Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation

Date: September 10, 2021
Program Name: Rock Creek Senior Living
Address: 3602 NW St. Ankeny, IA 50023
Type of Action: 96989-C
Date(s) of Action: 6/21/21 – 7/8/21

State Rule #	State Rule	Amount of Civil Penalty
67.3(1)	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. 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 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.	**$3000.00**

	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 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.	
67.3(2)	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. 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, 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 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 3-24-21 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 3-28-21 staff lifted Tenant #4 by her right 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 provide adequate and appropriate services to Tenant #4 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 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.	