, and further explained would usually do a verbal asked to fax them, they would do either. The DON further explained she would really think with 7.8 (INR) would send the resident out because facility was not a hospital. The DON further explained they would have sent the resident out that day with the INR of 9. On 9/26/24 at 10:47 AM the ADON queried about any computer issues, and responded the [electronic health record] system was kind of new for the facility, and the facility had only been using it for a year at present time. When queried if Staff L, LPN had computer issues, the ADON responded she did. The ADON explained she remembered Staff L received education on a few things. The ADON further explained Coumadin levels were kind of hard to put in too, and wanted to make sure right dose each day. Per the ADON, everyone got education on the first day they came and as needed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ridgecrest Village		STREET ADDRESS, CITY, STATE, ZIP CODE 4130 Northwest Boulevard Davenport, IA 52806	

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Facility Policy dated Administering Medications, dated 2001 and revised 4/19, revealed the following: Medications are administered in a safe and timely manner, and as prescribed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25855 Based on observation, facility policy review, and staff interviews, the facility failed to serve food that maintained a safe and appetizing temperature. The facility reported a census of 51 residents. Findings include: During the observation on 9/24/24 of the noon meal results of temperatures, in part, taken by Staff B, [NAME] were as follows: a. At 11:12 AM, pureed lasagna temperature at 148.4 degrees F (Fahrenheit.) At 1:09 PM after the last meal served, pureed lasagna temperature at 127 degrees F. b. At 11:14 AM, ground meat temperature at 153.6 degrees F. At 1:08 PM after the last meal served, ground meat temperature at 130 degrees F. Temperatures from a test tray for the noon meal on 9/24/24 at 1:17 PM were as follows: a. [NAME] beans temperature at 120.1 degrees F. B. Potato wedges temperature at 114.4 degrees F. The State Agency tested the tray, and the above food tasted lukewarm. During an interview on 9/25/24 at 9:20 AM, Staff B, Cook, stated when taking the temperature of the food after the meal is served, warm foods should have a temperature of at least 165 degrees Fahrenheit. The [NAME] stated there have been problems in the past with keeping foods at the required temperatures. She believed one of the problems is that the steam table did not have a heat lamp. She added residents have complained about low food temperatures and they are usually the ones who have room trays. Yesterday, there were 25 room trays served. During an interview on 9/25/24 at 9:44 AM, the Director of Dining Services stated when taking the temperature of the food after the meal is served, warm foods should have a temperature of above 145 to 165 degrees Fahrenheit. The Director stated on occasion, there have been problems with foods being above the required temps in the past. He stated there are as many as 40 to 50% room trays. Both the steam table and warmers are very old and getting replaced [DATE] with induction heat. The Director stated there have been resident complaints about the temperature of the food at resident council meetings, however, the last one was months ago. A review of the facility policy titled: Food Handling Guidelines, revision date January 2024, documented food should be held hot for service at a temperature of 135 degrees Fahrenheit or higher.

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	165049	A. Building B. Wing	09/26/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 25855 Based on observation, facility policy review and staff interviews, the facility failed to use standard food handling practices of washing hands and glove changes between tasks to prevent the potential for cross contamination during meal service. The facility reported a census of 51 residents. Findings include: Observations of the 9/24/24 noon meal revealed: At 11:44 AM Staff B, [NAME] while wearing gloves, picked up a bun. The staff, with the same gloved hand touched the edge of the tray that she placed a plate upon. Without a glove change, Staff B picked up the bun again. At 11:47 AM after hand hygiene and a change of gloves, Staff B touched the edge of tray, picked up the phone, and then picked up another plate and bun with the same gloves on. At 12:07 PM with gloved hands Staff B touched multiple surfaces, then picked up a piece of bread with same gloved hands and placed the bread on a plate. Staff B then opened a can of soup, poured it into a bowl, touching the handle and buttons on the microwave placed the soup in the microwave. With the same gloved hands, Staff B picked up another piece of bread. During an interview on 9/25/24 at 9:20 AM, Staff B, Cook, reported when using gloves, she would change them when she touches her face, hair or other surfaces. During an interview on 9/25/24 at 9:44 AM, the Director of Dining Services reported when using gloves, he would expect staff wash hands and change gloves any time they switch items, any time they touch their face, and any time they touch any surface. A review of the facility policy titled: Food Handling Guidelines, revised January 2024, documented: Single use disposable gloves are worn when preparing foods that will not be not be cooked again (ready to eat foods) and while serving food. Gloves are changed between tasks.

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NAME OF PROVIDER OR SUPPLIER Ridgecrest Village		STREET ADDRESS, CITY, STATE, ZIP CODE 4130 Northwest Boulevard Davenport, IA 52806	

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 49976 Based on the Centers for Medicare and Medicaid Services (CMS) Statement of Deficiencies forms, the facility Quality Assessment and Performance improvement (QAPI) Plan, and staff interview the facility failed to carry out Quality Assurance (QA) activities to ensure effective measures had been taken to prevent reoccurrence of deficiencies. The facility reported a census of 51 residents. Findings include: The CMS 2567, dated 1/03/24 listed, in part, the following deficiencies cited during Recertification Survey and Complaint Survey: F550, F641, F657, F812, and F880. The current Recertificaton survey, conducted 9/23/24-9/26/24, also identified the above citations. During an interview on 9/26/24 at 10:18 AM, the Administrator reported the staff had been educated on all of the above tags and could not explain why the problems have re-occurred. The facility policy titled Quality Assurance Process Improvement Plan for the Facility, revised 8/29/24 instructed the following: a. The Facility monitors provider and facility adherence to quality standards through ongoing review of complaints, adverse events, and sanctions and limitations on licensure. The purpose of the peer review program is to monitor accessibility, quality, adequacy, and outcomes of services delivered. b. The Facility performs audits to review clinical and administrative policies and procedures, clinical records against standards, adherence to timely access to care requirements, and administrative practices for the purpose of monitoring compliance with the Facility contract, including state and federal requirements. If the practitioner or facility treatment record review fails to meet an established goal, corrective action and/or re-audit is required. Follow-up reviews measure progress on corrective actions until the goal is met.

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	165049	A. Building B. Wing	09/26/2024

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 49976 Based on clinical record review, and policy review, and staff interview the facility failed to have the minimum required members participate in the facility Quality Assessment and Assurance (QAA) committee meetings. The facility reported a census of 51. Findings include: A review of the Facility QAA sign in sheet dated 2/21/24 revealed the Director of Nursing (DON), and Infection Preventionist failed to attend the quarterly meeting. The QAA sign in sheet dated 7/18/24 revealed the Medical Director, or an appointed designee, failed to attend the quarterly meeting. During an interview on 9/25/24 at 7:24 AM, the Administrator confirmed neither the DON or Infection Preventionist attended the February QAA meeting, and the Medical Director did not attend the July 2024 meeting. The facility policy titled Quality Assurance and Performance Improvement (QAPI) Program - Governance and Leadership, revised 3/2020 instructed the QAA committee to be composed of the following individuals: a. Administrator, or a designee who is in a leadership role; b. Director of nursing services; c. Medical director; d. Infection Preventionist; and e. Representatives of the following departments, as requested by the administrator: (1) Pharmacy; (2) Social services; (3) Activity services; (4) Environmental services; (5) Human resources; and (6) Medical records. It further instructed the committee to meet at least quarterly (or more often as necessary).

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49976

Based on observation, staff interview, and policy review the facility failed to wear appropriate Personal Protective Equipment (PPE) when providing care for residents with COVID-19, a tracheostomy and when performing wound care for 3 of 3 residents reviewed (Residents #257, #15 and #53). The facility reported a census of 51 residents.

Findings include:

1. The Minimum Data Set (MDS) report for Resident #257 indicated a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating moderate cognitive impairment. The MDS listed diagnoses included: pulmonary fibrosis, and pneumoconiosis due to asbestos and other mineral fibers (lung disease).

The Care Plan, updated 9/20/24, indicated the resident had been diagnosed with COVID-19. The Care Plan instructed staff to follow contact and airborne isolation precautions. It further instructed staff to keep the door closed at all times unless safety was a concern.

A review of the a Progress Note dated 9/19/20 at 12:19 PM revealed the resident tested positive for COVID-19.

During an observation on 9/24/24 at 8:27 AM Staff C, Licensed Practical Nurse (LPN) while wearing a regular surgical type mask, gloves, gown, and goggle knocked on Resident #257's door and entered the room. Staff C did not use a NIOSH (National Institute for Occupational Safety and Health) 95 mask (an N95 respirator is a protective device designed for a very close facial fit with efficient filtration of airborne particles).

Staff C took in the resident's medication and left the door open. Upon exiting, Staff C did not change her mask. The cart of supplies outside the room contained the required PPE, including a box N95 masks.

During an observation on 9/24/24 at 8:30 AM, Staff D, Certified Nursing Aide (CNA) entered Resident #257 room without goggle over her eyeglasses.

At 8:53 AM Staff D knocked on Resident #257 door and entered with a breakfast tray. Staff D did not don a gown, gloves, N95 mask, or goggles prior to entering the residents room. Staff D delivered the meal tray, assisted the resident to a sitting position, and exited the room.

During an observation on 9/24/24 at 12:16 PM, Staff H, Physical Therapist Assistant entered Resident #257 room without goggles.

During an interview on 9/24/24 at 2:12 PM Staff C, LPN acknowledged Resident #257 was on contact isolation. Staff C stated PPE is to be worn included, gloves, an N95 mask, and a gown. That is for any time staff enter the room.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/25/24 at 12:38 PM, Staff D, CNA explained she was not sure why the resident was in isolation but thought he had COVID-19. She was not sure when he would come off precautions. She explained staff must wear gloves, a gown, goggles, and an N95 mask when entering the room. She noted they usually have signs on the doors to indicate who is on precautions. During an interview on 9/25/24 at 1:08 PM, the Director of Nursing (DON) explained she expected staff to wear a full gown, gloves, and an N95 mask when entering a COVID-19 room. Staff can wear goggles if they think something will be in their eyes or there is a risk of splashing. They have been watching staff to make sure it is being worn. When staff exit the room, they must take off the gown and gloves, and the mask needs to be removed and changed. A facility policy, reviewed on 7/25/23, titled Infection Control instructed staff to follow Contact Precautions for COVID-19. This includes hand hygiene, gloves, and the use of a gown. It further instructed staff to follow Droplet Precautions for COVID-19. This includes hand hygiene, gloves, gown, plus the use of a surgical mask within at least 6 feet of the resident. A facility policy, revised on 6/16/23, titled Infection Control COVID-19 instructed all healthcare providers to utilize standard precautions for all patient-care encounters according to policies and procedures. If a resident/tenant is suspected or confirmed to have COVID-19 healthcare providers must utilize transmission-based precautions including an N95 or higher-level respirator, gloves, isolation gown, and eye protection. 25855 2. The MDS assessment dated [DATE] identified Resident #15 with a moderate cognitive impairment as a result of a BIMS score of 9 out of 15. The MDS listed diagnoses included: non-Alzheimer's dementia, anxiety disorder and respiratory failure. The MDS identified Resident #15 required respiratory treatments of suctioning and tracheotomy care. The MDS identified Resident #15 required partial/moderate staff assistance with toileting, putting on and taking off footwear and lower body dressing. The MDS also identified Resident #15 required substantial/maximal staff assistance with showering. The Care Plan, dated 7/21/23, identified Resident #15 with a tracheostomy and directed staff to use universal precautions [for infection control] as appropriate, and to provide suction as necessary. The Care Plan did not address the need for Enhanced Barrier Precautions. A review if Physician Orders revealed an order, dated 9/4/24, to change split dressings and change inner cannula to tracheostomy every day shift. During an observation of tracheostomy care on 9/25/24 at 2:03 PM, Staff F, Registered Nurse entered Resident #15 room. On the outside of the room, a sign indicated Enhanced Barrier Precautions in place. Staff F donned a mask, gown and gloves upon entering the room. At 2:08 PM, after suctioning and cleansing tracheostomy, Staff F removed the soiled split dressing. Without completing hand hygiene or changing gloves, Staff F placed a new dressing around the tracheostomy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER: Ridgecrest Village		STREET ADDRESS, CITY, STATE, ZIP CODE: 4130 Northwest Boulevard Davenport, IA 52806	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/24 at 10:01 AM, Staff F, RN reported when changing the dressings around a resident's tracheostomy, after she removes the soiled dressing she would not need to change her gloves in between putting new dressings on if the old dressing did not have a lot of drainage on it. During an interview on 9/26/24 at 11:59 AM, the Director of Nursing reported she would expect the nurse to change gloves during tracheostomy care after removing the dressings, then use hand sanitizer or wash hands and don new gloves. The nurse should have changed her gloves after removing the old dressing and before putting the new dressing on. 3. The Minimum Data Set, dated dated dated [DATE] identified Resident #53 as cognitively impaired with a BIMS of 09 and had the following diagnoses: respiratory failure, and atrial fibrillation (an abnormal heart rhythm). The MDS identified Resident #53 required partial/moderate staff assistance with showers and required substantial/maximal staff assistance with personal hygiene. On 9/12/24, the Care Plan identified Resident #53 with a lesion to her back. During an observation of wound care on 9/24/24 at 10:49 AM, Staff F, RN entered room (which did not have a sign posted to indicate the resident was on Enhanced Barrier Precautions) wearing a mask, placed dressing items on top of paper towels on top of tray table. Then Staff F washed her hands and left the room. At 10:52 AM, Staff F returned to the room, washed her hands and donned gloves, however, failed to don an isolation gown before providing wound care. After Staff F cleansed the wound, she did not change her gloves before she applied a Xeroform dressing and Optifoam dressing on the wound. During an interview on 9/25/24 at 10:18 AM, Staff G, LPN stated when providing wound care, the nurse should don an isolation gown, gloves and mask. During In an interview on 9/25/24 at 1:03 PM, Staff F, RN stated the Resident #53 should have been in Enhanced Barrier Precautions and staff should wear an isolation gown and gloves when providing cares. She stated she did not put on a gown when she provided wound care. Staff F stated she posted a sign outside Resident #53's room today. During an interview on 9/26/24 at 11:59 AM, the Director of Nursing stated Resident #53 should be on Enhanced Barrier Precautions and when providing cares, she would expect staff to don an isolation gown and gloves. Residents that would require to be placed on Enhanced Barrier Precautions would include those with pressure ulcers, catheters, Pleurex (chest tubes), GTs (gastric tubes), tracheostomies and catheters. A review of the facility policy, dated 2022, titled Enhanced Barrier Precautions dated 2022 documented: The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDRO (Multi-Drug Resistant Organism) to employees' hands and clothing during cares beyond situations in which staff anticipate exposure to blood or body fluids. Gown and gloves are required during device care or use (ie: tracheostomy) and wound care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0944 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 25855 Based on record review, staff interview and policy review the facility failed to document nursing education on the QAPI (Quality Assurance Performance Improvement) program for 4 out of 4 staff members reviewed. The facility reported a census of 51 residents. Findings include: A review of the human resources files for Staff F, RN, Staff G, LPN, Staff R, LPN and Staff S, LPN revealed the facility failed to document documentation these nurses received education on the QAPI program. The Administrator provided statement saying all above were trained, with the exception of the QAPI program. During an interview on 9/26/24 at 1:33 PM, the Administrator reported the facility did not have a policy on training staff on QAPI.