IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: 33193-C

April 15, 2011

Ms. Nicole Ellermeier, Administrator
Whispering Creek Assisted Living
2607 Nicklaus Blvd.
Sioux City, IA 51106

RE: Final Complaint Investigation Report, Whispering Creek Assisted Living, Sioux City, Iowa

Dear Ms. Ellermeier:

Enclosed is the **Final Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies, DIA accepts the POC. The Request for Reconsideration has been denied in reference to Staffing. The program didn't follow their own policies and procedures and subsequently tenant's needs were not met.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

LUCAS STATE OFFICE BUILDING, 321 EAST 12TH STREET, DES MOINES, IOWA 50319-0083

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FAX: (515) 242-6863

ADMINISTRATIVE HEARINGS
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Iowa Department of Inspections and Appeals
Assisted Living Program
Final Complaint Investigation Report

Assisted Living Program: **Complaint Intake #: 33193-C**

Nicole Ellermeier, Administrator
Whispering Creek Assisted Living
2607 Nicklaus Blvd.
Sioux City, IA 51106

Date of Investigation:

March 23, 2011

Monitor(s):

Hal L. Chase, RN BSN MPH

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to, and approved by, the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations. IAC r. 481-67.10(5). The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 481 IAC chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Whispering Creek Assisted Living on March 23, 2011. In preparing this report, the following information was considered:

Current Program Census

General Population Program (GPP)* – A program that does is not include a Dementia Specific unit, but may include have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	21
Current number of tenants with cognitive disorder:	4
Total Population of GPP:	25

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	9
Total Census of ALP:	34

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Program History – There were no Regulatory Insufficiencies found during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Service Plan

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Four tenant files were reviewed. Tenant #1, an 84 year old, was admitted on 4-28-10 and had a diagnosis of Dementia. The tenant was staged at six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. The tenant resided in the dementia unit. A service plan of 11-5-10 revealed interventions were added related to the tenant's disrobing in public and when the tenant paced. The service plan was updated on 1-5-11 and revealed an intervention was added related to the tenant's resistance to dressing and changing his/her undergarments. The service plan of 11-5-10 and 1-5-11 were not supported by functional, cognitive and health evaluations with a change in status.

  Tenant #2, an 86 year old, was admitted on 12-12-10 and had diagnoses of: Dementia, Hypertension (HTN), Hypothyroidism and Chronic Constipation. A cognitive evaluation was completed on 1-11-11 and staged the tenant at six on the GDS, which indicated severe cognitive decline. The service plan of 1-11-11 revealed the tenant resided in the general population but came to the dementia unit daily from 10:00 a.m. until 3:00 p.m. The program nurse stated the tenant wandered throughout the dementia unit and would stand by the exit door to the dementia unit but didn't push on the door. Staff #1, #2 and #3 reported the tenant wandered throughout the program. The service plan did not establish interventions related to wandering.

  Tenant #4, a 92 year old, was admitted on 12-3-10 and had diagnoses of: Dementia, Depression, History of Congestive Heart Failure, Arthritis, Acute Delirium, Peripheral Vascular Disease, Hyperlipidemia, Benign Prostatic Hypertrophy, HTN, History of Cervical Spinal Fracture, Syncopal Episodes, Degenerative Joint Disease (DJD) and Arthritis. The tenant was staged at five on the GDS, which indicated moderate severe cognitive decline. The tenant resided in the dementia unit. A service plan of 2-22-11 revealed an intervention was needed for toileting, but the intervention was incomplete, as it did not identify the intervention needed.

  The program nurse stated the tenant had a history of wandering and had left the dementia unit unaccompanied by staff the afternoon of 3-18-11. Staff had found the tenant in the hallway outside the dementia unit and returned the tenant to the dementia unit. Staff #1 stated the tenant had a history of wandering. Staff #2 stated the tenant left the program on 3-18-11 sometime after lunch. She stated she was transferring a tenant from a wheelchair to the toilet. She heard the door alarm go off and called staff from the general population for assistance but staff were on the second floor of the general population. The tenant was found outside the program nurse's office. The service plan did not establish interventions related to the tenant's wandering and exit seeking.

- Regulatory Insufficiency: 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. (IAC r. 481-69.26(1))

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum the tenant's identified needs and preferences for assistance. (IAC r. 481-69.26(4)(a))

B. Staffing

Complaint Allegation #33193-C: It was alleged a tenant left the dementia unit. No alarms sounded when the tenant left. The tenant was brought back to the dementia unit by staff. The tenant never left the program.

- Monitoring Observation: Tenant #1's service plan of 1-5-11, indicated the tenant paced throughout the perimeter of the program and staff were to assist the tenant when this behavior occurred. Staff schedule for 2-24-11, revealed one staff person was assigned to the dementia unit. An incident report of 2-24-11 revealed the tenant was at the front desk of the program, outside the dementia unit. Staff working in the dementia unit reported she was assisting another tenant with shaving and didn't hear the door alarm.

  Maintenance work log reports revealed monthly sound checks on door alarms in the dementia unit were completed on 10-6-10, 11-22-10, 12-10-10, 1-21-11, 2-10-11 and 3-15-11. Program schedule for 2-24-11 revealed Staff #1 worked on the day shift in the dementia unit. Staff #1 stated the day the tenant left the dementia unit the tenant had been up for most of the night and had been sitting in the living room. The program nurse stated there were tenants who wandered in the dementia unit. Tenants have pushed on the front door-exit seeking. She stated Tenant #1 and Tenant #2 had left the dementia unit, but both had been found by staff and were returned to the dementia unit. She stated there were enough staff to care for tenants in the dementia unit and staff could call other staff for assistance in the general population if needed.

  Staff #1 stated she assisted another tenant in their apartment. Approximately 7:20 a.m. the front desk receptionist had escorted the tenant back to the dementia unit, as the tenant had come to the front desk of the assisted living program. Staff #1 stated the front desk was adjacent to exit doors which lead to the outside. Staff #1 stated she didn't hear the alarm go off or the door didn't alarm. She stated there were other tenants in the dementia unit who wander throughout the program and who exit seek. She stated there was not enough staff to care for tenants in the dementia unit. If staff were assisting a tenant with cares staff weren't able to keep an eye on the other tenants.

  Staff #2 stated she knew about the tenant leaving the program, but didn't have any first- hand knowledge of the incident. She stated there was not enough staff to meet the needs of tenants. Tenants "escape when helping others." There were other tenants who wander throughout the program and try and push the exit doors until the alarm went off. Staff #3 stated Tenant #1 and other tenants wandered and attempted to exit seek.

During the course of the investigation, the following information was obtained:

Monitoring Observation: The program nurse stated Tenant #4 had a history of wandering and had left the dementia unit unaccompanied by staff the afternoon of 3-18-11. Staff had found the tenant in the hallway and returned the tenant to the dementia unit. Staff #1 stated the tenant had a history of wandering. Staff #2 stated the tenant left the program on 3-18-11 sometime after lunch. She stated she was transferring a tenant from a wheelchair to the toilet. She heard the door alarm go off and called staff from the general population for assistance but staff were on the second floor of the general population. The tenant was found outside the program RN's office. Staff #1 stated the tenant wandered throughout the program. Staff #2 stated the tenant left the program on 3-18-11 sometime after lunch. She stated she was transferring a tenant from a wheelchair to the toilet. She heard the door alarm go off and called staff from the general population for assistance but staff were on the second floor of the general population. The tenant was found outside the program RN's office. Staff #3 stated Tenant #4 left the dementia unit on 3-18-11 around 3:00 p.m.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

C. Other

Complaint Allegation #33193-C: It was alleged phone numbers to the Department of Inspections and Appeals (DIA), the long term care Ombudsman were not posted so individuals knew who to call.

- Monitoring Observation: A review of the program's occupancy agreement revealed the Department of Inspections and Appeals and the long term Ombudsman's phone numbers are listed. The Administrator stated the employee handbooks also included similar information. Assisted living regulations do not require the posting of the department's or long term care ombudsman phone numbers

- Regulatory Insufficiency: None noted.

Dated this 15th day of April, 2011.