STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165583	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE VILLAGE AT LEGACY POINTE NURSING FACILITY	**1645 SE HOLIDAY CREST CIRCLE WAUKEE, IA 50263**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of call light logs, resident council meeting minutes, and resident interviews, the facility failed to meet resident rights of dignity for one out of four residents interviewed. Resident #1 had an incontinent episode waiting over 15 minutes for staff to respond to the call light. The facility reported a census of 40 residents. Findings include: Resident #1's Minimum Data Set (MDS) revealed the resident had a BIMS of 15 (no cognitive impairment). The MDS identified the resident to require extensive assistance of one for bed mobility and toileting and two staff for transfers. The resident used a wheelchair. The MDS identified the resident as occasionally incontinent of urine and always incontinent of stool. According to the MDS,the resident had [DIAGNOSES REDACTED]. The MDS also revealed the resident used oxygen. Resident #1's Care Plan identified the resident as incontinent related to impaired mobility and medications. The resident careplan directed staff to walk the resident with assist of one, gaitbelt, and a walker. The care plan revealed the resident required prompt response to all requests for assistance. On 7/7/20 at 11:40 a.m. Resident #1 stated usually at night she sometimes waits a long time and recently when she pressed her call light, watched her clock and waited for almost 30 minutes for staff to come help her to the bathroom. The resident stated she was incontinent and she felt degraded because she used to be independent at home but had recently had frequent hospitalization s. A review of the call lights showed the resident waited for 27 minutes 7/3/20 at 7:02 AM, 18 minutes minutes on 7/4/20 at 6:16 AM, 19 minutes on 7/4/20 at 7:45 AM, for 18 minutes on 7/5/20 at 8:14 AM, for 21 minutes on 7/6/20 at 10:20 AM, for 27 minutes on 7/6 at 9:01 PM. Review of the Resident Council meeting minutes from February 2/27/20 showed there were complaints from residents regarding call light times. Due to COVID, staff didn't have Resident Council meetings following 2/27/20.

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

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.