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
	060996	A. BUILDING: _____ B. WING _____	C 12/14/2020

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 Complaint #94614-C, Complaint #93253-C, Complaint #94647-C, and a survey conducted to determine compliance with licensing rules for a Residential Care Facility. In addition to these investigations, an onsite infection control survey was conducted. No deficiencies were cited during this survey.	R 000		
R 366	481-57.11(5)c Personnel 57.11(5) *Supervision and staffing.* c. Direct care staff shall be present in the facility unless all residents are involved in activities away from the facility. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on staff interview the facility failed to ensure direct care staff were in the facility at all times on all shifts when residents were present. Findings follow: On 12/14/20 at 9:46 AM, Staff E stated she worked the overnight hours of 8:00 pm to 6:00 am. Staff E stated she was the only staff member in the building to cover both the assisted living (AL) program and the residential care facility (RCF) after 8:00 pm. As a result, if any tenants in the AL required	R 366		

1/14/21

4/13/21

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R 366	Continued From page 1 assistance the lone staff member in the building left the RCF leaving the facility unattended. On 12/14/20 at 1:24 pm, the Administrator confirmed only one staff was scheduled for the building on the overnight shift.	R 366	481-57.11(5c) Supervision and staffing. Direct care staffing shall be present in the facility unless all residents are involved in activities away from the facility. We have staff that live on site to help with the residents needs after hours. When they are not staying in the building the Administrator/DON is on call. She lives 4 minutes from the facility and has frequently come to assist with the residents needs. A formal policy will be completed by 3/19/21 that will assist staff in knowing the proper protocol. It will be the responsibility of the Administrator to ensure that there is staff available at all times to assist with the residents needs and this will be an on-going process. ★	
R 412	481-57.12(1)s 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) 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) s. Resident supervision; (II, III) This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to ensure a policy covering resident supervision/safety was in place. Findings include: On 12/10/20 at 4:00 pm, Resident #2 stated Staff E generally took approximately 45 minutes to	R 412		

★ Per the Administrator, there will be a Staff Person in the RCF at all times. If a tenant in the AL program requests assistance and the live-in staff is not available, the Administrator will come from the nearby home and assist the tenant.

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R 412	Continued From page 2 answer a call light during the overnight hours. She stated she was aware staff were to perform 2 hour supervision/safety checks on residents 24 hours a day. Resident #2 indicated on 12/3/20 she stayed awake all night playing games on her cell phone because she could not sleep. She stated Staff E never came in to her and her husband's room at all for 2 hour hour safety/supervision checks. A review of November 2020 head check/2 hour round sheets revealed the following open gaps in documentation for Resident C1: -11/8/20: No documentation for 8 pm, 10 pm, 12 am, 2 am, and 4 am. -11/16/20: No documentation for 8 am, 10 am, 12 pm, 2 pm, and 4 pm. -11/17/20: No documentation for 8 am, 10 am, 12 pm, 2 pm, and 4 pm. -11/20/20: No documentation for 10 am, 12 pm, and 2 pm. On 12/14/20 at 10:31 am, Staff I stated she did not do specifically timed head checks on residents. She checked on residents when she went to their rooms during routine activities such as administering medications or doing laundry. A review of policies on 12/9/20 revealed no policy regarding the supervision/safety of residents.	R 412	484-57.12(5) Continued. It is expected that staff do a wellness check on residents in the building every 2 hours and document that this was done on the "2 hour round" form. This generally done by the Residential aid unless other wise specified. Staff I was educated on the policy and shown were this is to be documented. A formal policy will be written on the supervision and safety of our residents. All staff will be educated on the process of doing wellness checks and documentation by 3/19/21 It will be the *Administrator/Designee to* monitor routinely to ensure that this policy is being followed.	
R 454	484-57.12(5) 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,	R 454		

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R 454	Continued From page 3 residents' families or legal representatives, and the public and shall be reviewed by the licensee annually. (II) 57.12(5) Emergency care. The facility shall establish written policies for the provision of emergency medical care to residents and employees in case of sudden illness or accident. The policies shall include a list of those individuals to be contacted in case of an emergency. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to have a policy in place regarding emergency care which included a list of individuals to be contacted in case of an emergency. Findings include: A review of Resident C1's closed record revealed an admission date of 3/9/19. Resident C1 passed away from complications of COVID-19 on 11/28/20. Resident C1 was diagnosed with COVID-19 in the afternoon of 11/17/20. Nurse's notes dated 11/20/20 at 2:30 pm, revealed Staff A sent Resident C1 to the emergency room when her oxygen level was at 35%. The notes also indicated Resident C1 was only mumbling when she spoke and was shaky. On 12/7/20 at 9:33 am, Staff H stated she worked on 11/20/20 during the first shift hours of 6 am to 2 pm. Staff H stated Resident C1 woke up and stated she felt "off." She allowed Resident C1 to sleep in and prompted her to eat breakfast later. The resident ate a small amount of breakfast and went back to bed. Immediately following breakfast	R 454	481-57.12 General Policies The facility will establish a written policy for the operation of the facility, including, but not limited to the following: Residents supervision. This policy will be completed by 3/19/21 and it will be the responsibility of the Administrator/ Designee to ensure that the policy is enforced. Staff member E has been provided education and disciplinary actions for not completing 2 hour rounds during her scheduled shift and completing the documentation on the appropriate form indicating the rounds have been done. All staff including Staff I will be provided the same education and have the policy reviewed with them individually to ensure that proper supervision and safety are being done correctly. This will be completed by the Administrator /designee by 3/19/21 and done with all new hires in the future as an on-going process	

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R 454	Continued From page 4 Resident C1 was not as responsive as usual, was tired, and had increased incontinence throughout the morning. After lunch was served, which Resident C1 did not eat, she appeared to have a paler color. Staff H stated she left for her shift at between 1:50 pm and 2:00 pm. Staff H stated that prior to her leaving, Resident C1 was incontinent and Staff H had Staff A assist her in changing her. On 12/2/20 at 9:25 am, Staff A stated she assisted Staff H in changing Resident C1 because she was incontinent just prior to 2:00 pm. Resident C1 had difficulty standing and was very shaky. Staff A took Resident C1's vitals which were within normal range, but her oxygen level was at 35%. Staff A called for an ambulance to take Resident C1 to the emergency room. She contacted Resident C1's physician earlier that morning because she had severe redness in her groin area and wanted to see if any new orders would be warranted. Staff A did not mention Resident C1 not feeling well to the physician as there was nothing unusual at that time. Staff A stated she did not take any vitals all morning on Resident C1 until after lunch when she noted her to be shaky when changing her. She said there were no rules or policies regarding residents who had COVID-19 and how they should monitor them or report symptoms/changes. On 12/9/20 at 10:00 am, Staff B stated staff could call the Administrator or Staff I (nurse) if they had a question. If it was an emergency the staff called 911. Staff B was not aware of any policy that indicated when to call a facility nurse versus calling 911. Staff B was not aware if a policy was in place that listed out when and how to call the Administrator and/or Staff I. On 12/14/20 at 1:24 pm, the Administrator	R 454	485-57.12(135C) General Policies-Emergency Care. The facility will establish a written policy for staff regarding Emergency Care. This policy will include a list of individuals to be contacted in case of and emergency. This policy will be completed by 3/19/21. All staff will be educated on this policy and it will be the responsibility of the Administrator to ensure that current and future staff have the proper training in regards to emergency care. Staff A will be included in the education process and Staff H is employed by agency. Moving forward all agency staff will be educated in emergency care before going on to the unit to provide any care. It will be the responsibility of the Administrator/Designee to provide said education to all Agency Staffing.	

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R 454	Continued From page 5 confirmed the facility did not have a policy on general emergencies that included a list of individuals to be contacted in case of an emergency.	R 454		
R 456	481-57.13(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 nursing care. (II,III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure written level of care orders were received prior to admission for 1 of 3 residents reviewed (Resident # 1). Findings include: A review of Resident #1's record on 12/7/20 revealed an admission date of 12/27/19. Resident #1's pre-admission physical was used at the signed certification for Resident #1's level of care. The pre-admission physical dated 12/24/20 indicated the plan was to send Resident #1 to Rock Ridge Assisted Living. A written order specifying residential care facility level of care could not be located.	R 456		

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R 456	Continued From page 6 On 12/14/20 at 1:24 pm, the Administrator confirmed the above finding.	R 456	481-57.13Admission, Transfers Discharge- All 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 that personal care and supervision and does not require routine nursing care. The administrator/Designee will ensure that this regulation is being met. It will be an on-going process over seen with each admission. Resident #1 has been discharged. Moving forward this will be monitored closely. 481-57.17 Incident records It will be the expectation all staff to complete an incident report vor every accident, incident or unusual occurrence with in the facility or on the premises that affects a resident, visitor or employee. An in-service will be conducted by the Administrator by 3/19/21 to re-educate staff on the incident reporting process. Staff member F is no longer employed with Rock Ridge.	
R 642	481-57.17(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 interview and record review, the facility failed to ensure written incident reports were completed regarding all injuries/unusual occurrences for 1 of 6 residents reviewed (Resident #5). Findings include: On 11/3/20 at 11:11 AM, Staff F stated on 11/30/20 she discovered Resident #5 fully incontinent in her bed. She assisted Resident #5 into the shower to be cleaned up. At that time she noted Resident #5's skin from her buttocks up to her right shoulder was chapped due to incontinence. Staff F did not fill out an incident report form. On 12/3/20 during a review of facility incident reports, no report was found regarding chapped skin for Resident #5. On 12/14/20 at 1:24 pm, the Administrator	R 642		

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R 642	Continued From page 7 confirmed the above finding. R 668 481-57.18(4) Resident Care & Personal Services 481-57.18(135C) Resident care and personal services. 57.18(4) Residents shall be encouraged to bathe at least twice a week. (II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were encouraged or assisted to bathe at least twice a week for 1 of 6 residents reviewed (Resident #3) Findings include: On 12/9/20 review of Resident #3's record revealed an admission date of 11/4/20. The resident had a diagnosis of dementia due to Alzheimer's disease. The initial service plan for Resident #3 dated 11/4/20 revealed he was to receive 2 showers a week on Tuesdays and Fridays. A review of shower schedules revealed Resident #3's name had not been added until 11/23/20. On 11/23/20, staff added Resident #3 to the shower list and documented he received a shower. On 12/14/20 at 1:24 pm, the Administrator confirmed the above finding.	R 642 R 668	Ensuring that the policy of following the incident reporting process will be done as an on-going process. 485-57.18 Resident Care and Personal Services. All residents will be encouraged to bathe at least twice a week. Resident #3 was not put on the shower sheet timely. The staff that were caring for him stated that they had given him a shower and that it was just not documented. Due to the Administrator/DON having Covid-19 this was not monitored closely. In the future the facility will have a designee in place that will be expected to ensure that no lapses in operational routines are present. By 3/19/21 all staff will be provided education related to proper documentations. The Covid-19 and General Emergency policies will reflect the protocol for the Administrators Designee to maintain operational duties. These policies will be written by 3/19/21	

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R 782	Continued From page 8 481-57.21(2)a Dietary 481-57.21(135C) Dietary. 57.21(2) Nutrition and menu planning. a. Menus shall be planned and followed to meet the nutritional needs of residents in accordance with the primary care provider's orders. Diet orders should be reviewed as necessary, but at least quarterly, by the primary care provider. (II, III) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 2 of 2 residents reviewed with special diets were served meals according to physician's orders (Resident #1, Resident #5). Findings include: On 11/30/20 at 11:30 am during an observation of meal preparation Staff D was in charge cooking lunch and putting the meal trays together. At 11:42 am when asked for a list of diet orders, Staff D presented a box containing index cards. The box of cards contained only resident likes/dislikes but had no diet orders. Staff D stated no residents in the building had a special diet. At 12:00 pm when the meal was served it consisted of a ham and cheese sandwich, mashed potatoes, green beans, 2 cookies, and milk/water/coffee. All residents received the same meal. Staff D stated residents could request and receive seconds.	R 782	481-57.21Nutrition and menu planning- Menus shall be planned and followed to meet the nutritional needs of the residents in accordance with the primary care providers orders. Diet orders will be reviewed as necessary by at least quarterly. Staff member D was filling in for the kitchen staff whom had called off with covid-19. She does not routinely work in the kitchen. She has since been shown where the index box that contains the diet orders are kept. All diet orders are accurate and kept up to date. They are reviewed quarterly by the Kitchen supervisor and the Director of nursing. An in-service will be provided for all staff to ensure that each member of our team have the tools to comply with all nutritional needs of the residents by 3/19/21 by the Administrator.	
R 782		R 782		

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R 782	Continued From page 9 On 12/7/20 review of Resident #1's record revealed a signed physician's order dated 9/4/20 for a low concentrated sweets (LCS) diet order. Resident #5's record revealed a signed physician's order dated 9/18/20 for an LCS diet. On 12/4/20 at 1:24 pm, the Administrator confirmed the above findings.	R 782	481-57.21Nutrition and menu planning continued- This in-service will review all types of diets to include (LCS) low concentrated sweets for the diabetics.	
R 834	481-57.22(3)c 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)	R 834	481-57.22 Orientation and Service Plan- All service plans will be modified to add or delete goals and objectives as the residents needs change. These changes will be expected to occur within 5 business days and the individuals inside and outside the residential care facility who work with the resident as well as the resident's responsible party. The Administrator/ Designee will audit all service plans to ensure that all changes of conditions and additional information is added to service plans correctly. This audit will be done by 3/19/21. Providing the necessary information on the service plan will be an on-going process and will be monitored by the Administrator/Designee	

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R 834	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to amend or change the service plan as needed for 1 of 3 discharged residents reviewed (Resident C2). Findings include: On 12/10/20 record review revealed Resident C2 passed away on 11/19/20 with hospice present. Resident C2's service plan dated 7/15/20 revealed staff were to assist the resident with using the toilet and with the completion of ADLs (activities of daily living) in order to help prevent falls. Nurse's notes dated 8/5/20 revealed a new order for Resident C2. The new order indicated staff were to begin telling Resident C2 what he was eating due to sight issues. The new order also added staff assistance with getting dressed. A new service plan was implemented for Resident C2 on 8/19/20. The new service plan did not contain previous objectives of assistance with toileting or ADLs. The new orders regarding assistance during meals and with dressing were not included. On 12/14/20 at 1:24 pm, the Administrator confirmed the above finding.	R 834	481-57.22 Orientation and service Plan – Service plans will be reviewed at least quarterly by relevant staff, the resident and appropriate others, such as the resident's family, case manager and responsible party. The review shall include a written order addressing a summary of the resident's progress towards goals and objectives and for needed continued services. Resident #1and Resident #5 had a service plan between April 2020 and July 2020 however it was inadvertently shredded, the staff member that shredded it has been educated. The Administrator/designee will monitor this requirement closely to ensure that this does not happen again. This will be an on-going process All Service plans will be updated and brought current by 3/19/2012	
R 836	481-57.22(3)d 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	R 836		

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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
R 836	Continued From page 11 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) d. The service plan shall be reviewed at least quarterly by relevant staff, the resident and appropriate others, such as the resident's family, case manager and responsible party. The review shall include a written report which addresses a summary of the resident's progress toward goals and objectives and the need for continued services. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 2 of 3 residents reviewed had service plans reviewed at least on a quarterly basis (Resident #1, Resident # 5). Findings include: A review of Resident #1's record on 12/7/20 revealed an admission date of 12/27/19. A 30 day service plan was completed on 1/25/20. No quarterly review was completed during the months of April 2020 or July 2020. A review of Resident #5's record on 12/7/20 revealed an admission date of 3/18/20. A 30 day service plan was completed on 4/18/20. No	R 836	481-57.22 Orientation and service Plan – Service plans will be reviewed at least quarterly by the Administrator /Designee. Each service plan will reflect all new orders, changes in the condition and weather or not their goals have been met for the quarter. While resident #1& # 5 had been completed, they were inadvertently shredded. Moving forward it will be the expectation that all service plans be placed immediately into the service plan binder after being signed by the appropriate people involved with generating the service plan. The Administrator/Designee will responsible for ensuring that these documents are filed and stored properly. The administrator will do an audit of service plans to be completed by 3/19/21 to account for all service plans. This will be completed routinely as an on-going process	

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	060996	A. BUILDING: _____ B. WING _____	C 12/14/2020

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R 836	Continued From page 12 quarterly review was completed during the month of July 2020. On 12/14/20 at 1:24 pm, the Administrator confirmed the above findings.	R 836	481-57..25 Dignity Preserved It is the expectation that all residents under the facilities care be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. Our facility had an out break in Covid-19, as a result it was necessary to utilize an agency personnel. There was a break down of communication between the facility OMT and this agency staff member. All of our staff members have been educated on how to handle emergency situations and a formal policy on emergencies will be completed by 3/19/21. It will be the responsivity of the Administrator/DON to ensure that all staff understand and can follow through with the policy in a competent manor. If Agency is utilized to supplement staffing issues, they will be educated be for working on the unit. Annual training will be completed on the subject of Dignity Preserved and the handling of emergencies.	
R 914	481-57.25 Dignity Preserved 481-57.25(135C) Dignity preserved. The resident shall be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs. (I, II) This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure all residents were treated with consideration, respect, and full recognition of dignity and individuality. Findings include: 1. A review of Resident C1's closed record revealed an admission date of 3/9/19. Resident C1 passed away from complications of COVID-19 on 11/28/20. Resident C1 was diagnosed with COVID-19 in the afternoon of 11/17/20. Nurse's notes dated 11/20/20 at 2:30 pm, revealed Staff A sent Resident C1 to the emergency room when her oxygen level was at 35%. The notes also indicated Resident C1 was only mumbling when she spoke and was shaky. On 12/7/20 at 9:33 am, Staff H stated she worked on 11/20/20 during the first shift hours of 6 am to 2 pm. Staff H stated Resident C1 woke up and stated she felt "off." She allowed Resident C1 to sleep in and prompted her to eat breakfast later.	R 914		

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R 914	Continued From page 13 The resident ate a small amount of breakfast and went back to bed. Immediately following breakfast Resident C1 was not as responsive as usual, was tired, and had increased incontinence throughout the morning. After lunch was served, which Resident C1 did not eat, she appeared to have a paler color. Staff H stated she left for her shift at between 1:50 pm and 2:00 pm. Staff H stated that prior to her leaving, Resident C1 was incontinent and Staff H had Staff A assist her in changing her. Staff H also stripped all of the bedding off of the bed because it was wet. On 12/2/20 at 9:25 am, Staff A stated she assisted Staff H in changing Resident C1 because she was incontinent just prior to 2:00 pm. Resident C1 had difficulty standing and was very shaky. Staff A took Resident C1's vitals which were within normal range, but her oxygen level was at 35%. Staff A called for an ambulance to take Resident C1 to the emergency room. Staff A stated she did not know whether or not the ambulance crew re-took her oxygen level when they arrived because she did not go to the room with them but told them if they needed anything she would be at the desk. On 12/1/20 at 10:25 am, one of the ambulance staff was interviewed. He stated when they arrived to the facility at approximately 2:30 pm on 11/20/20, they were told what room Resident C1 was in but staff did not go with them. Staff A met the ambulance staff at the door and gave them paperwork. Staff A stated Resident C1's oxygen level was 35%. He stated he was flabbergasted at the low number and asked Staff A who the nurse was for Resident C1. Staff A stated she did not know who her nurse was. The ambulance crew found Resident C1 in her room wearing a sweater and pants and lying on her bed. The bed	R 914	481-57.25 Dignity Preserved It is the expectation of this facility to ensure all residents are treated with consideration, respect and full recognition of dignity and individuality. Staff E has had a prior history of not recognizing her own strengths and weakness regarding her communication with dementia residents. The facility recognizes that the tensions were high during the COVID-19 outbreak in our facility. Staff F and Staff E did not like each other and both parties had complained about each other's tone and behaviors. Both parties were working in a very stressful situation and the Administrator was not available to mediate related to having been diagnosed with COVID-19 herself. Staff E denies calling Resident #5 a "Bitch" and denies touching a resident in a rough manor. When the Administrator talked with Resident #5, they were not able to recall any staff members that had been rude or rough. When this survey took place, the	

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R 914	Continued From page 14 was stripped of all bedding and the resident was not covered up. The resident was incontinent of bowel and bladder. She was responsive to pain and but only moaned when spoken to. Resident C1's oxygen level was taken and read 10% and her hands were bluish/purple. The ambulance staff was extremely concerned regarding the condition Resident C1 was found in on 11/20/20. 2. A review of personnel records on 11/30/20 revealed Staff E was hired on 1/30/15 as a certified medication aide. Staff E worked full time on the overnight shift (8 pm - 6 am). On 12/10/20 at 4:00 pm, Resident #2 stated Staff E usually took up to 45 minutes to answer a call light. She loved her home at the facility and loved all the staff except for Staff E. Resident #2 stated all other staff staff were helpful but Staff E appeared to have a "no hands on" stance and would not physically help you. In her opinion, Staff E gave residents the impression that she did not care about them. On 11/3/20 at 11:11 am, Staff F stated she worked with Staff E during the 2nd shift hours. and stated she could be rough with residents. Resident #6 needed the assistance of one staff for transfers. Staff F had seen Staff E transfer Resident #6 before "hard and fast" and heard the resident tell Staff E to not be so rough. She also heard Staff E yell at Resident #5 once. Staff E once took Resident #5's clothes from her room and took them to the washing machine to wash them. Resident #5 came out of her room to get her clothes back and told Staff E she was "just an old hag." Staff E responded by calling Resident #5 a "bitch." On 12/2/20 at 9:25 am, Staff A stated she did not	R 914	Administrator had just returned from having COVID-19. She had to counsel Staff E on several occasions regarding her tone. When the Administrator realized that Staff E had been working between 120 and 135 hours a pay period to help with the ill residents, she gave her time off to recoup. Upon returning to work she was much calmer and was able to perform her job duties adequately. Staff E was disciplined for the sited areas during this survey. She will do continued education related to communicating with dementia residents and become recertified in dementia care. She will retake the Adult Abuse Class and she will be removed from direct patient care until the Administrator is able to confidently say that she has internalized and demonstrated the communication techniques she has learned on a consistent basis. She will not be scheduled alone in the building and she will not be working more than 80 hrs in a pay period until further	

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R 914	Continued From page 15 work with Staff E but had heard Staff E answered staff and residents in a snotty demeanor/tone. On 12/9/20 at 10 am, Staff B stated she had not seen Staff E be rough with any residents but had heard her say: "This isn't a nursing home, you have to do it yourself." Staff B stated all of the residents at the facility had complained about Staff E at one time or another. On 12/14/20 at 9:46 am, Staff E stated she had not had any concerns or incidents with being rude or saying rude things to anyone since her incident in 2016. Staff E stated she now went outside and bit her tongue. On 12/5/20, the Administrator typed up a statement because she could not locate the original disciplinary paperwork regarding an incident in 2016. The statement indicated the following points: - Staff E had a history of having a rude tone when speaking to others - Staff E was disciplined and suspended for 10 days in 2016 for yelling at a resident and telling them she would not feed them lunch - Staff E has been spoken to on many instances, including recently by the Administrator for tone of voice. The administrator indicated in the statement that Staff E could come off as rude and somewhat aggressive. She had not witnessed this behavior personally from Staff E but learned of it from residents and other staff. Staff E had said things like: "I'm not your mother," or "I'm not your maid." On 12/14/20 at 1:24 pm, the Administrator confirmed Staff E continued to use a rude tone of voice toward residents and staff.	R 914	notice. Any further complaints regarding Staff E will lead to immediate termination. In the future, during a crisis situation (like the Covid-19 outbreak) the Administrator will have a designee in place to oversee facility operations if she becomes ill. The designee will be educated on the individual needs of the staff. The designee will be coached on how to avoid burn out and balance personnel conflicts. The general emergency policy will be completed by 3/19/21 and include the above notations.	

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R 914	Continued From page 16 A review of facility policies on 11/30/20 revealed a policy titled Dignity and Respect. The policy read: "The staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings."	R 914	481-57.32(5)Resident Abuse Prohibited – Every Staff member will receive training related to the identification and reporting of dependent adult abuse as required by iowa code section 235.16. Staff member D has now completed her Adult Abuse Training. All staff will complete this training within the first 6 months from their hire date. It will be the responsibility of the Administrator/ DON to ensure that these trainings are completed timely as an on-going process. All staff are presently current with this training	
R 985	481-57.32(5) Resident Abuse Prohibited 57.32(5) Staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure training relating to the identification and reporting of dependent adult abuse was completed as required for 1 of 5 staff reviewed employed longer than 6 months (Staff D). Findings follow: Chapter 235B requires that employees complete two hours of training relating to the identification and reporting of Dependent Adult Abuse within six months of initial employment and at least two hours of additional dependent adult abuse identification and reporting training every three years. Review of Staff D's file on 11/30/20 revealed a hire date of 3/16/20. No record of dependent adult abuse training could be located. Interview with the Administrator on 12/14/20 at 1:24 pm confirmed this finding.	R 985		

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R1026	Continued From page 17 481-57.34(3)d Safety 481-57.34(135C) Safety. The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II, III) 57.34(3) Resident safety. d. Storage areas for cleaning agents, bleaches, insecticides, or any other poisonous, dangerous, or flammable materials shall be locked. Residents permitted to access these materials shall be supervised by staff as identified in the resident's service plan. (I, II, III) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure all storage areas containing poisonous or dangerous chemicals were securely locked. Findings include: During a medication administration pass on 12/2/20 at 8:31 am, a closet door was partially open in the hallway adjacent to Resident #5's room. Upon inspection of the closet, it was discovered to contain Hotshot wasp and hornet spray, paint thinner, and all purpose cleaner. The door was pulled closed and locked at the time of the finding. At 10:30 AM, the Administrator confirmed the above finding.	R1026 R1026	481-57.34(3)d Safety It is the responsibility of the Administrator/DON to provide training to the provision and maintenance of a safe environment for residents and personnel. This requirement includes the storage areas for cleaning agents, bleaches insecticides or any other poisonous, dangerous or flammable materials shall be locked. All staff has been educated on the importance of following this regulation. The charge nurse/omt will do rounds at the start of their shifts to ensure that all doors leading to these chemicals are locked. Monitoring this will be done daily and continue as an on-going process	