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February 20, 2014

Complaint/Incident Intake: 46424-I

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

RE: Final Recertification Monitoring Evaluation & Incident Investigation Report – Whispering Creek Assisted Living, Sioux City, IA

Dear Ms. Ellermeier:

Enclosed is the **Final Recertification Monitoring Evaluation & 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, following a survey by DIA on **January 23, 27, 28 and 29, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Tenant Documents, Evaluations, Criteria for Admission and Retention, Service Plan and Record Checks..

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted to DIA within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Also enclosed you will find the Assisted Living Program Certificate **S0307** with effective dates of **January 4, 2014** through **January 3, 2016.**

If you have any questions in regard to this 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 Recertification Monitoring Evaluation and Incident Investigation Report

Assisted Living Program:

Complaint/Incident #: 46424-I

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

Date of Monitoring Visit:

January 23, 27, 28, and 29, 2014

Monitor(s):

Lori Miner, RN BSN

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 were provided by the Program at the time of the on-site.

General Population Program	
Number of tenants without cognitive disorder:	29
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	30
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	12
Total Population of Program at time of on-site	12
TOTAL census of Assisted Living Program	42

Tenant/Family Satisfaction Results – A meeting was held with 21 tenants. The best thing about the program was "everything," the clean building, the friendly people, the prepared food, and the provided entertainment. Housekeeping was completed to the tenants' satisfaction in apartments and common areas. Sidewalks and parking lots were kept clear in the winter. Tenants used a call button to request assistance. Staff were reported to respond in less than five minutes on the first floor, and less than 10 minutes on the second floor. Staff members were described as excellent and always pleasant. Staff members were reported to treat the tenants "wonderfully" and like family. Staff members were described as kind and respectful. The food was excellent but sometimes there was too much. Choices were available. A variety of meats, and fresh fruits and vegetables were available. Hot foods were served hot. Activities were plentiful, but the weekends were described as "dull." The tenants reported feeling safe at the program. Tenants were generally satisfied and would recommend the program to others.

Program History – During the course of the Recertification visit conducted on January 23, 27, 28, and 29, 2014 the program received regulatory insufficiencies in the areas of: Tenant Rights, Tenant Documents, Evaluation, Criteria for Admission and retention of tenants, Service Plans and Record Checks,

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

A. Tenant Documents

Monitoring Observation: Clinical records were reviewed for the following tenants who currently resided at the program: Tenant #1 had a 90-day nurse review and service plan update completed 11-25-13. Tenant #2 had a 90-day nurse review completed on 1-20-14 and a service plan update on 1-21-14. Tenant #4 had a 90-day nurse review and service plan update completed11-27-13.

Tenant #5 had a 90-day nurse review completed 12-6-13. Tenant #6 12-26-13 Tenant #7 had a 30-day evaluation with service plan update completed 1-16-14.

According to the Registered Nurse, the program utilized a computerized charting system. A functional assessment was included as part of the 90-day nurse review and 30-day evaluations. The computer system would not allow completion of the evaluations of health and cognition without the completion of a functional evaluation. The program was unable to provide documentation of any functional assessment for the tenants and dates listed above.

According to the Executive Director, it was determined there had been a glitch in the computer system, and the functional assessments had not been saved and were not able to be retrieved.

Regulatory Insufficiency: The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant. (IAC r. 481-69.25(2))

B. Evaluation of Tenant

Monitoring Observation: Tenant #1, an 84 year-old, was admitted on 9-24-11 and had diagnoses of: Coronary Artery Disease, Diverticulitis, Gastroesophageal Reflux Disease, Osteoarthritis, Osteoporosis, and Dementia. Tenant #1 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. Tenant #1 resided in the dementia unit.

On 10-7-13 the clinical notes documented Tenant #1 grabbed another tenant by the wrists after Tenant #1 thought he/she was being followed by the other tenant. On 10-14-13, Tenant #1 slapped another tenant. There was no documentation any tenant was injured. Evaluations of function, cognition, and health were not completed with a change of condition, behaviors that affected other tenants.

The clinical notes documented the administration of Ativan for agitation between 10-1-13 and 11-15-13. There was no documentation of the Ativan until 12-3-13. On 12-15-13, the family was notified Tenant #1 was showing increased agitation. Tenant #1 was also incontinent of urine. It was noted Tenant #1 had a history of urinary retention.

On 12-16-13 Tenant #1 was found in another tenant's apartment yelling at the other tenant. On 12-21-13 Tenant again was found in another tenant's apartment hitting the other tenant. Tenant #1 was transported to the hospital for evaluation. Tenant #1 returned with an antibiotic for urinary infection and retention. Evaluations of function, cognition, and health were not completed following continued behaviors and treatment for urinary infection and retention.

Tenant #7, an 85 year-old, was admitted to the program on 12-17-13 and had diagnoses of: Esophageal Reflux, Hypertension, Osteoporosis, Dementia, and History of Breast Cancer. Tenant #7 was staged at six on the GDS which indicated severe cognitive decline. Tenant #7 resided in the dementia unit.

The clinical notes dated 1-7-14 documented a nurse review was completed on 12-30-13 and "due to a computer malfunction" the review was not saved. The documentation revealed the review was completed because Tenant #7 needed two staff to assist with transfers. The LPN implemented a transfer study to determine the assistance needed for transfers. The transfer study was to be in effect from 12-30-13 to 1-13-14. The review concluded by stating this was not a change of function.

The assessment of the ability to transfer safely was left to the unlicensed staff by the use of a transfer study. A nursing assessment was not completed to assess Tenant #7's ability to assist with a transfer. Evaluations were not completed related to Tenant #7's upper body strength, ability to bear weight, and cognitive ability to participate safely during transfer. Evaluations were not completed with a change of condition.

During the onsite visit, the monitor observed Tenant #7 to routinely require the use of two persons for transfer. The monitor also observed Tenant #7 did not assist with eating, dressing, grooming, or ambulation. Clinical notes of 1-27-14 documented Tenant #7 had difficulty eating. Notes of 1-28-14 documented the physician was contacted in regards to crushing medications. The notes also documented the family requested medications be discontinued and a referral to hospice. Evaluations were not completed with a change of condition.

Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

C. Criteria for Admission and Retention

Monitoring Observation: Tenant #7, an 85 year-old, was admitted to the program on 12-17-13 and had diagnoses of: Esophageal Reflux, Hypertension, Osteoporosis, Dementia, and History of Breast Cancer. Tenant #7 was staged at six on the GDS which indicated severe cognitive decline. Tenant #7 resided in the dementia unit.

Prior to admission to this assisted living program, Tenant #7 resided at another assisted living program (ALP). The clinical record at this program contained documentation from the ALP. On 11-4-13 the ALP staged Tenant #7 at six on the GDS which indicated severe cognitive decline. The ALP notes dated 11-12-13 revealed Tenant #7 had been given a 30-day notice of discharge from the ALP related to exceeding level of care with behaviors and being maximal assist with cares. The notes indicated Tenant #7's physician had ordered Risperdal twice a day for the behaviors. The notes indicated the actual 30-day discharge letter was sent on 11-15-13.

In an interview with the RN, she stated she had been to the ALP twice to assess Tenant #7. She stated on the second visit, Tenant #7 had shown improvement because of the medication.

The clinical record for this assisted living program contained evaluations dated 12-3-13. The RN believed this was the second visit, and stated the first visit was not documented. The RN stated the ALP did not have a dementia unit and this assisted living program did.

Evaluations completed by the RN on 12-3-13, prior to admission, documented a failed cognitive scoring tool, form "functional assessment" which indicated Tenant #7 required "total assistance" with hygiene, and "substantial assistance." The functional assessment form was a scored tool. Tenant #7 rated "completely dependent." The health and functional assessment form dated 12-3-13 documented Tenant #7 was independent with eating, but was slow to eat, required minimal assistance with grooming, extensive assist with bathing, personal hygiene and dressing, required one person assistance to ambulate with a front-wheeled walker and to transfer. Tenant #7 exhibited bladder incontinence. In addition, the service plan of the same date indicated staff administered medications, Tenant #7 walked short distances and used a wheelchair for mobility; Tenant #7 was on a two-hour toileting schedule. The service plan also indicated Tenant #7 required food to be cut up before eating.

Clinical notes dated 12-17-13 indicated Tenant #7 was admitted to the program. Notes of 12-18-13 documented by the LPN revealed Tenant #7 was an assist of two with transfers and needed assistance of one for eating. Notes of 12-24-13 also documented by the LPN indicated Tenant #7 exhibited bladder incontinence and required the use of incontinence briefs at all times. Staff was to assist with changing the brief, and Tenant #7 was on a two-hour toileting schedule. The documentation indicated the service plan was updated.

The clinical notes dated 1-7-14 documented a nurse review was completed on 12-30-13 and "due to a computer malfunction" the review was not saved. The documentation revealed the review was completed because Tenant #7 needed two staff to assist with transfers. The LPN implemented a transfer study to determine the assistance needed for transfers. The transfer study was to be in effect from 12-30-13 to 1-13-14. The review concluded by stating this was not a change of function.

The assessment of the ability to transfer safely was left to the unlicensed staff by the use of a transfer study. A nursing assessment was not completed to assess Tenant #7's ability to assist with a transfer. Evaluations were not completed related to Tenant #7's upper body strength, ability to bear weight, and cognitive ability to participate safely during transfer.

The transfer study sheets revealed the following:

Date	**Number of two or three person transfers**		**Date**	**Number of two or three person transfers**
12-30-13	15		1-6-14	3 with no documentation until 8:50 pm
12-31-13	4 with no documentation between 7:15 am and 5:30 pm, and none after 5:40 pm		1-7 through 1-9-14	No documentation
1-1-14	12		1-10-14	2 with no documentation before 6 pm or after 6:15 pm
1-2-14	8 with no documentation between 8am and4 pm		1-11-44	11 with no documentation after

				2:10 pm
1-3-14	3 with no documentation until 1 pm		1-12-14	7
1-4-14	8		1-13-14	5 with no documentation after 2:10 pm
1-5-14	6 with no documentation from evening shift		1-14-14	3 with no documentation until 6 pm

The clinical notes dated 1-13-14 were documented by the Divisional RN. The Divisional RN noted the transfer study had been in place for two weeks. The Divisional RN documented she observed Tenant #7 and participated in transfers. Tenant #7 was a one person assist with a gait belt. The Divisional RN documented Tenant #7 was a one person assist with a second person on standby to and from the toilet. It was documented a second person occasionally should be on standby as Tenant #7 buckled legs when tired. The Divisional RN documented the need for two persons to be available for toileting, even if the second person did not directly provide hands on assistance. Evaluations were not documented as completed related to Tenant #7's upper body strength, ability to bear weight, and cognitive ability to participate safely during transfer.

On 1-16-14, the LPN completed the 30-day evaluations. Tenant #7 was staged at six on the GDS which indicated severe cognitive decline. The health assessment under "gait" indicated Tenant #7 used a wheelchair. The functional evaluation was not available because of a computer glitch at the program. The service plan of 1-16-14 should have been based on the functional evaluation. The service plan indicated the following: One person assist with bathing, hygiene, grooming, dressing, toileting, and set-up assistance with eating. Tenant #7 was a one person assist and occasionally a second person was needed for standby assist for ambulation and transfers. A gait belt was to be used. Tenant #7 used a wheelchair when out of the room.

The transfer study sheets revealed the following:

Date	**Number of two or three person transfers**		**Date**	**Number of two or three person transfers**
1-16-14	6 with documentation from 10:30 am to 1:30 pm		1-22-14	5 with no documentation after 1 pm
1-17-14	16		1-23-14	2 with no documentation after 1:30 pm
1-18-14	10 with no documentation after 2:30		1-24-14	8
1-19-14	5 with no documentation before 12:50 pm		1-25-14	10
1-20-14	No documentation		1-26-14	8 with no documentation after 5:30 pm
1-21-14	7		1-27-14	6

There were two occasions where the assist of one person was documented: 1-15-14 at approximately 10:00 a.m. from bed to wheelchair, wheelchair to toilet and toilet to wheelchair; and 1-27-14 at approximately 3:45 p.m. from bed to wheelchair, wheelchair to toilet and toilet to wheelchair.

The clinical notes documented on 1-22-14 documented by the LPN revealed Tenant #7 was at times unable to swallow medications and the physician was contacted to request an order to crush medication. Notes of 1-27-14 documented Tenant #7 was having difficulty swallowing food, was refusing to open mouth to eat or drink, would not chew or swallow food. Tenant #7 was reported to start coughing when being assisted to drink during mealtime.

Notes of 1-27-14 documented by the LPN revealed Tenant #7 was sitting at the table with eyes closed. Tenant #7 did not open eyes when told lunch was on the table. Eventually Tenant #7 opened eyes and indicated hunger. The LPN cut up the food and put food on the fork. Tenant #7 dropped the fork. Using hand-over-hand the LPN put the fork to Tenant #7's mouth. Tenant #7 did not open the mouth or did not open enough to allow food to be placed in the mouth. Tenant #7 was unable to bring a glass to the mouth to drink. Tenant #7 held food in the mouth and would not swallow.

Notes of 1-28-14 indicated the family requested medications be discontinued and referral to hospice be made.

Tenant #7 was given a 30-day notice of discharge from an ALP for exceeding criteria related to behaviors and requiring maximal assistance with activities of daily living. This assisted living program inappropriately admitted Tenant #7 and continues to retain Tenant #7 who exceeds criteria for retention in an assisted living program.

Staff #2 was interviewed and stated Tenant #7 required two persons for safe transfer. Tenant #7 would wipe the face if handed a washcloth, but did not assist with eating, dressing or grooming. Tenant #7 used a wheelchair to get from one place to another.

Staff #4 was interviewed and stated Tenant #7 exceeded level of care and routinely required two persons for assistance with transfers. Staff #4 also reported Tenant #7 assisted minimally with cares. Upon questioning, Staff #4 reported Tenant #7 did not assist with dressing and was unable to ambulate.

Staff #5 was interviewed and stated Tenant #7 exceeded level of care and routinely required two persons for assistance with transfers.

Staff #8 stated Tenant #7 had been a routine two-person transfer since admission. Tenant #7 does not feed self, does not assist with dressing or grooming. Tenant #7 can only walk a few steps and the legs buckle. Tenant #7 is pushed in a wheelchair to get from one place to another.

Staff #6 was interviewed and stated Tenant #7 required assistance of one and standby assistance of another "just in case" for transfers and ambulation. Staff #6 reported Tenant #7 barely assisted with bathing, did not groom self, did not dress self but after much cueing would put arms in sleeves of garments. Eating assistance for Tenant #7 required staff to assist Tenant #7's hand with the food to Tenant #7's mouth. Tenant #7 used incontinence briefs and did not verbalize urination had taken place. Tenant #7 did not assist with perineal care after toileting.

On 1-28-14 at approximately 11:28 a.m., Staff #5 and #7 were observed getting Tenant #7 out of bed. Tenant #7 was lying in bed making unintelligible sounds. Tenant #7 was cued several times to swing legs over the edge of the bed. Tenant #7 did not respond to the cues. Staff #5 assisted Tenant #7 to a seated position on the edge of the bed. The gait belt was applied. The walker was placed in front of Tenant #7 after shoes were applied. The gait belt was used to lift Tenant #7 off the bed. Staff #5, #7, and the walker were assisting Tenant #7 to take steps. Staff #5 reported not feeling safe as Tenant #7 "is not doing well walking." Tenant #7 had a shuffling gait and was hunched over. Tenant #7 was placed in a wheelchair. Tenant #7 was wheeled into the bathroom. Staff assisted Tenant #7 to lean forward and grab the grab bar next to the toilet. Staff #5 and #7 assisted Tenant #7 to stand, because Tenant #7 could not raise self from the wheelchair. Once standing, the two staff members assisted Tenant #7 to turn, and remove the incontinence brief. Tenant #7 began to sit and Staff #5 and #7 assisted Tenant #7 to the sit on the toilet. Tenant #7 did not sit squarely on the toilet. Tenant #7 was repeatedly asked to turn to sit correctly on the toilet. Tenant #7 did not respond. Staff #5 and #7 assisted Tenant #7 to a standing position to reposition on the toilet. Tenant #7 again began to sit, so Tenant #7 again was not square on the toilet. Tenant #7 began to lean forward on the toilet and Staff #5 expressed concern, that Tenant #7 would fall off the toilet. Staff #5 provided support so that Tenant #7 would not fall off the toilet. Staff #7 asked Tenant #7 to lift the foot for the application of socks. The shoes had been removed for dressing. Tenant #7 did not raise the feet despite repeated requests to do so.

Staff #5 stated Tenant #7 had been like this for about two and a half weeks.

Staff #7 applied the gait belt to lift Tenant #7 from the toilet so that Staff #5 could do perineal care. Tenant #7 did not bear weight. A third person was requested for transfer to the wheelchair once perineal care was completed. Staff #2 arrived to position the wheelchair once Staff #5 and #7 had brought Tenant #7 to a standing position. Tenant #7 did not assist with dressing or undressing.

Tenant #7 was given a washcloth and did wash eyes. Tenant #7 was handed a toothbrush and a hair comb. Tenant #7 did not assist in grooming.

Tenant #7 was given a glass of water. Staff #7 had to raise the glass to Tenant #7's lips. Tenant #7 opened the mouth and took a drink but coughed for several minutes afterwards.

Tenant #7 was observed to require the assistance of two persons and a gait belt for transfer. Tenant #7 had difficulty bearing weight or maintaining an upright posture. Tenant #7 did not exhibit strength enough to secure self to the grab bar with the use of the hands so that Tenant #7 could pull their self to a standing position, or maintain a standing position so that staff could provide perineal care.

Tenant #7 was wheeled into the dining room. Staff #2 put a spoon in Tenant #7's hand and lifted the hand to Tenant #7's mouth. Tenant #7 said "no," and the spoon was removed. A sandwich which had been cut was placed in front of Tenant #7. Tenant #7 did nothing. Staff #2 cued Tenant #7 and demonstrated how to hold the sandwich to eat. Tenant #7 did nothing. Staff #7 put a glass of water in Tenant #7's hand. Tenant #7 was unable to hold the glass. Staff #7 was using a fork to feed the sandwich to Tenant #7 who was taking a bite of food.

On 1-28-14 at approximately 4:00 p.m. Staff #2 and #5 were observed transferring Tenant #7 from the recliner to the wheelchair. Staff #2 and #5 applied the gait belt to Tenant #7. Both staff members transferred Tenant #7 to the wheelchair. Tenant #7 was leaning and not standing upright during the process of transfer. Both staff #2 and #5 stated they thought Tenant #7 would drop to the floor if they were not supporting Tenant #7. Once in the wheelchair, Tenant #7 did not raise the feet to be placed on the foot rest.

Staff #2 and #5 took Tenant #7 to the bathroom. Both staff members raised Tenant #7 to a standing position after placing Tenant #7's hands on the grab bar. Tenant #7 was unable to stand independently even with the use of the grab bar. After toileting was completed, Staff #2 and #5 lifted Tenant #7 to a standing position. A staff member provided perineal care. Tenant #7 kept trying to sit during the completion of perineal care. Staff #2 and #5 transferred Tenant #7 to the wheelchair and Tenant #7 was transported to the common area.

On 1-28-14 at approximately 5:10 p.m., Staff #2 was observed at the dining room table with Tenant #7. Tenant #7 had an onion ring in the hand and was not observed to feed self. Staff #2 stated Tenant #7 needed to be fed.

On 1-29-14 at approximately 10:00 a.m. Staff #5 and #7 entered Tenant #7's apartment to get Tenant #7 up to the bathroom. Staff #5 commented there was no bed pad for the ease of turning, as Tenant #7 was lying on the side facing the wall. When asked if ready to get up, Tenant #7 replied "yes" but did not move. Staff #8 entered. Staff #5 and #8 positioned Tenant #7 in a seated position on the side of the bed. Both staff provided support. Tenant #7 starts to fall over if staff members let go. Staff #5 and #8 retrieved the walker to have Tenant #7 attempt to stand. Tenant #7's hands were placed on the walker. Tenant #7 was brought to an upright position, but continued to lean forward. Staff #5 stated Tenant #7 was unable to stand, and Tenant #7 was seated back down on the bed. Staff #5 and #7 used a two-person transfer to get Tenant #7 from the bed to the wheelchair. Staff members were cueing Tenant #7 but Tenant #7 did not respond to the cues.

Tenant #7 was transferred from the wheelchair to the toilet and the toilet to the wheelchair with the assistance of two persons. Perineal care was completed by Staff #7 while Staff #5 held Tenant #7 in an upright position with the gait belt. Tenant #7 kept trying to sit down. Tenant #7 did not assist with dressing, or brushing of the teeth or hair.

On 1-29-14 at approximately 11:37 a.m., Tenant #7 was seated in the wheelchair in the dining room. Tenant #7 was served a sandwich and fruit. Staff #7 cued Tenant #7 on how to eat the sandwich with no success. Staff #7 fed the fruit cup to Tenant #7. At 1:15 p.m., Staff #8 was interviewed and stated she had to feed Tenant #7 lunch, because Tenant #7 did not feed herself even with cueing.

A review of the transfer sheets, staff interviews, and observations revealed Tenant #7 was routinely required two staff members to transfer safely. Tenant #7 did not assist with eating, dressing, grooming, transfer, and required the use of a wheelchair after more than a few steps.

The tenant exceeds the criteria for retention in an assisting living environment. The program was aware at admission 12-17-13 of the tenant's exceeding level of care for maximal assistance with activities of daily living and did not take action to initiate discharge after repeated transfers routinely taking two persons and continued maximal assistance with activities of daily living.

Regulatory Insufficiency: A program shall not knowingly admit or retain a tenant who: (b) Requires routine, two-person assistance with standing, transfer or evacuation; or (i) Requires maximal assistance with activities of daily living. (IAC r. 481-69.23(1)(b,i))

D. Service Plan

Monitoring Observation: According to the review of the clinical record it was determined that Tenant #1 had five instances of aggressive behaviors involving other tenants. The service plan dated 11-26-13 identified interventions for exit-seeking, but did not identify interventions for the aggressive behavior. The service plan was not updated after Tenant #1 continued to display aggression into December 2013. The service plan did not meet the identified needs of Tenant #1.

Tenant #3, a 75 year-old, was admitted on 4-12-11 and had diagnoses of: Depression, Hypertension, and History of Suicidal Ideations. Tenant #3 was staged at six on the GDS which indicated severe cognitive decline. Tenant #3 resided in the dementia unit. Tenant #3 was admitted to hospice on 7-29-13 for Alzheimer's Disease.

The clinical notes for Tenant #3 indicated on 10-22-13 Tenant #3 went to sit down and missed the chair, falling to the floor. On 11-15-13, Tenant #3 was observed to have a bruise on the left upper arm from shoulder to elbow. The notes documented Tenant #3 had an unsteady gait and frequently walked into a wall or door jamb. The functional evaluation of 11-16-13 indicated Tenant #3 was unsteady and would at times walk into walls or door jambs but identified Tenant #3 as independent with mobility.

Clinical notes of 12-3-13 documented staff heard a loud noise and found Tenant #3 attempting to get up from the floor. Tenant #3 was observed to have abrasions on the body. On 12-16-13 Tenant #3 was found lying on the floor with no injuries noted. On 12-23-13 staff heard a loud noise and found Tenant #3 lying on the floor. Staff reported it sounded like Tenant #3 hit the head. Skin tears were seen on the elbow. Tenant #3 was sent to the hospital for evaluation.

Comments on the hospice Physician's Plan of Care dated 11-3-13 indicated Tenant #3 ambulated slowly and had a staggering gait. Occupational Therapy (OT) had also been providing services. The hospice care report dated 12-11-13 documented Tenant #3 had a slow, unsteady gait and hospice documented safety concerns with decline. Hospice documented Tenant #3 was ambulatory with an assist of one person. The hospice care report dated 1-10-14 continued to document an unsteady gait and that Tenant #3 remained a fall risk.

Tenant #3's service plan dated 9-27-13 and included an update dated11-15-13. Neither the service plan nor the updated service plan contained the signature of the tenant or legal representative. OT was not identified on the service plan as a service provider.

The service plan did not indicate Tenant #3 required assistance with ambulation after an unsteady gait was identified, after hospice identified the need for assistance with ambulation and after falls with injury. The service plan indicated footwear was to be worn but did not identify any other interventions for falls.

Tenant #3 had dementia and resided in the dementia unit. The service plan did not identify activities, planned or spontaneous, based on Tenant #3's abilities and interests.

Tenant #4's service plan did not identify a nursing home preference.

Tenant #5, an 86 year-old, was admitted on 9-9-11 and had diagnoses of: Dementia, Depression, Arthritis of the Knees, and Chronic Kidney Disease. Tenant #5 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #5 resided in the dementia unit.

The clinical notes dated 1-22-14 documented Tenant #5 had increasing incontinence of bowel and bladder and required a two-hour toileting schedule during the day. The service plan dated 10-23-13 did not indicate the two-hour toileting plan. The service plan did not meet the identified needs of Tenant #5

Tenant #6, an 87 year-old, was admitted on 7-23-10 and had diagnoses of: Hypothyroidism, Dementia, Osteoporosis, and Hypertension. Tenant #6 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #6 resided in the dementia unit. A nurse review dated 10-10-13 indicated Tenant #6 had three falls in the 30 days prior. The falls resulted in Tenant #6 having a fractured clavicle and fractured nose. Tenant #6 had begun treatment for a urinary infection on 10-8-13.

Clinical notes dated 1-13-14 documented on 1-10-14 Tenant #6 was found on the floor and was bleeding from the mouth, had an abrasion to the upper lip, and bruise to the chin. On 1-16-13 documented Tenant #6 was found on the floor. Knees were abraded and the little finger on the right hand was cut, bruised and bleeding. Tenant #6 was sent to the hospital for evaluation. Tenant #6 returned with a diagnosis of a urinary infection and a fracture of the distal phalanx of the finger.

Discharge instructions included wound care to the broken finger. The service plan did not identify Tenant #6 had a wound that required care.

A review of the service plan dated 12-26-13 documented Tenant #6 ambulated independently, and staff was to ensure Tenant #6 had shoes on and did not ambulate in stocking or bare feet. There were no other interventions added related to falls following the falls of January 2014 which resulted in facial injuries and a broken finger. The service plan did not meet the identified needs of a tenant with a history of falls with injury.

During the onsite visit, the monitor observed Tenant #7 on three occasions and observed Tenant #7 routinely required the assistance of two persons for transfers, and Tenant #7 did not assist with eating, dressing, grooming, or ambulation. The service plan was last updated on 1-16-14 and did not meet the identified needs of Tenant #7.

Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: (a) The tenant's identified needs and preferences for assistance; (c) The service provider(s), if other than the program, including but not limited to providers of hospice care, home health care, occupational therapy, and physical therapy; (d) For tenants who are unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests; and (e) Preferences, if any, of the tenant or the tenant's legal representative for nursing facility care, if the need for nursing facility care presents itself during the assisted living program occupancy. (IAC r. 481-69.26(4)(a, c, d, e)

E. Tenant Rights

Incident Allegation: The program reported to the department a staff member had been verbally and possibly physically inappropriate with tenants in the dementia unit.

Monitoring Observation: On 11-22-13 staff members reported to the Executive Director and the Registered Nurse (RN) they were concerned the way another staff member was treating the tenants, specifically those with dementia. The staff described accounts of witnessed verbal and physical interactions between the staff Tenants #1, #2, #3, #4, #5, and #6. The program immediately suspended the pending an investigation. The Executive Director and the RN reported they were not aware of any inappropriate actions of any staff member until it was brought to their attention on 11-22-13. The program notified the Department and the staff member was terminated at the completion of the internal investigation.

Clinical records were reviewed for Tenants #1, #2, #3, #4, #5, and #6. There was no documentation of physical injury in the clinical records related to any encounter with a staff member. The RN indicated there was no physical harm observed.

The onsite visit resulted in further investigation by the Department.

The program responded to reports of verbal and physical interactions between a staff member and tenants with dementia in a timely manner.

Regulatory Insufficiency: None noted

F. Record Checks

Monitoring Observation: Background checks were reviewed for six employees. Staff #4, Certified Nursing Assistant, was hired in May 2013. A review of the time card for Staff #4 revealed Staff #4 worked hours on 5-20, 5-21, 5-22, 5-23, and 5-24-13. According to the time card, Staff #4 worked 5:45 a.m. to 2:15 p.m. on 5-24-13. According to the Executive Director Staff #4 was involved in staff training on 5-20 through 5-23-13. A background check of child abuse, dependent adult abuse, and criminal history was completed on 5-24-13 at 3:35 p.m. The background check showed no history of abuse and no criminal history.

Staff #4 had paid time prior to the completion of background checks.

Regulatory Insufficiency: Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. (IAC r. 481-67.19(3))