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 03/03/2022

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. Number of tenants without cognitive disorder: 26 Number of tenants with cognitive disorder: 16 Total Population of Program at time of on-site: 42 The following regulatory insufficiencies were cited during the investigation of Complaint #99691-C, Complaint #102667-C and Incident #102390-I.	A 000	The Plan of Correction is attached.	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to follow its policy on the completion of incident reports for 1 of 9 tenants reviewed. Findings include: On 2/28/22 at 11:25 a.m. interview with the Staff F revealed on 2/09/22 at 6:10 a.m. she found Tenant #3 asleep in a chair on the main floor of the program, soaked in urine with no pants or underwear on. Tenant #3 resided on the second floor of the building. Staff F stated she did not complete an incident report. They later learned Tenant #3 was dehydrated and had a urinary tract infection. On 2/28/22 at 12:44 p.m. incident report policy review revealed an incident report form was to be completed for all accidents, injuries or incidents	A 150		

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A 150	Continued From page 1 involving residents, staff and visitors. On 2/28/22 at 12:44 p.m. the Wellness Director confirmed an incident report regarding Tenant #3 sitting unclothed on the main floor had not been completed.	A 150		
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 2 of 2 tenants reviewed during the investigation of Incident 102390-I (Tenant #1, Tenant #2). Findings include: On 1/03/22 the program self-reported Tenant #1 and Tenant #2 eloped from the facility on the afternoon of 12/30/21. According to the report Tenant #1's daughter called on 12/30/21 at 3:32 p.m. to report she had learned Tenant #1 and Tenant #2 were located walking alone in the community by a concerned citizen. The citizen was able to obtain enough information from the two tenants to enable him to contact the family of Tenant #1 and arrange to have both Tenant #1 and Tenant #2 picked up at the local police station and safely returned to the program. The tenants were not noted as missing until alerted by Tenant #1's daughter. After realizing the tenants	A 160		

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A 160	Continued From page 2	A 160		

had exited the program, all Memory Care doors were checked. The door to the Memory Care unit that entered the lounge area was found disarmed and was rearmed at that time. Tenant #1's grandson transported Tenant #1 and Tenant #2 back to the program at 3:57 p.m. Following their return, Tenant #1 reported she had fallen while outside of the building. Head to toe assessments were completed on both residents with no noted injuries present. Tenant #1 was wearing 2 short sleeved shirts, a long sleeved shirt, a denim coat, jeans, socks and shoes. Tenant #2 was wearing a long sleeve shirt, a zip up sweater, a winter coat, jeans, socks and shoes.

Interview with Staff D on 2/18/22 at 12:47 pm revealed she had punched in at 2:06 pm on 12/30/21. She recalled seeing both Tenant #1 and Tenant #2 in the Memory Care unit's hallway at the start of her shift. She stated at the beginning of her shift she was to check the west lobby door, the activity exit door, the service entrance exit door and the pass through exit doors to ensure the alarms were operating properly. Staff D confirmed she hadn't yet checked the alarms before the call from Tenant #1's daughter at 3:32 p.m. to report Tenant #1 and Tenant #2 were off of the unit.

Review of Tenant #1's file revealed a diagnosis of "other symptoms and signs involving cognitive functions and awareness." The tenant's Global Deterioration Score (GDS) of 4 indicated moderate cognitive decline. The tenant's service plan documented a need area regarding status checks. The goal revised on 6/21/21 stated due to living on the Memory Care Unit, the tenant was to have status checks approximately every hour.

Review of Tenant #2's file revealed a diagnosis of

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A 160	Continued From page 3	A 160		

Alzheimer's dementia. The tenant's GDS of 4 indicated moderate cognitive decline. The tenant's service plan documented a need area regarding status checks. The goal dated 8/13/21 stated the tenant was to have status checks approximately every hour.

Review of status checks documentation revealed staff only document one time a shift that hourly checks were completed. As a result the last time Tenants #1 and 2 were checked could not be determined.

Interview with the Memory Care Unit Director on 2/24/22 at 11:07 am revealed on the afternoon of 12/30/21 at approximately 2:00 pm Tenant #9 pushed on the door of the Memory Care Unit that entered the lounge area, activating the alarm. The Unit Director silenced the alarm with the key and redirected Tenant #9 away from the door. She believed when she silenced the alarm she accidentally disarmed the alarm and hadn't realized she had done so until after the elopement. The Unit Director confirmed she had been trained on the alarm system and was aware of how to turn the alarm off and on.

On 3/03/22 at 4:30 pm the Administrator and Wellness Director confirmed these findings.

According to program documentation Tenant #1's daughter believed the two tenants had been located near the intersection of 18th and Irvindale Drive between 2:30 p.m. and 3:00 p.m. which is approximately 1.2 miles from the program.

The possible route the tenants took was east on NW 5th and then north on NW Irvindale Drive. Both were two lane roads with sidewalks located in residential areas. According to

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A 160	Continued From page 4 wunderground.com the weather in Ankeny at approximately 3:00 pm was 28 degrees with a light wintry mix.	A 160		
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 evaluate the functional, cognitive and health status of 1 of 1 tenants reviewed with a significant change in condition (Tenant #3). Findings include: On 2/28/22 at 11:25 a.m. interview with the Staff F revealed on 2/09/22 at 6:10 a.m. she found Tenant #3 asleep sitting in a chair located on the main floor of the program, soaked in urine with no pants or underwear on. Tenant #3 resided on the second floor of the building. They later learned Tenant #3 was dehydrated and had a urinary tract infection (UTI). The staff were to push fluids. On 3/02/22 record review revealed Tenant #3's	A 145		

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A 145	Continued From page 5 physician ordered labs which indicated urine consistent for a UTI. The physician ordered Macrobid 100mg twice daily for five days. On 3/02/22 at 12:40 p.m. the Wellness Director confirmed no functional, cognitive or health status evaluation was completed regarding this change of condition.	A 145		
A 370	481-69.26(3)a Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. a. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure updated service plans were signed and dated by all parties for 1 of 1 former tenants reviewed (Tenant C-1). Findings include: On 3/02/22 record review revealed the program updated Tenant C-1's service plan on 9/7/21 to reflect a high risk of falling. The updated service plan was not signed and dated by all parties. On 3/03/22 at 2:45 p.m. the Wellness Director confirmed this finding.	A 370		

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A 635	Continued From page 6	A 635		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure the Memory Care Unit's alarm system remained operational at all times. Findings include: On 1/03/22 the program self-reported Tenant #1 and Tenant #2 eloped from the facility on the afternoon of 12/30/21. According to the report Tenant #1's daughter called on 12/30/21 at 3:32 p.m. to report she had learned Tenant #1 and Tenant #2 were located walking alone in the community by a concerned citizen. The citizen was able to obtain enough information from the two tenants to enable him to contact the family of Tenant #1 and arrange to have both Tenant #1 and Tenant #2 picked up at the local police station and safely returned to the program. The tenants were not noted as missing until alerted by Tenant #1's daughter. After realizing the tenants had exited the program, all Memory Care doors were checked. The door to the Memory Care unit that entered the lounge area was found disarmed and was rearmed at that time. Tenant #1's grandson transported Tenant #1 and Tenant #2 back to the program at 3:57 p.m. Interview with Staff D on 2/18/22 at 12:47 pm revealed she had punched in at 2:06 pm on 12/30/21. She recalled seeing both Tenant #1 and Tenant #2 in the Memory Care unit's hallway at the start of her shift. She stated at the beginning	A 635		

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A 635	Continued From page 7 of her shift she was to check the west lobby door, the activity exit door, the service entrance exit door and the pass through exit doors to ensure the alarms were operating properly. Staff D confirmed she hadn't yet checked the alarms before the call from Tenant #1's daughter at 3:32 p.m. to report Tenant #1 and Tenant #2 were off of the unit. Interview with the Memory Care Unit Director on 2/24/22 at 11:07 am revealed on the afternoon of 12/30/21 at approximately 2:00 pm Tenant #9 pushed on the door of the Memory Care Unit that entered the lounge area, activating the alarm. The Unit Director silenced the alarm with the key and redirected Tenant #9 away from the door. She believed when she silenced the alarm she accidentally disarmed the alarm and hadn't realized she had done so until after the elopement. The Unit Director confirmed she had been trained on the alarm system and was aware of how to turn the alarm off and on. On 3/03/22 at 4:30 p.m. the Administrator and Wellness Director confirmed these findings. The Wellness Director confirmed the Program did not have a policy in place regarding when direct care staff were required to check the alarms.	A 635		

PLAN OF CORRECTION

Provider/Supplier Name:	Rock Creek Senior Living
Street Address, City, Zip:	3602 NW 5th Street, Ankeny, IA 50023
Date of Survey:	03/03/2022

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
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 criminal action against the community or any employee, agent, officer, director, attorney, or shareholder of the community or affiliated companies.	
A150	**Correction of Cited Deficiency:** This was a new behavior for Tenant # 3. Behavior started on 2/9 and her daughter took resident to the doctor on 2/10. Lab reports show the resident had a UTI and was dehydrated. Resident received antibiotic therapy and is doing better. Her behavior is at her baseline.	2/13/2022
A150	**Assessment to Identify other Residents that may be affected:** Staff Education was provided to include reporting all behaviors noted to be outside of the normal behavior for that resident to the Wellness Supervisor for further evaluation. Incident reports will be created for residents exhibiting abnormal behaviors. Physicians and Families will be made aware as well.	5/10/22
A150	**Procedure to ensure on-going compliance:** The Director of Wellness or designee will monitor the 24 hour report daily for changes in resident behavior. Audit tool will be completed daily and submitted to the Executive Director on a	5/10/22

ok 5/6/22

	will be reviewed by a minimum of 3 staff members to include the Director of Wellness or designee and 2 other staff signatures.	
A370	**Procedure to ensure on-going compliance:** Staff education was provided regarding a multi-disciplinary approach to the service plan. Service Plans will be audited monthly to include type of assessment and signatures of staff, resident, and or family X 6 months.	5/10/2022
A370	**Monitoring for on-going compliance:** The Service Plan Audit tool will be reviewed monthly X 6 months during the Quality Assurance Risk Management Meeting for ongoing compliance.	5/10/22
A635	**Correction of Cited Deficiency:** Keyed door alarm will be replaced with a keypad door alarm system on all exit doors in Memory Care. Doors will be checked at shift change by the Memory Care or Wellness team and routinely by the Plant Ops Director.	5/15/22
A635	**Assessment to Identify other Residents that may be affected:** Staff inservice on ensuring the alarm system that is connected to the exit doors in the Memory Care Unit are checked at change of shift. Staff will receive additional inservicing with KeyPad door Alarm once installed.	5/15/22
A635	**Procedure to ensure on-going compliance:** Hourly checks on all residents residing in the Memory Care unit will be audited on a regular basis by the Memory Care Director or designee. Audit tool will include door checks during shift change. Audit results will be shared at Department Head Meeting Weekly.	5/15/22
A635	**Monitoring for on-going compliance:** Audit tools will be reviewed monthly X3 months at the Quality Assurance Risk Management meeting to ensure compliance with the door alarm system.	5/15/22

	weekly basis. Findings from the audit will be discussed during the weekly Department Director Meeting.	
A150	**Monitoring for on-going compliance:** Audit tools will be reviewed during the monthly Quality Assurance Risk Management meeting X 3 months for compliance.	5/10/22
A160	**Correction of Cited Deficiency:** Tenant # 1 & # 2 were placed on 15 minute checks for 30 days. The Memory Care Director was re-educated on the importance of keeping the alarms on the doors at all times. Both tenant # 1 & # 2 are currently on 1 hour checks which started on 2/1/22. No further attempts of elopement have been noted.	4/26/22
A160	**Assessment to Identify other Residents that may be affected:** All staff were inserviced on how to alarm the doors and how to reset them. Routine unit head counts will be conducted during shift change rounds. All doors will be checked during shift change to ensure alarms are on and working properly.	5/10/22
A160	**Procedure to ensure on-going compliance:** Daily audit will be completed at change of shift. Audit tool will show doors were checked and alarms were functioning properly as well as the head count of the resident at the time. Audit tools will be submitted to the Memory Care Director or Wellness Director on a daily basis. Audit tools will be reviewed weekly at the Department Director meeting.	5/10/22
A160	**Monitoring for on-going compliance:** Audit tools will be reviewed during monthly Quality Assurance Risk Management meeting X 3 months for ongoing compliance.	5/10/22
A145	**Correction of Cited Deficiency:** Resident #3 received a health evaluation related to her significant change by Dr. Questad on 2/9/22.	2/9/2022
A145	**Assessment to Identify other Residents that may be affected:** Residents who exhibit the need for a significant change assessment will be assessed by their physician, nurse practitioner or RN along with the Director of Wellness or designee.	5/1/2022
A145	**Procedure to ensure on-going compliance:** DOW will audit all significant change assessments weekly which will include who conducted the assessment as well as the functional, cognitive and health status as it relates to the significant change assessment.	5/1/2022
A145	**Monitoring for on-going compliance:** DOW will review audit tools during the monthly Quality Assurance Risk Management Meeting monthly X 3 months.	5/1/2022
A370	**Correction of Cited Deficiency:** Service Plan for Tenant C-1 was reviewed and updated on 9/7/2021.Service Plan for fall was last updated and signed off by DOW on 1/23/22. Resident passed away on 1/31/22.	1/31/22
A370	**Assessment to Identify other Residents that may be affected:** Service Plans will be updated within 30 days of move in, quarterly, and with significant change assessment. Service plan	5/10/2022