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 12/08/2022

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 population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 29 Number of tenants with cognitive impairment: 19 Total census: 48 No regulatory insufficiencies were cited during the investigation of Complaint 107618-C. The following regulatory insufficiencies were cited during the investigation of Complaints 104736-C, 104780-C, 105284-C, 107056-C and 107432-C.	A 000		
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 ensure 1 of 4 tenants reviewed received care, treatment and services which were adequate and appropriate (Tenant #1). Finding follows: Review of Tenant #1's file on 12/7/22 revealed a MercyOne Neurology encounter note for a follow-up visit regarding possible dementia with	A 160	The 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 160	Continued From page 1 Lewy bodies. According to the note the physician requested a phone call within two weeks to give him an update to see if the tenant's delusions and hallucinations had stabilized. Record review revealed no notation in the tenant's record that this follow-up call occurred. An interview on 12/6/22 at 8:54 am with a family member revealed the program nurse failed to return telephone calls to family members regarding the request of the physician. When interviewed on 12/8/22 at 4:00 p.m. the Executive Director (ED) and Director of Wellness (DOW) explained once the former program nurse left the Program they found many things had not been completed as required.	A 160		
A 220	481-69.24(1)b Involuntary Transfer from Program 69.24(1) Program initiation of transfer. If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply: b. The program shall immediately provide to the office of long-term care ombudsman, by certified mail, a copy of the notification and notify the tenant's treating physician, if any. This REQUIREMENT is not met as evidenced by:	A 220		

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A 220	Continued From page 2 Based on interview and record review the Program failed to immediately notify the office of long-term care ombudsman, by certified mail, of the intention to involuntarily transfer 1 of 3 former tenants reviewed (Tenant C1). Finding follows: Record review on 12/8/22 revealed a Progress note dated 9/6/22 indicating the Program received an encounter note from Tenant C1's physician stating she required a higher level of care. Further record review revealed a letter from the Program to Tenant C1's daughter and son dated 9/12/12 regarding transfer and discharge. When interviewed on 12/8/22 at 10:53 a.m. the Executive Director confirmed he did not send the notification to the long-term care ombudsman.	A 220		
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 ensure service plans were developed at the time of occupancy for 1 of 4 tenants reviewed (Tenant #2). Findings include: Record review on 12/7/22 revealed Tenant #2 became an occupant of the Program on 8/1/22.	A 350		

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A 350	Continued From page 3 No service plan for the tenant could be located. When interviewed at 2:30 p.m. the Director of Wellness (DOW) confirmed the Program failed to complete Tenant #2's service plan.	A 350		
A 360	481-69.26(3) 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans were updated within 30 days of occupancy for 2 of 4 tenants reviewed (Tenant #1, Tenant #2). Finding follows: Record review on 12/7/22 revealed Tenant #2 became an occupant of the Program on 8/1/22. No service plan for the tenant could be located. When interviewed at 2:30 p.m. the Director of Wellness (DOW) confirmed the Program failed to complete Tenant #2's initial service plan. As a result, an updated service plan could not be completed within 30 days of occupancy. Record review on 12/8/22 revealed Tenant #1 became an occupant of the Program on 4/15/22. The tenant's initial service plan was dated 4/15/22. The plan was not revised until 6/8/22 which was well after 30 days of occupancy.	A 360		

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A 360	Continued From page 4 When interviewed on 12/8/22 at 4:00 p.m. the Executive Director (ED) and Director of Wellness (DOW) explained once the former delegating nurse left the Program found many service plans and evaluations were out of date or had not be completed as required and they had a plan to address the concerns.	A 360		
A 525	481-69.29(3) Staffing 69.29(3) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure 4 of 4 contract/agency staff reviewed were appropriately trained to meet tenant needs (Staff E, F, G, H). Finding follows: Record review on 12/7/22 revealed no training documentation for 4 of 4 agency staff reviewed (Staff E, F, G, H). When interviewed on 12/7/22 at 4:15 p.m. the Executive Director and Memory Care Director confirmed the Program failed to ensure agency/contract staff received the required training. They confirmed the Program used agency/contract staff daily.	A 525		
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	A 545		

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A 545	Continued From page 5 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 ensure staff received eight house of dementia-specific training within 30 days of employment for 2 of 2 new staff reviewed (Staff A, Staff B). Findings include: Record review on 12/8/22 revealed the Program hired Staff A on 6/29/22 and Staff B on 6/6/22. Review of dementia-specific training documentation revealed specific classes listed but no amount of time listed for the training modules. There was no way to determine if Staff A or B had completed the required eight hours of training. When interviewed on 12/8/22 at 4:00 p.m. the Executive Director (ED) and Director of Wellness (DOW) acknowledged the hours of training could not be determined based on the documentation provided.	A 545		
A 555	481-69.30(3)a Dementia Specific Education for Personnel 69.30(3) Dementia-specific continuing education a Except as otherwise provided in this subrule, all personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of dementia-specific continuing education annually.	A 555		

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A 555	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received eight hours of dementia-specific training annually for 2 of 2 long-term staff reviewed (Staff C, Staff D). Finding follows: Record review on 12/8/22 revealed the Program hired Staff C on 5/20/19 and Staff D on 3/29/21. Review of dementia-specific training documentation revealed specific classes listed but no amount of time listed for the training modules. There was no way to determine if Staff C or D had completed the required eight hours of training. When interviewed on 12/8/22 at 4:00 p.m. the Executive Director (ED) and Director of Wellness (DOW) acknowledged the hours of training could not be determined based on the documentation provided.	A 555		

PLAN OF CORRECTION

Provider/Supplier Name:	Rock Creek Senior Living
Street Address, City, Zip:	3602 NW 5Th Street, Ankeny IA 50023
Date of Survey:	12/8/22

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.	
A160-481-67.3 (2)	**Correction of Cited Deficiency:** Director of Wellness reviewed resident chart and ensured physician communication had occurred after the initial request. This was completed on 12/08/2022.	12/08/2022
	Assessment to Identify other Residents that may be affected: Reviewed all resident charts and found no other missed follow up requests. This was completed on 12/08/2022.	12/08/2022
	Procedure to ensure on-going compliance: Training of physician follow-up will occur during the orientations of nurses. Additional training will be provided annually and as needed throughout the year by the Director of Wellness or designee after that.	Ongoing

	Monitoring for on-going compliance: Business office Director or designee to monitor for compliance with training completion. DOW will do a chart review audit monthly to ensure staff and her are timely communicating with physicians and staff	Ongoing
A220-481-69.24(1)b	**Correction of Cited Deficiency:** Resident had previously moved out of the community, therefore, no action could be taken. Inservice of Executive Director and Wellness team was completed to ensure compliance moving forward.	03/15/2023
	Assessment to Identify other Residents that may be affected: Audit of resident charts found no other missed communication.	
	Procedure to ensure on-going compliance: Executive Director or designee will draft appropriate communication to the resident, family (POA), and Ombudsman and ensure all documents are retained for the files. All documents will be sent to the appropriate parties by certified mail and tracked for receipt.	Ongoing
	Monitoring for on-going compliance: Executive Director or designee will draft appropriate communication to the resident, family (POA), and Ombudsman and ensure all documents are retained for the files. All documents will be sent to the appropriate parties by certified mail and tracked for receipt.	Ongoing
A350-481-69.26(1)	**Correction of Cited Deficiency:** All resident Individualized Service plans reviewed and updated as necessary. This was completed on 12/08/22 as evidenced by state surveyor.	12/08/2022
	Assessment to Identify other Residents that May be Affected. Review of all resident care plans and individualized service plans and updated as necessary. This was completed on 12/08/2022 as evidenced by state surveyor.	12/08/2022
	Procedure to Ensure On-Going Compliance:	Ongoing

	Care based assessment and individualized service plan will be completed at move-in, semi-annually and with any significant change. Director of Wellness or designee will do random audit of care-based assessment and individualized service plan monthly to ensure they are accurate and up to date.	
	Monitoring for On-Going Compliance: Director of wellness or designee will do scheduled audits bi-weekly for the next 60 days ensuring the care-based assessment are being completed timely, then monthly audits.	Ongoing
A360-481-69.26(3)	**Correction of Cited Deficiency:** All resident Individualized Service plans reviewed and updated as necessary. This was completed on 12/08/2022 as evidenced by state surveyor.	12/08/2022
	Assessment to Identify other Residents that may be affected: Review of all resident care plans and individualized service plans and updated as necessary. This was completed on 12/08/2022 as evidenced by state surveyor.	12/08/2022
	Procedure to ensure on-going compliance: Care based assessment and individualized service plan will be completed at move-in, semi-annually and with any significant change. Director of Wellness or designee will do random audit of care-based assessment and individualized service plan monthly to ensure they are accurate and up to date.	Ongoing
	Monitoring for on-going compliance: Director of wellness or designee will do scheduled audits bi-weekly for the next 60 days ensuring the care-based assessment are being completed timely, then monthly audits.	Ongoing
A525-481-69.29 (3)	**Correction of Cited Deficiency** Agency orientation binder was created and implemented for training of each agency vendor at time of arrival.	02/16/2023
	Assessment to Identify other Residents that may be affected: The Director of Wellness or designee will review the Agency/Vendor Orientation binder with all agency and vendor staff before the staff member works their 1st shift at the community. In addition, agency/Vendor staff and	02/16/2023

	DOW/designee will sign an acknowledgment form for the understanding of policies and procedures.	
	Procedure to ensure on-going compliance: The Director of Wellness or designee will review the Agency/Vendor Orientation binder with all agency and vendor staff before the staff member works their 1st shift at the community. In addition, agency/Vendor staff and DOW/designee will sign an acknowledgment form for the understanding of policies and procedures.	Ongoing
	Monitoring for on-going compliance: The Business Office Director or designee will house signed audit forms to ensure compliance and submit with monthly logs.	Ongoing
A545-481-69.30(1)	**Correction of Cited Deficiency:** Audit of all staff was completed and determined that staff had the training but the hours were not able to be documented.	12/08/22
	Assessment to Identify other Residents that may be affected: An audit will be conducted by the Executive Director or designee of all employees' training plans to identify those out of compliance. Any staff out of compliance will be trained and corrected. This will occur using our web-based training program with reporting function to ensure compliance.	Monthly
	Procedure to ensure on-going compliance: An audit will be conducted by the Executive Director or designee of all employees' training plans to identify those out of compliance. Any staff out of compliance will be trained and corrected. The Business Office Director or designee will ensure all staff has completed eight hours of Dementia specific training per policy within 30 days of onboarding.	Ongoing

	Monitoring for on-going compliance: Monthly audits will be conducted by the Executive Director or designee until 100% compliance with training plans and required education is achieved then quarterly thereafter.	Ongoing
A555-481-69.30 (3)	**Correction of Cited Deficiency:** Audit of all staff was completed and determined to be in compliance after the initial discovery.	12/08/2022
	Assessment to Identify other Residents that may be affected: An audit will be conducted by the Executive Director or designee of all employees' training plans to identify those out of compliance. Any staff out of compliance will be trained and corrected. The Business Office Director or designee will ensure all staff has completed 2 hours of Dementia specific training per policy by the employee's anniversary date or before, not exceeding 12 months between training.	
	Procedure to ensure on-going compliance: Quarterly training will be offered by the Executive Director or designee for all employees. All employees will complete required annual training within the first 30 days of employment and annually thereafter.	Ongoing
	Monitoring for on-going compliance: Monthly audits will be completed on current staff based on hire date to ensure the minimum hour and proper educational methods are completed.	Ongoing