STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave, Suite 200, Vancouver, WA 98684

AMENDED

Riverview Sr Living LLC
Riverview Sr Living
7510 SE Evergreen Hwy
Vancouver, WA 98664

RE: Riverview Sr Living License # 755577

Dear Provider:

This letter addresses Compliance Determination(s) 37145 (Completion Date 02/22/2024) and 32092 (Completion Date 11/21/2023).

The Department completed a follow-up inspection of your Adult Family Home on 02/22/2024 and found that you have corrected the violations listed in the Complaint report dated 11/21/2023. Your home is back in compliance as of 12/14/2023 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10430-1, WAC 388-76-10430-2-c, WAC 388-76-10430-2-d, WAC 388-76-10430-2-a

The Department staff who did the on-site verification:
Robert Hennig, NCI ALF Complaint Investigator
Michael Burdick, AFH Nurse Field Manager

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Michael Burdick, Field Manager
Region 3, Unit F
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Riverview Sr Living
Provider Type: Adult Family Home
License/Cert.#: 755577
Compliance Determination #: 32092
Intake ID: 104949
Investigator: Robert Hennig
Region/Unit #: RCS Region 3 / Unit F
Investigation Date(s): 11/03/2023 through 11/21/2023
Complainant Contact Date(s):

Allegation(s):

1. Staff documenting medications given that were not given to residents.
2. Resident not receiving medications for days and wound care not performed for days.
3. Staff not giving medications as ordered and giving medications not ordered to residents.
4. Medications not stored and locked appropriately.
5. Residents not receiving safe care and services.

Investigation Methods:

Sample:
Total residents: 5
Resident sample size: 4
Closed records sample size: 0

Observations:
Residents
Resident care equipment
Resident rooms
Staff to resident interactions
Medication administration
Medication storage

Interviews:
Identified staff
Nursing staff
Residents
Family members
Social services staff

Record Reviews:
Assessment
Progress Notes
Medication Administration Records
Medical records
Hospital Records

Investigation Summary:

1. Staff documenting medications given that were not given to residents. The unannounced on-site investigation was conducted in relation to all allegations and/or incidents identified in the intakes. Based on interviews, observations and records review, failed facility practice was identified. Additional residents reviewed for safety,

care and services, with concerns. Facility was cited under WAC 388-76-10400 (1)(2)(3)(a)(b)(c), and WAC 388-76-10430 (1)(2)(c)(d).
2. Resident not receiving medications for days and wound care not performed for days. The unannounced on-site investigation was conducted in relation to all allegations and/or incidents identified in the intakes. Based on interviews, observations and records review, failed facility practice was identified. Additional residents reviewed for safety, care and services, with concerns. Facility was cited under WAC 388-76-10400 (1)(2)(3)(a)(b)(c), and WAC 388-76-10430 (1)(2)(c)(d).
3. Staff not giving medications as ordered and giving medications not ordered to residents. The unannounced on-site investigation was conducted in relation to all allegations and/or incidents identified in the intakes. Based on interviews, observations and records review, failed facility practice was identified. Additional residents reviewed for safety, care and services, with concerns. Facility was cited under WAC 388-76-10400 (1)(2)(3)(a)(b)(c), and WAC 388-76-10430 (1)(2)(c)(d).
4. Medications not stored and locked appropriately. The unannounced on-site investigation was conducted in relation to all allegations and/or incidents identified in the intakes. Based on observations and interviews, no failed facility practice was substantiated during the investigation. Observation of medications in locked location. Additional residents reviewed for safety, care and services.
5. Residents not receiving safe care and services. The unannounced on-site investigation was conducted in relation to all allegations and/or incidents identified in the intakes. Based on interviews, observations and records review, failed facility practice was identified. Additional residents reviewed for safety, care and services, with concerns. Facility was cited under WAC 388-76-10400 (1)(2)(3)(a)(b)(c), and WAC 388-76-10430 (1)(2)(c)(d).

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Riverview Sr Living
Provider Type: Adult Family Home
License/Cert.#: 755577
Compliance Determination #: 32092
Intake ID: 104922
Investigator: Robert Hennig
Region/Unit #: RCS Region 3 / Unit F
Investigation Date(s): 11/03/2023 through 11/21/2023
Complainant Contact Date(s): 11/08/2023

Allegation(s):
1. Staff member was falsifying documents for resident's medication administration records and not being given prescribed medications for unknown amount of time.

Investigation Methods:

Sample:	Total residents: 5 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions
Interviews:	Nursing staff Residents Family members Social services staff Collateral contact Administrator
Record Reviews:	Assessment Negotiated Care Plan Progress notes Medication Administration Record

Investigation Summary:
1. Staff member was falsifying documents for resident's medication administration records and not being given prescribed medications for unknown amount of time. Failed practice identified. The unannounced on-site investigation was conducted in relation to all allegations and/or incidents identified in the intakes. Based on interviews, observations and records review, failed facility practice was identified and cited under WAC 388-76-10430 (1)(2)(c)(d). Additional residents reviewed for safety, care and services.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Riverview Sr Living
Provider Type: Adult Family Home
License/Cert.#: 755577
Compliance Determination #: 32092
Intake ID: 96441
Investigator: Robert Hennig
Region/Unit #: RCS Region 3 / Unit F
Investigation Date(s): 11/03/2023 through 11/21/2023
Complainant Contact Date(s):

Allegation(s):
1. Staff performed undelegated catheter care for resident.
2. Resident not receiving care and services as required.

Investigation Methods:

Sample:	Total residents: 5 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions
Interviews:	Identified staff Nursing staff Residents Family members Social services staff
Record Reviews:	Assessment Negotiated Care Plan Progress Notes

Investigation Summary:
1. Staff performed undelegated catheter care for resident. The unannounced on-site investigation was conducted in relation to allegations and/incidents identified in the intakes. Based on interviews, observations and records review, no failed facility practice was substantiated during the investigation. Additional residents reviewed for safety, care and services.
2. Resident not receiving care and services as required. The unannounced on-site investigation was conducted in relation to allegations and/or incidents identified in the intakes. Based on interviews, observations and records review, failed facility practice was identified and cited under WAC 388-76-10400 (1)(2)(3)(a,b,c). Additional residents reviewed for safety, care and services.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Riverview Sr Living
Provider Type: Adult Family Home
License/Cert.#: 755577
Compliance Determination #: 32092
Intake ID: 97210
Investigator: Robert Hennig
Region/Unit #: RCS Region 3 / Unit F
Investigation Date(s): 11/03/2023 through 11/21/2023
Complainant Contact Date(s): 11/08/2023

Allegation(s):
1. Resident not receiving prescribed medication for days.

Investigation Methods:

Sample:	Total residents: 5 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents Resident rooms Staff to resident interactions Medication administration
Interviews:	Identified staff Nursing staff Residents Family members Social services staff Collateral contact Administrator
Record Reviews:	Assessment Medication Administration Record Progress notes Medical records Hospital records

Investigation Summary:
1. Resident not receiving prescribed medication for days. The unannounced on-site investigation was conducted in relation to all allegations and/or incidents identified in the intakes. Based on interviews, records review and observations, failed facility practice was identified and cited under WAC 388-76-10430 (1)(2)(c)(d). Additional residents reviewed for safety, care and services, with concerns and facility was cited.

Conclusion / Action:

☐ Failed Provider Practice Identified / Citation(s) Written

☒ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Riverview Sr Living
Provider Type: Adult Family Home
License/Cert.#: 755577
Compliance Determination #: 32092
Intake ID: 105077
Investigator: Robert Hennig
Region/Unit #: RCS Region 3 / Unit F
Investigation Date(s): 11/03/2023 through 11/21/2023
Complainant Contact Date(s): 11/08/2023

Allegation(s):
1. Residents not being administered medications consistently and medications documented as given when they were not given.

Investigation Methods:

Sample:	Total residents: 5 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents Resident rooms Medication storage General home
Interviews:	Identified staff Residents Family members Social services staff Collateral contact Administrator
Record Reviews:	Medical records hospital records Assessment Medication Administration Record

Investigation Summary:
1. Residents not being administered medications consistently and medications documented as given when they were not given. The unannounced on-site investigation was conducted in relation to all allegations and/or incidents identified in the intakes. Based on interviews, observations and records review, failed facility practice was identified and cited under WAC 76-388-10430 (1)(2)(c)(d). Additional residents reviewed for safety, care and services, with concerns.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Riverview Sr Living
Provider Type: Adult Family Home
License/Cert.#: 755577
Compliance Determination #: 32092
Intake ID: 105269
Investigator: Robert Hennig
Region/Unit #: RCS Region 3 / Unit F
Investigation Date(s): 11/03/2023 through 11/21/2023
Complainant Contact Date(s): 11/08/2023

Allegation(s):
1. Resident medications not given as prescribed.
2. Wound care not being completed as ordered.

Investigation Methods:

Sample:
Total residents: 5
Resident sample size: 4
Closed records sample size: 0

Observations:
Residents
Resident rooms
Staff to resident interactions
Medication administration

Interviews:
Identified resident
Residents
Family members
Social services staff
Administrator
Collateral Contact

Record Reviews:
Medical records
Hospital records
Assessment
Negotiated Care Plan
Progress Notes
Medication Administration Record

Investigation Summary:
1. Resident medications not given as prescribed. The unannounced on-site investigation was conducted in relation to all allegations and/or incidents identified in the intakes. Based on interviews, records review and observations, failed facility practice was identified and cited under WAC 788-76-10430 (1)(2)(c)(d). Additional residents reviewed for safety, care and services with concerns.
2. Wound care not being completed as ordered. The unannounced on-site investigation was conducted in relation to all allegations and/or incidents identified in the intakes. Based on interviews, observations and records review, failed facility

practice was identified and cited under WAC 388-76-10400 (1)(2)(3)(a)(b)(c). Additional residents reviewed for safety, care and services with concerns.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave, Suite 200, Vancouver, WA 98684

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 11/03/2023 and 11/22/2023 of:

Riverview Sr Living
7510 SE Evergreen Hwy
Vancouver, WA 98664

This document references the following complaint number(s): 104949, 104922, 96441, 97210, 105077, 105269

The following sample was selected for review during the unannounced on-site visit: 4 of 5 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Robert Hennig, NCI ALF Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit F
800 NE 136th Ave, Suite 200
Vancouver, WA 98684

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services _____ Date _____

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative) Date

WAC 388-76-10430 Medication system.

(1) If the adult family home admits residents who need medication assistance or medication administration services by a legally authorized person, the home must have systems in place to ensure the services provided meet the medication needs of each resident and meet all laws and rules relating to medications.

(2) When providing medication assistance or medication administration for any resident, the home must ensure each resident:

(a) Assessment indicates the amount of medication assistance needed by the resident;

(c) Medication log is kept current as required in WAC 388-76-10475 ;

(d) Receives medications as required.

This requirement was not met as evidenced by:

Based on interview and record review the Adult Family Home (AFH) failed to have a system in place to ensure medications were available, failed to administer medications as required, and failed to keep the medication log current for 4 of 5 residents (Resident 1 [R1], Resident 2 [R2], Resident 3 [R3], Resident 4 [R4]) sampled for medication administration. This failure resulted in 4 residents not receiving medication as required and being admitted to a local hospital.

Findings included…

An unannounced on-site complaint investigation was conducted on 11/03/2023.

Resident 1 (R1)

Record review of R1 showed R1 was admitted to the AFH on [redacted]/2023 with diagnoses which included [redacted].

Record review of Resident assessment dated 09/07/2023, showed R1 required medication assistance.

Record Review of Negotiated Care Plan, dated 09/06/2023, showed R1 was to receive medication assistance.

Record review of resident records dated 11/10/2023 showed the resident was admitted to the hospital on [redacted]/2023 and returned to the AFH on [redacted]/2023.

Record review of R1's MAR, dated September and October 2023, revealed the following missed medication doses:

Eliquis (Anticoagulant used to treat and prevent blood clots and stroke. It is a high-risk medication with risk for cardiac arrest/stroke/death if not given per MD order) 5 milligrams (mg) 0.5 tablet by mouth twice per day to start 09/16/2023. The medication was filled by the pharmacy on [redacted]/2023, with a quantity of 60 each. The first of two "Ready Med Bubble Pack" (the medication came from the pharmacy in a bubble pack designed for ease of administration and record keeping) had 13 tablets remaining. The second bubble pack, with an additional 30 tablets, had 28 remaining. With a start date 09/16/2023 the medication should have been completed by 10/16/2023. A total of 41 doses were not given. The MAR was initialed as given between the dates 09/16/2023 and 10/16/2023.

Furosemide (Diuretic used to treat fluid retention caused by congestive heart failure) one 40mg tablet by mouth once daily. The bubble pack was filled by the pharmacy on [redacted]/2023 with a quantity of 30 tablets. This medication should have been completed by 10/13/2023. 21 tablets remained in the bubble pack. A total of 21 doses were missed. The MAR was initialed as given between the dates [redacted]/2023 and 10/13/2023.

Lisinopril (Used to treat high blood pressure and heart failure) one 20mg tablet by mouth twice a day. This medication was filled by the pharmacy on 07/07/2023 with a quantity of 60 tablets. Bubble pack number 1 of 2 had 19 tablets remaining. Bubble pack number 2 of 2 had 19 tablets remaining, for a total of 38 missed doses. According to the start date and dosing, this medication should have been completed in 30 days (by 08/08/2023) if administered correctly. Lisinopril was filled again by the pharmacy on 07/28/2023 with a quantity of 60 doses. Since returning from the hospital on [redacted]/2023, between [redacted]/2023-11/02/2023, 30 doses of this medication were missed. The MAR was initialed as given between the dates [redacted]/2023 and 11/02/2023.

Sertraline (Used to treat depression and anxiety) one 25mg tablet by mouth, once daily. The bubble pack was filled on 07/17/2023 with 15, 50mg tablets tabs cut in half for a total of 30 doses. 21 doses remained in bubble pack. MAR signed as given between the dates 07/17/2023 and 10/27/2023.

Albuterol nebulizer (An Albuterol nebulizer is a device filled with a medication that turns the liquid medicine into a mist which is then inhaled through a mouthpiece or a mask.) There were 4 boxes present with only one box opened since returning from the hospital on [redacted]2023. As of 11/03/2023 this medication should be nearly gone. The MAR's were signed as given from [redacted]/2023 to 11/03/2023.

Resident 2 (R2)

Record review of R2 showed R2 was admitted to the AFH on [redacted]/2023, with diagnoses which included [redacted].

Record review of Resident assessment dated 10/12/2023, showed R2 required medication assistance.

Record Review of Negotiated Care Plan, dated 06/02/2023, showed R2 was to receive medication assistance.

Record review of R2's October 2023 and November 2023 MAR revealed medications and missed doses as follows:

Xifaxan (Antibiotic used to treat liver disease) one 550mg tablet by mouth twice daily. Between 10/01/2023, and 11/02/2023, there were 7 missed doses. No documentation was found on the MAR stating reason medication was missed.

Hydralazine (Used to treat high blood pressure) 25mg tabs; 1.5 tablets by mouth once daily. Between 10/01/2023 and 11/02/2023, there were 6 missed doses. No documentation was found on the MAR stating reason medication was missed.

Atorvastatin (Used to treat high cholesterol and reduces risk of heart attack and stroke) one 20mg tablet by mouth once daily. Between 10/01/2023 and 11/02/2023, there were 6 missed doses. No documentation was found on the MAR stating reason medication was missed.

Olanzapine (Used to treat mental disorders) one 7.5mg tablet by mouth once daily in the evening. Between 10/01/2023 and 11/02/2023, there were 6 missed doses. No documentation was found on the MAR stating reason medication was missed.

Amlodipine (Used to treat high blood pressure) one 10mg tablet by mouth once daily in the morning. Between 10/25/2023 and 11/02/2023., there were 4 missed doses. No documentation was found on the MAR stating reason medication was missed.

Aspirin (Used to decrease risk of stroke) two 81 mg tablets by mouth once daily. Between 10/25/2023 and 11/02/2023, there were 4 missed doses. No documentation was found on the MAR stating reason medication was missed.

Carvedilol (Used to treat high blood pressure and heart failure) one 25mg tablet by mouth in the afternoon. Between 10/25/2023 and 11/02/2023., there were 4 missed doses. No documentation was found on the MAR stating reason medication was missed.

Folic acid (Used to treat anemia) one 1mg tablet by mouth once daily. Between 10/25/2023 and 11/02/2023, there were 4 missed doses. No documentation was found on the MAR stating reason medication was missed.

Losartan (Used to treat high blood pressure) one 50mg tablet by mouth once daily. Between 10/25/2023 and 11/02/2023., there were 4 missed doses. No documentation was found on the MAR stating reason medication was missed.

Carvedilol (Used to treat high blood pressure and heart failure) one 25mg tablet by mouth in the morning. Between 10/01/2023 and 11/02/2023, there were 27 missed doses. No documentation was found on the MAR stating reason medication was missed.

Tamsulosin (Used to treat enlarged prostate) one 0.4mg tablet by mouth once daily. Between 10/01/2023 and 11/02/2023, there were 27 missed doses. No documentation was found on the MAR stating reason medication was missed.

Duloxetine (Used to treat depression) one 20mg tablet by mouth once daily. Between 10/26/2023 and 11/02/2023there were 6 missed doses. No documentation was found on the MAR stating reason medication was missed.

During an interview with Collateral Contact 2 (CC2), power of attorney (POA) for R2, CC2 stated R2 informed them they were “not receiving their medications for days, maybe over a week”.

Resident 3 (R3)

Record review of R3 showed R3 was admitted to the AFH on [redacted]/2023 with diagnoses which included [redacted].

Record review of Resident assessment dated 09/20/2023, showed R3 required medication assistance.

Record Review of Negotiated Care Plan, dated 09/06/2023, showed R3 was to receive medication assistance.

During an interview with R3 on 11/03/2023 at 1:45 PM, R3 stated they receive all medications to the "best of their knowledge". R3 stated they had no concerns about the home or care they are receiving and feels safe in the home.

During Resident 3's (R3) medication review on 11/03/2023, medications were identified as not given based on medications remaining and documented doses in the MAR. The medications errors are as follows:

Eliquis, one 0.5 tablet by mouth, twice daily. The prescription was filled [redacted]/23 with a quantity of 30 tablets. This medication should have been completed by 10/25/23 if administered per MD order. There were 14 tablets in the bottle remaining on 11/03/23. Between October 26, 2023, and November 3, 2023, there were 7 missed doses. No documentation was found on the MAR stating reason medication was missed.

Vitamin C supplement: Observed a full bottle of this supplement and noted it to be expired on 9/2022. The bottle of Vitamin C had R4's initials on it. Staff A (SA), Provider, was questioned about the expired bottle and why R4's initials were on the bottle. SA stated, "I don't know how that got in there, I'm sure we weren't using it for R3".

Metoprolol (Used to treat high blood pressure, chest pain, and heart failure) one 12.5 mg tablet by mouth twice daily. Between 09/28/2023 and 11/03/2023, there were 43 missed doses. No documentation was found on the MAR stating reason medication was missed.

Resident 4 (R4)

Record review showed R4 was admitted to the AFH on [redacted]/2022 with diagnoses which included [redacted].

Record review of Resident assessment dated 03/28/2023, showed R4 required medication assistance.

Record Review of Negotiated Care Plan, dated 08/23/2023, showed R4 was to receive medication assistance.

Record review of MAR dated 10/01/2023 to 10/31/2023 showed that R4 missed medication administration for 10/30/2023. The medications missed were:

Ropinirole HCL (Used to treat Parkinson's and restless leg) One 1 MG tablet by mouth three times daily.

Trazadone (Used to treat depression) One 100 MG tablet by mouth once daily at bedtime.

Zonisamide (Used to treat seizures) One 50 MG tablet by mouth once every morning (Handle with gloves).

Myrbetriq ER (Used to treat overactive bladder) One 50 MG tablet by mouth daily every morning.

Protonix DR (Used to treat reflux) One 40 MG tablet by mouth every morning 30 minutes before breakfast.

Xalatan 0.005% EYE (Used to treat glaucoma) Instill one drop into both eyes daily at bedtime.

Keppra (Used to treat seizures) Two 750 MG tablets by mouth twice daily (1500 MG).

Cozaar (Losartan Potassium) (Used to treat hypertension) One 50 MG tablet by mouth once every morning.

Glucophage (Metformin) (Used to treat diabetes Type 2) One 500 MG tablet by mouth every morning with breakfast.

Tylenol (Acetaminophen) (Used to treat pain) Two 500 MG tablets by mouth three times daily.

Lipitor (Atorvastatin) (Used to treat high cholesterol) One 40 MG tablet by mouth daily at bedtime.

Cymbalta (Duloxetine HCL) (Used to treat anxiety and nerve pain) One 60 MG tablet by mouth daily every morning.

Eliquis: One 5 MG tablet by mouth twice daily.

Vimpat (Lacosamide) (Used to treat partial seizures) One 200 MG tablet by mouth twice daily.

During an interview on 11/03/2023 at 1:35 PM, CC1 stated “I tried to review the medication packs from the previous pharmacy, but they were missing today. They were stored in a brown paper bag in the closet by the back door last night, but SA claims to have no knowledge of their whereabouts now. When I asked [SA] about the bag of other medications, [SA] stated that the caregiver, [Former Staff 1 (FS1)], destroyed them. I reached out to [FS1] via text, and they replied, "No, I didn't. I don't know what happened to the bag, but I did not destroy any meds."

During an interview with R4 on 11/03/2023 at 1:45 PM, R4 stated they receive all medications, “as far as I know”, and had no concerns about the care they are receiving.

During an interview with Collateral Contact 1 (CC1) on 11/03/2023 at 1:18 PM, CC1 stated two residents, Resident 1 (R1) and Resident 2 (R2) were transferred to the hospital for observation on 11/02/2023, due to serious medical concerns found after conducting a medication reconciliation for these residents. This reconciliation resulted in discovering multiple medications not being administered.

On 11/08/2023 at 2:30 PM, during an interview with FS1, they denied disposing of any medications and denied documenting medications given by another staff person. FS1 stated “things became very disorganized after previous caregiver left at the end of September 2023”.

During an interview with SA on 11/03/2023 at 1:40 PM, they stated battling an illness and have been sick off and on for approximately a month. SA stated they were in the hospital this week. SA stated, “Everything went downhill since I have been sick, and my caregiver quit”. They also stated, “[Staff B (SB), Caregiver] was supposed to be keeping up with everything, but apparently did not do a good job with medications”. SA acknowledged all residents need medication administration assistance, except Resident 5 (R5), who is independent with medication administration.

On 11/03/2023 at 2:30 PM R3 and R4 were transported to a local hospital due to serious health concerns resulting from medication administration errors.

Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Riverview Sr Living is or will be in compliance with this law and / or regulation on (Date)_____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Provider (or Representative) _____ Date _____