IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

March 2, 2011

Incident Intake #: 32664-I

Ms. Colleen Henderson, Community Director
RidgeView Assisted Living
2975 F Avenue NW
Cedar Rapids, IA 52405

RE: Final Incident Investigation & Recertification Monitoring Evaluation Report – RidgeView Assisted Living, Cedar Rapids, IA

Dear Ms. Henderson:

Enclosed is the **Final Incident Investigation & Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has completed the review of your Plan of Correction (POC) and your Request for Reconsideration in response to the Preliminary **Incident Investigation & Recertification Monitoring Evaluation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC.

Based on the information provided, DIA accepts your Request for Reconsideration.

Enclosed you will find the Assisted Living Program Certificate **S0205** with effective dates of **January 18, 2011** through **January 17, 2013**.

LUCAS STATE OFFICE BUILDING, 321 EAST 12TH STREET, DES MOINES, IOWA 50319-0083

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ADMINISTRATIVE HEARINGS (515) 281-6468 FAX: (515) 281-4477
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INVESTIGATIONS (515) 281-5714 FAX: (515) 242-6507
Telephone Number for the Hearing Impaired: (515) 242-6515

If you have any questions in regard to this certification, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Incident Investigation & Recertification Monitoring Evaluation Report

Assisted Living Program: **Incident Intake #: 32664-I**

Colleen Henderson, Community Director
Ridgeview Assisted Living
2975 F Avenue NW
Cedar Rapids, IA 52405

Date of Incident Investigation/Monitoring Visit:

February 3, 2011

Monitor(s):

Stephanie Cummins, MA

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to, and approved by, the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations. IAC r. 481-67.10(5). The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of an Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 481 IAC - chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Ridgeview Assisted Living on February 3, 2011. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	42
Current number of tenants with cognitive disorder:	1
Total Population:	43

Dementia Specific Program (DSP)* – Not applicable.

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Tenant/Family Satisfaction Results – A community meeting with seven tenants and two visitors was held. Housekeeping was completed appropriately in the common areas; however, housekeeping services in the apartments needed improvement. The tenants requested more time spent on cleaning the apartments and indicated the bathroom floors needed cleaning. Some of the tenants requested they be present in the apartments when cleaning services were provided. There were some inquiries regarding deep cleaning. Nursing services were available and staff responded promptly. The tenants received the services promised in the occupancy agreement. The tenants requested a receptionist at the main entrance door. Staff knocked before entering the apartments; however, it was requested by some tenants that staff wait for an acknowledgement before entering. The tenants received all the services they requested. Medications were administered on time and cares were completed appropriately. The breakfast meal was good; however, the remaining meals needed improvement. The variety of the items served needed improvement and too many starches were served at meals. The tenants requested more balanced meals and improved sanitation with the meal service. They received an activity calendar and the majority of the tenants stated there were sufficient activities. There was a request for more weekend activities and the ability to view the activity calendar via the internet. The tenants requested improved customer service regarding tenant requests. The tenants were satisfied with the program and would recommend it to others.

Program History – The program did not receive any regulatory insufficiencies during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

A. Other

Incident Allegation: The program reported a tenant was missing Lortab tablets. It was reported the tenant's family ordered and set up medications for the tenant.

- Monitoring Observation: Tenant #3, an 82 year old, was admitted on 9-17-10 and diagnoses include: Status Post (S/P) fall with Altered Mental Status, Aortic Stenosis, Chronic Dementia, Chronic Pain, Hypothyroidism, Chronic Depression, Glaucoma, Peripheral Neuropathy, and Degenerative Disc Disease (DDD).

  According to the service plan, the tenant did not receive program administration of medications. The tenant stored the medications independently and family ordered and set up the medications. The tenant had an order for Lortab take one tablet by mouth every three to four hours as needed for pain.

  According to a program document, on 1-19-11 the tenant's family reported there were 52 Lortab tablets missing from the tenant's supply. Family reported the last refill of the medication was on 12-28-10 and the medication was noted to be missing on 1-13-11. The document indicated the tenant self-administered medications and kept the medications in the tenant's apartment at the tenant's discretion. The family ordered and set up the medications. The tenant kept his/her door locked approximately 80-90 percent of the time during the day and almost always kept it locked during night hours, according to the document. According to a program document, the Community Director, the Maintenance Supervisor, the Director of Nursing (DON), housekeeping staff, the receptionist when on duty and direct care staff when on duty had master keys at the time the medications were missing. An investigation was completed and staff were interviewed.

  Staff #1 and #2 stated Tenant #3 had medication missing. Staff #1 and #2 did not know what happened to the medications and reported there had not been any unusual visitors in the building. They stated nursing staff, housekeeping and maintenance staff had master keys.

  The DON stated Tenant #3 had missing Lortab tablets. She stated there were no others tenants she was aware of that had missing medication. The tenant self-administered medication. The tenant did not lock his/her apartment all the time. She stated they were not able to determine what happened to the medications. There were no issues with the program administered medications and there had not been any unusual visitors in the building. The local police department and the department were notified of the missing medications.

  The Community Director stated Tenant #3 had missing Lortab tablets. She stated they were not able to determine what happened to the medications and there were no issues with program administered medications. She stated family, other guests, other providers and some former employees visited the program. She said staff who were on the schedule and had access were interviewed. She stated the local police and the department were notified.

  The tenant stated he/she administered medications independently and the tenant's family set up the medications one time per week. The tenant had not observed anyone in the tenant's apartment that was not supposed to be there. The tenant received assistance with bathing and housekeeping services. The tenant stated he/she had not seen anyone take the medications.

It could not be determined what happened to the missing medications. The program became aware of the missing medications on 1-19-11 and reported on 1-20-11. The incident was reported appropriately.

Although an incident report regarding the missing Lortab tablets was not completed, the program did investigate the incident and report appropriately it to the Department.

- Regulatory Insufficiency: None noted.

Dated this 24th day of February, 2011.