

DEPARTMENT OF INSPECTIONS AND APPEALS

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                   |                                                                                                                          |                                                                    |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>S0205</b>                         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/26/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>RIDGEVIEW ASSISTED LIVING</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2975 F AVENUE NW</b><br><b>CEDAR RAPIDS, IA 52405</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| A 000                                                                | <p>Initial Comments</p> <p>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.</p> <p>Number of tenants without cognitive impairment: 33<br/>Number of tenants with cognitive impairment: 3<br/>Total census: 36</p> <p>No regulatory insufficiencies were cited during the investigation of Incident #121502-I or the recertification visit conducted to determine compliance with certification rules for an Assisted Living Program</p> | A 000                                                                                             |                                                                                                                          |                                                                    |

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE