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 10/02/2025

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. Tenants without cognitive impairment: 50 Tenants with cognitive impairment: 25 Total census: 75 The following regulatory insufficiencies were cited during the investigation of Incident #129931-I and Complaint #129332-C.	A 000	See attached POC 1/2/26	
A 395	481-69.26(4)a Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interviews and record review the program failed to ensure service plans were individualized and identified tenants' needs and preferences for 1 of 1 discharged tenants reviewed (Tenant C2). Finding follows: Record review from 10/01/25 to 10/02/25 of Tenant C2's file revealed the Program admitted her on 5/12/22. An Evaluation for Tenant C2, dated 3/04/25 noted a "6-month review" revealed Tenant C2 required: a. Assistance with transfer/mobility and required	A 395		

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A 395	Continued From page 1 "two-person physical transfer assistance", use of a transfer belt, and the tenant utilized a 4-wheeled walker and wheelchair. b. Assistance with bathing and required transfer assistance in and out of the shower or tub and partial bathing assistance. Bathing preferences were noted as "prefers showers." c. Assistance with dressing/undressing and required "complete dressing assistance" to dress both her upper and lower body and assist with socks and shoes. The evaluation further noted Tenant C2 required the use of thromboembolic deterrent (TED) compression products and required staff assistance in putting on the TED hose in the a.m. and removing the TED hose at bedtime. d. Assistance with continence and required "complete continence assistance" and noted the tenant used adult briefs, a grab bar or transfer aid, a raised toilet seat or riser, and a bed pan or disposable (chux) pad. e. Assistance with escorting and required "physical escorting throughout community such as propelling a wheelchair." f. Assistance with evacuation and required "more than minimal assistance to locate and access an exit or area of refuge." Tenant C2's service plan dated 3/23/25 noted the above activities of daily living categories, required assistance, but failed to list her preferences, interventions, or provide individualized instructions on how to care for the tenant. The plan instead reflected blank areas under the interventions column which would describe these	A 395		

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A 395	Continued From page 2 needs. When interviewed on 10/02/25 at 12:35 p.m., the Executive Director explained the service plan goal section noted Tenant C2's required assistance from staff, but was unsure why the interventions column of the service plan was not complete, as the evaluation should have pulled the information on the tenant's needs directly to the service plan. During an interview on 10/2/25 the Executive Director confirmed the above findings.	A 395		
A 637	481-69.32(4)a Life Safety - Emergency Policies / Structure 69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have: a. Written procedures regarding alarm systems, if an alarm system is in place. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the program failed to develop written procedures regarding alarm systems, with the potential to affect 25 of 75 tenants with cognitive impairment residing at the program. Finding follows: A tour of the memory care unit on 10/02/25 revealed the program had alarms on doors as required. Record review on 10/01/25 revealed the Program's "Elopement Policy" which addressed appropriate staff response when a tenant's service plan indicated a risk of elopement or when a tenant exhibited wandering behavior as	A 637		

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A 637	Continued From page 3 well as appropriate staff response if a tenant went missing. The policy failed to address alarm systems. The Program failed to have a separate written policy or procedures for alarm systems. When interviewed on 10/02/25 at 1:05 p.m., the Executive Director believed the Elopement policy addressed alarm systems and read the following from the Elopement policy under the section "Elopement Response": Specific protocol will differ from community to community, depending on security features and resident behaviors. She further explained the Program was accredited through the Joint Commission and the policy had been reviewed and accepted at the time of the commission's onsite accreditation visit. No reference regarding alarm systems was noted in the policy. During a follow-up interview on 10/02/25 at 1:25 p.m., the Executive Director indicated the management company agreed to create and implement a written policy regarding alarm systems. Program management was in process of writing such a policy. During the exit meeting on 10/02/25 the Executive Director confirmed the above findings.	A 637		

PLAN OF CORRECTION

Provider/Supplier Name:	Rock Creek Senior Living
Street Address, City, Zip:	3602 NW 5th Street Ankeny, IA 50323
Date of Survey:	10/2/2025

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.	
A395	**Correction of Cited Deficiency:** Tenant C2 no longer resides in the community.	10/2/2025
	Assessment to Identify other Residents that may be affected: The Wellness Director or designee will conduct audits of service plans following each significant change in condition or annual assessment to ensure timely and accurate updates. Wellness staff have received in-service training emphasizing that service plans must be updated at least annually and after any significant change in condition, including return from hospitalizations or short-term rehabilitation stays.	10/10/2025
	Procedure to ensure on-going compliance: The Wellness Director or designee will conduct audits of service plans following each significant change in condition or annual assessment to ensure timely and accurate updates. Audits will be conducted over a three-month period to ensure compliance.	1/10/2026
	Monitoring for on-going compliance: The Wellness Director will present audit findings during weekly	1/10/2026

	Department Head Meetings for three consecutive months to confirm adherence to service plan requirements.	

PLAN OF CORRECTION

Provider/Supplier Name:	Rock Creek Senior Living
Street Address, City, Zip:	3602 NW 5th Street Ankeny, IA 50323
Date of Survey:	10/2/2025

PROVID/ER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

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A637	**Correction of Cited Deficiency:** The Elopement Policy has been revised and re-distributed to all staff, emphasizing immediate response to any door alarm notifications.	12/10/25
	Assessment to Identify other Residents that may be affected: All residents with exit-seeking behaviors, cognitive impairment, or high elopement risk were reviewed to ensure their service plans accurately reflect their needs and interventions.	10/10/25
	Procedure to ensure on-going compliance: All staff will receive retraining on elopement protocols and procedures to include recognizing door alarms with required response. New hires will receive this training during orientation and must demonstrate competency before independent assignment.	12/10/25
	Monitoring for on-going compliance: The Director of Wellness or designee will conduct random audit checks of door alarm function and staff responsiveness 3 times per week for 4 weeks, then weekly for 2 months, and monthly	

	thereafter. Results will be submitted to the weekly department head meeting for review, tracking, and further action as needed. Any staff found not responding timely to alarms will receive immediate corrective coaching and re-training.	