DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0430	A. BUILDING: _____ B. WING _____	C 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD PLACE AT RIDGECREST VILLAGE	4130 NORTHWEST BLVD DAVENPORT, IA 52806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Tenants without cognitive impairment: 35 Tenants with cognitive impairment: 0 Total census: 35 The following regulatory insufficiencies were cited during the investigation of Incident #130864-I, Incident #131431-I and Incident #131196-I.	A 000	See attached POC 5/21/26	
A 116	481-67.2(2) Program Policies and Procedures 67.2(2) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review staff failed to follow the missing tenant/elopement policy affecting 1 of 3 discharged tenants reviewed (Tenant C3). Finding follows: Record review on 3/23/26 revealed Tenant C3's service plan, dated 8/11/25, indicated he was diagnosed with Parkinson's Disease, Chronic Kidney Disease Stage 5 and Atrial Fibrillation. Tenant C3 had moderate cognitive impairment which had recently declined (as of 5/29/24). He required staff reminders and would get mixed up at times. During an interview on 3/24/26 at 8:45 a.m. Staff A explained Tenant C3's wife called the Program on 1/10/26 concerned he might be out of the building. Tenant C3 told his wife his car was in a ditch a couple of miles away from the building	A 116		

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A 116	Continued From page 1	A 116		

and he needed to check on it (he was confused, he no longer had a truck). Staff A went and checked on Tenant C3. She attempted to redirect him when he talked about the truck, but it did not work. Staff A kept a closer eye on Tenant C3 through the rest of her shift, but did not put him on regular safety checks.

When interviewed on 3/23/25 at 9:05 a.m. Staff B recalled when she entered Tenant C3's apartment on 1/10/26 he said he needed to get to his tractor which was in the ditch a few miles from town. Staff B attempted to deescalate Tenant C3 who was upset. Tenant C3's wife came to the building. He did seem to calm down. She remembered telling the second shift staff they should keep an eye on Tenant C3. Staff B did not put Tenant C3 on regular safety checks.

The Program policy, Missing Tenant/Elopement (dated 5/11/23) indicated the protocol should be followed in the event any tenant was observed wandering or with elopement or exit-seeking behavior. If a tenant was observed having wandering or exit-seeking type behavior, staff should attempt to meet any unmet needs and redirect them to a common area with a preferred activity. If the behavior continued, staff should immediately implement 15-minute rounding, inform the nurse on call, inform the tenant's power of attorney and physician.

During an interview on 3/25/26 at 1:15 p.m. the and the Director of Nursing confirmed there was no documentation of the event with Tenant C3 on 1/10/26 or evidence Staff A and Staff B notified a nurse when he talked about wanting to leave the property. The Village Home Services (VHS) Director indicated the staff did not follow the Missing Tenant/Elopement Policy for Tenant C3.

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A 122	481-67.3(2) Tenant Rights 481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights: 67.3(2)?To receive care, treatment and services that are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide appropriate services to 1 of 3 discharged tenants reviewed (Tenant C1). Finding follows: Record review on 3/23/26 revealed an incident report dated 11/18/25 at 6:00 a.m. noted Tenant C1 was found outside wandering. She told staff she was dreaming of a lost baby boy. When discovered, Tenant C1 was wet and muddy. Her temperature was 97.4 degrees, pulse was 120, respirations 22, blood pressure 126/66 and oxygen at 97 percent (%). Tenant C1 was not alert or oriented. She complained of pain at an "8" to her left arm and left leg. Tenant C1 reported she hit her head. The medics were called and she went to the hospital. Tenant C1 was transported to the emergency department for evaluation of a fall. The ED Physician's Notes indicated Tenant C1 told the doctor she was trying to keep a toddler from running into the road. She had scrapes to her head, left armpit and superficial abrasions over her lateral lower left leg. She also had an abrasion and hematoma on her head. Tenant C1 had a CT scan, electrocardiogram and chest x-ray with no abnormal findings. Tenant C1's Nursing Health Assessment, dated	A 122		

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A 122	Continued From page 3	A 122		

11/18/25, identified she was diagnosed with Diabetes Mellitus Type II, Protein-Calorie Malnutrition, Glaucoma and Depression. A cognitive screening completed on 11/18/25 noted she had moderately advancement impairment.

An admission progress note dated 10/13/25 documented Tenant C1 moved to the Program from the Independent Living building. She required reminders to remain in the building (and not return to her old apartment). Tenant C1 was put on 30 minute safety checks.

A review of safety checks from 4:30 a.m. to 6:30 a.m. on 11/18/25 for Tenant C1 were as follows:
4:30 a.m. - Staff D documented completion of the check at 4:30 a.m.
5:00 a.m. - Staff D documented completion of the check at 5:02 a.m.
5:30 a.m. - Staff D documented completion of the check at 5:02 a.m.(28 minutes before the time of the check)
6:02 a.m. - Staff B documented completion of the check at 12:52 p.m.
6:30 a.m. - Staff B documented completion of the check at 12:52 p.m.

During an interview on 3/24/26 at 9:40 a.m. Staff D explained Tenant C1 was on 30 minute checks which she completed every 30 minutes during the third shift on 11/17/25 to 11/18/25. The last time she did a physical check on Tenant C1 was at 5:00 a.m. on 11/18/25. Staff D reported it was questionable who did the 5:30 a.m. check on tenants, but she was sure it got done.

When interviewed on 3/24/26 at 9:05 a.m. Staff B reported Staff D was responsible for the 5:30 AM checks. The first shift staff began checks on tenants starting at 6:00 a.m. Staff B believed she

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A 122	Continued From page 4	A 122		

was busy taking care of another tenant at 6:00 a.m. so she did not realize Tenant C1 was not in her apartment at 6:00 a.m.

When interviewed on 3/24/26 at 8:20 a.m. Staff E recalled on the trip into work on 11/18/25 her boyfriend told her he thought he saw a woman along the road at the back of the Program building. He turned the car around and Staff E realized the person was Tenant C1. She was covered in mud and had some scrapes. Tenant C1 kept talking about being outside to get a baby. They got her to a door of the building, brought her inside and covered her with a blanket. They then contacted a nurse. Tenant C1 had a gash on her leg that wouldn't stop bleeding. She did not have shoes or socks on her feet. She was wearing a short-sleeve, light night gown without a coat. There was also a cut on her forehead.

According to the State Climatologist of Iowa, the temperature at 5:52 a.m. on 11/18/25 was 40 degrees (32-34 degrees with the wind chill). Sunrise was at 6:55 a.m.

During an interview on 3/24/26 at 2:25 p.m. the Village Home Services (VHS) Director and the Director of Nursing confirmed there was no evidence staff provided the required safety check on Tenant C1 at 5:30 a.m. It was unknown how long Tenant C1 was outside during the early morning of 11/18/25 before she was found by Staff E. When Staff D signed off she completed the 5:30 a.m. check at 5:02 a.m., there was no notification on the computer alerting Staff B she needed to perform a safety check on Tenant C1 at 5:30 a.m.

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A 279	Continued From page 5	A 279		
A 279	481-69.25(3) Tenant Documents 481-69.25(231C) Tenant documents. 69.25(3) All records shall be protected from loss, damage and unauthorized use. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to protect Communication records from loss. This pertained to all tenants for the month of January, 2026. Findings follow: Attempted record review on 3/24/26 of the Communication log revealed there were no documents available for the month of January, 2026. During an interview on 3/25/26 at 12:30 p.m. the Village Home Services (VHS) Director and the Director of Nursing reported these records could not be located. The Program did not have a full-time nurse at this time and the current Directors did not believe the logs were retained.	A 279		
A 282	481-69.26(3) Service Plans 481-69.26(231C) Service plans. 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. The service plan shall be signed by all parties, including the tenant or tenant's legal representative.	A 282		

DEPARTMENT OF INSPECTIONS AND APPEALS

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A 282	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans for 2 of 3 discharged tenants reviewed when they experienced a significant change (Tenant C2 and Tenant C3). Findings follow: 1. Record review on 3/23/25 of Tenant C3's progress notes revealed the following: - On 8/5/25 Tenant C3 came down and headed to the front door at night. He told staff he had to wait for his sister to pick him up for an appointment at 10:10. Tenant C3 proceeded to sit on the bench outside. Staff let him know it was not safe to sit in the dark alone. Staff let him know the appointment was likely at 10:10 a.m., not 10:10 p.m. Staff monitored him from inside. Tenant C3 tried to call someone on his phone but did not appear to get through. He eventually returned to his apartment. - On 8/8/25 at 7:45 p.m. a staff member reported seeing Tenant C3 attempting to leave through the front door. He said he was late for an appointment. Tenant C3 told another employee he was going for a walk. - Tenant C3's spouse reported his blood glucose levels were trending upward and requested the numbers be sent to his primary care provider. - On 12/17/25 the former Registered Nurse (RN) contacted Tenant C3's wife about a request for him to start a diabetic diet. The RN let her know the Program did not offer diabetic diets, however the RN offered to provide Tenant C3 with diabetic education. She would keep Tenant C3's wife informed of progress or setbacks. The RN would begin this after the holidays. - On 1/5/26 Tenant C3's wife requested a print out of his blood glucose levels. She requested the RN begin the diabetic education and the RN	A 282		

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A 282	Continued From page 7	A 282		

documented she would make time to do so during the week.
- On 1/11/26 at approximately 12:50 p.m. Tenant C3 was found outside the building by two residents of the independent living program. They saw him leaning against an object, thought they heard him say something and stopped to check on him. When they asked if he needed something he responded "yes". The two residents sought help at the front desk and on their return found two staff members with Tenant C3. He was not wearing a jacket and was not using his walker.

When interviewed on 3/24/26 at 9:05 a.m. Staff B reported Tenant C3 would get frustrated at times and want to leave the building. She noticed if his wife told him he had an appointment the following day, Tenant C3 would get agitated the night before. Tenant C3 walked around the building but she hadn't been told he'd tried to leave. Tenant C3 told staff they didn't know what they were talking about and swore at them.

When interviewed on 3/24/26 at 11:00 a.m. Staff C recalled Tenant C3 didn't get up every night but there might be a stretch of days when he was awake. During that period of time she might find him downstairs with his coat on. Tenant C3 said he was there because his wife was going to take him to an appointment. On one occasion Tenant C3 sat outside on a bench waiting for his wife.

During an interview on 3/24/26 at 9:40 a.m. Staff D explained Tenant C3 believed his wife was coming to pick him up at night. He often wandered during the night because he was confused about the time.

Tenant C3's service plan dated 8/11/25 included

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A 282	Continued From page 8	A 282		

the dates when each intervention was added to it. On 7/16/24, the nurse noted Tenant C3 required staff reminders and redirection as he would get mixed up. The plan noted he had moderate cognitive impairment which had recently declined (5/29/24). The plan noted Tenant C3 was to follow a diabetic diet (5/29/24).

Tenant C3's service plan was not updated to reflect his confusion about the time of day, especially related to upcoming appointments. It did not alert staff to his wandering behaviors. The plan noted he was to follow a diabetic diet and did not include the intervention of the RN providing Tenant C3 with education in this area due to the elevation of his blood glucose numbers.

2. Record review on 3/24/26 revealed a Negotiated Risk Agreement for Tenant C2 dated 1/2/26, identified Tenant C2 tended to wander and could be forgetful. Due to the wandering, Tenant C2 could potentially be a risk for elopement.

Tenant C2's service plan, dated 4/17/25, noted under the section of the plan titled "elopement risk" staff should observe her location in the community. The plan was not updated to address her wandering or risk for elopement as noted in the Negotiated Risk Agreement.

During an interview on 3/25/26 at 1:15 p.m. the Village Home Services (VHS) Director and the Director of Nursing confirmed the Program failed to update the service plans for Tenant C2 and Tenant C3 when they experienced changes related to diet and/or wandering behaviors.

Plan of Correction

Oakwood Place at Ridgecrest Village

License #: S0430

Survey Date: 3/23/26 to 3/25/26

Tag#131196-1

Deficiency Statement: A 116 481-67.2(2) Program Policies and Procedures

1. Corrective Action for Residents Affected

- Resident was placed in Gardens, secured memory care unit.

2. Corrective Action for Residents Potentially Affected

- A comprehensive audit was conducted by DON to ensure that safety checks were entered into and charted on as required.
- Staff were educated on charting via paper for those residents on 15- or 30-minute safety checks to ensure that they are doing visual checks on the residents as required.

3. Systemic Changes to Prevent Recurrence

- Staff were educated on missing resident/elopement policy which discusses wandering or exit-seeking behaviors.

4. Monitoring and Quality Assurance

- The Director or designee will audit 50% of all safety checks monthly for six months to ensure compliance.

5. Completion Date

- 5/21/2026

Deena Dhuse, Director

Kim Dominguez, DON

Plan of Correction

Oakwood Place at Ridgecrest Village

License #: S0430

Survey Date: 3/23/26 to 3/25/26

Tag#130864-1

Deficiency Statement: A 122 481-67.3(2) Tenant Rights

1. Corrective Action for Residents Affected

- The identified resident was moved to Gardens secure memory unit.
- Staff were educated on timeliness of documentation

2. Corrective Action for Residents Potentially Affected

- A comprehensive audit was conducted by DON to ensure that safety checks were entered into and charted on as required.
- Staff were educated on charting via paper for those residents on 15- or 30-minute safety checks to ensure that they are doing visual checks on the residents as required.

3. Systemic Changes to Prevent Recurrence

- Staff were educated on missing resident/elopement policy which discusses wandering or exit-seeking behaviors.

4. Monitoring and Quality Assurance

- The Director or designee will audit 50% of all safety checks monthly for six months to ensure compliance.

5. Completion Date

- 5/21/2026

Deena Dhuse, Director

Kim Dominguez, DON

Plan of Correction

Oakwood Place at Ridgecrest Village

License #: S0430

Survey Date: 3/23/26 to 3/25/26

Tag#131431-1

Deficiency Statement: A 279 481-69.25(3) Tenant Documents

1. Corrective Action for Residents Affected

- Communication logs were initiated and placed in designated locations.
- All staff were educated on placement and documentation requirements of communication logs
- All staff were educated on procedure of staff to nurse communication forms.

2. Corrective Action for Residents Potentially Affected

- DON or designee will check communication logs daily to ensure completion and follow up is completed.
- DON or designee will make progress notes in Point Click Care if communication to nurse was made and any updated in the communication log were noted.

3. Systemic Changes to Prevent Recurrence

- Communication binders were created for all sections.
- DON or designee will remove communication sheets monthly and place in communication binder.

4. Monitoring and Quality Assurance

- The Director or designee will audit 50% of monthly communication logs for completion monthly for six months to ensure compliance.

5. Completion Date

May 21,2026

Deena Dhuse, Director

Kim Dominguez, DON

Plan of Correction

Oakwood Place at Ridgecrest Village

License #: S0430

Survey Date: 3/23/26 to 3/25/26

Tag#131196-1

Deficiency Statement: A 282 481-69.26(3) Service Plans

1. Corrective Action for Residents Affected

- The identified resident's service plan was updated to include individualized fall interventions and prevention strategies based on current needs.
- Staff were educated on the requirement to update service plans timely following a change in condition, including falls.

2. Corrective Action for Residents Potentially Affected

- A comprehensive audit of all resident service plans is being conducted by the DON or designee to ensure fall prevention interventions are in place where indicated.
- All service plans will be reviewed for accuracy, completeness, and alignment with current resident needs by May 21, 2026.
- Any identified deficiencies will be corrected at the time of review.

3. Systemic Changes to Prevent Recurrence

- The DON or designee will complete a review of service plans at least every thirty (30) days to ensure they reflect current care needs and interventions.

4. Monitoring and Quality Assurance

- The Director or designee will audit 10% of resident service plans monthly for a period of six (6) months to ensure compliance with service plan requirements.
- If compliance falls below 100%, immediate corrective action, including re-education and increased monitoring, will be implemented.
- Monitoring will continue until sustained compliance is achieved.

5. Completion Date

- May 21, 2026

Director

Deena Dhuse, Director

RN

Kim Dominguez, DON

Plan of Correction

Oakwood Place at Ridgecrest Village

License #: S0430

Survey Date: 3/23/26 to 3/25/26

Tag#131431-1

Deficiency Statement: A 282 481-69.26(3) Service Plans

1. Corrective Action for Residents Affected

- The identified resident's service plan was updated to include individualized fall interventions and prevention strategies based on current needs.
- Staff were educated on the requirement to update service plans timely following a change in condition, including falls.

2. Corrective Action for Residents Potentially Affected

- A comprehensive audit of all resident service plans is being conducted by the DON or designee to ensure fall prevention interventions are in place where indicated.
- All service plans will be reviewed for accuracy, completeness, and alignment with current resident needs by May 21, 2026.
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5. Completion Date

- May 21, 2026

Deena Dhuse, Director

Kim Dominguez, DON