IOWA DEPARTMENT OF
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Complaint/Incident Intake #:
45459-C

December 6, 2013

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

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

Dear Ms. Ellermeier:

Enclosed is the **Final Complaint/Incident 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/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiency, DIA accepts the POC.

The Request for Reconsideration has been denied related to Tenant Rights. The Program failed to uphold the rights of Tenant #1 and #2 who had an ongoing known relationship while in the general population of the Program. When the tenants were transferred to the memory care unit, the Program did not uphold the tenants' rights to continue their established relationship.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Nicole Ellermeier, Executive Director
Whispering Creek Assisted Living
2607 Nicklaus Blvd.
Sioux City, Iowa 51106

Complaint/Incident Intake #:

45459-C

Date of Complaint/Incident Investigation:

October 1 and 2, 2013

Monitor(s):

Maribeth Freland RN

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	24
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	25
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	15
Total Population of Program at time of on-site	15
TOTAL census of Assisted Living Program	40

Program History – There were regulatory insufficiencies found in the areas of Nurse Review, Evaluations and Medications during this certification period.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Tenant Rights

Complaint/Incident Allegation: It was alleged two unrelated cognitively impaired tenants residing at the program participated in an intimate relationship. One of the tenants began groping the other in the common areas of the program without the first tenants consent.

- Monitoring Observation: The program identified two tenants, Tenants #1 and #2, who were unrelated and had participated in an intimate relationship.

  Tenant #1, an 83 year old, was admitted initially to the general population area of the program on 4-2-12, was later admitted to the program's secured dementia unit on 6-17-13 and continued to reside in the secured dementia unit at the time of the on-site visit. Tenant #1 had diagnoses of Hypertension, Alzheimer's type dementia and Depression. Tenant #1 scored a 4 on the Global Deterioration Scale (GDS), completed on 3-13-13, indicating moderate cognitive decline. Tenant #1's physician enacted his/her Durable Power of Attorney to make health care decisions for Tenant #1 on 4-25-12.

  According to Tenant #1's evaluation of health and functional status, dated 3-13-13, Tenant #1 experienced an upper respiratory infection and a urinary tract infection for which he/she was treated with antibiotics. Tenant #1 experienced lethargy and malaise during the illness.

Tenant #1 required minimal stand by assistance while showering, was independent with grooming but at times was unkempt, required staff member assistance with one to two clothing items that needed secured using eye and hooks or buttons and toileted, ambulated and ate independently.

According to Tenant #1's nurse review, dated 5-20-13, Tenant #1 was evaluated to ensure he/she was having an appropriate consensual intimate relationship with Tenant #2. Both tenants were spending the nights in each other's apartments, attended all meals and activities together and walked throughout the program holding hands. Tenant #1 was "bubbly and giggled" when around Tenant #2. At times, Tenant #1 and Tenant #2 were seen having intimate contact in public areas but, when brought to their attention, both were easily redirected into one of the apartments without incident. Tenant #1's Durable Power of Attorney for Health Care Decisions (DPOA) was contacted. The DPOA had no concerns with Tenant #1 and Tenant #2 participating in an intimate relationship. The program determined the relationship to be consensual and appropriate.

According to Tenant #1's nurse review, dated 6-17-13, Tenant #1 began layering clothes and wearing odd combinations of clothes. Tenant #1 experienced a choking episode at a meal in the general population dining area. The program contacted Tenant #1's DPOA and the decision was made to move Tenant #1 to the secured dementia unit as the added dressing needs changed Tenant #1 to a GDS of 5, indicating moderately severe cognitive decline and the secured dementia unit dining room area was more heavily supervised during tenant meals.

Tenant #2, a 91 year old, was admitted initially to the general population area on 12-12-10, was later admitted to the program's secured dementia unit on 6-25-13 and no longer resided at the program at the time of the on-site visit. Tenant #2 had diagnoses of Hypertension, Memory Loss, Chronic Stage III Kidney Disease, and Atrial Fibrillation. Tenant #2 scored a 5 on the GDS, completed on 6-25-13, indicating moderately severe cognitive decline. Tenant #2's physician enacted his/her DPOA to make health care decisions for Tenant #2 on 11-12-11 to 4-25-12.

According to Tenant #2's evaluation of health and functional status, dated 6-25-13, Tenant #2 required minimal stand by assistance while showering, was independent with grooming and was well groomed, required staff member assistance with one to two clothing items that needed secured using eye and hooks or buttons, required set up with meals and toileted and ambulated independently.

According to a nurse review, dated 6-12-13, the nurse noted Tenant #2 enjoyed sitting outside at the front of the building with Tenant #1. Tenant #2 had never walked beyond the benches where he/she sat and never went on walks outside without staff member assistance.

During interview, the Executive Director reported she was told Tenant #2 should not be allowed to sit outside in an unsecured area due to his/her cognitive status. Tenant #2's DPOA was contacted and the decision was made to have Tenant #2 move to the program's secured memory care unit which allowed Tenant #2 to go outside into a secured outside courtyard.

During interview, Staff #1, #2 and #3, all direct care workers who worked both in the general population area and in the secured dementia unit, reported Tenant #1 and Tenant #2 shared an intimate relationship while residing in the general population area of the program. All three staff members reported Tenant #1 and Tenant #2 spent times together during the day holding hands and kissing, spent the night in each other's apartments and at times were observed showering together in the mornings.

When Tenant #1 and Tenant #2 moved to the program's secured dementia unit, the service plans for both indicated each would try to go to the other's apartments but staff members were not to allow this to occur. Direction was given to staff members to attempt redirection when observing either walking in the direction of the other's apartment. Staff members were directed to encourage the two tenants to gather in a common area of the dementia unit so staff members could observe the contact between the two.

Tenant #2 attempted to go to Tenant #1's apartment on multiple occasions while in the dementia unit. Tenant #2 and Tenant #1 attempted to shower together on at least one occasion. Staff members intervened, preventing Tenant #2 from entering Tenant #1's apartment or by removing Tenant #2 from the apartment when found visiting Tenant #1. Tenant #1 and Tenant #2 often sat in the common area of the dementia unit when wanting to be together. Tenant #2 was seen on multiple occasions touching Tenant #1 in a sexual manner while seated in the common areas of the unit, at times when Tenant #1 had fallen asleep sitting on the couch. Tenant #2 began exhibiting anger and aggression toward staff members after being kept from entering Tenant #1's apartment or when being separated from intimate contact with Tenant #1.

On 8-22-13, Tenant #2 pushed a staff member when he/she was stopped from going outside and became verbally aggressive with staff members when kept from going into Tenant #1's apartment. The program obtained a physician's order to begin administering Ativan (an anti-anxiety medication) twice daily and to utilize Haldol (an anti-psychotic medication) as needed for emotional and physical outbursts and aggression.

On 9-4-13, the program sent Tenant #2 for a psychiatric evaluation and Tenant #2 returned to the program with new orders for Aricept (a medication given to cognitively impaired individuals for memory improvement) and Paxil (an antidepressant). Tenant #2 continued to escalate in aggression when being kept from Tenant #1. The program gave Tenant #2's DPOA notice of a 30 day involuntary discharge due to Tenant #2's behaviors on 9-5-13. The program required Tenant #2's DPOA to hire a one on one caregiver to sit with him/her from 7:00 a.m. to 9:00 p.m. until Tenant #2 was moved from the program. The one on one caregiver was to stay with Tenant #2 at all times to keep him/her from having contact with Tenant #1. Tenant #2 began exhibiting even more aggression, pushing and hitting staff members and the one on one caregiver. Tenant #2 was court-ordered to be hospitalized on 9-6-13. Tenant #2 did not exhibit any sexual aggression or sexual inappropriateness while hospitalized. Tenant #2 was returned to the program. Tenant #2 began attempting to go into Tenant #1's apartment after his/her return to the program. On 9-13-13 the program added bells to Tenant #1 and Tenant #2's apartment doors to help staff members identify potential entry into either apartment. On 9-18-13, Tenant #2 moved from the program to a nursing home in a nearby town.

During interview, Tenant #1, who continued to reside at the program at the time of the on-site visit, visited with the monitor. Conversation was appropriate in context and flow. Tenant #1 was able to identify family pictures located in his/her apartment. Tenant #1 asked the monitor if Tenant #2 had moved or had Tenant #2 died. Tenant #1 reported he/she really missed Tenant #2. Tenant #1 told the monitor he/she had an intimate relationship "that was headed somewhere" before Tenant #2 left the program. Tenant #1 indicated he/she enjoyed spending time with Tenant #2, reported he/she did have an intimate relationship with Tenant #2 and had never felt forced to participate intimately in a relationship with Tenant #2. Tenant #1 denied feeling afraid or being hurt by Tenant #2.

During interview, Tenant #1's DPOA reported full knowledge of Tenant #1 and Tenant #2's intimate relationship. The DPOA reported visiting often and seeing a healthy, happy relationship. Tenant #1 "was always skipping around with a smile" after beginning a relationship with Tenant #2. The DPOA felt the relationship to be consensual on Tenant #1's part.

During interview, the Executive Director reported she was told by a consultant that tenants residing in the dementia unit could not be intimate. While Tenant #1 and Tenant #2 lived in the general population area, both were allowed to sleep in each other's apartments and have an intimate relationship. After moving into the dementia unit, both Tenant #1 and Tenant #2 were not allowed to interact intimately and were kept from entering each other's apartments as the Executive Director believed this to be what was required.

Tenant #1 and Tenant #2's autonomy was not allowed after moving into the program's secured dementia unit. Tenant #1 and Tenant #2 had a consensual intimate relationship prior to moving to the unit. After moving to the dementia unit, both were kept from entering each other's apartments, kept from showering, required to be together only in common areas, resulting in episodes of intimate contact in the common areas. Tenant #2 was medicated with anti-anxiety and anti-psychotic medications after becoming aggressive when not allowed to spend time with Tenant #1 in his/her apartment or to continue an intimate relationship with Tenant #1. Tenant #1 indicated his/her relationship with Tenant #2 to be consensual and indicated he/she missed Tenant #2 following Tenant #2's involuntary discharge.

- Regulatory Insufficiency: All tenants have the right to be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481-67.3(1))

B. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged a tenant residing at the program expressed suicidal ideations. It was alleged a tenant routinely refused personal care assistance, resulting in sores.

- Monitoring Observation: The program identified one tenant, Tenant #3, who had expressed suicidal ideations in the previous six month period.

Tenant #3, an 80 year old, was admitted to the program on 12-3-10 and resided in the general population area of the program. Tenant #3 had diagnoses of Lung Cancer with Metastasis to the Prostate and Bone, History of Pulmonary Embolism and History of Pneumonia. Tenant #3 scored a 1 on the GDS completed on 9-8-13, indicating no cognitive decline. Tenant #3 was admitted to hospice services on 6-10-13. Tenant #3 made the decision to have only comfort care on 8-7-13. On 8-29-13 Tenant #3 expressed suicidal ideation to his/her hospice nurse. Immediate action was taken by the program to initiate 15 minute safety checks for 12 hours and hourly safety checks for an additional 10 days. The hospice social worker initiated a No Harm Agreement with Tenant #3. Tenant #3 expressed no further talk of suicide, did not express any plan to harm him/herself and did not harm him/herself after the initial ideations.

During interview, Tenant #3 reported he/she went through a period of depression and anger related to the terminal diagnosis of cancer. Tenant #3 reported he/she made a comment about harming him/herself but never intended to do so. Tenant #3 reported coming to more of an acceptance of the terminal illness and no longer felt angry and depressed over the situation. Tenant #3 denied ever trying to harm him/herself, no longer felt like he/she wanted to end things and reported no plan to attempt suicide.

The program appropriately following up after Tenant #3 expressed suicidal ideations. Tenant #3 had expressed no further suicidal ideations and had not actually attempted to harm him/herself.

The monitor interviewed Staff #1, #2 and #3, all direct care workers. Staff #1, #2 and #3 reported Tenant #4 required two to three person assistance with transfers and had recently become bedbound, Tenant #5 routinely refused personal care assistance, resulting in sores on the buttocks and legs and Tenants #6 and #7 had been urinating and/or defecating in common areas of the program or in the closet rather than the bathroom.

Tenant #4, a 100 year old, was admitted to the program on 6-23-10, resided in the program's secured dementia unit and was admitted to hospice on 9-27-13. According to the 9-25-13 nurse review, Tenant #4 began refusing all cares and began requiring the assistance of two to three persons to transfer on 9-15-13. Tenant #4 had not been getting out of bed for three to four days. The monitor observed Tenant #4 lying in bed during the two day on-site visit. Tenant #4 slept most of the time but easily awakened and responded to the monitor with answers to questions that were appropriate in context. Tenant #4's skin was very pale, without mottling and very cool to touch. Tenant #4 had not been requiring 2-3 persons for transfer and had not been bed bound for greater than 21 days; therefore, could not yet be considered to exceed assisted living level of care.

Tenant #5, a 91 year old, was admitted to the program on 2-25-10 and resided in the general population area of the program. Tenant #5 had diagnoses of Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease and Anxiety. Tenant #5 scored a 3 on the GDS completed on 7-30-13, indicating mild cognitive decline. According to Tenant #5's clinical record, the program had initiated Managed Risk Statements with Tenant #5 multiple times since Tenant #5's admission to the program with the most recent being initiated on 7-30-13.

The Managed Risk Statement, dated 7-30-13, identified Tenant #5's refusal of care and toileting assistance as a concern, resulting in skin breakdown and foul odor. The program and Tenant #5 agreed to allow staff members to toilet ever two hours during the day and twice during the night to prevent sitting in soiled briefs and clothing for a long period of time. Tenant #5 agreed to go to the bathroom with staff members only if he/she was soiled at the two hour checks.

According to nurse notes, dated 8-9-13, Tenant #5 had two open areas on his/her coccyx. Tenant #5 had been refusing to toilet, sitting in soiled briefs. The nurse notified Tenant #5's physician about the wounds, assessed and measured the wounds and kept in contact with the physician about the treatment and healing of the wounds. The Managed Risk Agreement was reviewed with Tenant #5. The program attempted to get Tenant #5 to comply with the Managed Risk Agreement for one week. On 8-19-13, staff members identified open wounds on Tenant #5's feet and ankle areas. The physician was notified of the cellulitis and treatment orders were obtained. The program stayed in contact with the physician about the treatment and healing of the cellulitis. The program worked with Tenant #5 on compliance issues with toileting and personal care assistance for one month. The wounds had not healed and new shin ulcers were identified. Tenant #5 was transferred to the hospital for treatment of the wounds due to his/her refusal to comply with treatment orders and toileting at the program on 9-13-13. Tenant #5 went to a local nursing home on 9-19-13 and had not returned to the program.

Tenant #6, an 85 year old, was admitted to the program on 4-12-11, was admitted to hospice on 7-19-13 and currently resided in the secured dementia unit. Tenant #6 had diagnoses of Alzheimer's type Dementia, Anxiety, Weight Loss and History of Falls. Tenant #6 scored a 6 on the GDS assessments completed on 7-19-13 and 9-27-13, indicating severe cognitive decline.

According to the Nurse Notes, dated 9-27-13, Tenant #6 began urinating in his/her closet. Tenant #6's closet door and bathroom door looked exactly the same and were located along the same wall. Tenant #6's service plan indicated signs were posted on the closet door directing Tenant #6 to the toilet by stating "BATHROOM ----->".

Tenant #6 had not been exhibiting unmanageable bladder incontinence for greater than 21 days; therefore, Tenant #6 did not yet exceed the assisted living level of care.

Tenant #7, a 70 year old, was admitted to the program on 9-20-13 and currently resided in the secured dementia unit. Tenant #7 had diagnoses of Dementia, Diabetes and Depression. Tenant #7 scored a 6 on the GDS assessments completed on 9-27-13, indicating severe cognitive decline. Tenant #7 was unable to verbalize any longer and could understand only one word commands.

According to the Nurse Review, dated 9-27-13, Tenant #7 began urinating in the common areas of the dementia unit. Staff members took Tenant #7 to the toilet every two hours but he/she often did not understand to urinate then would later urinate in the common areas. Tenant #7 had not been exhibiting unmanageable bladder incontinence for greater than 21 days; therefore, Tenant #7 did not yet exceed the assisted living level of care.

- Regulatory Insufficiency: None noted.

C. Service Plans

Complaint/Incident Allegation: It was alleged 15 minute checks service planned for a tenant who expressed suicidal ideations were not completed as service planned.

- Monitoring Observation: The monitor reviewed the clinical records of eight tenants, Tenants #1, #2, #3, #4, #5, #6, #7 and #8. All eight tenants' service plans reflected individualized interventions to adequately meet the needs of each tenant.

  Tenant #3's service plan indicated Tenant #3 was admitted to hospice services on 6-10-13. Tenant #3 made the decision to have only comfort care on 8-7-13. On 8-29-13 Tenant #3 expressed suicidal ideation to his/her hospice nurse. Immediate action was taken by the program to initiate 15 minute safety checks for 12 hours and hourly safety checks for an additional 10 days.

  The forms used to document the safety checks included spaces every 15 minutes from 10:00 p.m. on 8-29-13 to 2:00 p.m. on 8-30-13 and spaces every hour from 3:00 p.m. on 8-30-13 to 2:00 p.m. on 9-10-13. All spaces were initialed by staff members as completed as scheduled in each slot with the exception of when Tenant #3 was out of the facility.

- Regulatory Insufficiency: None noted.