10/5/18

PRINTED: 08/22/2018
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 08/07/2018

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: 3 Memory Care Unit Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 9 TOTAL Census of Assisted Living Program for People with Dementia: 22 The following regulatory insufficiencies were cited during the investigaiton of Complaint #76620 as well as the recertification visit conducted to determine compliance with certification rules for a Dementia Specific Assisted Living Program.	A 000		
A 013	481-67.3(2) Tenant Rights 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. This REQUIREMENT is not met as evidenced by:	A 013	A 013 #1 Whispering Willow does ensure all tenants have the rights to receive care, treatment and services which are adequate and appropriate. 1. All Staff was reeducated on proper procedure for glove use and medication administration. 2. Nurse Manager and Management held an in-service on 08/28/18 to go over proper procedure for glove use and medication administration. 3. Nurse manager will randomly watch medication administration procedure and keep a record. 4. Facility corrected regulatory insufficiency on 08/28/18.	

DD 10/5/18

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A 013	Continued From page 1 Based on interview and record review the Program failed to provide care, treatment and services that were adequate and appropriate for 4 of 4 current (Tenants #1, #5, #10 and #11) and one former tenant (Tenant #2) reviewed who resided in the dementia unit. Findings follow: 1. Observation on 7-30-18 at revealed Staff G administer medications to two tenants including Tenant #11. Staff G used hand sanitizer, donned gloves, then touched the medication drawer with a gloved hand. Staff G crushed medications for Tenant #11 using a medication crusher. Staff G then touched contaminated surfaces including the medication room door, refrigerator and storage room door. Staff G mixed the crushed medications in applesauce and spoon fed the medications to Tenant #11 seated at the dining room table for lunch. Staff G removed gloves, obtained Tenant #11's eye drops and Chapstick and donned new gloves. Staff G attempted to administer Tenant #11's eye drops in a tall back dining room chair with other tenants seated at the table. Tenant #11 refused the eye drop in one eye and it not appear Tenant #11's head was tilted back to administer the drops properly. 2. Record review revealed a Medication/Treatment Error Report dated 3-15-18 indicating Staff G crushed up medications for Tenant #10, put them in applesauce and handed the cup to Tenant #10. As staff served other tenants, Tenant #10 gave the cup to Tenant #5 at the same table. Tenant #5 consumed 3/4 of Tenant #10's medications mixed with applesauce. The report indicated there needed to be more assistance in the dementia unit during medication and meal times.	A 013	A 013 #2 1. All staff was reeducated on proper procedure of medication administration. 2. Nurse Manager and Management held an In-service on 08/28/18 to go over the proper procedure for medication administration. A time management study was completed and staff was educated on time management due to study showing a lot of wasted time by staff. 3. Nurse manager will randomly watch medication administration procedure and keep a record. 4. Facility corrected the regulatory insufficiency on 08/28/18.	

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A 013	Continued From page 2 When interviewed on 8-1-18 at 12:27 p.m. the Nurse confirmed Tenant #5 consumed much of Tenant 10's medications in error. 3. Observation on 7-30-18 at approximately 12:00 p.m. revealed Staff B and Staff G assisted Tenant #1 to the dining room table. Tenant #1 appeared to have been incontinent. Following lunch, the chair where the tenant had sat appeared to be soiled. Staff did not assist Tenant #1 with toileting cares prior to the meal despite being incontinent. When interviewed on 7-30-18 at 2:45 p.m. Staff G confirmed Tenant #1 had been incontinent when they assisted him to the lunch table that day. When interviewed on 8-7-18 at 11:01 a.m. the Nurse indicated the expectation would be a tenant who was incontinent would be attended to before being seated for a meal. 4. Observation on 7-30-18 at approximately 11:15 a.m. revealed an exhaust fan in an unoccupied apartment in the dementia unit that did not function. When interviewed on 7-30-18 at 2:45 p.m. Staff G revealed two exhaust fans did not work in the dementia unit, including in the apartment previously occupied by Tenant #2. The fans "whistled." The exhaust fan in Tenant #2's previously occupied apartment had not worked for months. When interviewed on 7-24-18 at 1:43 p.m. Staff C revealed the exhaust fan in Tenant #2's apartment overheated and did not remove odors.	A 013	A 013 #3 1. Staff C & G were given a verbal warning. Staff C & G were given education on proper procedure. 2. Nurse Manager and Management held an in-service on 08/28/18 to go over proper procedure on incontinence care. All staff read and signed the policy and procedure on incontinence. 3. Nurse Manager will perform quarterly evaluations on staff members on incontinence care. 4. Facility corrected the regulatory insufficiency on 08/28/18. A 013 #4 1. Management has placed a clipboard in each staff office to write items that need fixed on. This document will have the date noticed need fixed along with the date it was fixed. 2. If the item is on the clipboard more than 3 days, staff to let owners know of the issue needing fixed. 3. Owners will check clipboard on a weekly basis. 4. Facility corrected the regulatory insufficiency on 08/28/18.	

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A 013	Continued From page 3 There had been an attempt to repair it. When interviewed on 7-30-18 at 1:35 p.m. Staff F revealed the exhaust fan in the currently empty apartment (Tenant #2's prior apartment) did not work. When interviewed on 7-31-18 at 4:01 p.m. the Manager revealed the exhaust fan in the apartment previously occupied by Tenant #2 was working last he knew about it and he had not made aware it was not working.	A 013		
A 055	481-67.9(1) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide a sufficient number of staff to fully meet identified needs for 2 of 4 tenants reviewed who resided in the dementia unit (Tenants #1 and #5). Findings follow: When interviewed on 7-30-18 at 1:35 p.m. Staff F revealed Tenants #1 and Tenant #5 were gotten up on the 6:00 p.m. to 6:00 a.m. shift as it took too long to get them up on day shift. Staff F revealed there was a memo that indicated which tenants to get up early. Staff F revealed there was not enough staff in the dementia unit.	A 055	A 055 Whispering Willow does have the sufficient number of trained staff available at all times to fully meet the tenants' identified needs. 1. Management performed a time management study to see if staff did or did not have enough time to complete their tasks with the amount of staff available. 2. Management has moved the meal times in Memory Wing to allow more time to get the tenants ready for breakfast. 3. A monthly, periodic time study will be completed to see if staff number is still acceptable. 4. Facility corrected the regulatory insufficiency on 08/28/18.	

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A 055	Continued From page 4 When interviewed on 7-30-18 at 2:45 p.m. Staff G revealed the 6:00 p.m. to 6:00 a.m. shift woke up Tenant #1 and Tenant #5 around 5:00/5:30 a.m. They were up when the 6:00 a.m. to 6:00 p.m. shift arrived. Staff G said they were the two most difficult tenants to get up. Tenant #5 never wanted to get up. When interviewed on 8-1-18 at 12:27 p.m. the Nurse revealed staff woke Tenant #1 and Tenant #5 up on the 6:00 p.m. to 6:00 a.m. shift to have time before breakfast. Breakfast was served at 6:45 a.m. and it was to allow staff to get all tenants ready for breakfast; however, staff was not to wake anyone up before 5:00 a.m. When interviewed on 7-24-18 at 1:43 p.m. Staff C revealed there was not enough staff in the dementia unit to meet the needs of the tenants. When interviewed a family member revealed staff reported they were getting tenants up in the dementia unit and ready for the day at 4:30 a.m. A tenant had gotten up at 4:30 a.m. and requested something to eat and it was not provided. Review of a Memo dated 12-5-17 indicated staff on the 6:00 p.m. to 6:00 a.m. shift were expected to get some people up and dressed if it was not a bath day. Staff on that shift were directed to get up three tenants including Tenant #1 and #5. Staff was directed if they could not get someone on that list up, they were to document in the behavior notes why the tenant didn't get up, and substitute with another person. Review of Tenant #1 and Tenant #5's files revealed they resided in the dementia unit. Both	A 055		

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A 055	Continued From page 5 tenants had a Global Deterioration Scale of six, which indicated severe cognitive decline. The ALP Monitoring Entrance Form filled out by the Program revealed two staff were present and on duty 24 hours per day, from 6:00 a.m. to 6:00 p.m. and from 6:00 p.m. to 6:00 a.m. One staff was assigned to the general population area and one staff to the dementia unit.	A 055		
A 066	481-67.9(5) Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(5) Prohibited services. A program staff member shall not be designated as attorney-in-fact, guardian, conservator, or representative payee for a tenant unless the program staff member is related to the tenant by blood, marriage, or adoption. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program engaged in prohibited services by serving as representative payees for 3 of 3 tenants reviewed whose funds were managed by the Program (Tenants #7, #8, and #9). Findings follow: Review of the ALP Monitoring Entrance form completed by the Program revealed Tenants #7, #8 and #9 had funds managed by the Program. Record review on 7-24-18 and 7-25-18 revealed documents from the Social Security Administration indicated the Program was	A 066	A 066 1. Management has been in contact with our Program Coordinator. Management has filled out the Petition for Waiver/Request for Variance form. 2. Facility will consult with Program Coordinator if any questions arise. 3. Facility will consult with Program Coordinator when needed. 4. The Petition for Waive/Request for Variance was faxed on 09/05/18.	

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A 066	Continued From page 6 chosen as the representative payee for Tenants #7, #8 and #9. When interviewed on 7-31-18 at 4:05 p.m. the Manager revealed the Program was named the representative payee and he was writing the checks on behalf of the tenants. The tenants did not have any family involvement and had very limited resources. The Manager said he was not related to the tenants indicated above by blood, marriage or adoption.	A 066		
A 121	481-67.19(3)c Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3)c If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program. This REQUIREMENT is not met as evidenced by: Based on record review and interview the Program failed to obtain the approval from the Department of Human Services (DHS) to determine if employment was prohibited prior to employment for 1 of 6 staff reviewed (Staff E). Findings follow:	A 121	A 121 Whispering Willow does perform criminal, dependent adult abuse, and child abuse record checks before employment. 1. Management will not allow anyone to work in the facility, whether it be training or independently, prior to the final approval of record check. 2. Management will make sure final report is back before allowing staff to start working. 3. Owner will review all new staff files weekly. 4. Facility corrected the regulatory insufficiency on 08/28/18.	

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A 121	Continued From page 7 Record review on 7-25-18 revealed Staff E's date of hire as 11-14-17. A criminal history background check was completed on 11-10-17 which indicated further research was required. The abuse registries background check did not reveal any records. Iowa Record Check Request Form S dated 11-14-17 revealed a record was found. A letter from DHS dated 11-17-17 indicated Staff E could work at the Program. A review of timecard records revealed Staff E received paid wages on 11-13-17, prior to the receipt of the approval from DHS regarding Staff E's employment. When interviewed on 7-31-18 at 2:25 p.m. the Assistant Manager confirmed Staff E received training on 11-13-17.	A 121	A 045 Whispering Willow does follow the criteria for admission and retention of tenants. 1. Management and Nurse Manager will meet with tenant's family to discuss transfer due to unmanageable incontinence. Management and Nurse Manager discussed with the family beginning hospice care on tenant. Family agreed, stating they would like him to stay at Whispering Willow Assisted Living and Memory Wing. An order was received on 08/30/18 to admit tenant to hospice care. Management is filing for waiver to keep tenant in our facility. 2. Nurse Manager and Management will discuss when they feel there is a tenant who may be beyond our level of care. 3. Nurse Manager and Management will monitor for any change in conditions that will go beyond our level of care. 4. Request for Waiver of Administrative Rule (Health-Related) was faxed on 09/05/18.	
A 045	481-69.23(1)g Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: g. Has unmanageable incontinence on a routine basis despite an individualized toileting program This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review the Program failed to follow the criteria for admission and retention of tenants by retaining a tenant who had unmanageable incontinence. This pertained to 1 of 6 tenants reviewed (Tenant	A 045		

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A 045	Continued From page 8 #1). Findings follow: Observation on 7-30-18 at approximately 12:00 p.m. revealed Staff B and Staff G assisted Tenant #1 to the dining room table. Tenant #1 appeared to have been incontinent. Following lunch, the chair where the tenant had sat appeared to be soiled. Record review on 7-24-18 and 7-31-18 of Tenant #1's file revealed a diagnosis of advanced dementia. He was staged at a six on the Global Deterioration Scale (GDS), which reflected severe cognitive decline. Tenant #1 resided in the dementia unit. The service plan dated 6-11-18 indicated Tenant #1 was incontinent and required assistance with toileting. Tenant #1 had a toileting schedule at 2:00 a.m., 6:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m., 4:00 p.m., 6:00 p.m. and 8:00 p.m. Behavior Log Notes indicated the following: a. On 12-4-17 it was noted Tenant #1 often urinated through clothing and on furniture. b. On 12-18-17 Tenant #1 had his pants and brief pulled down and there was bowel movement (BM) everywhere. After lunch Tenant #1 urinated on himself. The toileting schedule did not help. c. On 12-19-17 Tenant #1's clothes were changed twice that day due to bowel or bladder incontinence. The tenant was not agreeable to the toileting schedule. Two staff were needed to assist with toileting. d. On 1-20-18 when staff woke Tenant #1 he had his pants and brief pulled down and had urinated on the bed and himself. e. On 1-28-18 Tenant #1 urinated on the carpet	A 045		

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A 045	Continued From page 9 in the activity room. f. On 3-6-18 Tenant #1 urinated on an end table in another tenant's apartment and on a new water mug. g. on 4-18-18 Tenant #1 pulled up his brief and pants and had urinated on the couch and carpet. h. On 4-22-18 Tenant #1 got up from the supper table and urinated by the patio door all over the floor. i. On 5-5-18 Tenant #1 had a BM in another tenant's apartment and it was on the bedding and floor. j. On 6-7-18 at 11:00 a.m. upon getting the tenant up to use the toilet, staff noticed his pants were around his ankles. His pants and brief were wet. Tenant #1 would not stand up and called staff names. It was noted at 12:45 p.m. he urinated on another tenant's door. k. On 7-6-18 Tenant #1 urinated on the staff desk and carpet. A clinic note dated 5-23-18 from the nurse practitioner indicated Tenant #1 needed a care environment that was a long term residential care facility. He needed nearly full assistance with all aspects of activities of daily living, was incontinent and urinated/defecated on areas other than the toilet. He was not able to recognize or communicate his needs. A 90 day review/annual update note dated 6-11-18 indicated Tenant #1 seemed to not recognize early cues of needing to have a bowel movement and at times appeared to resist even when the BM was imminent. During an interview on 7-24-18 at 6:16 p.m. Staff A said Tenant #1 was not able to tell staff when he needed to use the restroom. Although the	A 045		

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A 045	Continued From page 10 tenant tried to help by pulling up his pants, it took 2 staff to assist with toileting. When interviewed on 7-24-18 at 1:43 p.m. Staff C said it took two staff to assist Tenant #1 with toileting. He was not able to let staff know when he needed to use the restroom. As a result, staff took him to the restroom every 4 hours. During an interview on 7-30-18 at 1:35 p.m. Staff F said Tenant #1 was incontinent of bladder and bowel. Even though he was taken to the restroom 5 to 6 times a shift, he was often incontinent through clothing. He was unable to say when he needed to use the restroom and required 2 people to assist. When interviewed on 7-30-18 at 2:45 p.m. Staff G said Tenant #1 was unmanageably incontinent.	A 045		
A 077	481-69.25(1)o Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: o. Incident reports involving the tenant, including but not limited to those related to medication errors, accidents, falls, and elopements (such reports shall be maintained by the program but need not be included in the tenant's medical record) This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete incident reports as needed for 4 of 7 tenants reviewed (Tenants #1 ,	A 077	A 077 Whispering Willow does maintain documentation for each tenant, including incident reports. 1. All Staff was reeducated on Incident reports and when to fill them out. 2. Nurse Manager and Management held an in-service on 08/28/18 to discuss when to fill out an incident report. All staff read and signed the policy and procedure on Incident reports. 3. Management will monitor all Incident reports weekly. 4. Facility corrected the regulatory insufficiency on 08/28/18.	

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(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 077	Continued From page 11 #3, #6, #12). Findings follow: 1. Record review on 7-24-18 and 7-31-18 of Tenant #1's file revealed a diagnosis of advanced dementia. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which reflected severe cognitive decline. Tenant #1 resided in the dementia unit. Incident reports could not be located related to the incidents below. Behavior Notes/Log indicated the following: a. On 1-15-18 Tenant #1 rubbed another tenant's neck/back and then kissed her on the mouth. b. On 2-2-18 Tenant #1 put his hand down another tenant's blouse. c. On 3-5-18 Tenant #1 had his hands in another tenant's "crotch." d. On 3-7-18 Tenant #1 called staff names and punched staff in the jaw when assisting with bedtime cares. e. On 4-12-18 Tenant #1 kissed another tenant on the lips. f. On 4-20-18 Tenant #1 was in the dining room and grabbed another tenant's breast under her shirt. g. On 5-5-18 Tenant #1 was in another tenant's apartment and had his genitals in her face. h. On 6-7-18 staff attempted to assist with tolleting and Tenant #1 tried punching staff and "breaking their hands/fingers." 2. Record review on 7-30-18 of Tenant #3's file revealed she resided in the dementia unit with her spouse, Tenant #12. A 90 day review form dated 6-14-18 indicated Tenant #3 had verbal arguments with Tenant #12.	A 077		

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	S0284	A. BUILDING: _____ B. WING _____	C 08/07/2018

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

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A 077	Continued From page 12 On 5-1-18 In the tenants engaged in a loud verbal argument with foul language. Tenant #12 put his hands on Tenant #3 and pushed her as staff intervened. Behavior Log notes indicated on 5-1-18 staff heard Tenant #3 scream for her spouse to "stop it." Staff heard Tenant #12 use foul language. When staff entered the apartment Tenant #3 was crying hysterically. Tenant #12's hands were on Tenant #3. Staff tried to redirect Tenant #3 out of the room as Tenant #12 attempted to throw shoes at both Tenant #3 and staff. Staff continued to try to remove Tenant #3 from the room as Tenant #12 kept pushing her. Tenant #12 ended up pushing and hitting staff as they intervened. No incident report related to this event could be located. 3. Record review on 7-31-18 of Tenant #6's file revealed diagnoses including mixed/moderate dementia, possible Alzheimer's disease and silent strokes. Tenant #6 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Incident reports were not found related to incidents below. Behavior Log notes indicated the following: a. On 6-27-18 Tenant #6 asked another tenant if she was ready for bed. She was very affectionate towards the other tenant. b. On 7-14-18 Tenant #6 and two other tenants were in her apartment with the door locked. As staff unlocked the door, staff overheard Tenant #6 tell another tenant that she could meet her on the bed. Staff observed Tenant #6 hugging another tenant, rubbing her back and stating she	A 077		

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A 077	Continued From page 13 loved her. Tenant #6 again told the other tenant to meet her on the bed. The other tenants were taken out of the apartment by staff. Later on 7-14-18 Tenant #6 asked another if she was ready for bed, gave her a hug and said she could come to her bed anytime as the door was unlocked. 4. When interviewed on 8-7-18 at 10:45 a.m. the Assistant Manager confirmed incident reports the above findings could not be located.	A 077	A 083 Whispering Willow does develop a service plan to meet the specific service needs of the tenant and they are updated annually and whenever changes are needed. 1. Nurse Manager will develop the ISP and Management will review the ISP to ensure all Individual needs will be addressed. Nurse Manager will provide Management with a list of dates when annual reviews are due. Exercises and 1-on-1 activities have been added to the activity calendar in Memory Wing to help with progression of behaviors throughout the day. Staff started implementing on 08/23/18 and have seen a decrease in behaviors. 2. Management to review all ISPs and talk with staff on specific service needs. Management will also review all dates when annual reviews are due. 3. Management will monitor all dates when reviews are due. Management will also monitor the staff to make sure they are doing the exercises and 1-on-1 activities to help decrease the behaviors. 4. Facility will ensure regulatory insufficiency corrected by 09/14/18.	
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans addressed all need areas and was updated at least annually for 5 of 6 current tenants (Tenants #1, #3, #4, #5 and #6) and 1 of 1 former tenants (Tenant #2)reviewed. Findings include: 1. Review of Tenant #1's file on 7-24-18 and 7-31-18 revealed a 90 day review/Annual Update	A 083		

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A 083	Continued From page 14 dated 6-11-18 that indicated Tenant #1 displayed behaviors at times toward staff during personal cares included hitting, attempting to bite, grabbing hands and squeezing, and head butting. Behavior Log Notes indicated the following: a. On 1-28-18 Tenant #1 urinated on the carpet in the activity room. b. On 3-6-18 Tenant #1 urinated on an end table in another tenant's apartment and on a new water mug. c. On 4-18-18 Tenant #1 was observed pulling up his brief and pants after urinating on the couch and carpet in the common area. d. On 4-22-18 Tenant #1 got up from the supper table and urinated by the patio door all over the floor. e. On 5-5-18 Tenant #1 had a BM in another tenant's apartment and it was on the bedding and floor. f. On 7-6-18 Tenant #1 urinated on the staff desk and carpet. During an interview on 7-24-18 at 6:16 p.m. Staff A said although the tenant tried to help by pulling up his pants, it took 2 staff to assist with toileting. On 7-24-18 at 1:43 p.m. Staff C said it took 2 staff to assist Tenant #1 with toileting. On 7-30-18 at 1:35 p.m. Staff F said Tenant #1 required 2 staff to assist during toileting. Review of the PRN (as needed) Medication Administration Notes revealed Tenant #1 had received Imodium over 25 times between 4-7-18 and 7-2-18 for loose stools. The service plan dated 6-11-18 indicated Tenant #1 was incontinent and included a toileting	A 083		

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A 083	Continued From page 15 schedule for staff to follow. However the service plan did not address Tenant #1's urination/defecation in places outside his apartment, the need for 2 staff to assist when using the restroom, the frequent loose stools requiring medication, or physical behaviors displayed towards staff during cares. 2. Review of Tenant #2's file on 7-25-18 and 7-31-18 revealed health and functional evaluations were last completed on 5-3-17. A 90 day review was completed on 1-16-18 and the service plan was reviewed; however, only a cognitive evaluation was completed. An annual service plan, based on evaluations, was not completed. The May 2018 Medication Administration Record reflected a treatment of Anticavity Mouthwash, give 10 cubic centimeter to rinse and spit. It was not documented as given for the month of May 2018, due to refusals. The service plan did not reflect Tenant #2's routine refusals of the mouthwash. 3. Review of Tenant #3's file on 7-30-18 revealed diagnoses including dementia, depression, restless leg syndrome and generalized anxiety disorder. Tenant #3 was staged at a five on the GDS, which indicated moderately severe cognitive decline. She resided in the dementia unit. The PRN Medication Administration Notes revealed between 5-6-18 and 6-4-18 there were nine entries where Imodium was administered for loose stools. Pain relievers, such as Excedrin Headache Relief, Tramadol HCL and Tylenol Extra Strength were administered over 20 times	A 083		

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A 083	Continued From page 16 between 5-4-18 and 6-4-18 for body aches, leg pain and all over pain. Behavior Log notes indicated the following: a. On 4-10-18 Tenant #3 was crying. When asked why she did not know what was wrong but said she felt like she was dying. b. On 4-13-18 Tenant #3 began to cry and shouted she was going to cut her leg off. c. On 6-8-18 Tenant #3 came out of the apartment twice without wearing pants. d. On 6-29-18 Tenant #3 was observed sitting on a couch in the lobby undressing. e. On 7-21-18 Tenant #3 told staff and her spouse "Just kill me! I can't take this pain!" Later on the same date she came out and asked staff to "kill" her and then yelled that she wanted Excedrin for her legs. Staff explained that's not what that medication was for and Tenant #3 said "I want to die!" A 90 day review dated 6-14-18 indicated Tenant #3 had a history of frequent stools even when formed. The tenant would seek staff when she had needs and made frequent use of as needed medications. Tenant #3 resided in the apartment with her spouse (Tenant #12) and had complaints about, and verbal arguments with, her spouse. Tenant #3 and Tenant #12 had an incident on 5-1-18 when they engaged in a loud verbal argument with foul language. Tenant #12 put his hands on Tenant #3 and pushed her as staff intervened. The service plan dated 2-20-18 did not address the history of loose stools and interventions, chronic pain and interventions, disrobing or coming into common area in a state of undress, comments regarding wanting to die, or the	A 083		

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A 083	Continued From page 17 arguments between Tenant #3 and her spouse. 4. Review of Tenant #4's file on 7/31/18 revealed Behavior Log notes documenting the following: a. On 6-15-18 Tenant #4 had put two briefs on and the briefs were on top of her pants. She also had a brief on under her pants. b. On 6-16-18 Tenant #4 came out of the apartment multiple times with a brief on top of her pants. c. On 6-17-18 Tenant #4 had four shirts on and three briefs. d. On 7-3-18 Tenant #4 was very confused in the morning and was unable to follow simple step by step directions. The service plan dated 5-7-18 reflected Tenant #4 was independent with dressing. The tenant's issues with wearing briefs on the outside of her clothing or wearing multiple briefs/shirts was not addressed in the plan. 5. Record of Tenant #5's file on 7-31-18 file revealed a fax to the physician dated 5-15-18 indicating the tenant displayed intermittent physical agitation/aggression during cares such as toileting and showering. These behaviors included attempting to hit people with the walker, hitting with closed and open fist and scratching. The service plan dated 5-16-18 reflect staff provided a full assist with bathing three times per week. The service plan did not address the behaviors indicated above. 6. Review of Tenant #6's file on 7-31-18 revealed a 30 day Review dated 5-24-18 indicating Tenant #6 frequently attempted to assist other tenants in the dementia unit and had a pattern of taking	A 083		

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A 083	Continued From page 18 other tenants' belongings and saying they were stolen from her. Behavior Log notes indicated the following: a. (undated) Tenant #6 stated not to let her die 40 times in a 20 minute period b. On 5-22-18 Tenant #6 shouted to let her die and that she wanted to die. c. On 6-27-18 Tenant #6 asked another tenant if the other tenant was ready for bed. Tenant #6 was very affectionate towards the other tenant. d. On 7-13-18 Tenant #6 touched another tenant on the shoulder for a long time. e. On 7-13-18 Tenant #6 and another tenant were in Tenant #6's apartment with the door locked. f. On 7-14-18 Tenant #6 and two other tenants were in her apartment with the door locked. As staff unlocked the door staff overheard Tenant #6 tell another tenant that she could meet her on the bed. Staff observed Tenant #6 hugging another tenant, rubbing her back and telling her she loved her. Tenant #6 again told the other tenant to meet her on the bed. The other tenants were taken out of the apartment by staff. Later on 7-14-18 Tenant #6 asked another if she was ready for bed, gave her a hug and said she could come to her bed anytime as the door was unlocked. The service plan dated 4-26-18 did not address Tenant #6's behaviors as noted above. 7. When interviewed on 8-1-18 at 12:27 p.m. the Nurse confirmed the above finding.	A 083		
A 092	481-69.26(4)d Service Plans 481-69.26(231C) Service plans.	A 092		

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A 092	Continued From page 19 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: d. For tenants who are unable to plan their own activities, including tenants with dementia, a list of person-centered planned and spontaneous activities based on the tenant's abilities and personal interests. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to reflect person-centered planned and spontaneous activities on the service plans for 5 of 6 tenants reviewed unable to plan their own activities (Tenants #1, #3, #4, #5 and #6). Findings follow: 1. Review of Tenant #1's file on 7-24-18 and 7-31-18 revealed a diagnosis of advanced dementia. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which reflected severe cognitive decline. Tenant #1 resided in the dementia unit. The service plan dated 6-11-18 reflected the Program would provide a calendar of activities monthly. Staff provided spontaneous and one to one activities daily based on interests and referred to an Activity Pursuit Patterns interest sheet in the file. The service plan did not reflect specific planned and spontaneous activities. 2. Review Tenant #3's file on 7-30-18 of revealed diagnoses including dementia, depression and generalized anxiety disorder. Tenant #3 was	A 092	A 092 Whispering Willow does develop a service plan to meet the specific needs of the tenant, including activities. 1. Management, Nurse Manager, Staff, and Family will be included in a 1-on-1 activity list decision making for each tenant in our Memory Wing. Family was given a form to complete on their family member's history, likes, and dislikes. 2. Management will monitor to make sure staff and family will complete forms when they have a change in condition or a new admit. 3. Management will monitory 1-on-1 activity list monthly. 4. Facility will ensure regulatory insufficiency corrected by 09/14/18.	

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A 092	Continued From page 20 staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #3 resided in the dementia unit. The service plan dated 2-20-18 indicated staff provided spontaneous and one to one activities daily based on interests and referred to an Activity Pursuit Patterns interest sheet in the file. The service plan did not reflect specific planned and spontaneous activities. 3. Review of Tenant #4's file on 7-31-18 revealed she was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #4 resided in the dementia unit. The service plan dated 5-7-18 indicated staff provided spontaneous and one to one activities daily based on interests and referred to an Activity Pursuit Patterns interest sheet in the file. The service plan did not reflect specific planned and spontaneous activities. 4. Review of Tenant #5's file on 7-31-18 revealed a diagnosis of vascular dementia with behavioral disturbance. Tenant #5 was staged at a six on the GDS, which indicated severe cognitive decline. Tenant #5 resided in the dementia unit. The service plan dated 5-16-18 indicated staff provided spontaneous and one to one activities daily based on interests and referred to an Activity Pursuit Patterns interest sheet in the file. The service plan did not reflect specific planned and spontaneous activities. 5. Review of Tenant #6's file on 7-31-18 revealed diagnoses including mixed/moderate dementia, possible Alzheimer's disease and silent strokes. Tenant #6 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #6 resided in the dementia unit.	A 092		

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A 092	Continued From page 21 The service plan dated 4-26-18 indicated staff provided spontaneous and one to one activities daily based on interests and referred to an Activity Pursuit Patterns Interest sheet in the file. The service plan did not reflect specific planned and spontaneous activities. 6. When interviewed on 8-1-18 at 12:27 p.m. the Nurse confirmed the above finding.	A 092		
A 107	481-69.28(5)a(3) Food Service 481-69.28(231C) Food service. 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. a. In addition to the requirements above, a minimum of one person directly responsible for food preparation shall have successfully completed a state-approved food protection program by: (3) Successfully completing an ANSI-accredited certified food protection manager program meeting the requirements for a food protection program included in the Food Code adopted pursuant to Iowa Code chapter 137F. Another program may be substituted if the program's curriculum includes substantially similar competencies to a program that meets the requirements of the Food Code and the provider of the program files with the department a statement indicating that the program provides substantially similar instruction as it relates to sanitation and safe food handling.	A 107	A 107 Whispering Willow does provide on orientation on sanitation and food safety to their employees upon hire. 1. Management will not allow anyone to work directly with food in the facility, whether it be training or independently, prior to the completion of Food Safety & Sanitation. A member of management is now enrolled in the ServSafe class. 2. Management will make sure Food Safety & Sanitation is completed before allowing staff to start working directly with food. 3. Owner will review all new staff files bi-weekly. 4. Facility will ensure regulatory insufficiency corrected by 09/19/18.	

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A 107	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to have 2 of 6 staff reviewed complete an orientation on sanitation and safe food handling prior to handling food (Staff A, C). The Program also failed to have one person directly responsible for food preparation complete a state-approved food protection course. This potentially affected all tenants (census of 22). Findings follow: 1. Record review on 7-25-18 of staff files revealed Staff A and C did not have food safety training completed prior to handling food. 2. Continued record review revealed a Servsafe certificate was provided for Staff H. Staff H was not listed on the staff list provided by the Program. 3. When interviewed on 7-31-18 at 4:01 p.m. the Manager revealed Staff H did not usually make food. Staff H checked food orders once per month. No other staff currently at the Program had completed a state-approved food protection course.	A 107		
A 121	481-69.30(1) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(1) All personnel employed by or contracting with a dementia-specific program	A 121		

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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 121	Continued From page 23 shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure 1 of 1 new staff hired since May 2018 received eight hours of dementia-specific education within 30 days of employment (Staff D). Findings follow: Review of Staff D's on 7-25-18 file revealed a hire date of 6-12-18. Staff D did not have eight hours of dementia-specific education within 30 day of employment. The Assistant Manager confirmed this finding on 7-31-18 at 2:25 p.m.	A 121	A 121 Whispering Willow does require Dementia-specific training to all employees upon hire and annually. 1. Upon hire, management will schedule 1-2 days in the first 2 weeks of employment to complete dementia-specific education. 2. All new staff to complete education within the 30-day time frame; facility scheduling 2 days in the first 2 weeks. 3. Management will monitor all employees training on a weekly basis. 4. Facility corrected regulatory insufficiency on 07/30/18.	
A 125	481-69.30(5) Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(5) Dementia-specific training shall include hands-on training and may include any of the following: classroom instruction, Web-based training, and case studies of tenants in the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure dementia-specific training included hands-on training within 30 days	A 125		

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 08/07/2018

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

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A 125	Continued From page 24 of hire for 5 of 6 staff reviewed (Staff A, B, C, D and E). Findings follow: Record review of staff files on 7-25-18 revealed Staff A, B, C, D and E did not have hands-on dementia training as part of their dementia specific training completed within 30 days of hire. The Assistant Manager confirmed this finding on 7-31-18 at 2:25 p.m.	A 125	A 125 Whispering Willow does require Dementia-specific training to all employees upon hire and annually, including hands-on training. 1. Management will update the orientation checklist to include hands-on dementia-specific training. Management and Nurse Manager will also include hands-on dementia-specific training in bi-monthly in-services. 2. Management will ensure the orientation checklist is being completed by both trainee and trainer. 3. Management will monitor the employee orientation process to ensure they are completing everything on the orientation checklist. 4. Facility will ensure regulatory insufficiency corrected by 09/14/18.	
A 149	481-69.34(1) Activities 481-69.34(231C) Activities. 69.34(1) The program shall provide appropriate activities for each tenant. Activities shall reflect individual differences in age, health status, sensory deficits, lifestyle, ethnic and cultural beliefs, religious beliefs, values, experiences, needs, interests, abilities and skills by providing opportunities for a variety of types and levels of involvement. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide activities appropriate for each tenant. This potentially affected all tenants in the dementia unit (census of 10). Findings follow: 1. On 7-24-18 at 1:43 p.m. Staff C stated activities took "a hit." There was one staff in the dementia unit and that staff completed housekeeping, served meals and assisted with cares. Staff C felt there could be more activities offered and an activity director was needed.	A 149		

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A 149	Continued From page 25 There could more more activities and different types of activities were needed. On 7-30-18 at 2:45 p.m. Staff G stated providing activities to tenants in the dementia unit depended on if staff from the general population could come to help. Staff G was not sure if the tenants were capable or had the abilities to participate in the activities that were offered. When interviewed the Nurse revealed most of the activities on the calendar took place. Activities were adequate in the general population; however, both the number of activities and the type offered could be improved in the dementia unit. More individualized activities were needed. 2. Review of the July 2018 activity calendar for the dementia unit listed two activities planned on each day including bubbles outside, bingo, floor basketball, horse shoes, bean bag toss, dominos and share the news. 3. Continued record review revealed there were 10 tenants in the dementia unit with 9 tenants having a Global Deterioration Scale of four or greater.	A 149	A 149 Whispering Willow does provide appropriate activities for each tenant. 1. A time management study was completed on staff showing that they do have the time to complete activities as scheduled. Management investigated on the internet appropriate activities for mid to late stage dementia activities. When compared that list to what was scheduled on our monthly calendar, they were similar. Staff was educated on how to approach and encourage activity participation with the dementia tenants. Activities are currently scheduled twice a day, as well as 1-on-1 different times of the day. Staff was also asked about what they would like seen done for activities. These were added to calendar to try. 2. Management will ask for staff input monthly when creating the Activity calendar to see what they would like to see added or removed 3. Management will monitor staff to ensure activities are getting completed as scheduled. 4. Facility corrected regulatory insufficiency on 09/01/18.	
A 155	481-69.35(1)c Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. c. Programs shall have private dwelling units with a single-action, lockable entrance door. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	A 155		

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A 155	Continued From page 26 review the Program failed to have single-action lockable entrance doors on tenant apartments (census of 22). Findings follow: 1. Observation on 7-30-18 at approximately 11:15 a.m. of an unoccupied tenant apartment revealed the entrance door did not have an single-action, lockable entrance door. The Monitor remained in the unoccupied apartment and locked the dead bolt on the entrance door to the dwelling unit. When the door lever was pushed down the dead bolt lock did not release. The dead bolt lock had to be unlocked manually, then the door opened from inside the apartment when the door lever was pushed down. 2. When interviewed on 7-30-18 at 11:15 a.m. the Assistant Manager confirmed all tenant apartment entrance doors had the same locking mechanism. 3. When interviewed on 7-31-18 at 4:05 p.m. the Manager confirmed all tenant apartment entrance doors had the same locking mechanism. 4. Record review revealed the Assisted Living Program Certificate indicated there were 26 double occupancy dwelling units.	A 155	A 155 1. Management will be replacing all locks in the Assisted Living with single-action locks. In the Memory Wing, Management will be removing all the locking mechanisms. 2. When locks are changed, we should not have that problem again. 3. Management will make sure all locks get changed. 4. Facility will ensure regulatory insufficiency corrected by 09/14/18.	