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
	S0409	A. BUILDING: _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW MEMORY CARE VILLAGE - MA	720 OAKBROOK DRIVE MARION, IA 52302

(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 for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 11 Number of tenants with cognitive impairment: 18 Total census: 29 The following regulatory insufficiencies were cited during the recertification visit to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program:	A 000	The Plan of Correction is attached	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its policy and procedure related to incident reports. This pertained 1 of 1 tenant reviewed with a history of suicidal ideation (Tenant #1). Findings follow: 1. Review of Tenant #1's file on 2/10/25 revealed Progress Notes indicating the following: - On 11/5/24 it was noted on 11/4/24 the primary care provider (PCP) was there for rounds and during the visit with Tenant #1 she said she wanted to end her life. Tenant #1 had a long and significant history of suicidal ideation. She had been informed her home was up for sale. The PCP advised staff to call an ambulance to	A 150		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0409	A. BUILDING: _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW MEMORY CARE VILLAGE - MA	720 OAKBROOK DRIVE MARION, IA 52302

(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 150	Continued From page 1	A 150		

transfer her to the emergency department (ED) for evaluation and treatment. Tenant #1 was admitted to the psychiatric floor at the hospital.
- On 11/5/24 (late entry) it was noted Tenant #1 returned to the Program accompanied by family. Per family, the physician did not feel that she was a risk to herself or to others. New orders were received.

Review of a hospital After Visit Summary (AVS) indicated Tenant #1 was seen for a moderate episode of recurrent major depressive disorder from 11/4/24 to 11/5/24. New medication orders were listed. The AVS indicated Tenant #1 presented to the psychiatric unit with her family. She had reported at her memory care program that she had a plan to kill herself by suffocation and had several plastic bags in her room to do it. Upon admission to the unit (psychiatric), she denied depression, suicidal ideation, anxiety, hopelessness but also said if "she can't live a life of her own making, she'd rather be dead." It was noted Tenant #1 refused to believe she had Alzheimer's disease and denied having any history of suicidal ideation or self-harm.

Further review of Tenant #1's file revealed diagnoses included unspecified psychosis, manic episode, bipolar disorder, unspecified dementia with mood disturbance and major depressive disorder (recurrent). Tenant #1 was staged at a three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline.

Tenant #1's Health and Functional evaluation dated 11/6/24 indicated it was completed related to a 24 hour psychiatric stay and return to the Program. Tenant #1 being told that her house was for sale was believed to have started the episode. Staff attempted to post the number for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW MEMORY CARE VILLAGE - MA	720 OAKBROOK DRIVE MARION, IA 52302

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A 150	Continued From page 2 the suicide prevention hotline which she refused and threw in the garbage. Staff also attempted to remove her garbage bag liners since she had stated in the ED she could use them to end her life. Tenant #1 became very angry with the attempt. During the assessment Tenant #1 said she had no desire or intent to harm herself or to end her life. She said she made those comments as it was the only way to get anyone's attention. No incident report regarding the event on 11/4/24 could be located.	A 150		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans that reflected the identified needs and preferences for assistance. This pertained to 2 of 5 tenants reviewed (Tenants #3 and #4). Findings follow: 1. Review of Tenant #3's file on 2/10/25 revealed the service plan reflected staff provided a room tray if she was not able to come out to the dining room. Staff assisted with cutting up and setting up her foods related to her vision impairment. Staff provided her with reminders and set up for all meals.	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 395	Continued From page 3 When interviewed on 2/11/25 at 1:19 p.m. Staff A said up until recently staff provided cueing at meals due to Tenant #3's vision. A week or two ago, she started to need physical assist with eating and staff were helping her eat. Staff A said it was dependent on Tenant #3's mood, regarding what type of assistance she needed with meals. She said about two days per week staff physically assisted Tenant #3 to eat. Continued record review revealed Tenant #3's service plan did not reflect she needed physical assistance with eating at times.. 2. Review of Tenant #4's file on 2/10/25 revealed his service plan reflected he had a history of falls, used a walker for ambulation and had a wood platform for the recliner to aid in transfers. Tenant #1 managed his own transfers. Review of the Adult Services Monitoring Entrance Form reflected Tenant #4 was one of the tenants identified that utilized a bed rail. Tenant #4's service plan did not reflect the bed rail. 3. When interviewed on 2/10/25 at 4:31 p.m. the Assisted Living Director of Nursing confirmed all service plans were provided for the tenants reviewed.	A 395		

Department of Inspections and Appeals
Attn: Catie Campbell
6200 Park Avenue Suite 100
Des Moines, Iowa 50321

Dear Ms. Campbell:

On behalf of Meadowview Assisted Living, Marion Iowa, I respectfully submit our Plan of Correction for your approval. This response is specific to the recertification visit, for the onsite visit 2/5/2025-2/11/2025. 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.

67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program

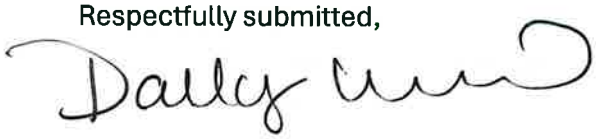
1. Elements detailing how the Program will correct each regulatory insufficiency
    - The program shall follow the policies and procedures established by the program, including completion of incident reports, per program policy.
    - An incident report was completed for tenant #1.
2. Measures taken to ensure the problem does not recur
    - The Director of Nursing/Assistant Director of Nursing were re-educated on the program policy and procedures for incident reporting.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Nursing and/or Designee will complete ongoing audits to ensure the program is following policies established by the program.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before April 9, 2025.

69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance

1. Elements detailing how the Program will correct each regulatory insufficiency
    - The tenant service plans have been updated to identify their current needs and preferences for assistance.
2. Measures taken to ensure the problem does not recur
    - The Director of Nursing/Assistant Director of Nursing were re-educated on developing an individualized service plan for each tenant.
    - Service Plans will be based on the evaluation, individualized, updated whenever changes are needed and at least annually in accordance with regulation.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Nursing and/or Designee will complete ongoing audits of the tenant service plans to ensure the program follows regulatory requirements.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before April 9, 2025.

If you have any questions regarding this plan of correction, please contact me at (319) 390-8439.

Respectfully submitted,



Department of Inspections and Appeals
Attn: Catie Campbell
6200 Park Avenue Suite 100
Des Moines, Iowa 50321

Dear Ms. Campbell:

On behalf of Ridgeview Assisted Living Marion, I respectfully submit our Plan of Correction for your approval. This response is specific to the recertification and complaint 121429-C Visit, for the onsite visit 2/5/2025-2/11/2025. 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.

69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception.

1. Elements detailing how the Program will correct each regulatory insufficiency
    - Documentation for each tenant shall include nursing notes by exception for tenants that receive any personal or health-related care.
2. Measures taken to ensure the problem does not recur
    - The Director of Nursing/Assistant Director of Nursing were re-educated on documentation of nurses' notes written by exception when a tenant delegates personal or health related care to the program.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Nursing and/or Designee will complete ongoing audits to ensure nursing notes by exception are documented when at tenant receives personal or health related care.
4. The date by which the regulatory insufficiency will be corrected
    - The regulatory insufficiency will be corrected on or before April 9, 2025.

69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.

1. Elements detailing how the Program will correct each regulatory insufficiency
    a. The tenant's service plans will reflect the specific needs of the individual tenant and will be updated at least annually and whenever changes are needed.
2. Measures taken to ensure the problem does not recur
    a. The Director of Nursing/Assistant Director of Nursing on developing an individualized service plan for each tenant.

a. Service Plans will be based on the evaluation, individualized, and updated whenever changes are needed, at least annually, in accordance with regulations.

3. How the Program plans to monitor performance to ensure compliance
    a. The Director of Nursing and/or Designee will complete ongoing audits of tenant service plans to ensure they are following regulatory requirements.
4. The date by which the regulatory insufficiency will be corrected
    a. The regulatory insufficiency will be corrected on or before April 9, 2025.

If you have any questions regarding this plan of correction, please contact me at (319) 390-8439.

Respectfully submitted,

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
	S0228	A. BUILDING: _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW MEMORY CARE VILLAGE	3005 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 for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 11 Number of tenants with cognitive impairment: 18 Total census: 29 The following regulatory insufficiencies were cited during the recertification visit to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program:	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its policy and procedure related to incident reports. This pertained 1 of 1 tenant reviewed with a history of suicidal ideation (Tenant #1). Findings follow: 1. Review of Tenant #1's file on 2/10/25 revealed Progress Notes indicating the following: - On 11/5/24 it was noted on 11/4/24 the primary care provider (PCP) was there for rounds and during the visit with Tenant #1 she said she wanted to end her life. Tenant #1 had a long and significant history of suicidal ideation. She had been informed her home was up for sale. The PCP advised staff to call an ambulance to	A 150		

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW MEMORY CARE VILLAGE	3005 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 150	Continued From page 1	A 150		

transfer her to the emergency department (ED) for evaluation and treatment. Tenant #1 was admitted to the psychiatric floor at the hospital.
- On 11/5/24 (late entry) it was noted Tenant #1 returned to the Program accompanied by family. Per family, the physician did not feel that she was a risk to herself or to others. New orders were received.

Review of a hospital After Visit Summary (AVS) indicated Tenant #1 was seen for a moderate episode of recurrent major depressive disorder from 11/4/24 to 11/5/24. New medication orders were listed. The AVS indicated Tenant #1 presented to the psychiatric unit with her family. She had reported at her memory care program that she had a plan to kill herself by suffocation and had several plastic bags in her room to do it. Upon admission to the unit (psychiatric), she denied depression, suicidal ideation, anxiety, hopelessness but also said if "she can't live a life of her own making, she'd rather be dead." It was noted Tenant #1 refused to believe she had Alzheimer's disease and denied having any history of suicidal ideation or self-harm.

Further review of Tenant #1's file revealed diagnoses included unspecified psychosis, manic episode, bipolar disorder, unspecified dementia with mood disturbance and major depressive disorder (recurrent). Tenant #1 was staged at a three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline.

Tenant #1's Health and Functional evaluation dated 11/6/24 indicated it was completed related to a 24 hour psychiatric stay and return to the Program. Tenant #1 being told that her house was for sale was believed to have started the episode. Staff attempted to post the number for

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW MEMORY CARE VILLAGE	3005 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 150	Continued From page 2 the suicide prevention hotline which she refused and threw in the garbage. Staff also attempted to remove her garbage bag liners since she had stated in the ED she could use them to end her life. Tenant #1 became very angry with the attempt. During the assessment Tenant #1 said she had no desire or intent to harm herself or to end her life. She said she made those comments as it was the only way to get anyone's attention. No incident report regarding the event on 11/4/24 could be located. 2. Review of the Program's Accident, Incident and Medication Error Reporting policy and procedure indicated staff would document unusual accidents and incidents that involved tenants, staff, visitors or others within the building or on the premises. Tenant accidents and incidents would be documented on the Incident Report Form. It would be completed in detail on the Incident Report Form and the person in charge at the time of the incident would prepare and sign the form. All accidents or unusual occurrences in the building or on the premises that affected tenants would be reported as incidents. 3. When interviewed on 2/11/25 at approximately 2:00 p.m. the Assisted Living Director of Nursing confirmed all incident reports were provided that were available. In an email sent on 2/11/25 at 1:01 p.m. the Assisted Living Director of Nursing confirmed there were no incident reports for Tenant #1 during the time period requested.	A 150		
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized	A 395		

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 395	Continued From page 3 and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans that reflected the identified needs and preferences for assistance. This pertained to 2 of 5 tenants reviewed (Tenants #1, #3 and #4). Findings follow: 1. Review of Tenant #3's file on 2/10/25 revealed the service plan reflected staff provided a room tray if she was not able to come out to the dining room. Staff assisted with cutting up and setting up her foods related to her vision impairment. Staff provided her with reminders and set up for all meals. When interviewed on 2/11/25 at 1:19 p.m. Staff A said up until recently staff provided cueing at meals due to Tenant #3's vision. A week or two ago, she started to need physical assist with eating and staff were helping her eat. Staff A said it was dependent on Tenant #3's mood, regarding what type of assistance she needed with meals. She said about two days per week staff physically assisted Tenant #3 to eat. Continued record review revealed Tenant #3's service plan did not reflect she needed physical assistance with eating at times.. 3. Review of Tenant #4's file on 2/10/25 revealed his service plan reflected he had a history of falls,	A 395		

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
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A 395	Continued From page 4 used a walker for ambulation and had a wood platform for the recliner to aid in transfers. Tenant #1 managed his own transfers. Review of the Adult Services Monitoring Entrance Form reflected Tenant #4 was one of the tenants identified that utilized a bed rail. Tenant #4's service plan did not reflect the bed rail. 4. When interviewed on 2/10/25 at 4:31 p.m. the Assisted Living Director of Nursing confirmed all service plans were provided for the tenants reviewed.	A 395		

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW ASSISTED LIVING - MARION	720 OAKBROOK DRIVE MARION, IA 52302

(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 impairment: 23 Number of tenants with cognitive impairment: 0 Total census: 23 The following regulatory insufficiencies were cited related the investigation of Complaint #121429-C and the recertification visit to determine compliance with certification for an Assisted Living Program:	A 000		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurse's notes by exception. This pertained to 1 of 4 current tenants reviewed (Tenant #1) and 2 of 2 discharged tenants reviewed (Tenant C1 and Tenant C2). Findings follow: 1. Review of Tenant #1's file on 2/6/25 revealed a	A 290		

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
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A 290	Continued From page 1 Progress Notes dated 11/25/24 indicating he returned from his eye appointment with cataract removal. A new order was received for prednisone acetate 1% (eye drops) to the right eye for 7 days. Continued review revealed a nurse's note was not completed when the eye drops were completed. 2. Review of Tenant C1's file on 2/6/25 revealed an Incident Report Form dated 5/20/24 reflecting staff found her on the floor in the bedroom. Tenant C1 reported she had tried to use the bathroom. Her right outer calf had a bruise and it was fluid filled. Tenant C1 reported right hip pain. Ice was applied to the right hip and calf. Continued record review revealed a Health and Functional evaluation dated 5/23/24 (90 day review) reflected she had a fall on 5/20/24. Tenant C1 said she rushed to get to the bathroom and lost her footing as she went around the corner. She hit her leg on the wall on the way down, which caused a fluid filled hematoma to her right lower extremity (RLE). Tenant C1 declined the need to call her primary care provider (PCP) and ice and tubigrips were put on the RLE hematoma at her request. Tenant C1 reported the hematoma had become red around it and was warm. She went to the PCP and was diagnosed with cellulitis and received antibiotics. She managed the medication and a daily bacitracin gauze dressing independently. There were no nurse's notes completed when Tenant C1 fell and sustained an injury; when Tenant C1 reported redness and warmth to the area on the RLE; when and where she received medical treatment; a new diagnosis of cellulitis with antibiotics and a daily dressing change; or	A 290		

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
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RIDGEVIEW ASSISTED LIVING - MARION	720 OAKBROOK DRIVE MARION, IA 52302

(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 290	Continued From page 2 when the area was resolved. Continued record review revealed the Move In Record indicated she was discharged on 6/23/24 to a private home. A nurse's note was not completed related to Tenant C1's discharge, including when she was discharged and the reason for her discharge. 3. Review of Tenant C2's file on 2/6/25 revealed the Move In Record sheet indicated Tenant C2 moved in on 4/4/24 and was discharged on 6/30/24. It noted Tenant C2 was discharged to an acute care hospital. A nurse's note was not completed when Tenant C2 moved in and there was no note completed related when Tenant C2 was discharged and the reason for the discharge. 4. When interviewed on 2/10/25 at 4:31 p.m. the Assisted Living Director of Nursing confirmed all nurse's notes were provided for the tenants reviewed.	A 290		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.	A 350		

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
	S0408	A. BUILDING: _____ B. WING _____	C 02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW ASSISTED LIVING - MARION	720 OAKBROOK DRIVE MARION, IA 52302

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A 350	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed to reflect the service needs of the tenants. This pertained to 3 of 4 current tenants reviewed (Tenants #2, #3 and #4) and 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Review of Tenant #2's file on 2/6/25 revealed Progress Notes indicating the following: - On 10/10/24 the primary care provider (PCP) signed an order for Tenant #2 to self-administer Pepto-Bismol as needed. - On 10/24/24 the PCP signed an order for Tenant #2 to self-administer and store diclofenac sodium external gel 1% to be used as needed. Tenant #2's Order Summary Report reflected the following orders: - Pepto-Bismol give one dose by mouth as needed for diarrhea, use per package directions, (tenant) may use independently. - Diclofenac sodium external gel 1%, apply to bilateral knees topically as needed for pain, okay to self administer and (tenant) may keep in apartment. Further record review revealed Tenant #2's service plan reflected staff administered her medications which were stored in a locked area. The service plan did not reflect Tenant #2 self-administered the Pepto-Bismol and diclofenac gel and stored the medications in her apartment. 2. Review of Tenant #3's file on 2/6/25 revealed Progress Notes indicating the following: - On 11/21/24 Tenant #3 went to an urology	A 350		

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
	S0408	A. BUILDING: _____ B. WING _____	C 02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW ASSISTED LIVING - MARION	720 OAKBROOK DRIVE MARION, IA 52302

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A 350	Continued From page 4 appointment and returned with new orders, including estradiol cream. Tenant #3 would manage the cream independently. - On 12/26/24 a signed order was received from the PCP for Tenant #3 to self-administer and store TUMS. Continued record review revealed an After Visit Summary dated 11/20/24 which reflected an order for estradiol cream. A handwritten note on the AVS indicated per family and the PCP, Tenant #3 managed it independently. Tenant #3's service plan reflected staff administered her medications which were stored in a locked medication cabinet. The service plan did not reflect Tenant #3 self-administered and stored the TUMS and estradiol cream. 3. Record review on 2/6/25 of Tenant #4's file revealed a Health and Functional evaluation dated 1/23/25 indicated Tenant #4 was hospitalized for observation for 24 hours. On 1/22/25 Tenant #4 reported she was not feeling well. During an assessment she complained of nausea and weakness. Tenant #4 had an increased blood pressure and was not sure about taking her medications. She was transported to the hospital. Tenant #4's legal representative requested the Program begin to administer her medications sometime next week. Continued record review revealed an Order Summary Report reflected an order for blood glucose checks twice daily for diabetes. The order date was 1/23/25. Further record review revealed Tenant #4's service plan reflected staff administered her medications and stored the medications in a	A 350		

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
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A 350	Continued From page 5 locked area. The service plan also reflected Tenant #4 had oxygen and a continuous positive airway pressure (CPAP) machine that she managed independently. The service plan did not reflect staff assistance with blood glucose monitoring twice daily. 4. Review of Tenant C1's file on 2/6/25 revealed an Incident Report Form dated 5/20/24 reflecting staff found Tenant C1 on the floor in the bedroom. Tenant C1 reported she had tried to use the bathroom. Her right outer calf had a bruise which was fluid filled. Tenant C1 reported right hip pain. Ice was applied to the right hip and calf. Continued record review revealed a Health and Functional evaluation dated 5/23/24 (90 day review) which reflected she had a fall on 5/20/24. She went to the PCP and was diagnosed with cellulitis and received antibiotics. She managed the medication and a daily bacitracin gauze dressing independently. Tenant C1's service plan reflected she administered her medications and stored them in her apartment. The service plan did not reflect the history of cellulitis with antibiotic therapy. It also did not reflect Tenant C1 was independent with the daily gauze and bacitracin treatment. 5. When interviewed on 2/10/25 at 4:31 p.m. the Assisted Living Director of Nursing confirmed all service plans were provided for the tenants reviewed.	A 350		