DEPART	MENT OF INSPECT	TIONS AND APPEALS			
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION S:	(X3) DATE SURVEY COMPLETED
			,	Value of the latest and the latest a	C
		060996	B. WING		12/14/2020
NAME OF F	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	•
ROCK RI	DGE RESIDENTIAL (CARE CENTER	ON STREE URG, IA 52		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIEMENCY)	ULD BE COMPLETE
R 000	Initial Comments		R 000		·
	investigation of Co #93253-C, Compla conducted to deter rules for a Residen In addition to these infection control su	iencies were cited during the mplaint #94614-C, Complaint int #94647-C, and a survey mine compliance with licensing itial Care Facility. Investigations, an onsite irvey was conducted. No sited during this survey.			
R 366	481-57.11(5)c Pers	sonnel	R 366	·	
	57.11(5) Supervision	on and staffing.			
		shall be present in the facility s are involved in activities away , II, III)			
	by: Based on staff inte	INT is not met as evidenced erview the facility failed to staff were in the facility at all when residents were present.			
	worked the overnig am. Staff E stated in the building to c (AL) program and (RCF) after 8:00 p				
DIVISION O	F HEALTH FACILITIES -	enants in the AL required STATE OF IOWA	<u> </u>		
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TILE	(X6) DATE
STATE FOR	M Josh	buews	6899	036111 Administrata	2/28/2/ If continuation sheet 1 of
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DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C B. WING 12/14/2020 060996 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **400 CANTON STREET NW ROCK RIDGE RESIDENTIAL CARE CENTER** SHELLSBURG, IA 52332 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) R 366 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 481-57.11(5c) Supervision and confirmed only one staff was scheduled for the staffing. Direct care staffing shall be building on the overnight shift. present in the facility unless all R 412 residents are involved in activities R 412 481-57.12(1)s General Policies away from the facility. We have 481-57.12(135C) General policies. The licensee staff that live on site to help with shall establish and implement written policies and the residents needs after hours. procedures as set forth in this rule. The policies and procedures shall be available for review by When they are not staying in the the department, other agencies designated by building the Administrator/DON is lowa Code section 135C.16(3), staff, residents, on call. She lives 4 minutes from residents' families or legal representatives, and the public and shall be reviewed by the licensee the facility and has frequently come annually. (II) to assist with the residents needs. A formal policy will be completed by 57.12(1) Facility operation. The licensee shall establish written policies for the operation of the 3/19/21 that will assist staff in facility, including, but not limited to the following: knowing the proper protocol. It will (III)be the responsibility of the s. Resident supervision; (II, III) 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. X 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 DIVISION OF HEALTH FACILITIES - STATE OF IOWA If continuation sheet 2 of 18 STATE FORM 036111

A Fer the administrator, there will be a still power in the Ref of all times. If a tonat in the the program regues assistance and the live in stylis not accidable, the administrator will come from her rearry home and assist he terest and

DEPARTMENT OF INSPECTIONS AND APPEALS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: С 060996 B. WING 12/14/2020

OCK R	IDGE NEGIDENTIAL GARE GENTER	ON STREET URG, IA 523		
(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) COMPLET DATE
R 412	Continued From page 2	R 412		
	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 am11/16/20: No documentation for 8 am, 10 am, 12 pm, 2 pm, and 4 pm11/20/20: No documentation for 8 am, 10 am, 12 pm, 2 pm, and 4 pm.		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.	
R 454	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. 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 lowa Code section 135C.16(3), staff, residents,	R 454	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.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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If continuation sheet 3 of 11

PRINTED: 02/19/2021 FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: C 12/14/2020 B. WING 060996 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **400 CANTON STREET NW ROCK RIDGE RESIDENTIAL CARE CENTER** SHELLSBURG, IA 52332 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R 454 R 454 Continued From page 3 481-57.12 General Policies residents' families or legal representatives, and The facility will establish a written the public and shall be reviewed by the licensee policy for the operation of the annually. (II) facility, including, but not limited to 57.12(5) Emergency care. The facility shall the following: Residents establish written policies for the provision of emergency medical care to residents and supervision. This policy will be employees in case of sudden illness or accident. completed by 3/19/21 and it will be The policies shall include a list of those the responsibility of the individuals to be contacted in case of an Administrator/ Designee to ensure emergency. (I, II, III) that the policy is enforced. Staff member E has been provided This REQUIREMENT is not met as evidenced education and disciplinary actions by: Based on interviews and record review, the for not completing 2 hour rounds facility failed to have a policy in place regarding during her scheduled shift and emergency care which included a list of completing the documentation on individuals to be contacted in case of an the appropriate form indicating the emergency. Findings include: rounds have been done. A review of Resident C1's closed record revealed an admission date of 3/9/19. Resident C1 passed All staff including Staff I will be away from complications of COVID-19 on provided the same education and 11/28/20. Resident C1 was diagnosed with have the policy reviewed with them COVID-19 in the afternoon of 11/17/20. Nurse's notes dated 11/20/20 at 2:30 pm, revealed Staff A individually to ensure that proper sent Resident C1 to the emergency room when supervision and safety are being her oxygen level was at 35%. The notes also done correctly. This will be indicated Resident C1 was only mumbling when she spoke and was shaky. completed by the Administrator /designee by 3/19/21 and done On 12/7/20 at 9:33 am, Staff H stated she worked with all new hires in the future as on 11/20/20 during the first shift hours of 6 am to 2 pm. Staff H stated Resident C1 woke up and an on-going process 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

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

DEPARTMENT OF INSPECTIONS AND APPEALS STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING; C B. WING 060996 12/14/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 CANTON STREET NW ROCK RIDGE RESIDENTIAL CARE CENTER** SHELLSBURG, IA 52332 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY** R 454 Continued From page 4 R 454 485-57.12(135C) General Policies-Resident C1 was not as responsive as usual, was Emergency Care. The facility will tired, and had increased incontinence throughout establish a written policy for staff the morning. After lunch was served, which Resident C1 did not eat, she appeared to have a regarding Emergency Care. This paler color. Staff H stated she left for her shift at policy will include a list of between 1:50 pm and 2:00 pm. Staff H stated that individuals to be contacted in prior to her leaving. Resident C1 was incontinent and Staff H had Staff A assist her in changing her. case of and emergency. This policy will be completed by On 12/2/20 at 9:25 am, Staff A stated she 3/19/21. All staff will be educated assisted Staff H in changing Resident C1 because she was incontinent just prior to 2:00 on this policy and it will be the pm. Resident C1 had difficulty standing and was responsibility of the very shaky. Staff A took Resident C1's vitals Administrator to ensure that which were within normal range, but her oxygen level was at 35%. Staff A called for an ambulance current and future staff have the to take Resident C1 to the emergency room. She proper training in regards to contacted Resident C1's physician earlier that emergency care. Staff A will be morning because she had severe redness in her groin area and wanted to see if any new orders , included in the education process would be warranted. Staff A did not mention and Staff H is employed by Resident C1 not feeling well to the physician as agency. Moving forward all there was nothing unusual at that time. Staff A agency staff will be educated in stated she did not take any vitals all morning on Resident C1 until after lunch when she noted her emergency care before going on to be shaky when changing her. She said there to the unit to provide any care. It were no rules or policies regarding residents who will be the responsibility of the had COVID-19 and how they should monitor them or report symptoms/changes. Administrator/Designee to provide said education to all On 12/9/20 at 10:00 am, Staff B stated staff could Agency Staffing. 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

DEPARTMENT OF INSPECTIONS AND APPEALS STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		OOM LEILD	
		060996	B. WING		C	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BUCK BI	DGE RESIDENTIAL (CARE CENTER 400 CANT	TON STREET	r NW		
KOCK KI	DGE RESIDENTIAL (SHELLSE	IURG, IA 52	332		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE	
R 454	Continued From pa	ige 5	R 454			
	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 456	481-57.13(1)a Adm	ission, Transfer, Discharge	R 456			
	481-57.13(135C) A discharge.	dmission, transfer and				
	57.13(1) General a	dmission policies.				THE PARTY OF THE P
	care facility only on primary care provid and certifying that t requires no more the	be admitted to a residential a written order signed by a ler, specifying the level of care, the individual being admitted nan personal care and es not require routine nursing				
	by: Based on interview failed to ensure wri received prior to ac	NT is not met as evidenced and record review, the facility ten level of care orders were limission for 1 of 3 residents i # 1). Findings include:				
	revealed an admiss Resident #1's pre-a the signed certifica care. The pre-adm indicated the plan v Rock Ridge Assiste					

FORM APPROVED DEPARTMENT OF INSPECTIONS AND APPEALS (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ С B. WING 12/14/2020 060996 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **400 CANTON STREET NW ROCK RIDGE RESIDENTIAL CARE CENTER** SHELLSBURG, IA 52332 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) R 456 R 456 Continued From page 6 481-57.13Admission, Transfers Discharge- All residents shall be On 12/14/20 at 1:24 pm, the Administrator admitted to a residential care confirmed the above finding. facility only on a written order signed by a primary care provider, R 642 481-57.17(3)e Records R 642 specifying the level of care and 481-57.17(135C) Records. certifying that the individual being admitted requires no more that 57.17(3) Incident record. personal care and supervision and e. An incident report shall be completed for every does not require routine nursing accident, incident or unusual occurrence withincare. The administrator/Designee the facility or on the premises that affects a will ensure that this regulation is resident, visitor, or employee. (II, III) being met. It will be an on-going process over seen with each admission. Resident #1 has been This REQUIREMENT is not met as evidenced discharged. Moving forward this by: Based on interview and record review, the facility will be monitored closely. failed to ensure written incident reports were completed regarding all injuries/unusual 481-57.17 Incident records occurrences for 1 of 6 residents reviewed (Resident #5). Findings include: It will be the expectation all staff to complete an incident report vor On 11/3/20 at 11:11 AM, Staff F stated on every accident, incident or unusual 11/30/20 she discovered Resident #5 fully incontinent in her bed. She assisted Resident #5 occurrence with in the facility or on into the shower to be cleaned up. At that time she the premises that affects a noted Resident #5's skin from her buttocks up to resident, visitor or employee. An inher right shoulder was chapped due to service will be conducted by the incontinence. Staff F did not fill out an incident report form. Administrator by 3/19/21 to reeducate staff on the incident

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

skin for Resident #5.

On 12/3/20 during a review of facility incident

On 12/14/20 at 1:24 pm, the Administrator

reports, no report was found regarding chapped

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Ridge.

reporting process. Staff member F

is no longer employed with Rock

A BUILDING: COMPLETED	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 400 CANTON STREET NW SHELLSBURG, IA 52332 PROVIDERS PLAN OF CORRECTION (ESCHIERCYCON ORLS DEPTHYMO INFORMATION) R 642 Continued From page 7 confirmed the above finding. R 648 481-57.18(4) Resident Care & Personal Services 481-57.18(4) 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 (Resident #3) Findings include: On 12/9/20 review of Resident #3's record revealed an admission date of 11/4/20. The 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 #3 date of 11/4/20 and Services 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 date develor of a shower is and documented he received a shower. On 12/14/20 at 1:24 pm, the Administrator	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
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CALIDER RESIDENTIAL CARE CENTER SHELLSBURG, IA 52332	NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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485-57.18 Resident Care and Personal Services. All residents will 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	R 668	481-57.18(4) Resid	ent Care & Personal Services	R 668		ing	
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will be encouraged to bathe at least twice a week. (II, III) 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 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		services.			485-57.18 Resident Care and		
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list and documented he received a shower. On 12/14/20 at 1:24 pm, the Administrator maintain operational duties. These policies will be written by		#3's name had not	been added until 11/23/20. On		•		
On 12/14/20 at 1:24 pm, the Administrator These policies will be written by					_		
On 12/14/20 at 1.24 pm, the Administrator					· ·		
					1	Y	

		TIONS AND APPEALS			D(0) C	UD1/51/
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` .	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		JOIN! L	
					C	
		060996	B. WING	and the second s	12/14	1/2020
NAME OF P	ROVIDER OR SUPPLIER			TATE, ZIP CODE		
POCK BI	DGE RESIDENTIAL (ADE CENTED	ON STREET			
NOOK IN	DOE REGIDERATION OF	SHELLSB	URG, IA 523	32		
(X4) ID		ATEMENT OF DEFICIENCIES	CI CI	PROVIDER'S PLAN OF CORRECTION CONTROL OF CON		(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE
170		• • • • • • • • • • • • • • • • • • •	,,,,	DEFICIENCY)		
D 700	O ('	0	R 782			
R 782	Continued From pa	age 8	K /02			
R 782	481-57.21(2)a Diet	ary	R 782			
	481-57.21(135C) E	Dietary.				
	E7.04/05 N 1 "			481-57.21 Nutrition and men	u	
	57.21(2) Nutrition a	and menu planning.		planning- Menus shall be pla	nned	
	a Manue chall ha	planned and followed to meet		and followed to meet the		
		Is of residents in accordance		nutritional needs of the resid	lants !-	
		re provider's orders. Diet				
		eviewed as necessary, but at		accordance with the primary	care	
		the primary care provider. (II,		providers orders. Diet orders	will be	
	III)			reviewed as necessary by at	least	
	•			guarterly. Staff member D w		
				·	1	
				filling in for the kitchen staff		
				had called off with covid-19.	She	
	This DECUIDEME	NT is not met as evidenced		does not routinely work in th	ne l	
	by:	INT IS NOT THE LAS EVIDENCED		kitchen. She has since been s	shown	
		tion, interview, and record		where the index box that cor	ntains	
	review, the facility	failed to ensure 2 of 2 residents				
		cial diets were served meals		the diet orders are kept. All o		
		cian's orders (Resident #1,		orders are accurate and kept	-	
	Resident #5). Find	ings include:		date. They are reviewed qua	rterly	
				by the Kitchen supervisor an	d the	
	On 11/30/20 at 11:	30 am during an observation of		Director of nursing. An in-ser		
		Staff D was in charge cooking the meal trays together. At		will be provided for all staff t		
		ked for a list of diet orders,		ensure that each member of		
		a box containing index cards.		'		
		contained only resident		team have the tools to comp	ly with	
		ad no diet orders. Staff D		all nutritional needs of the		
		s in the building had a special		residents by 3/19/21 by the		
		when the meal was served it		Administrator.		
		n and cheese sandwich,		- 1007777770007 000007 0		The state of the s
		green beans, 2 cookies, and	1			
		All residents received the same				
	receive seconds.	ed residents could request and				
	receive seconds.					

		TONS AND ATTEACH	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		(X3) DATE SURVEY	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED	
AND PLAN	OF CORRECTION	IDEIALII 1001 1014 1401810FLV	A. BUILDING:			
					C	
		060996	B. WING		12/14/2020	
		OTOEET AD	DEGG CITY C	TATE ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		-	TATE, ZIP CODE		
ROCK RI	DGE RESIDENTIAL (A DE CENTED	ON STREET			
		SHELLSB	URG, IA 523			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID DDEELY	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		
ind		·		DEFICIENCY)		
	A :: .=		R 782			
R 782	Continued From pa	age 9	K 102	404 57 0411		
		of Resident #1's record		481-57.21Nutrition and menu		
		physician's order dated 9/4/20		planning continued- This in-ser	vice	
	for a low concentra	ited sweets (LCS) diet order.		will review all types of diets to		
		rd revealed a signed		include (LCS) low concentrated		
	physician's order d	ated 9/18/20 for an LCS diet.		sweets for the diabetics.		
	0 45(4)00 14.04	41 . A		sweets for the diabetics.		
		pm, the Administrator				
	confirmed the abov	ve unaings.				
			D 004			
R 834	481-57.22(3)c Orie	entation and Service Plan	R 834			
				481-57.22 Orientation and Serv	rice	
		lan. Within 30 days of		Plan- All service plans will be		
	admission, the adr			modified to add or delete goals	and	
		signee, in conjunction with the ent's responsible party, the		i	· ·	
		am, and any organization that	ALL CONTRACTOR OF THE PROPERTY	objectives as the residents nee	as	
		es the resident, shall develop a		change. These changes will be		
		zed, and integrated service plan		expected to occur within 5 bus	iness	
		ne service plan shall be		days and the individuals inside		
		plemented to address the				
		and assessed needs, such as	-	outside the residential care fac		
	activities of daily liv	ving, rehabilitation, activity, and		who work with the resident as	well	
		emotional, physical and mental		as the resident's responsible p	arty.	
	health. (I, II, III)			The Administrator/ Designee w		
		n should be modified to add or		audit all service plans to ensure		
		objectives as the resident's immunications related to		that all changes of conditions a		
1		immunications related to ges or changes in the resident's		additional information is added	d to	
		cur within five working days of		service plans correctly. This au	dit	
		nall be conveyed to all		will be done by 3/19/21. Provi		
		and outside the residential care		i e	, i	
		with the resident, as well as to		the necessary information on	i i	
		ponsible party. (I, II, III)		service plan will be an on-goin		
	•			process and will be monitored	by	
				the Administrator/Designee		
				and realisting and a second	1	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		060996	B. WING		C 12/14/2020
	PROVIDER OR SUPPLIER	ARE CENTER 400 CANT	ORESS, CITY, S ON STREET URG, IA 523		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE COMPLETE
R 834	This REQUIREMENT by: Based on interview failed to amend or oneeded for 1 of 3 d (Resident C2). Find the contained of the contained on the contained of the cont	and record review, the facility change the service plan as ischarged residents reviewed lings include: I review revealed Resident C2 /19/20 with hospice present. Ice plan dated 7/15/20 to assist the resident with with the completion of ADLs ving) in order to help prevent de 8/5/20 revealed a new order ne new order indicated staff g Resident C2 what he was issues. The new order also nace with getting dressed. Was implemented for Resident new service plan did not objectives of assistance with he new orders regarding neals and with dressing were	R 834	481-57.22 Orientation and sent 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 responsible party. The review sinclude a written order address a summary of the resident's progress towards goals and objectives and for needed continued services. Resident #1 Resident #5 had a service plan between April 2020 and July 20 however it was inadvertently shredded, the staff member the shredded it has been educated Administrator/designee will monitor this requirement close ensure that this does not happen again. This will be an on-going process All Service plans will be updated and brought current be	r and hall ling land 20 at . The ly to en
R 836	57.22(3) Service pl admission, the adm administrator's des resident, the reside	ntation and Service Plan an. Within 30 days of ninistrator or the ignee, in conjunction with the nt's responsible party, the m, and any organization that	R 836	3/19/2012	

PRINTED: 02/19/2021 **FORM APPROVED** DEPARTMENT OF INSPECTIONS AND APPEALS (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ С B. WING 060996 12/14/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 CANTON STREET NW ROCK RIDGE RESIDENTIAL CARE CENTER** SHELLSBURG, IA 52332 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) R 836 Continued From page 11 R 836 works with or serves the resident, shall develop a written, individualized, and integrated service plan 481-57.22 Orientation and service for the resident. The service plan shall be Plan - Service plans will be developed and implemented to address the reviewed at least quarterly by the resident's priorities and assessed needs, such as activities of daily living, rehabilitation, activity, and Administrator / Designee. Each social, behavioral, emotional, physical and mental service plan will reflect all new health. (I, II, III) orders, changes in the condition d. The service plan shall be reviewed at least and weather or not their goals have quarterly by relevant staff, the resident and been met for the quarter. While appropriate others, such as the resident's family, resident #1& #5 had been case manager and responsible party. The review shall include a written report which addresses a

This REQUIREMENT is not met as evidenced by:

summary of the resident's progress toward goals

and objectives and the need for continued

services. (I. II. III)

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

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

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		060996	B. WING		12/14/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ROCK RI	DGE RESIDENTIAL (ARE CENTER	ON STREET			
7		SHELLSB	URG, IA 52:		SMI Jara	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE COMPLETE	
R 836	Continued From pa	ige 12	R 836			
	quarterly review wa of July 2020.	as completed during the month		481-5725 Dignity Preserved		
	•			It is the expectation that all		
	On 12/14/20 at 1:24 confirmed the above	4 pm, the Administrator		residents under the facilities c	1	
	Committee the above	e mungs.	,	be treated with consideration,	1	
R 914	481-57.25 Dignity F	Preserved	R 914	respect, and full recognition of	1	
1	404 E7 05/4050\ F	Name the common man of The consideration		dignity and individuality, inclu-		
		(5(135C) Dignity preserved. The resident privacy in treatment and in care treated with consideration, respect, and				
	full recognition of d	ignity and individuality,	personal needs. Our facility had a out break in Covid-19, as a result		į.	
	including privacy in personal needs. (treatment and in care for			!	
	personal necus. (i, i <i>ij</i>		was necessary to utilize an age personnel. There was a break (* 1	
				of communication between th	\$	
	This REQUIREME	NT is not met as evidenced		facility OMT and this agency st	•	
	by:			member. All of our staff member.	1	
		and record review the facility residents were treated with		have been educated on how to	ł	
		ect, and full recognition of		handle emergency situations a	1	
	dignity and individu	ality. Findings include:		formal policy on emergencies	i	
	1. A review of Resi	dent C1's closed record		be completed by 3/19/21. It w	1	
	revealed an admiss	sion date of 3/9/19. Resident		the responsivity of the		
		om complications of COVID-19 ent C1 was diagnosed with		Administrator/DON to ensure	that	
		fternoon of 11/17/20. Nurse's		all staff understand and can fo	llow	
	notes dated 11/20/2	20 at 2:30 pm, revealed Staff A		through with the policy in a	,	
		o the emergency room when as at 35%. The notes also		competent manor. If Agency is		
	indicated Resident	C1 was only mumbling when		utilized to supplement staffing		
	she spoke and was	s shaky.		issues, they will be educated be	e for	
	On 12/7/20 at 9:33	am, Staff H stated she worked		working on the unit. Annual		
	on 11/20/20 during	the first shift hours of 6 am to		training will be completed on t	L L	
		d Resident C1 woke up and " She allowed Resident C1 to		subject of Dignity Preserved ar	na	
		"She allowed Resident C1 to oted her to eat breakfast later.	The second secon	the handling of emergencies.		

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPLETED
		060996	B. WING		C 12/14/2020
			<u> </u>		1 12/14/2020
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE	
ROCK R	IDGE RESIDENTIAL C	ARE CENTER	ON STREE		
		······································	URG, IA 52	2332	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	DBE COMPLETE
				DEFICIENCY)	
R 914			R 914	481-57.25 Dignity Preserved	
		small amount of breakfast and mmediately following breakfast		It is the expectation of this fa	i i
		ot as responsive as usual, was		to ensure all residents are tro	eated
1	tired, and had incre	ased incontinence throughout		with consideration, respect a	ınd
	the morning. After I	unch was served, which		full recognition of dignity and	t
	paler color. Staff H	t eat, she appeared to have a stated she left for her shift at		individuality. Staff E has had	a
	between 1:50 pm a	nd 2:00 pm. Staff H stated that		prior history of not recognizi	ng
	prior to her leaving,	Resident C1 was incontinent		her own strengths and weak	ness
	Staff H also strippe	Iff A assist her in changing her. If all of the bedding off of the		regarding her communicatio	n
	bed because it was			with dementia residents. The	•
	0 40/0/00 -4 0.05	0. %		facility recognizes that the	
		am, Staff A stated she changing Resident C1		tensions were high during th	e
	because she was in	continent just prior to 2:00		COVID-19 outbreak in our fac	cility.
	pm. Resident C1 ha	d difficulty standing and was		Staff F and Staff E did not like	•
111111111111111111111111111111111111111	which were within n	ook Resident C1's vitals ormal range, but her oxygen		each other and both parties	had
	level was at 35%. S	taff A called for an ambulance		complained about each othe	rs
	to take Resident C1	to the emergency room. Staff		tone and behaviors. Both page 1	arties
		know whether or not the took her oxygen level when		were working in a very stress	1
	they arrived becaus	e she did not go to the room		situation and the Administra	
	with them but told the	nem if they needed anything		was not available to mediate	
				related to having been diagn	1
	On 12/1/20 at 10:25	am, one of the ambulance		with COVID-19 herself. Staff	E
Ī	staff was interviewe	d. He stated when they		denies calling Resident #5 a	
	arrived to the facility	at approximately 2:30 pm on told what room Resident C1		"Bitch" and denies touching	a
		not go with them. Staff A met		resident in a rough manor. V	/hen
	the ambulance staff	at the door and gave them		the Administrator talked wit	h
	paperwork. Staff A s	tated Resident C1's oxygen		Resident #5, they were not a	ble
	evel was 35%. He s	tated he was flabbergasted asked Staff A who the		to recall any staff members t	:hat
	nurse was for Resid	ent C1. Staff A stated she did		had been rude or rough. Wh	
	not know who her nu	urse was. The ambulance		this survey took place, the	
	crew found Resident	t C1 in her room wearing a		· ·	
	sweater and pants a	nd lying on her bed. The bed			

DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: C **B WING** 12/14/2020 060996 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **400 CANTON STREET NW ROCK RIDGE RESIDENTIAL CARE CENTER** SHELLSBURG, IA 52332 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY** Administrator had just returned R 914 Continued From page 14 R 914 from having COVID-19. She had to was stripped of all bedding and the resident was counsel Staff E on several not covered up. The resident was incontinent of occasions regarding her tone. bowel and bladder. She was responsive to pain and but only moaned when spoken to. Resident When the Administrator realized C1's oxygen level was taken and read 10% and that Staff E had been working her hands were bluish/purple. The ambulance between 120 and 135 hours a pay staff was extremely concerned regarding the condition Resident C1 was found in on 11/20/20. period to help with the ill residents, she gave her time off 2. A review of personnel records on 11/30/20 to recoup. Upon returning to revealed Staff E was hired on 1/30/15 as a certified medication aide. Staff E worked full time work she was much calmer and on the overnight shift (8 pm - 6 am). was able to perform her job duties adequately. On 12/10/20 at 4:00 pm, Resident #2 stated Staff E usually took up to 45 minutes to answer a call Staff E was disciplined for the light. She loved her home at the facility and loved sited areas during this survey. She all the staff except for Staff E. Resident #2 stated will do continued education all other staff staff were helpful but Staff E appeared to have a "no hands on" stance and related to communicating with would not physically help you. In her opinion, Staff dementia residents and become E gave residents the impression that she did not recertified in dementia care. She care about them. will retake the Adult Abuse Class On 11/3/20 at 11:11 am. Staff F stated she and she will be removed from worked with Staff E during the 2nd shift hours. direct patient care until the and stated she could be rough with residents. Resident #6 needed the assistance of one staff Administrator is able to for transfers. Staff F had seen Staff E transfer confidently say that she has Resident #6 before "hard and fast" and heard the internalized and demonstrated resident tell Staff E to not be so rough. She also heard Staff E yell at Resident #5 once. Staff E the communication techniques once took Resident #5's clothes from her room she has learned on a consistent and took them to the washing machine to wash basis. She will not be scheduled them. Resident #5 came out of her room to get her clothes back and told Staff E she was "just an alone in the building and she will old hag." Staff E responded by calling Resident not be working more than 80 hrs #5 a "bitch." in a pay period until further

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

On 12/2/20 at 9:25 am, Staff A stated she did not

DEPARTMENT OF INSPECTIONS AND APPEALS (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: C B. WING 060996 12/14/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 CANTON STREET NW ROCK RIDGE RESIDENTIAL CARE CENTER** SHELLSBURG, IA 52332 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) R 914 R 914 Continued From page 15 notice. Any further complaints work with Staff E but had heard Staff E answered regarding Staff E will lead to staff and residents in a snotty demeanor/tone. immediate termination. On 12/9/20 at 10 am, Staff B stated she had not seen Staff E be rough with any residents but had In the future, during a crisis heard her say: "This isn't a nursing home, you situation (like the Covid-19 have to do it yourself." Staff B stated all of the outbreak) the Administrator will residents at the facility had complained about Staff E at one time or another. have a designee in place to oversee facility operations if she On 12/14/20 at 9:46 am. Staff E stated she had becomes ill. The designee will be not had any concerns or incidents with being rude educated on the individual needs or saving rude things to anyone since her incident in 2016. Staff E stated she now went outside and of the staff. The designee will be bit her tongue. coached on how to avoid burn out and balance personnel On 12/5/20, the Administrator typed up a statement because she could not locate the conflicts. The general emergency original disciplinary paperwork regarding an policy will be completed by incident in 2016. The statement indicated the 3/19/21 and include the above following points: - Staff E had a history of having a rude tone notations. 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.

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED
	060996	B. WING		C 12/14/2020
PROVIDER OR SUPPLIER	ARE CENTER 400 CANT	ON STREET	NW	,
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE
A review of facility p policy titled Dignity a "The staff shall disp speaking with, caring as constant affirmation	oolicies on 11/30/20 revealed a and Respect. The policy read: lay respect for residents when a for, or talking about them, tion of their individuality and	R 914	_	
57.32(5) Staff shall identification and re	receive training relating to the porting of dependent adult	R 985	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	
by: Based on interview failed to ensure trail identification and re abuse was complet reviewed employed	and record review the facility ning relating to the porting of dependent adult ed as required for 1 of 5 staff longer than 6 months (Staff			
two hours of training and reporting of De months of initial em hours of additional of	g relating to the identification pendent Adult Abuse within six ployment and at least two dependent adult abuse			
hire date of 3/16/20 adult abuse training Interview with the Ad	No record of dependent could be located. dministrator on 12/14/20 at			
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa A review of facility p policy titled Dignity a "The staff shall disp speaking with, carir as constant affirmal dignity as human be 481-57.32(5) Staff shall identification and re abuse as required b 235B.16. This REQUIREMEN by: Based on interview failed to ensure train identification and re abuse was complete reviewed employed D). Findings follows: Chapter 235B requi two hours of training and reporting of De- months of initial em- hours of additional of identification and re years. Review of Staff D's hire date of 3/16/20 adult abuse training Interview with the Ac-	OF CORRECTION OG0996 PROVIDER OR SUPPLIER STREET ADIA 400 CANT SHELLSB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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." 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 lowa 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	OF CORRECTION OG0996 B. WING	OF CORRECTION DENTIFICATION NUMBER: B. WING

FORM APPROVED DEPARTMENT OF INSPECTIONS AND APPEALS (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: C B. WING 060996 12/14/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 CANTON STREET NW ROCK RIDGE RESIDENTIAL CARE CENTER** SHELLSBURG, IA 52332 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R1026 R1026 Continued From page 17 R1026 R1026 481-57.34(3)d Safety 481-57.34(135C) Safety. The licensee of a residential care facility shall be responsible for the 481-57.34(3)d Safety provision and maintenance of a safe environment for residents and personnel. (I, II, III) It is the responsibility of the Administrator/DON to provide 57.34(3) Resident safety. training to the provision and d. Storage areas for cleaning agents, bleaches, maintenance of a safe environment insecticides, or any other poisonous, dangerous, for residents and personnel. This or flammable materials shall be locked. Residents permitted to access these materials requirement includes the storage shall be supervised by staff as identified in the areas for cleaning agents, bleaches resident's service plan. (I, II, III) insecticides or any other poisonous, dangerous or flammable materials This REQUIREMENT is not met as evidenced shall be locked. All staff has been educated on the importance of Based on observation and interview, the facility following this regulation. The failed to ensure all storage areas containing poisonous or dangerous chemicals were securely charge nurse/omt will do rounds at locked. Findings include: the start of their shifts to ensure that all doors leading to these During a medication administration pass on 12/2/20 at 8:31 am, a closet door was partially chemicals are locked. Monitoring open in the hallway adjacent to Resident #5's this will be done daily and continue room. Upon inspection of the closet, it was as an on-going process 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.