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
	S0205	A. BUILDING: _____ B. WING _____	C 12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW ASSISTED LIVING	2975 F AVENUE NW CEDAR RAPIDS, IA 52405

(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. Number of tenants without cognitive disorder: 26 Number of tenants with cognitive disorder: 4 Total census: 30 The investigation of Complaint #105894-C was completed and the following regulatory insufficiency was cited:	A 000		
A 361	481-67.9(4)f Staffing 67.9(4) Nurse delegation procedures. The program ' s registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. This STANDARD is not met as evidenced by: Based on interview and record review the Program failed to provide medication administration in accordance with training provided for 1 of 3 tenants reviewed (Tenant #1). Findings follow: 1. Record review on 12/7/22 revealed a Incident Report Form dated 7/14/22 at 7:15 a.m. The type of incident was indicated as a medication error. The report indicated Staff A was administering medications to tenants. She prepared medications for Tenant #2 and "got distracted and mistakenly" went to Tenant #1's apartment and	A 361	The Plan of Correction is attached	

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A 361	Continued From page 1	A 361		

administered Tenant #2's medications to Tenant #1. Staff A "immediately" called the nurse on-call and reported the error. Staff A took Tenant #1's vital signs and explained to Tenant #1 what had occurred. Her primary care provider (PCP) recommended Tenant #1 be sent out to the hospital for evaluation.

2. When interviewed on 12/7/22 at 1:23 p.m. and on 12/8/22 at 1:58 p.m. Staff A said she administered Tenant #2's medications to Tenant #1. Staff A said she was distracted by other staff talking to her and went to the wrong apartment. She realized it immediately and tried to get Tenant #1 to stop swallowing the meds. She called the Director of Nursing (DON). The DON looked at the medications and notified Tenant #1's PCP and family. The PCP wanted her to be evaluated. She took Tenant #1's vital signs every 15 minutes until the ambulance arrived. Staff A said she did not administer Tenant #1's morning medications that morning. When asked why the medications were signed off on the MAR (medication administration record) as being given, she did not know. Staff A said Tenant #2 received her morning medications that morning. The DON talked to Staff A after the incident about slowing down and not getting distracted. The DON went over the proper way to administer medications, to not be distracted and to take her time.

3. Review of Tenant #1's July medication administration record (MAR) reflected her 7:00 a.m. meds on 7/14/22 were documented as administered by Staff A.

An After Visit Summary (AVS) dated 7/14/22 indicated Tenant #1 was seen in the emergency department on 7/14/22 for an accidental

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A 361	Continued From page 2 medication error. The AVS indicated to hold Tenant #1's enalapril for that night and resume enalapril the next day. All other meds could be given that evening. The program's Oral Medication Administration training form indicated to open the MAR to the correct tenant ,check the MAR for timeframe of medication administration, remove the medications from the cart and compare the medications to the MAR including for name, dose, routine and time. Review of Staff A's training records on 12/7/22 and 12/8/22 revealed nurse delegated training including medication administration on 8/11/21 and on 9/8/22. 4. When interviewed on 12/8/22 at 4:50 p.m. the Regional Director of Operations confirmed there were no other medication errors in the past six months and per the nurse review completed related to Tenant #1, there was no adverse outcome related to the error.	A 361		

Department of Inspections and Appeals
Attn: Deb Dixon
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Dixon:

On behalf of Ridgeview Assisted Living in Cedar Rapids, Iowa, I respectfully submit our Plan of Correction for your approval. This response is specific to complaint #105894-C report for the onsite visit 12/06/2022-12/08/2022. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusions set forth in the statement of insufficiencies. The Plan of Correction is executed solely because it is required by the provisions of Iowa Law.

Staffing-Nurse Delegation Procedures

1. Elements detailing how the program will correct each regulatory insufficiency
    - Tenants shall be provided services in accordance with the training provided via delegations including but not limited to administration of medications.
    - Re-delegation regarding medication administration was completed with Staff A on 12/19/2022.
2. Measures taken to ensure the problem does not recur
    - All staff will receive delegations according to the services to be provided within 30 days of initial employment and as needed.
    - All staff who provide medication administration will complete an approved medication manager course and receive delegations by the RN prior to administering any medications and ongoing as needed.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Nursing and/or Designee will monitor completion of delegation for all new employees. Staff who do not complete within 30 days of hire will be removed from the schedule.
    - Ongoing education will be provided as needed or at least annually regarding medication administration policies and procedures.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before March 2, 2023.

✓ 3/31/23