PRINTED: 05/13/2025
FORM APPROVED

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
	S0430	A. BUILDING: _____ B. WING _____	C 04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD PLACE AT RIDGECREST VILLAGE	4130 NORTHWEST BLVD DAVENPORT, IA 52806

(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: 37 Number of tenants with cognitive impairment: 2 Total census: 39 The following regulatory insufficiencies were cited related to the investigation of Complaint #127859-C	A 000		
A 285	481-67.5(2)f(4) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medications and treatments as ordered. This pertained to 4 of 4 tenants reviewed who received staff assistance with blood glucose monitoring and insulin administration (Tenants #1, #2 #3 and #4). Findings follow:	A 285		

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A 285	Continued From page 1 Review of tenant files on 4/10/25 and 4/14/25 revealed the following: 1. Tenant #1's February 2025 medication administration record (MAR) reflected an order for Humalog Kwik-Pen solution 100 unit/milliliters (ml), 7 units subcutaneously (SQ), before meals. The insulin was to be held if the blood glucose reading was equal to or below 100. The MAR noted administration times of 7:00 a.m., 11:00 a.m. and 4:00 p.m. The MAR reflected "NA" for the blood glucose readings at 4:00 p.m. on 2/1/25, 2/2/25, 2/10/25, 2/15/25, 2/16/25, 2/24/25 and 2/27/25; however, it was noted insulin was documented as administered for all of those dates at 4:00 p.m. Insulin was administered despite no recorded blood glucose readings documented at those dates and times. The March 2025 MAR reflected "NA" for the blood glucose readings at 4:00 p.m. on 3/1/25, 3/2/25, 3/6/25, 3/7/25 and 3/13/25; however, it was noted insulin was documented as administered for all of those dates at 4:00 p.m. The MAR reflected insulin was documented as administered for all of those dates at 4:00 p.m. Insulin was administered despite no recorded blood glucose readings documented at those dates and times. 2. Tenant #2's March 2025 MAR reflected an order to check blood glucose readings twice daily and to call the primary care provider (PCP) if less than 60 or greater than 400. On 3/14/25 (twice) and on 3/16/25 (twice), staff initialed they completed the blood glucose monitoring; however, no blood glucose values were documented as ordered. 3. Tenant #3's February 2025 MAR reflected an	A 285	Emergency meeting held with all MM 4/15/25 after state visit. Reviewed med adminstration policy, delegation of blood glucose monitoring and insulin administration with all MM, delegations signed. Insulin is to be double verified with another staff member prior to adminstration and a progress note entered with who verified insulin. Insulin should never be given without checking blood glucose prior and documenting reading in EMAR. If PCC does not prompt to record blood sugar RN must be notified to clarify order. Reviewed delegation for parameters on EMAR and new delegation created for Communication/ documentation of results outside of parameters. All values outside of EMAR parameters are to be reported to RN and progress note stating who was contacted and further instructions given by RN. Demonstrated to staff how to create progress note in PCC and use of progress notes to have a "paper trail" for events. Importance of overall documentation, if it wasn't charted in PCC it wasn't done. DON to use PCC dashboard daily to monitor EMAR documentation, checking parameters and med administration of values outside of parameters. Its the nurses responsibility to ensure all BP and insulin orders have parameters associated with order. Review of current orders completed and updated. New orders must have parameters before entering order into PCC. All orders must have an order uploaded into PCC under misc.If V.O recieved this must be faxed to doctor to be signed. All faxes sent to doctors are now kept in binder by fax and removed once returned with doctor signature. Binder reviewed weekly by nurse. All new orders are communicated to staff on PCC by RN. DON to perform EMAR audits every 2 weeks.	4/15/25

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A 285	Continued From page 2 order for Lantus SoloStar Solution, 30 units SQ, once per day. It was noted as held on 2/10/25. The MAR revealed a one-time dose of Lantus SoloStar Solution, 15 units SQ on 2/10/25. Staff initialed for the administration of the 15 units of insulin on 2/10/25 at 6:30 a.m. Review of Tenant #3's file did not reveal an order for the 15 units of insulin administered on 2/10/25 or a hold order for the 30 units held on 2/10/25. 4. Tenant #4's February and March 2025s MAR reflected the following orders: - Blood glucose monitoring in the morning and before the evening meal. It was scheduled at 7:30 a.m. and 4:00 p.m. Check before the meal and notify the nurse of blood glucose was below 70 or above 300. - Humalog Kwik-Pen Solution 100 unit/ml, 5 units SQ, before meals. It was scheduled at 7:00 a.m., 11:00 a.m. and 4:00 p.m. - Lantus SoloStar Solution 100 unit/ml, 25 units SQ at bedtime. It was scheduled at 8:00 p.m. The February MAR reflected all doses of the Lantus insulin were administered as ordered except on 2/20/25. All doses of Humalog insulin were administered. Blood glucose levels were documented as less than 70 at 7:30 a.m. on 2/2/5, 2/12/25, 2/14/25, 2/17/25, 2/24/25 and 2/26/25. Blood glucose levels were documented as greater than 300 at 4:00 p.m. on 2/2/25, 2/9/25 and 2/26/25. There was no documentation provided that staff notified a nurse of the blood glucose levels outside of the ordered parameters on those dates. The March 2025 MAR reflected all doses of the Lantus insulin were administered as ordered. It also reflected all doses of the Humalog insulin were documented as administered except on	A 285		

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A 285	Continued From page 3 3/25/25 at 11:00 a.m. and 4:00 p.m. when it was noted Tenant #4 was absent from the building. Blood glucose levels were documented as less than 70 on 3/7/25, 3/8/25, 3/12/25, 3/15/25, 3/20/25, 3/21/25, 3/22/25, 3/23/25 and 3/27/25. Blood glucose levels were documented as greater than 300 at 4:00 p.m. on 3/26/25 and 3/28/25. There was no documentation provided that staff notified the nurses of the blood glucose levels outside of the ordered parameters with the exception of 3/26/25. The April 2025 MAR reflected the same orders until 4/11/25. It was documented Lantus was administered from 4/1/25 to 4/9/25. From 4/1/25 to 4/11/25 Humalog was documented as administered except on 4/8/25. It was noted as a "9" which indicated other/see progress notes. Notes indicated the insulin was held per the nurse's directive due to a low blood glucose. Blood glucose values from 4/1/25 to 4/11/25 were below 70 at 7:30 a.m. on 4/1/25, 4/5/25, 4/6/25, 4/7/25, 4/8/25 and 4/10/25. There was no documentation provided that staff notified a nurse of the blood glucose levels outside of the ordered parameters with the exception of 4/8/25 when the insulin was held. New orders for Tenant #4 were received on 4/11/25 and 4/12/25 for insulin and blood glucose monitoring. The April MAR was updated and reflected the following: - Check blood glucose before meals and at bedtime (four times per day). It started on 4/11/25 - Humalog Kwik-Pen Solution 100 unit/ml, 5 units SQ, before meals. Hold if blood glucose levels are less than 120. It started on 4/12/25 (previously did not have an order for parameters to hold the insulin). - Lantus SoloStar Solution 100 unit/ml, 22 units	A 285		4/15/25 4/15/25

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A 285	Continued From page 4 SQ at bedtime. It was scheduled at 8:00 p.m. It started on 4/10/25. The April 2025 MAR for the dates of 4/11/25 to 4/15/25 (last date MARs were requested) revealed Humalog was administered to the tenant on 4/12/25 at 7:00 a.m. and 4/13/25 at 7:00 a.m. and 11:00 a.m. when the order indicated it was to be held based on blood glucose values below 120. 5. When interviewed on 4/14/25 at approximately 9:55 a.m. and 4/15/25 at 12:17 p.m. the Director said she was not able to locate any other documentation of blood glucose values for Tenant #1 and Tenant #2. She confirmed a hold order could not be located for Tenant #3 for the 30 units of Lantus insulin on 2/10/25 or a replacement order for 15 units for that day. The Director said there was no documentation (other than provided) in nurse's notes or in the electronic MAR related to Tenant #4's blood glucose readings and the notification of any nurses. She did not locate any staff to nurse documentation sheets related to blood glucose readings. She was unable to find any documentation related to the three doses of Humalog administered to Tenant #4 on 4/2/25 and 4/13/25 when blood sugars were below parameters. She confirmed all MARs and orders requested were provided for the tenants reviewed.	A 285		
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:	A 361		

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A 361	Continued From page 5 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 ensure staff provided services in accordance with training provided. This pertained to 1 of 1 tenants reviewed with blood glucose readings outside of parameters (Tenant #4) as well as 7 of 7 staff reviewed (Staff A, B, C, D, E, F and G). Findings follow: 1. On 4/10/25 and 4/14/25 review of Tenant #4's file revealed the February and March 2025 MARs (medication administration records) reflected the following orders: - Blood glucose monitoring in the morning and before the evening meal. It was scheduled at 7:30 a.m. and 4:00 p.m. Check before the meal and notify the nurse of blood glucose below 70 or above 300. - Humalog Kwik-Pen Solution 100 unit/milliliters (ml), inject 5 units subcutaneously (SQ) before meals. It was scheduled at 7:00 a.m., 11:00 a.m. and 4:00 p.m. The February MAR reflected blood glucose levels were documented as less than 70 at 7:30 a.m. on 2/2/5, 2/12/25, 2/14/25, 2/17/25, 2/24/25 and 2/26/25. Blood glucose levels were documented as greater than 300 at 4:00 p.m. on 2/2/25, 2/9/25. There were 8 entries of blood glucose levels outside of parameters at 7:30 a.m. and 4:00 p.m., completed by 6 different staff (Staff B, C, D, E, F and G). There was no documentation provided that staff notified the nurses of the blood glucose levels outside of the ordered parameters	A 361		

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A 361	Continued From page 6 on those dates. Tenant 4's March MAR reflected blood glucose levels were less than 70 at 7:30 a.m. on 3/7/25, 3/8/25, 3/12/25, 3/15/25, 3/20/25, 3/21/25, 3/22/25, 3/23/25 and 3/27/25. There were 9 entries of blood glucose levels outside of the parameters at 7:30 a.m., completed by 5 different staff (Staff A, C, D, F and G). There was no documentation provided that staff notified the nurses of the blood glucose levels outside of the ordered parameters on those dates. The April 2025 MAR reflected the same orders until 4/11/25. Blood glucose values from 4/1/25 to 4/11/25 were below 70 at 7:30 a.m. on 4/1/25, 4/5/25, 4/6/25, 4/7/25, 4/8/25 and 4/10/25. There were 6 entries of blood glucose values outside of parameters, completed by 3 staff (Staff A, C and G). A nurse's note was completed dated 4/8/25 that indicated the nurse was notified and insulin was held. There was no other documentation completed related to the notification of a nurse of the blood glucose values outside of parameters. New orders for Tenant #4 were received on 4/11/25 and 4/12/25 for insulin and blood glucose monitoring. The April MAR was updated and reflected the following: - Check blood glucose before meals and at bedtime (four times per day). It started on 4/11/25 - Humalog Kwik-Pen Solution 100 unit/ml, 5 units SQ, before meals. Hold if blood glucose levels are less than 120. It started on 4/12/25 (previously did not have an order for parameters to hold the insulin). The April MAR reflected from 4/12/25 to 4/15/25 (last date MARs were requested) Humalog was documented as administered on 4/12/25 and	A 361		

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A 361	Continued From page 7 4/13/25 at 7:00 a.m., 11:00 a.m. and 4:00 p.m. It was also documented as administered on 4/14/25 at 11:00 a.m. and 4:00 p.m. and on 4/15/25 at 11:00 a.m. There were two entries dated 4/14/25 and 4/15/25 at 7:00 a.m. that reflected the insulin was not administered due to parameters outside of administration. Blood glucose values were below 120 (hold Humalog if below 120) on 4/12/25 at 7:00 a.m. and on 4/13/25 at 7:00 a.m. and 11:00 a.m. There were three doses of Humalog administered on 4/12/25, 4/13/25 at 7:00 a.m. and 4/13/25 at 11:00 a.m. when the order indicated it was to be held based on blood glucose values below 120. There was no documentation of any nurse notification of the blood glucose readings outside of the parameters for insulin administration. 2. On 4/15/25 review of the Program's nurse delegation for parameters on the electronic MAR, including blood glucose checks, weights and blood pressure indicated to review the tenant's MAR for parameters and document the reading in the MAR. Staff was to report to the nurse if the result was below or above the reading and follow any directions the nurse provided. It also indicated to document any additional information or results in the MAR as needed. Staff A, B, C, D, E, F and G had documented nurse delegation training regarding parameters. 3. When interviewed on 4/14/25 at approximately 9:55 a.m. and 4/15/25 at 12:17 p.m. the Director said there was no documentation (other than provided) in nurse's notes or in the electronic MAR related to Tenant #4's blood glucose readings and the notification of the nurses. She did not locate any staff to nurse documentation sheets related to blood glucose readings.	A 361		