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
	S0359	A. BUILDING: _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK SENIOR LIVING	3602 NW 5TH STREET ANKENY, IA 50023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 22 Number of tenants with cognitive disorder: 3 Memory Care Unit Number of tenants without cognitive disorder: 3 Number of tenants with cognitive disorder: 10 Total census: 38 No regulatory insufficiencies were cited during the onsite infection control survey. The following regulatory insufficiencies were cited during the investigation of Complaint #96989-C and the recertification visit conducted to determine compliance with certification of an Assisted Living Program for People with Dementia.	A 000	✓ 10/14/21	
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced	A 155	Plan of Correction is attached.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 155	Continued From page 1 by: Based on interview and record review the Program failed to ensure 1 of 3 tenants reviewed was treated with consideration, respect and personal dignity (Tenant #4). Findings follow: Review of Tenant #4's file on 6-24-21 revealed diagnoses of macular degeneration, glaucoma, severe hearing loss, hypertension, arteriosclerotic heart disease of native coronary artery without angina pectoris, nonrheumatic mitral stenosis, cardiomyopathy, unspecified atrial fibrillation, congestive heart failure, polyosteoarthritis, osteoporosis, and varicose veins of lower extremities. Review of the service plan revealed she required assistance with transfers using a gait belt and assistance with medication administration. Review of video footage revealed the following: On 12-14-2020 two staff grabbed Tenant #4's clothing and/or incontinence briefs, lifted her under her arms, and roughly transferred to her wheelchair. No gait belt was utilized. On 12-27-2020 Staff E pulled under her arms and another staff pulled on her clothing and roughly transferred her to her wheelchair. No gait belt was utilized. On 1-27-21 Tenant #4 told Staff E she needed to go to the bathroom. Staff E ignored her request to use the bathroom, handed her the medications, and walked away without ensuring she swallowed her medication. On 1-28-21 Tenant #4 told Staff E something about a heart attack and Staff E responded "You are not having a heart attack, it's just cramping" and failed to address her concerns. On 2-10-21 Staff E entered Tenant #4's apartment and failed to inform her what she was doing, handed her the medications, and walked	A 155		

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A 155	Continued From page 2	A 155		

away without ensuring she swallowed her medications.

On 2-13-21 a staff failed to lock the brakes on the wheelchair, lifted Tenant #4 under her arms, and roughly transferred into the wheelchair. The tenant almost missed the seat as the wheelchair rolled back. No gait belt was utilized.

On 2-26-21 Staff E pulled the clothing and/or incontinence briefs and roughly transferred Tenant #4 into the wheelchair. No gait belt was utilized.

On 3-8-21 Tenant #4 asked staff to use the restroom and the staff told her to wait 10 minutes. The staff returned approximately one hour later and failed to toilet Tenant #4.

On 3-21-21 Staff E ignored her request to use the bathroom and told Tenant #4, "You just went to the bathroom."

On 3-23-21 the staff ignored her request to use the bathroom and told Tenant #4, "You just went to the bathroom."

On 3-24-21 the staff ignored her request for Tylenol and told Tenant #4, "You have no Tylenol PRN." (Review of March Medication Administration Record revealed Tylenol was available for PRN (as needed) pain control.)

On 3-25-21 Staff E reset Tenant #4's pendent, walked away, and failed to ask what she needed.

On 3-25-21 Tenant #4 pushed her pendant approximately 20 minutes later. Staff E and another staff arrived and Staff E said, "Oh be quiet" to Tenant #4. Tenant #4 stated something to Staff E and she replied, "You didn't tell me."

On 3-28-21 staff lifted Tenant #4 by her right arm and roughly transferred her into the wheelchair and failed to use a gait belt.

During an interview on 7-6-21 at 11:30 a.m. the Executive Director (ED), Wellness Coordinator, and Licensed Practical Nurse (LPN) confirmed

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A 155	Continued From page 3 staff failed to treat Tenant #4 with consideration and respect based on the video evidence reviewed. They confirmed some of the staff no longer worked at the Program and some of the staff were temporary agency employees. The ED stated it was not acceptable for staff to reset a pendent and leave without asking what a person needed, to walk away without observing a person take their medications or to deny a PRN medications when requested, and to transfer in manner that was not in accordance with the training provided. The ED stated she planned to start an investigation regarding Staff E and another staff for failure to provide compassionate care and failure to address Tenant #4's immediate needs.	A 155		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide adequate and appropriate services to 1 of 3 tenants reviewed (Tenant #4). Findings follow: Review of Tenant #4's file on 6-24-21 revealed diagnoses of macular degeneration, glaucoma, severe hearing loss, hypertension, arteriosclerotic heart disease of native coronary artery without angina pectoris, nonrheumatic mitral stenosis,	A 160		

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A 160	Continued From page 4	A 160		

cardiomyopathy, unspecified atrial fibrillation, congestive heart failure, polyosteoarthritis, osteoporosis, and varicose veins of lower extremities. Review of the service plan revealed she required assistance with transfers using a gait belt and assistance with medication administration.

Review of Tenant #4's Progress Notes revealed the following:
On 2-27-21 the Licensed Practical Nurse (LPN) spoke to Tenant #4's son regarding transfer techniques.
On 3-14-21 it was noted she required an increase in assistance with mobility/transfers and inability to bear weight. Tenant #4 continued to experience pain after a Fentanyl patch was prescribed for chronic pain.
On 3-29-21 the LPN noted Tenant #4 complained of pain in her shoulder, knees, and feet.
On 3-30-21 Tenant #4 suffered a skin tear on her leg after staff transferred her from the toilet to her wheelchair.

Review of video footage revealed the following:
On 12-14-2020 two staff grabbed Tenant #4's clothing and/or incontinence briefs, lifted her under her arms, and roughly transferred to her wheelchair. No gait belt was utilized.
On 12-15-2020 a physical therapist observed two staff transfer her to her wheelchair. No gait belt was utilized. The staff stated she doesn't like to use the gait belt.
On 12-27-2020 Staff E pulled under her arms and another staff pulled on her clothing and roughly transferred her to her wheelchair. No gait belt was utilized.
On 1-27-21 Tenant #4 told Staff E she needed to go to the bathroom. Staff E ignored her request

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A 160	Continued From page 5 to use the bathroom, handed her the medications, and walked away without ensuring she swallowed her medication. On 2-10-21 Staff E entered Tenant #4's apartment and failed to inform her what she was doing, handed her the medications, and walked away without ensuring she swallowed her medications. On 2-13-21 a staff failed to lock the brakes on the wheelchair, lifted Tenant #4 under her arms, and roughly transferred into the wheelchair. The tenant almost missed the seat as the wheelchair rolled back. No gait belt was utilized. On 2-26-21 Staff E pulled the clothing and/or incontinence briefs and roughly transferred Tenant #4 into the wheelchair. No gait belt was utilized. On 3-8-21 Tenant #4 asked staff to use the restroom and the staff told her to wait 10 minutes. The staff returned approximately one hour later and failed to toilet Tenant #4. On 3-21-21 Staff E ignored her request to use the bathroom and told Tenant #4, "You just went to the bathroom." On 3-23-21 the staff ignored her request to use the bathroom and told Tenant #4, "You just went to the bathroom." On 3-24-21 the staff ignored her request for Tylenol and told Tenant #4, "You have no Tylenol PRN." (Review of March Medication Administration Record revealed Tylenol was available for PRN (as needed) pain control.) On 3-25-21 Staff E reset Tenant #4's pendent, walked away, and failed to ask what she needed. On 3-25-21 Tenant #4 pushed her pendant approximately 20 minutes later. Staff E and another staff arrived and Staff E said ,"Oh be quiet" to Tenant #4. Tenant #4 stated something to Staff E and she replied "you didn't tell me." On 3-28-21 staff lifted Tenant #4 by her right	A 160		

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A 160	Continued From page 6 arm and roughly transferred her into the wheelchair and failed to use a gait belt. Review of Staff E's file on 7-6-21 revealed the following: 1. Medication Skills Checklist dated 4-15-2020 revealed she received training on medication administration that included to watch and wait for resident to swallow medications. 2. Competency Skills Checklist dated 4-15-2020 revealed she received training on one person transfers and use of gait belt. 3. On 11-11-2020 Staff E received a written warning for failure to follow medication administration procedure when she left medications unattended in a tenant's room and failed to observe her swallow the medications. 4. Staff E received additional education on proper transfers using a gait belt and resident rights during an in-service training on 12-2-2020. She received additional education on proper technique for transfers using a gait belt and other additional education specific to Tenant #4 on 2-10-2020. During an interview on 7-6-21 at 11:30 a.m. the Executive Director (ED), Wellness Coordinator, and Licensed Practical Nurse (LPN) confirmed staff failed to treat Tenant #4 with consideration and respect based on the video evidence reviewed. They confirmed some of the staff no longer worked at the Program and some of the staff were temporary agency employees. The ED stated it was not acceptable for staff to reset a pendent and leave without asking what a person needed, to walk away without observing a person take their medications, to deny a PRN medications when requested, and to transfer in manner that was not in accordance with the training provided. The Wellness Coordinator	A 160		

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A 160	Continued From page 7 confirmed she failed to review delegation training with all staff as required. The ED stated she planned to start an investigation regarding Staff E and another staff for failure to provide appropriate cares and services to Tenant #4.	A 160		
A 340	481-67.9(4)a Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program's Registered Nurse failed to document a review of competency for staff within 60 days of her employment. This pertained to 3 of 4 staff that required a competency review (Staff A, Staff B, and Staff E). Findings follow: Record review of staff files on 6-21-21 revealed the following: 1. The Registered Nurse (RN) was hired 3-17-21. 2. Staff A failed to receive a competency review within 60 days of the RN's hire date as required.	A 340		

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A 340	Continued From page 8 3. Staff B received a competency review on 6-6-21, more than 60 days after the RN's hire date. 4. Staff E failed to receive a competency review within 60 days of the RN's hire date as required. The Registered Nurse confirmed these findings on 6-22-21 at 3:23 p.m.	A 340		
A 380	481-67.9(6) Staffing 67.9(6) Dependent adult abuse training. Program 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 Program failed to provide training related to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16 to 5 of 8 staff reviewed (Staff B, Staff C, Staff E, Staff F, and Staff H). Findings follow: Record review of staff files on 6-21-21 revealed the following: 1. Staff B was hired 12-14-20. No training on dependent adult abuse could be located. 2. Staff C was hired 9-18-19. No training on dependent adult abuse could be located. 3. Staff E was hired 4-6-20. No training on dependent adult abuse could be located.	A 380		

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A 380	Continued From page 9 4. Staff F was hired 12-7-20 and completed a training on dependent adult abuse 6-10-16. No current training on dependent adult abuse could be located. 5. Staff H was hired 10-16-20. No training on dependent adult abuse could be located. The Administrator confirmed these findings on 6-22-21 at 3:23 p.m.	A 380		
A 140	481-69.22(2) Evaluation of Tenant 69.22(2) Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to evaluate tenant's functional, cognitive, and health status within 30 days of occupancy. This pertained to 2 of 3 tenants reviewed (Tenant #1 and Tenant #2). Findings follow: 1. Record review on 6-22-21 of Tenant #1's file revealed an admission date of 7-9-20. No functional, cognitive, and health evaluation completed within 30 days of occupancy could be located. 2. Record review on 6-22-21 of Tenant #2's file	A 140		

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A 140	Continued From page 10 revealed an admission date of 11-1-20. A functional and health evaluation was completed 8-6-20 but no cognitive evaluation completed within 30 days of occupancy could be located. On 7-7-21 at 11:30 a.m. the Executive Director and Wellness Coordinator confirmed these findings.	A 140		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to a cognitive evaluation when a tenant exhibited a significant change in health status for 1 of 3 tenants reviewed (Tenant #2). Findings follow: Record review on 6-22-21 of Tenant #2's file revealed a functional and health evaluation completed 3-20-21 for hospice care. A cognitive evaluation for the significant change in health status could not be located.	A 145		

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A 145	Continued From page 11 On 7-7-21 at 11:30 a.m. the Executive Director and Wellness Coordinator confirmed these findings.	A 145		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans based on the required evaluations and failed to include specified service needs for 3 of 3 current (Tenant #1, Tenant #2, and Tenant #3) and 1 of 3 former tenants (Tenant C4) reviewed. Findings follow: 1. Review on 6-22-21 of Tenant #1's file revealed an admission date of 7-9-20. No functional, cognitive, and health evaluation completed within 30 days of occupancy could be located. Review of Progress Notes dated 7-30-20 revealed Tenant #1 refused showers since admission and noted she had no intentions of showering and wanted a bath. Continued review of Progress Notes dated 8-16-20 revealed Tenant #1 continued to refuse bathing assistance from staff. No updated service plan for 8-11-20 could be located. 2. Review on 6-22-21 of Tenant #2's file revealed an admission date of 11-1-20. A functional and	A 350		

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A 350	Continued From page 12 health evaluation was completed 11-30-20 but no cognitive evaluation could be located. Further review revealed a functional and health evaluation completed 3-20-21 for hospice care. A cognitive evaluation for the significant change in health status could not be located. No updated service plan for 11-1-20 or 3-20-21 could be located. A comprehensive resident evaluation completed 6-17-21 revealed she required assistance with transfers using a gait belt, toileting, grooming, bathing, dressing, and socializing. The service plan dated 6-17-21 revealed she was independent in these areas and failed to reflect the increased service needs for assistance with her activities of daily living. 3. On 6-22-21 review of Tenant #3's Comprehensive Resident Evaluation dated 6-8-21 revealed she ate breakfast and supper in her room and required staff to set up the plate, her drinks, open any containers. It also noted an allergy to shellfish. Further review revealed she required 1-2 staff for transfers with a gait belt and required assistance to reposition in bed. She required a supportive environment from staff to speak softly and provide reassurance to manage symptoms of depression and/or verbal aggression. The service plan dated 6-8-21 failed to include Tenant #3's specified service needs. 4. Review on 6-22-21 of former Tenant C4's file revealed a functional assessment dated 10-16-20 which indicated she required assistance for transfers, toileting, grooming, and to set up clothing. The service plan dated 10-16-20 revealed she was independent in these areas and failed to reflect the increased service needs for assistance with her activities of daily living. Continued review revealed a functional assessment dated 2-7-21 indicating she required	A 350		

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A 350	Continued From page 13 assistance for transfers and required a gait belt. The service plan dated 2-7-21 revealed she required no assistance with transfers and failed to reflect her continued need for transfer assistance. On 7-7-21 at 11:30 a.m. the Executive Director and Wellness Coordinator confirmed these findings.	A 350		
A 410	481-69.26(4)d Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to include a list of person-centered planned and spontaneous activities for 2 of 3 tenants reviewed unable to plan their own activities (Tenant #1 and Tenant #2). Findings follow: 1. Review of Tenant #1's file on 6-22-21 revealed she resided in the memory care unit. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. The service plan dated 5-12-21 revealed she required assistance with socialization but failed to include a list of planned and spontaneous activities based on her interests.	A 410		

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
	S0359	A. BUILDING: _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK SENIOR LIVING	3602 NW 5TH STREET ANKENY, IA 50023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 410	Continued From page 14 2. Review of Tenant #2's file on 6-22-21 revealed she resided in the memory care unit. Tenant #2 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. The service plan dated 6-17-21 revealed she required assistance with socialization but failed to include a list of planned and spontaneous activities based on her interests. On 7-7-22 at 4:14 p.m. the Executive Director and the Wellness Coordinator confirmed these findings.	A 410		
A 465	481-69.28(5) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide training on safe food handling prior to handling food for 8 of 8 staff reviewed (Staff A, Staff B, Staff C, Staff D, Staff E, Staff F, Staff G, and Staff H). Finding follow: Record review of staff files on 6-21-21 revealed the following: 1. Staff A was hired 5-20-19. No training on safe food handling could be located.	A 465		

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
	S0359	A. BUILDING: _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK SENIOR LIVING	3602 NW 5TH STREET ANKENY, IA 50023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 465	Continued From page 15 2. Staff B was hired 12-14-20. No training on safe food handling could be located. 3. Staff C was hired 9-18-19. No training on safe food handling could be located. 4. Staff D was hired 3-17-21. No training on safe food handling could be located. 5. Staff E was hired 4-6-20. No training on safe food handling could be located. 6. Staff F was hired 12-7-20. No training on safe food handling could be located. 7. Staff G was hired 4-6-20. No training on safe food handling could be located. 8. Staff H was hired 10-16-20. No training on safe food handling could be located. The Administrator confirmed these findings on 6-22-21 at 3:23 p.m.	A 465		
A 510	481-69.28(8) Food Service 69.28(8) All perishable or potentially hazardous food shall be cooked to recommended temperatures and held at safe temperatures of 41°F (5°C) or below, or 135°F (57°C) or above. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure potentially hazardous foods were held at acceptable temperatures. This potentially affected all 13 tenants who resided in the memory care unit. Findings follow:	A 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0359	A. BUILDING: _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK SENIOR LIVING	3602 NW 5TH STREET ANKENY, IA 50023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 510	Continued From page 16 On 6-22-21 observation of the noon meal revealed at 11:46 a.m. Staff A walked to the locked door of the memory care unit, brought the cart of prepared food into the kitchen, and walked away. She gathered tenants to the dining room and served them drinks. At 12:13 p.m. Staff A removed the food containers from the cart, placed them into the food warmer, and started to plate the food. The surveyor asked Staff A if she had a food thermometer to take the food temperature. She stated the memory care kitchen did not have one and called the main kitchen. The Registered Nurse arrived with one at 12:17 p.m. and Staff A checked the temperature of the food. Although the pasta held a temperature of 163 degrees, the corn held a temperature of 134 degrees, and the french fries held a temperature of 125 degrees, the fish (a potentially hazardous food) was temped at 133 degrees. When asked the appropriate temperature food should be held at Staff A stated she did not know. When asked what temperature the food must be reheated to Staff A stated she did not know. She confirmed she failed to turn on the food warmer and stated she usually did. She stated she never took temperatures of food prior to serving. When interviewed on 6-22-21 at 12:35 p.m. Staff I stated he brought the food cart to the memory care unit by 11:30 a.m. and left it at the door. He stated he always left it at the door and assumed the memory care staff arrived timely to take the cart into the unit and place into the food warmer. He stated he failed to think about other people possibly contaminating the food when left unattended in the hallway and stated this was how it was always done.	A 510		

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	S0359	A. BUILDING: _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 510	Continued From page 17 Record review on 6-22-21 of the Food Preparation and Presentation policy revealed food temperatures were to be checked on a meal to meal basis and thermal containers were used for food transportation. When interviewed on 6-22-21 at 3:23 p.m. the Administrator confirmed these findings.	A 510		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide 8 hours of dementia training within 30 days of employment for 3 of 8 staff reviewed (Staff D, Staff F, and Staff H). Findings follow: Record review of staff files on 6-21-21 revealed the following: 3. Staff D was hired 3-17-21. The staff completed 6.75 hours of dementia training by 4-13-21. No further dementia training within 30 days of employment could be located. 4. Staff E was hired 12-7-2020. One hour of dementia training was completed on 12-26-2020. No further dementia training within 30 days of	A 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0359	A. BUILDING: _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK SENIOR LIVING	3602 NW 5TH STREET ANKENY, IA 50023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 545	Continued From page 18 employment could be located. 5. Staff H was hired 10-16-2020. No dementia training within 30 days of employment could be located. The Administrator confirmed these findings on 6-22-21 at 3:23 p.m.	A 545		
A 565	481-69.30(5) Dementia Specific Education for Personnel 69.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of tenants in the program This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide 8 hours of dementia training within 30 days of employment that included hands-on training for 3 of 8 staff reviewed (Staff D, Staff F, and Staff H). Findings follow: Record review of staff files on 6-21-21 revealed the following: 3. Staff D was hired 3-17-21. No documented hands-on training could be located. 4. Staff E was hired 12-7-2020. No documented hands-on training could be located. 5. Staff H was hired 10-16-2020. No documented hands-on training could be located.	A 565		

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
	S0359	A. BUILDING: _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK SENIOR LIVING	3602 NW 5TH STREET ANKENY, IA 50023

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 565	Continued From page 19 The Administrator confirmed these findings on 6-22-21 at 3:23 p.m.	A 565		

10/14/21

PLAN OF CORRECTION	
Provider Name:	Rock Creek Senior Living
Street Address, City, Zip:	3602 Northwest 5th Street, Ankeny, IA 50023
Date of Survey:	06/21/2021-07/08/2021
Provider number:	S0359

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency cited are correctly applied. Any changes to the community policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or	

10/8/21

	criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies.	
A 155 - 481-67.3 (1)	Tenant Rights to be treated with consideration, respect, and full recognition of personal dignity and autonomy **Correction of Insufficiency:** As a result of the internal investigation, Staff E and the other employee identified are no longer employed at this community. All other staff have been provided with re-education regarding Resident Rights, as well as interpretation guidance. **Actions to Prevent Insufficiency from Reoccurring:** Care staff participated in a skills fair led by the Director of Wellness and were also provided re-education by on-site therapy team to ensure proper transfer and gait belt training was provided. All residents now have a gait belt in their individual apartments that is available at all times. The Director of Wellness provided all appropriate staff with inservice regarding proper medication administration practices, and follow up documentation. The Director of Wellness and Executive Director will provide an inservice re-educating all staff on resident rights, honoring preferences, and Resident specific needs. **Monitoring to Ensure Ongoing Compliance:** To ensure ongoing compliance, all new employees will be inserviced as part of orientation on proper procedures by the Director of Wellness or Executive Director regarding Resident Rights, Resident Care, Safety with Transfers, and Responding to Pendant Lights. Staff will be in-serviced annually on these topics during skills validation. Director of Wellness or designee will complete 2 random select staff in either Memory Care or in Assisted Living to monitor proper transfer technique and medication administration weekly x4 weeks and monthly thereafter.	**11/30/2021**

A 160 - 481-67.3 (2)	Tenant Rights To receive care, treatment and services which are adequate and appropriate **Correction of Insufficiency:** Tenant #4 no longer resides at this community, due to a need for a higher level of care. As a result of the internal investigation, Staff E and an additional employee identified are no longer employed at this community. All other staff were provided with re-education. **Actions to Prevent Insufficiency from Recurring:** Care staff participated in a one day skills fair offered for 3 days (7/14/21-7/16/21) and were inserviced by on-site therapy team to ensure proper transfers, gait belt training, and securing assistive devices prior to transfers. Review of the importance of securing assistive devices prior to transfer was included. All residents now have a gait belt in their individual apartments that is available at all times. Staff were also inserviced on proper medication administration practices, resident rights honoring preferences and resident specific needs. New employees will be inserviced as part of orientation regarding resident rights, resident care, safety with transfers, and responding to pendant lights. Ongoing, staff will be in-serviced annually during skills validation. **Monitoring to Ensure Ongoing Compliance:** Director of Wellness or designee will do audits of transfers and medication administration weekly until 100% compliance then monthly.	**11/30/21**
A 340 - 481-67.9 (4)a	Staffing Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: the program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to	**9/30/2021**

	ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated. **Correction of Insufficiency:** Care staff who were not delegated within the first 60 days of the delegating RN's employment were identified. Direct care staff participated in a skill/delegation fair 7/14/2021-7/16/2021 to ensure compliance on all delegated skills by the Director of Wellness and assisted by other registered nurses. Direct care staff who were not able to attend the fair were delegated by the Director of Wellness on a one on one basis or in small groups. All current staff have been delegated at this time. **Actions to Prevent Insufficiency from Recurring:** New direct care staff will be delegated by RN/Director of Wellness before they are given their own assignment. Annual skills fair will be held annually during quarter 3 for review of skills and delegations. Director of Wellness or designee will be responsible for agendas and content. **Monitoring to Ensure Ongoing Compliance:** Review of delegations will be done quarterly by the DOW or designee.	
A 380 - 481-67.9(6)	Staffing Dependent adult abuse training. Program staff shall receive training relating to the identification and reporting of dependent adult abuse as required by Iowa Code section 235B.16 **Correction of Insufficiency:** An audit will be conducted by the Executive Director or Designee of all employee's training plans to identify those out of compliance. Any staff not in compliance will complete their dependent adult abuse training by November 30, 2021. **Actions to Prevent Insufficiency from Recurring:** The Executive Director will conduct a review of training plans to ensure the new hire and annual plans include	**11/30/2021**

	8 hours of dementia training for all staff who work directly or indirectly with residents . **Monitoring to Ensure Ongoing Compliance:** Monthly audits will be conducted by the Executive Director or designee until 100% compliance with training plans and required education is achieved then monthly thereafter.	
A 140 - 481-69.22(2)	Evaluation of Tenant. Evaluation within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. **Correction of Insufficiency:** Resident files were reviewed and any late assessments were reviewed and completed as of this time. Upon move in, the Director of Wellness will schedule the required 30 day and quarterly assessment in the EMR system. **Actions to Prevent Insufficiency from Recurring:** All tenants will receive an evaluation within 30 days of admission. Evaluation including functional status, cognitive status and health status as written directed by Iowa regulations. Cognitive assessments will be scored and objective tests. If residents show moderate cognitive decline on sequential tests a GDS may be used. Assessments will be completed by Wellness staff including the Director of Wellness who will complete or delegate to LPN when appropriate all assessments.Direct care staff will receive education regarding recognizing and reporting significant changes in resident conditions by 11-15-21. **Monitoring to Ensure Ongoing Compliance:** Monthly audits of new tenants will be done by the Director of Wellness or designee until 100% compliance is achieved. When significant changes	**11/15/2021**

	occur, evaluations will be done by a registered nurse at that time.	
A 145 481-69.22(3)	Evaluation of Tenant. Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. **Correction of Insufficiency:** An audit was completed by the Director of Wellness of all residents, and any outstanding assessments were completed and documented in the resident's electronic medical record by the Director of Wellness and Nurse Manager by August 31, 2021 **Actions to Prevent Insufficiency from Recurring:** All tenants will be evaluated per regulations at least annually or as significant changes occur. Significant changes will be evaluated by a Registered Nurse and care plan will be updated to reflect any changes. The Director of Wellness or designee will re-educate wellness staff and members of leadership on recognizing and reporting a significant change with any Resident's condition, Re-education will be done by 11-30-21 **Monitoring to Ensure Ongoing Compliance:** Weekly audits will be be done by the Director of Wellness or Designee until 100% compliance is achieved, then monthly audits will be completed	**11/30/21**

A 350 481-69.26 (1)	Service Plans. (1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. **Correction of Insufficiency:** Director of Wellness, Nurse Manager, and Memory Care Director conducted audits of all service plans and assessments, and all service plans and assessments were updated as needed. Any outstanding assessments were also completed, and documented within resident's electronic medical records, **Actions to Prevent Insufficiency from Recurring:** Service plans will be updated by nursing staff at each significant change. The Director of Wellness or designee will provide re-education to all nursing staff regarding service plans. Education will include ensuring service plans are resident specific, and updated when there is any significant change in resident's condition, ability, or preference. **Monitoring to Ensure Ongoing Compliance:** Monthly random audits will be conducted by the Director of Wellness or designee to ensure those tenants who have a significant change have had the proper assessments and updates to the care plan. Weekly review of alerts from Caregiver charting looking for changes in resident conditions.	**10/31/2021**
A 410 481-69.26(4)d	Service Plans. The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. **Correction of Insufficiency:**	**11/30/21**

	An audit of service plans will be completed by the Director of Wellness, Memory Care Director or designee to determine any residents who's service plans do not include person-centered activities. Service plans will be updated to reflect individualized activities. Service plans will be individualized for tenants with dementia to follow regulations. Activities will be added to service plans for all tenants with dementia for group and personal activities based on tenants abilities and interests. **Actions to Prevent Insufficiency from Recurring:** Weekly meetings will be done with Director of Wellness and Memory Care director to review any changes and and need to update personalized activities. Director of Wellness will review **Monitoring to Ensure Ongoing Compliance:** Monthly audits of 3 residents with dementia will be completed by Director of Wellness, Memory Care Director of Designee to ensure compliance with the above requirement	
A 465 481-69.28 (5)	Food Service. Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. **Correction of Insufficiency:** Staff participated in food safety and sanitation training at an all-staff meeting on 7/23/2021. An audit was conducted of staff who missed this meeting, and make-up meetings are being conducted. All staff will be inserviced by 11-30-21. The Executive Director will monitor for compliance **Actions to Prevent Insufficiency from Recurring:** The Executive Director has ensured that Food safety and sanitation has been added to the annual inservice plan, as well as new hiring training. A food handler training program will be part of new hire education and completed annually by all staff.	**11/30/2021**

	Monitoring to Ensure Ongoing Compliance: Staff training will be audited quarterly by the Executive Director or designee for compliance with state regulations.	
A 510 481-69.28 (8)	Food Service. All perishable or potentially hazardous food shall be cooked to recommended temperatures and held at safe temperatures of 41 F or below, or 135 or above. **Correction of Insufficiency:** Staff were inserviced by the Executive Director on safe food temperatures, and safe food temperatures will be posted for staff to reference. Food served in Memory Care satellite kitchens will be held at safe temperatures, and recorded at each meal. New and current staff will be required to complete a food service handler program as approved by the facility. **Actions to Prevent Insufficiency from Recurring:** Logs will be weekly and records will be maintained by the Culinary Director or designee. Log of temperatures will be kept for 6 months **Monitoring to Ensure Ongoing Compliance:** Logs will be reviewed weekly by Memory Care Director or designee. 100% compliance by 11-30-21	**11/30/2021**
A 545 481-69.30(1)	Dementia Specific Education for Personnel. All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. **Correction of Insufficiency:** An audit will be conducted of all employees to identify those out of compliance. Any staff who has not completed 8 hours of dementia specific training upon hire will be educated and participate in training **Actions to Prevent Insufficiency from Recurring:**	**11/30/2021**

	All new employees will complete 8 hours of dementia specific training within the first 30 days of employment. **Monitoring to Ensure Ongoing Compliance:** Audits of staff education will be completed monthly by Executive Director or Designee.	
A565 481-69.30(5)	Dementia specific education for personnel. Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, web-based training, and case studies of tenants in the program. **Correction of Insufficiency:** An audit of all staff will be conducted by the Executive Director or designee to identify those staff who have not met the requirements per regulations. Any staff who are out of compliance with their annual training will be provided with education, and complete training by 11-30-21. This training will include hands on training. **Actions to Prevent Insufficiency from Recurring:** Quarterly hands-on training will be offered by the Executive Director, the Director of Wellness, Memory Care Director or designee for all current staff. All employees will complete required annual training within the first 30 days of employment and annually thereafter. Review of education for new employees will be done within 35 days of hire. **Monitoring to Ensure Ongoing Compliance:** Monthly audits will be completed on current staff based on start date to ensure the minimum hour and proper educational methods are completed.	**11/30/2021**