

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 12/10/2025
NAME OF PROVIDER OR SUPPLIER Ridgecrest Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, clinical record review and staff interviews, the facility failed to provide care that promotion each resident's dignity, demonstrated when staff failed to assist a dependent resident change out of a heavily soiled shirt that the resident continued to wear throughout the day, in front of other residents and facility visitors, for 1 of 7 residents in the open sample (Resident #7). The facility reported a census of 55 residents. Findings include:The Minimum Data Set (MDS) Assessment tool with reference date 9/19/25 revealed Resident #7 had diagnoses that included non-Alzheimer's dementia, depression and hypertension (high blood pressure), had severe cognitive impairment without symptoms of delirium present, rarely/never able to make himself understood and rarely/never able to understand others. The assessment described the resident able to feed himself, and substantial staff assistance was required for dressing, toileting, personal hygiene, bathing and transfers to and from bed and chair, the resident unable to stand or ambulate, utilized a wheelchair for motility and always incontinent of urine. A problem entitled Resident #7 has an ADL (activity of daily living) self-care performance deficit related to Dementia and limited mobility related to recent hospitalization, initiated 7/10/24 on the Nursing Care Plan identified a 12/18/25 goal that Resident #7 will maintain current level of function through the review date. Staff were directed with interventions that included:DRESSING: Resident #7 requires maximum assistance x1 staff with dressing upper and lower body, staff to put on sock and shoes, initiated 7/10/24.EATING: Resident #7 is able to feed himself most of the time, however he does require supervision and cueing/encouragement, initiated 7/10/24.PERSONAL HYGIENE/ORAL CARE: Resident #7 requires assistance with personal hygiene x1. Please shave daily or per family may shave every 2-3 days, initiated 7/10/24, revised 10/18/24.TOILET USE: Assist x 1 staff to complete toileting tasks. Resident #7 incontinent of bowel and bladder. He prefers to wear adult incontinent briefs for dignity concerns, initiated 7/10/24, revised on 7/5/25.TRANSFER: Resident #7 transfers using sit to stand non-mechanical lift x1 staff assist. He is non-ambulatory at this time and utilizes a wheelchair for mobility. He can propel self with feet. Staff assist as needed, initiated 7/10/24. Observations on 12/9/25 revealed:Continuous observations between 8:05 a.m. and 8:26 a.m. revealed Resident #7 seated in his wheelchair at a table in the Station 2 Dining Room, the resident fed himself sausage with his fingers and drank from a handled mug held in his right hand that he held to his mouth. The resident held the mug near the area of his right upper chest when he didn't hold the mug to his mouth.8:46 a.m. the resident remained in the Dining Room in his wheelchair, now positioned approximately 3 feet away from the table where he had been seated, wore a white T-shirt with a plaid material shirt over the top, unbuttoned that exposed an approximate 10 inch across area of the white undershirt, with at least 3 large, and several smaller brown colored stains and smears on the resident's right mid to upper chest area of the T-shirt. The larger stains measured approximately 3 to 4 inches across and 4 to 5 inches high, the smaller stains varied from approximately 1/2 inch to 2 inches in size, irregular shaped and spotted the</p> <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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 165049	Facility ID: 165049 If continuation sheet Page 1 of 2

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>shirt in between the larger stains. 9:29 a.m. the resident was seated in his wheelchair in his room, wore the same stained shirt.9:33 a.m. the resident self-propelled his wheelchair out to the hall headed to a different resident's room across the hall, with same soiled shirt on.9:35 a.m. Staff C, Registered Nurse (RN) directed Staff A, Certified Nursing Assistant (CNA) to assist the resident, and Staff A pushed the resident in his wheelchair into his room, then came out of his room. At 9:38 a.m. Staff A, CNA asked Staff D, CNA for help with the resident as she pushed a mechanical stand lift into his room. The resident remained seated in his wheelchair in his room in the same soiled clothes. 9:46 a.m. Staff A, CNA went into the resident's room with Staff B, CNA and closed the door. Both staff came out of the room at 9:47 a.m., Staff B pushed the mechanical lift from the room, the resident remained seated in his wheelchair dressed in the same clothes.9:58 a.m. Staff A, CNA went into the resident's room with Staff D, CNA who pushed a different mechanical stand lift into the resident's room and closed the door.10:06 a.m. resident seated in his room in his wheelchair, dressed in the same soiled clothes.12:03 p.m. resident dressed in the same soiled clothes, seated in his wheelchair at a table in the Station 2 Dining Room with 6 other residents for the noon meal.1:19 p.m. resident self-propelled wheelchair in the hallway dressed in the same soiled clothes, family visitors of other residents present in the hall. Staff interviews revealed:ON 12/9/25 at 1:16 p.m. Staff E, CNA, stated 1 of the mechanical stand lifts was out of service because the leg strap was missing from the lift, the lift was marked out of service and positioned in the resident's hall.On 12/9/25 at 1:31 p.m. Staff D, CNA, stated she assisted Staff A, CNA with the resident at 9:58 a.m. when incontinence care was provided as the resident stood with the mechanical stand lift. Staff D stated the resident was assigned to Staff A, Staff D was assigned to Station 1 and assisted with Station 2 residents as able, and the resident was always cooperative with care.On 12/10/25 at 11:55 a.m., the Director of Nursing (DON) stated staff were expected to assist dependent residents with care that included clothing changes when needed.</p>		