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
	080996	A. BUILDING: _____ B. WING _____	C 08/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK RIDGE RESIDENTIAL CARE CENTER	400 CANTON STREET NW SHELLSBURG, IA 52332

(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
R 000	Initial Comments The following deficiencies were cited during the investigation of complaints 61285-C, 61284-C, 61703-C and Incident 62064-I as well as the survey conducted to determine compliance with licensing rules.	R 000		
R 266	57.7(5)b General Requirements 481-57.7(135C) General requirements. 57.7(5) The licensee shall: b. Be responsible for compliance with all applicable laws and with the rules of the department. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to comply with requirements related to reporting suspected dependent adult abuse as written in Iowa Administrative Code 235E - Chapter 52. Findings include: A review of Department records and an interview with the facility administrator revealed the facility failed to report suspected dependent adult abuse according to Iowa Administrative Code rule 235E - 52.2(2)a. The Administrator confirmed this finding. See deficiency under 52.2(2)a.	R 266		
R 358	57.11(3) Personnel 481-57.11(135C) Personnel.	R 358		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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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R 358	Continued From page 1 57.11(3) Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse. The facility shall comply with the requirements found in Iowa Code section 135C.33 as amended by 2014 Iowa Acts, chapter 1040, and rule 481-50.9(135C) related to completion of criminal record checks, child abuse checks, and dependent adult abuse checks and to employment of individuals who have committed a crime or have a founded abuse. (I,II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to comply with requirements related to conducting employee criminal record checks for personnel found in Iowa Administrative Code 481 - chapter 50. Findings include: A review of employee files revealed the facility failed to request an evaluation by the Department of Human Services of a criminal record history as required by Iowa Administrative Code rule 481-50.9(3)c for 1 staff reviewed with a positive criminal history record (Staff B). The Administrator confirmed this finding. See deficiency under 50.9(3)c.	R 358		
R 372	57.11(6) Personnel 481-57.11(135C) Personnel.	R 372		

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DEPARTMENT OF INSPECTIONS AND APPEALS

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R 372	Continued From page 2 57.11(6) Physical examination and screening. Employees shall have a physical examination no longer than 12 months prior to beginning employment and every four years thereafter. Screening and testing for tuberculosis shall be conducted pursuant to 481-Chapter 59. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on staff interview and personnel record review, the facility failed to ensure one staff member secured a physical examination prior to employment (Staff F). Findings include: On 8/23/16, a personnel record review for Staff F revealed a hire date of 5/17/16. Staff F secured a physical examination on 6/25/16. The administrator confirmed this finding on 8/23/16.	R 372	**R372 57.11 (6) Physical Examination and Screening** All employees shall have a physical examination no longer than 12 months prior to beginniing employment and every four years thereafter. Screening and testing for tuberculosis shall be conducted persuant to 481-Chapter 59 All employees employed, hired after 8/23/16 have adhered to this policy and will continue to maintain this standard. This will be monitored ongoingly by the Administrator or designee.	
R 373	57.11(7) Personnel Orders for medications and treatments. Orders for medications and treatments shall be correctly implemented by qualified personnel. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on staff interview and resident record review, the facility staff failed to follow all physicians' orders for 2 of 8 residents reviewed (Resident #2 and Resident #8). Findings include: Resident #2 was admitted to the facility on 12/9/15. Nurse's notes revealed concerns with edema around 4/26/16. Resident #2's record revealed a physician's order dated 4/26/16 with	R 373	**R373 57.11 (17) Personnel** Orders for mediations and treatments shall be correctly implemented by qualified licensed personnel. Education was provided to all the licensed personnel on correctly implementatiing doctors orders on 11/2/16. This will be monitored ongoingly by the Administrator or designee. Annual reviews will be completed by the Administartor or designeegoing forward.	

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R 373	Continued From page 3 the following information: "Increase Lasix to 60 mg daily. Chest X-ray please. Weigh today please and on Thursday call me. Discontinue aspirin." A review of Resident #2's weight charting and medication administration records revealed staff neglected to follow the physician's order of weighing Resident #2 and reporting back to the physician. Resident #3 was admitted to the facility on 4/18/16. The medication orders at admission could not be located within the resident's record. A physician's note dated 4/21/16 revealed the resident complained to the doctor that he/she was not getting all of his/her medications. The physician's notation revealed he looked at the medication the facility had listed and it was incorrect in comparison to the admission/hospice orders. The physician faxed the facility an order for the medications they had not started upon admission. The order was for Dulcolax suppository as needed, Zofran as needed and Polyethylene glycol daily. On 8/29/16 at 12:47 PM, the Administrator confirmed the above findings and stated she was unaware the events had occurred.	R 373		
R 390	57.12(1)h General Policies 481-57.12(135C) General policies. The licensee shall establish and implement written policies and procedures as set forth in this rule. The policies and procedures shall be available for review by the department, other agencies designated by Iowa Code section 135C.16(3), staff, residents, residents' families or legal representatives, and the public and shall be reviewed by the licensee annually. (II)	R 390	**R390 57.12 (1)h General policies** **481-57-12 (135C)** **The license shall establish and implement written policies and procedures as set forth in this rule. The policies and procedures were reviewed on 11/2/16 and will be reviewed annuallymoving forward. All new hires will review these policies and procedures within the first 30 days of hire. Training will be completed and monitored routinely by the Administrator or designee. The licenses personnel will be expected to follow all policy and procedures. Qualified personnel/and the Administer/DON will monitor routinely. Staff member was terminated prior to inspection from the Department.**	

DEPARTMENT OF INSPECTIONS AND APPEALS

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R 390	Continued From page 4 57.12(1) Facility operation. The licensee shall establish written policies for the operation of the facility, including, but not limited to the following: (III) h. Medication management, including self-administration of medications and chemical restraints; (III) This REQUIREMENT is not met as evidenced by: Based on staff interview and resident record review, facility staff failed to follow all written policies regarding medication administration for 3 of 8 residents reviewed (Residents #3, #4 and #7). Findings include: Review of Resident #3's medication administration records revealed on 12/14/15, Staff A documented the resident #3 had 27 mL left of liquid Lorazepam. The Lorazepam was not counted again until 1/13/16 by the Administrator and a second staff. The count was 25 mL leaving 2 mL unaccounted for. Staff A did not contact a supervisor to report the discrepancy in the medication. Review of Resident #4's medication administration records revealed on 3/22/16, the resident's narcotic record for Lorazepam showed 27 pills remaining in the double locked storage. On 3/23/16, Staff A documented that the count was "wrong" and changed the count number to 26, leaving one Lorazepam tablet unaccounted for. Staff A did not contact a supervisor to report	R 390		

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R 390	Continued From page 5 the discrepancy in the medication. Review of Resident #7's medication administration records revealed on 3/24/16, the resident's narcotic count sheet for Tramadol showed a count of 22 tablets. The medication was not administered again until 4/6/16, but on 4/5/16 Staff A documented that the count was off on 3/24/16 and that as of 4/5/16 the count was only 20 tablets. This left two Tramadol tablets unaccounted for. Staff A did not contact a supervisor to report the discrepancy in the medication. The facility's Narcotic Shift Count and Usage Policy revealed the following: "If there is a discrepancy in the count or it is observed that the medication or packaging has been tampered with, it is the responsibility of the nurses to call the Director of Nursing or the Assistant Director of Nursing immediately." Staff A failed to follow facility policy. On 8/31/16 at 1:39 PM, the Administrator confirmed the above findings.	R 390		
R 456	57.13(1)a Admission, Transfer, Discharge 481-57.13(135C) Admission, transfer and discharge. 57.13(1) General admission policies. a. Residents shall be admitted to a residential care facility only on a written order signed by a primary care provider, specifying the level of care, and certifying that the individual being admitted requires no more than personal care and supervision and does not require routine	R 456	**R456 57.13 (1)General admission policies** Resident shall be admitted to RCF only on written order signed by primary care doctor cerifiying that the individual being admitted requres no more than personal care and supervision, and soes not require routine nursing care. All admissions going forward will have a signed doctors order to admit to RCF level of care prior to admission. This will be an ongoing standard of practice monitored routinely by the Administrator or designee.	

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R 456	Continued From page 6 nursing care. (II,III) This REQUIREMENT is not met as evidenced by: Based on staff interview and resident record review, the facility failed to obtain a written order for Residential Care Facility (RCF) level of care for 4 out of 8 residents reviewed (Residents #5, #6, #7 and #8). Findings include: Resident #5 was admitted on 2/25/16. A review of admission orders revealed a letter from Resident #5's physician dated 2/25/16. The letter revealed the following statement: "It is my medical opinion that with [name] worsening Dementia [he/she] should be placed in an assisted living center." An admission order noting the resident required residential services was dated and signed by Resident #5's physician on 3/7/16, which was after the resident moved in. A second letter from Resident #5's physician dated 3/22/16 revealed the following statement: "It is my medical opinion that [name] would be best suited to be admitted to an assisted living home, sooner than later, for [his/her] safety." The resident's admission orders/letters were inconsistent and the RCF certification occurred after admission. Resident #6 was admitted on 12/31/15. A review of admission orders revealed a signed physician's statement ordering RCF level of care on 1/11/16 which was after the resident was admitted into the facility. Resident #7 was admitted on 7/31/15. A review	R 456		

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R 456	Continued From page 7 admission orders revealed the facility failed to secure a physician's order approving the resident for RCF level of care.. Resident #8 was admitted on 4/18/16. A review of admission orders revealed the facility failed to secure a physician's order approving the resident for RCF level of care. The resident was also admitted with active hospice services which indicated the resident required some form of nursing services at the time of admission. Residential care services are for personal care and supervision and does not include nursing care. On 8/31/16 at 1:39 PM, the Administrator confirmed the above findings:	R 456		
R 458	57.13(1)b Admission, Transfer, Discharge 481-57.13(135C) Admission, transfer and discharge. 57.13(1) General admission policies. b. No residential care facility shall admit or retain a resident who is in need of greater services than the facility can provide. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on staff interview and resident record review, one resident was admitted to the facility who was in greater need of services than the facility could provide (Resident #8) Findings include: Resident #8 was admitted on 4/18/16 with a	R 458	**R458.57 (1) b General admission policies** No RCF care facility shall admit or retain a resident who is in need of greater service than the facility can provide. General policy is to screen potential residents to ensure they are qualified to be placed in RCF level of care. The Administrator.DON will ensure that all future admissions are adequatley qualified for RCF level of care.	

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R 458	Continued From page 8 diagnosis of renal cell cancer. A review of Resident #8's admission orders revealed the facility failed to secure a physician's order approving the resident for RCF level of care. The resident was also admitted with active hospice services which indicated the resident required some form of nursing services at the time of admission. Residential care services are for personal care and supervision and does not include nursing care. Resident #8's health declined after admission and he/she passed away several months later. On 8/29/16 at 12:47 PM, the Administrator confirmed the above findings.	R 458		
R 642	57.17(3)e Records 481-57.17(135C) Records. 57.17(3) Incident record. e. An incident report shall be completed for every accident, incident or unusual occurrence within the facility or on the premises that affects a resident, visitor, or employee. (II, III) This REQUIREMENT is not met as evidenced by: Based on staff interview and resident record review, the facility staff failed to document all incidents or unusual occurrences on a printed incident report form. Findings include: Review of Resident #3's medication administration records revealed on 12/14/15, Staff A documented that Resident #3 had 27 mL	R 642	**R642 57.17 (3) e Records** **R481-57.17 (135C) Records** **R57.17 (3) Incident record** An incident report shall be completed for every accident, incident or unusual occurance with in the facility or on the premisis that affects a resident, visitor, or employee. This rule was covered/reviewed in a mondatory in service for all licensed personell. As of 8/31/16, incident reports are being filled out accordingly to the policy. Staff member A was terminated for not following the policy.	

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R 642	Continued From page 9 left of liquid Lorazepam. The Lorazepam was not counted again until 1/13/16 by the Administrator and a second staff. The count was 25 mL leaving 2 mL unaccounted for. No medication error form/incident report was completed regarding this occurrence. Review of Resident #4's medication administration records revealed on 3/22/16, Resident #4's narcotic record for Lorazepam showed 27 pills remaining in the double locked storage. On 3/23/16, Staff A documented that the count was "wrong" and changed the count number to 26, leaving one Lorazepam tablet unaccounted for. No medication error form/incident report was completed regarding this occurrence. Review of Resident #7's medication administration records revealed on 3/24/16, Resident #7's narcotic count sheet for Tramadol showed a count of 22 tablets. The medication was not administered until 4/6/16, but on 4/5/16, Staff A documented that the count was off on 3/24/16 and that as of 4/5/16 the count was only 20 tablets. This left two Tramadol tablets unaccounted for. No medication error form/incident report was completed regarding this occurrence. The facility's Incident Report Policy revealed the following: "Incident Reports must be completed on all falls and unusual occurrences. This means (but is not limited to) any elopements or disputes between residents that result in physical contact." Staff A failed to follow facility policy. On 8/31/16 at 1:39 PM, the Administrator confirmed the above findings.	R 642		

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R 794	57.21(2)e Dietary 481-57.21(135C) Dietary. 57.21(2) Nutrition and menu planning. e. Menus shall be written at least one week in advance. The current menu shall be located in an accessible place for easy use by persons purchasing, preparing, and serving food. (III) This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, the facility failed to have written menus available one week in advance at the time of the survey. Findings include: During a review of the dietary department on 8/23/16 and 8/24/16, it was observed that the written menus only were available up until 8/21/16. There was no menu available for the week of 8/22/16 through 8/28/16. The facility policy regarding menus, revealed that "menus for regular and therapeutic diets are written at least 2 weeks in advance and are dated and posted in the kitchen at least one week in advance." On 8/23/16 at 11 AM, the Administrator confirmed the available menus was only written up until 8/21/16. The Administrator stated menus were not currently being approved by a dietician and the dietary department was putting together meal plans on a daily basis at the time.	R 794	**R794 57.12 (2) e Dietary** **R481-57.21 (135C) Dietary** **57.21 (2) Nutrition and menu planning** Menus shall be written at least one week in advance. The current menu shall be located in an accessible place for easy use by persons purchasing, preparing and serving food. A change in dietary management required that menus be re done. At this time, we have 5 week menu for winter that has been approved by a dietitian. The Dietary Supervisor is generating a summer menu to meet dietary requirements.	

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DEPARTMENT OF INSPECTIONS AND APPEALS

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R 834	57.22(3)c Orientation and Service Plan 481-57.22(135C) Orientation and service plan. 57.22(3) Service plan. Within 30 days of admission, the administrator or the administrator's designee, in conjunction with the resident, the resident's responsible party, the interdisciplinary team, and any organization that works with or serves the resident, shall develop a written, individualized, and integrated service plan for the resident. The service plan shall be developed and implemented to address the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and social, behavioral, emotional, physical and mental health. (I, II, III) c. The service plan should be modified to add or delete goals and objectives as the resident's needs change. Communications related to service plan changes or changes in the resident's condition shall occur within five working days of the change and shall be conveyed to all individuals inside and outside the residential care facility who work with the resident, as well as to the resident's responsible party. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on staff interviews and resident record review, the facility failed to amend or modify the service plan as individual resident needs changed for 3 of 8 residents reviewed (Residents #1, #4 and #5). Findings include: 1. Resident #1 was admitted to the facility in	R 834	**R834 57.22 (c) Orientation and service plans** Within 30 days of admission, the admisitator, or administrators designee in conjunction with the resident and resident responsible party shall develop a service plan to implemented to address the priorities and assessed needs of the resident. The service plan will be ammended with changes in the residents needs or condition. All service plans will be updated to reflect changes in the residents needs with in 30 daysof receipt of this ruling. This will be kept up to date by the Administrator/DON on goingly in the future.	

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ROCK RIDGE RESIDENTIAL CARE CENTER	400 CANTON STREET NW SHELLSBURG, IA 52332

(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
R 834	Continued From page 12	R 834		

November 2014. On 8/24/16 at 1:36 PM, the Administrator stated that Resident #1 went through a tough period back in June/July 2016 when staff needed to make sure he/she did not enter the dining room without staff present. Resident #1 was getting used to a new diet order that included half desserts. The resident was upset about the diet change started becoming aggressive at meals as well as taking other residents' food and eating it. For a short time, staff had Resident #1 wait in the seating outside of the dining room until staff were able to go in with him/her. Resident #1's service plan last dated 4/9/16 was not amended during June and July of 2016 to demonstrate a change in services/staff duties. On 8/24/16 at 1:36 PM, the Administrator confirmed the service plan was not amended to reflect the new changes.

2. Resident #4 was admitted to the facility in February 2014. Resident #4 had diagnoses including Huntington's disease, anxiety, confusion and chronic kidney disease. The following entries were found in Resident #4's nurse's notes:

a.) 6/20/16 - difficulty swallowing at the meal.

b.) 6/30/16 - swallowing difficulties and coughing at the meal.

c.) 7/9/16 - asked a staff person for assistance as he/she was having problems with swallowing.

d.) 7/10/16 - spouse reported to staff that Resident #4 had difficulties chewing/swallowing that day

e.) 7/30/16 - reported to staff that he/she was having difficulty swallowing.

f.) 8/8/16 - spouse reported resident was having difficulties swallowing water at the meal.

On 8/24/16 at 1 PM, the Administrator stated Resident #4 received a diet order change and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060996	A. BUILDING: _____ B. WING _____	C 08/30/2016

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ROCK RIDGE RESIDENTIAL CARE CENTER	400 CANTON STREET NW SHELLSBURG, IA 52332

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R 834	Continued From page 13 was placed on a ground diet. Resident #4's current service plan dated 3/2/16 did not indicate a history of choking/swallowing difficulties or that his/her diet order had been changed to ground. The Administrator confirmed the service plan for Resident #4 was not amended as needed. 3. Resident #5 was admitted to the facility in February 2016. The nurse's notes for Resident #5 revealed on 8/16/16 a fax was sent to Resident #5's physician revealing the resident had been having difficulties with swallowing. The physician ordered a ground diet on 8/17/16. A review of the service plan dated 4/5/16 showed Resident #5 was on a general diet with small portions. The service plan was not amended as of 8/24/16 to include the resident having a history of swallowing difficulties or that his/her diet order had changed. The Administrator confirmed the service plan for Resident #5 was not amended as needed.	R 834		
R 838	57.23(1) Resident Activities Program 481-57.23(135C) Resident activities program. 57.23(1) Activities program. Each residential care facility shall provide an organized resident activities program for the group and for the individual resident which shall include suitable activities. The facility shall offer at least two organized evening group activities per week and two organized weekend group activities per month. (III) This REQUIREMENT is not met as evidenced by:	R 838	**R838 57.23 (1) Resident activity program** **481-57.23 135C Resident activity program** Each RCF shall provide an organized resident activity program for group and individuals, which shall include suitable activities. The facility shall offer at least 2 organized evening group activitiesper week and 2 organized weekend group activities per month. The 2 organized evening group activities and 2 organized weekend activities have been added to the current activity calendar. The Activity Director/Administrator will ensure that future activities calendars refecit the necessary activities.	

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R 838	Continued From page 14 Based on observations, staff interview and policies/procedures, the facility failed to include at least two scheduled evening activities a week. Findings include: During observations of the facility activity program on 8/23/16, the posted activity calendar was reviewed. The August 2016 activity calendar did not show any evening activities for the month. On 8/23/16 at 2 PM, Staff I confirmed that no evening activities were scheduled. A review of the activity director policy titled Department Duty Hours revealed the following: "Two activities are scheduled daily, including weekends. One evening activity is scheduled weekly."	R 838		
C 206	01-50.9(3)c Background Checks 481-50.9(135C) Criminal, dependent adult abuse, and child abuse record checks. 50.9(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a facility, the facility shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. c. If a person being considered for employment has been convicted of a crime. If a person being considered for employment in a facility has been convicted of a crime under a law of any state, the department of public safety shall notify the facility that upon the request of the facility the	C 206	**C206 01-50.9 (3) c Backgroud Checks** **481-50.9 (135c) Criminal, dependant, adult abuse, and child abuse record checks** Prior to employment of a person in the facility, the faculity shall request the Dept of Public Safety perfom a criminal history check and dependant adult abuse records check of the person in this state. If a person being considered for employment has been convicted of a crime under a law of any state, the facility will submit further documentationto the department of human services to determin if that person maywork in the facility. This will be done with all persons whom are considering employment with the facility. This will be monitored by the Administator or designee on goingly.	

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C 206	Continued From page 15 department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person ' s employment in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of personnel records, the facility failed to request an evaluation by the Department of Human Services, and obtain approval before hiring Staff B. Findings include: Record review on 8/23/16 of the employee personnel files, revealed Staff B had a date of hire as 10/9/15. A criminal history check was returned to the facility from the Iowa Division of Criminal Investigation on 9/30/15 revealing further research required. No follow-up from this report could be located in Staff B's file. A second criminal history check was returned to the facility from the Iowa Division of Criminal Investigation identifying a criminal record on 7/15/16. The facility did not send a request to the Department of Human Services for approval to hire or for Staff B to continue to work. The Administrator confirmed the above finding on 8/23/16 at 1 PM.	C 206		
D103	481--52.2(2)a Reporting Suspected Dependent Adult Abuse 52.2(2) Reporting suspected dependent adult abuse in facilities or programs. a. If a staff member or employee is required to make a report pursuant to this rule, the staff member or employee shall immediately notify the	D103	**D103 Reporting suspected dependant adult abuse** If a staff member or employee is required to make a report pursuant to this rule, the staff member shall immediately notify the person in charge and will be reported to the department with in 24 hours of reporting. On 11/2/16, at a mandatory inservice all staff reviewed the suspected adult abuse policy. This will be done annually ~~and every 4 years.~~ DON This policy will be reviewed with all new hires and monitored routinely by the administrator or designee. Staff member A was terminated.	

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ROCK RIDGE RESIDENTIAL CARE CENTER	400 CANYON STREET NW SHELLSBURG, IA 52332

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D103	Continued From page 18 person in charge or the person's designated agent who shall then notify the department within 24 hours of such notification or the next business day. This Statute is not met as evidenced by: Based on staff interviews and record review, the facility failed to report an alleged dependent adult abuse to the Department of Inspections and Appeals within 24 hours or the next business day. Findings follow: Record review on 8/23/16 indicated the MAR (Medication Administration record) for Residents #3, #4 and #7 were found to have gaps leading to the possibility of missing medications. Resident #3 was missing 2 milliliters (ml) of liquid Lorazepam (antianxiety medication) on 1/13/16. Staff A conducted the last count of the liquid Lorazepam as identified on the narcotic count record. The MAR identified Resident #4 missed 1 tablet of Lorazepam on 3/23/16 according to Staff A's documentation on the narcotic count record. Resident #7 missed 2 tablets of Tramadol between 3/24/16 and 4/5/16, according to Staff A's documentation. On 8/24/16 at 1:36 p.m., the Administrator was interviewed. The Administrator stated during the months of March and April 2016, she monitored Staff A for incorrect medication management. The Administrator stated on 4/12/16, she placed Staff A on administrative leave for not following medication administration/nursing policies. According to the Administrator on Staff A's	D103		

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D103	Continued From page 17 second night back to work after the administrative leave, two Lorazepam tablets were unaccounted for. The Administrator stated Staff A was terminated on 4/19/16 for repeatedly not following facility policies regarding medication administration. The facility was unable to find sufficient evidence to demonstrate dependent adult abuse. According to Department records, in July a surveyor was on site surveying a separately licensed program at the building and discovered the medication discrepancies and in-house investigation completed in March/April of 2016. The surveyor gave the Administrator a recommendation to report her suspicions and concerns to the Department as a number of the residents involved were living under the Residential Care Facility licensed side of the building. The Administrator contacted the Department and an investigation ensued. On 8/23/16 at 1 PM, the Administrator confirmed the facility did not contact the Department within 24 hours of their suspicions of dependent adult abuse by Staff A.	D103		

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