✓ 2/9/18

FORM APPROVED

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
	S0284	A. BUILDING: _____ B. WING _____	C 02/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING WILLOW ASSISTED LIVING	601 DAWN AVENUE FREDERICKSBURG, IA 50630

(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. General Population Number of tenants without cognitive disorder: 9 Number of tenants with cognitive disorder: 4 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 8 Total census of Assisted Living Program for People with Dementia: 21 The following regulatory insufficiency was cited during the investigation of Complaint #73710-C.	A 000		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) 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 included identified needs for 1 of 1 tenants reviewed (Tenant #1). Findings include:	A 089	A089 Whispering Willow does identify tenant needs. 1. Whispering Willow Nurse will develop the ISP and management will review the ISP to ensure individual needs will be addressed. 2. Management to review all ISPs and talk with staff on cares provided to make sure they are all addressed. 3. Management will review all ISPs. 4. Whispering Willow will ensure regulatory insufficiency corrected by 02/16/18.	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

DD 3/1/18

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A 089	Continued From page 2 the tenant was found on his/her back in the kitchen area of the apartment on 1-27-18. The tenant's service plan did not indicate he/she was at risk for falls or include interventions to prevent falls. 2. Following the fall on 11-27-17, Tenant #1's physician ordered physical and occupational therapy for gait, balance and fall risk on 11-28-17. A Physical and Occupational Therapy Discharge Summary document located in the file indicated Tenant #1 had previously received services from 7-5-17 to 8-9-17. The service plan did not include therapy services for Tenant #1 either time therapy was ordered. 3. A fax to Tenant #1's physician dated 12-27-17 documented the tenant continued to speak frequently regarding visual hallucinations, refused cares at times, displayed inappropriate toileting behavior and made sexual comments to staff. The service plan did not include the tenant's hallucinations, refusal of cares, inappropriate toileting behaviors or sexual comments. 4. According to a fax to Tenant #1's physician dated 12-14-17, the tenant had developed a superficial open area on left ischial tuberosity. A request for Barrier Cream of choice to red or open skin was requested to be used as needed. The physician approved the request. The service plan did not indicate any skin issues or need for treatment.	A 089		

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A 089	Continued From page 3 5. When interviewed on 2-7-18 at 2:10 p.m. the Nurse Manager acknowledged the service plan did not reflect Tenant #1's identified needs.	A 089		