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
	S0090	A. BUILDING: _____ B. WING _____	C 01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOUSE	1320 LITCHFIELD DR HIAWATHA, IA 52233

(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. Number of tenants without cognitive disorder: 6 Number of tenants with cognitive disorder: 12 Total Census of Assisted Living Program for People with Dementia: 18 No regulatory insuffieicnies were cited during the investigation of complaint #87446-C. The following regulatory insufficiencies were cited during the investigation of complaints #86910-C, #86979-C, #87057-C & #87726-C.	A 000		
A 012	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the Program failed to ensure consideration and dignity were afforded to 1 of 1 tenants reviewed utilizing a video monitoring system (Tenant #1). Findings follow: Review of Tenant #1's file on 12-17-19 and 1-6-20 revealed she was admitted on 9-30-19 with diagnoses including depression, generalized	A 012	Promise House Hiawatha will continue to treat all Tenants with respect, autonomy, and with dignity. All policies will be changed and adapted to assure compliance is maintained. The QA&A committee will periodically monitor all Tenant rights to assure their needs are being met.	03/01/2020

2/13/20

2/13/20

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A 012	Continued From page 1 anxiety disorder and dementia of Alzheimer's type. A 30 Day Nurse Review and Assessment dated 10-25-19 indicated Tenant #1 occasionally spoke of committing suicide and was admitted to the Program from the hospital after she made several attempts to kill herself at another facility. Staff completed 30 minute checks on Tenant #1 to ensure her safety and all items she could possibly use to harm herself were removed from her apartment. Tenant #1's family was agreeable to the placement of a monitor (video camera) in the apartment for safety. It allowed staff to watch her without having to enter into her apartment which irritated her. On 1-9-20 a monitor for a video camera located in Tenant #1's apartment was observed on the shelf of a stand next to the medication cart in the dining area of the building. It was noted the monitor was not plugged in; however, an image was still on the screen of a bed in Tenant #1's apartment. When interviewed throughout the investigation staff reported the following: - Staff E said the monitor was kept on a small stand by the medication cart. She stated the screen of the monitor was visible to staff and anyone else in the dining room. - Staff I stated the monitor could be viewed by anyone who tried to look at it. On 1/7/20 at 9:56 am the Assistant Director confirmed the screen of the video monitoring system used by Tenant #1 was located on a stand facing the medication cart located in the dining area.	A 012		

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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: Based on interview and record review the Program failed to provide adequate care and treatment for 1 of 1 tenants reviewed who sustained a significant injury (Tenant #3). Findings follow: 1. Review of Tenant #3's file on 12-17-19 revealed diagnoses including Alzheimer's disease and acute anxiety. Tenant #3 was staged at a six to seven on the Global Deterioration Scale, which indicated severe to very severe cognitive decline. She no longer resided at the Program. An Incident Report indicated on 10-25-19 at 4:15 a.m. staff went to Tenant #3's apartment to assist her to the bathroom and found her laying on her stomach in bed "which is not typical behavior for her." Staff attempted to get her out of bed and she cried. Staff rolled her to her back and attempted to perform range of motion (ROM); however, stopped as Tenant #3 cried out in pain. Staff called the on-call nurse (Director) to report and she came in for assessment. A Transfer Form completed by the Director noted on 10-25-19 Tenant #3 was found laying on her	A 013	Promise House Hiawatha Tenants will continue to receive care, treatment, and services which are adequate and appropriate. Compliance shall be maintained by adjusting and altering policies to assure compliance.The QA&A committee will periodically monitor Tenants rights issue to assure compliance.	03/01/2020

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A 013	Continued From page 3 stomach, which was not her usual. Repositioning was painful and a bump was noted to the left knee. Tenant #3 was unable to identify the exact location of pain due to dementia and unclear speech. Tenant #3 was positioned on her back and rested until then. During the Director's assessment at 5:35 a.m. it was noted Tenant #3 rubbed her left hip area into the groin. Attempts to reposition were painful and Tenant #3 was unable to sit up or reposition. Tenant #3's physician was notified at 5:29 a.m. Review of the October 2019 medication administration record (MAR) reflected the tenant received 2 tablets of acetaminophen (650mg) on 10-25-19 at 4:15 a.m. for pain. It was charted as not effective at 4:45 a.m. The EMS Pre-Hospital Radio Report indicated on 10-25-19 at 6:14 a.m. a report received indicated Tenant #3 was found prone on her stomach at the Program. There was rotation noted of the left hip but no fall was known. The ED Call Ahead Report indicated on 10-25-19 at 6:14 a.m. Tenant #3 had a suspected hip fracture, was independent with mobility and might have fallen. Tenant #3 got herself back into bed and it was a non-witnessed fall. Hospital records indicated Tenant #3 was found face down at the Program at approximately 4:00 a.m. She had "obvious external rotation and shortening of the leg and was immobile." She was transferred with the assistance of approximately eight people to the ambulance. Tenant #3 had a "nondisplaced, comminuted type II odontoid process fracture and comminuted, angulated, and displaced left intertrochanteric acute hip fracture."	A 013		

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A 013	Continued From page 4 2. When interviewed on 12-19-19 at 11:26 a.m. Staff A revealed she found Tenant #3 laying on her stomach, half off the edge of the bed when completing her last rounds of her shift. It was abnormal for her to be in that position. When checked earlier at 2:00 a.m. Tenant #3 was asleep. She assisted Tenant #3 to the bathroom and back to into bed at that time. When she found the tenant laying on her stomach half off the bed at approximately 4:00 a.m. she called Staff B in to assist. They rolled her over onto her back. ROM was attempted but Tenant #3 was in pain as evidenced by small grimacing and saying "ow." It was noted one leg was shorter than the other leg. She called the Director and explained the situation including that one leg was shorter than the other. She stated she was told not to call the ambulance until the Director arrived to complete an assessment. After the first phone call, the Director called back and said the tenant's physician had suggested putting her in a wheelchair if possible. Staff A said that was not possible and she did not do it. Two Tylenol tablets were given for pain but it was difficult to assess pain/effectiveness as Tenant #3 was essentially non-verbal. The Director arrived approximately 45 minutes after being called. Staff A stayed with Tenant #3 until the Director arrived. Calls were placed to 911 and the family. When interviewed on 1-7-20 Staff B said when Staff A called her to Tenant #3's apartment the tenant was laying on her side in severe pain. Tenant #3 couldn't verbalize the location of the pain. She yelled when they tried to turn her over. Once turned over, Staff A observed Tenant #3's leg was shorter than the other. Staff A called the Director who said she would come in. Staff A	A 013		

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A 013	Continued From page 5 stayed with Tenant #3 and Staff B went back to the other side of the building. On 1-7-20 at 9:56 a.m. the Assistant Director said Tenant #3 had sustained a fractured hip and neck. When she arrived that morning paramedics were transferring Tenant #3 to a gurney. She did not observe Tenant #3 or complete an assessment. On 1-9-20 at 8:55 a.m. the Director said she received a telephone call from staff at 4:15 a.m. Staff A reported Tenant #3 was found laying on her stomach with her feet hanging over the edge of the bed. It appeared as if she had crawled into bed. The Director said she was on her way and to give two Tylenol and keep her comfortable. Staff had not reported any shortening of the leg or external rotation. When she arrived, Tenant #3 was on her back in bed. Facial grimacing was observed and Tenant #3 kept rubbing her left hip. She called the physician and obtained an order to be evaluated. Tenant #3 had no outward sign of a neck injury. There were no complaints of pain with the neck and she was able to raise her neck for EMS. Staff stayed with Tenant #3 until she was transported safely. 3. Tenant #3 was found on her bed in pain at approximately 4:15 a.m. Hospital records revealed there was obvious external rotation and shortening of the leg. The tenant was in pain and cried out when staff moved her or attempted ROM. Emergency services was not contacted until approximately 5:41 a.m.	A 013		
A 040	481-69.23(1)c(1) Criteria for Admission/Retention of Tenants	A 040		

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A 040	Continued From page 6 481-69.23(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: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to discharge 2 of 2 current tenants reviewed who were sexually aggressive, physically aggressive or displayed unmanageable verbal abuse or aggression (Tenants #2 and #5). Findings follow: 1. Review of Tenant #2's file on 12-19-19 and 1-6-20 revealed a diagnosis of dementia with behavioral disturbance. Tenant #2 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Incident Reports indicated the following: - On 10-27-19 it was noted Tenant #2 tried to enter the staff clock-in room. When it was explained what was in there Tenant #2 told staff "How dead do you want to be?" Later the tenant trapped a staff in the corner of his apartment. The staff was using a foot stool to try and keep the tenant away from her. When Staff K tried to assist, the tenant kicked her in the legs leaving bruises and marks. A call was made to 911 to assist. - On 12-29-19 Staff H asked Tenant #2 for a	A 040	Promise House Hiawatha will continue to only admit/retain Tenants who are appropriate for the program. Compliance shall be maintained by the QA&A periodically monitoring all Tenants to assure appropriate placement.	03/01/2020

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A 040	Continued From page 7	A 040		

pillow that was behind that he wasn't using. When he said no, staff attempted to take the pillow. Tenant #2 then grabbed staff's arm and hit her in the side of the head with his fist. He kept a hold of staff's arm and shirt, which pulled tight against staff's neck.
- On 12-30-19 it was noted Tenant #2 shoved another tenant and staff was asked to take Tenant #2's to his apartment. In the apartment the tenant shoved the staff and hit her with a newspaper. Staff F staff stepped in to help and was also assaulted by the tenant as was a third staff who tried to help.

A fax to Tenant #2's physician dated 10-30-19 indicated Tenant #2 displayed aggressive verbal behaviors in the common area without provocation for 25 minutes the previous evening.

Nurse's Notes indicated the following:
- On 10-27-19 it was indicated the tenant tried to enter the staff clock-in room and he was informed the door was locked and he could not get in. Another staff heard him say "How dead do you really want to be." Another staff went to Tenant #2's apartment to fill his nebulizer treatment. Before staff could get it filled Tenant #2 walked into the room with his fists up and said "How dead to you really want to be" and walked towards the staff and said it again. The staff grabbed a foot stool to keep the tenant away from her and started screaming. Two other staff tried to help and were assaulted. Staff ran out of the room and called 911. Police arrived and stayed about 15 minutes until things were calm. An order was received to send Tenant #2 to the emergency room (ER) to evaluate and treat.
- On 12-28-19/12-29-19 it was noted staff called for assistance in the common area. Staff had

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A 040	Continued From page 8	A 040		

attempted to obtain a pillow that was resting on the couch behind Tenant #2. Tenant #2 grabbed staff's arm and grabbed her shift and pulled it right around her neck. Another staff attempted to intervene and asked to let her go as he was hurting her. Tenant #2's response was "I don't give a ----." Staff and Tenant #2 were separated and Tenant #2 went to his apartment. Staff had red marks around her neck and bruising and scratches to the left arm. Tenant #2 was sent to the ER for evaluation. Tenant returned back to the Program with a new order for increased Lamictal to 100 milligram twice daily.

- On 12-30-19 it was noted Tenant #2 shoved another tenant on the arm. Staff encouraged Tenant #2 to come to his apartment to comb his hair. In the apartment the tenant shoved the staff. Other staff intervened and were assaulted. Paramedics and police were called. Tenant #2 was transported to the hospital. Tenant #2's spouse was informed Tenant #2 could not come back until a medication adjustment was made. The goal was to get medication adjusted and to bring him back. Tenant #2 was admitted for medication adjustments and displayed paranoid behavior into the ER.

Interviews throughout the investigation revealed the following:

- Staff D stated staff were nervous around the tenant because of his size and unpredictability of behaviors.
- Staff E said the tenant displayed verbal behavior to both tenants and staff. She knew of one physical aggression towards another tenant. Tenant #2 had been physical towards staff. The behaviors seemed like they were getting worse.
- Staff G said there had been an incident when Tenant #2 corned a staff in the apartment. Staff

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A 040	Continued From page 9 were concerned regarding the tenant's size and his physical aggression. He had daily verbal behaviors. There had been a couple of incidents on first shift when he was sent to the ER. - Staff H said Tenant #2 had cornered staff one time. He had not gone after any tenants. There had been improvement with Tenant #2 and there had been no further outbursts. - Staff J said Tenant #2 had verbal behaviors daily and it was towards both staff and tenants. There had been no physical behaviors towards tenants. On 1/7/20 at 9:56 am the Assistant Director said Tenant #2 was appropriate for the Program and there were no concerns for safety as long as his agitation was under control with a medication adjustment. They planned to reassess him before he returned from the hospital. On 1/9/20 at 8:55 am the Director said Tenant #2 was still in the hospital. There were no plans to discharge him from the Program. She confirmed Tenant #2 had pushed one tenant and they were immediately separated. In addition, there was an incident of aggression towards staff members when told to comb his hair. His verbal behaviors were more of commands. She felt there were no safety concerns as his medications were currently being adjusted. Further interview with the Director on 1-16-20 revealed Tenant #2 returned to the Program on 1-14-20. 2. Review of Tenant #5's file on 12-19-19 and 1-6-20 revealed a diagnosis of dementia without behavioral disturbance. Tenant #5 was staged at a five to six on the GDS, which indicated moderately severe to severe cognitive decline.	A 040		

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A 040	Continued From page 10 Nurse's Notes indicated the following: - On 11-3-19 it was noted staff went to put a gait belt on Tenant #5 and he reached down staff's shirt. - On 11-14-19 it was noted Tenant #5 had been agitated all shift. One staff tried to get him to sit down and he grabbed and held her arms. Another staff came over to help and Tenant #5 kicked her between the legs. - On 11-17-19 it was noted Tenant #5 grabbed a staff's buttocks. - On 11-18-19 it was noted Tenant #5's spouse was made aware of the behaviors from the previous evening. She indicated he would touch his family members inappropriately at home but had not done it for sometime. - On 12-10-19 it was noted Tenant #5's grabbed staff's breast when she put on his gait belt. - On 12-11-19 it was noted Tenant #5's physician was notified the tenant attempted to bite staff's breast. - On 12-12-19 it was noted staff sat by Tenant #5 as he would not stay seated. Tenant #5 took his hand and put it between staff's legs. - On 12-13-19 it was noted staff reported the tenant grabbed her breast. - On 12-13-19 it was noted Tenant #5's spouse was notified of the behaviors. The spouse informed the writer he used to do it previously. - On 12-25-19 it was noted Tenant #5 grabbed staff by the waist of her pants and tried to pull them down. - On 12-28-19 it was noted Tenant #5 grabbed staff's breast when she was putting on his gait belt. - On 1-4-20 it was noted Tenant #5 stood up and staff went over to help. He began to hit staff. A second staff who went to help was also hit.	A 040		

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A 040	Continued From page 11 Interviews throughout the investigation revealed the following: - Staff D said Tenant #5 displayed inappropriate behaviors towards staff almost daily. Nursing staff was aware his behaviors were unchanged. - Staff E said Tenant #5 displayed sexual behaviors towards staff. It was difficult to determine the frequency. - Staff F said Tenant #5 would hit at staff at times. He displayed sexual behaviors daily towards staff. Staff were told to tell the tenant not to touch them when putting on the gait belt. It was not effective. - Staff G said the tenant displayed sexual behaviors almost daily. It was directed towards staff; however, one time he asked a tenant to give him a kiss. - Staff H said Tenant #5 had sexually inappropriate behaviors almost daily, mostly on second shift. Tenant #5 had grabbed staff. - Staff I said Tenant #5 displayed sexual behaviors approximately two to three times per week, both verbal and physical. Tenant #5 was not easily redirected. - Staff J said Tenant #5 displayed inappropriate behavior daily towards staff. Tenant #5 had touched staff and swung at staff. On 1/9/20 at 8:55 am the Director said Tenant #5's sexual behaviors were not daily. When asked about Tenant #5's level of care the Director said he would not be appropriate for the care center and had nowhere else to go. The tenant was sensitive to medications and different things had been tried, including Trazodone as needed. She indicated it was generally effective.	A 040		
A 083	481-69.26(1) Service Plans	A 083		

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A 083	Continued From page 12 481-69.26(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 were updated as needed and identified service needs for 5 of 6 tenants reviewed (Tenants #1, #3, #4, #5 and #6). Findings follow: 1. Review of Tenant #1's file on 12-17-19 and 1-6-20 revealed diagnoses including depression, generalized anxiety disorder and dementia of Alzheimer's type. Tenant #1's date of admission was 9-30-19. Nurses' Notes indicated the following: - On 10-1-19 it was noted when staff completed a check, which were scheduled every 30 minutes, Tenant #1 asked where she was at, why she was there and demanded sleeping pills. Tenant #1 pushed staff out of her apartment and shut and locked the door. Staff left the area and later heard a banging noise. When staff responded the tenant was in the hallway banging on the walls. Tenant #1 was redirected to her apartment. She stated she would kill herself if	A 083	Promise House Hiawatha will continue to develop service plans based on Tenant evaluations conducted in accordance with the appropriate rules and subrules. Periodically, the QA&A committee will review the service plans to assure they meet the requirements for the Tenants.	03/01/2020

DEPARTMENT OF INSPECTIONS AND APPEALS

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	S0090	A. BUILDING: _____ B. WING _____	C 01/16/2020

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A 083	Continued From page 13	A 083		

she did not get her aspirin.
- On 10-1-19 it was noted Tenant #1's family member was made aware of the behaviors observed during the night and was asked how the family felt about using a baby monitor with a screen to monitor Tenant #1. The family was agreeable with the use of the monitor.
- On 10-4-19 it was noted a fax was sent to the physician regarding the behaviors from 10-2-19 and the use of the monitoring system.

A Promise House Consultation Sheet dated 10-22-19 reflected new orders including light therapy 20 minutes twice daily.

The service plan was updated on 10-25-19; however, did not reflect the light therapy twice daily or the use of the video monitoring system. The service plan dated 12-23-19 did did reflect the light therapy however, did not include the video monitoring system.

2. Review of Tenant #3's file on 12-17-19 revealed a diagnoses of Alzheimer's disease and acute anxiety. Tenant #3 was staged at a six to seven on the Global Deterioration Scale, which indicated severe to very severe cognitive decline.

Incident Reports and FSI Fall Scene Investigation Reports indicated the tenant had falls on 8-21-19, 9-13-19 and 9-19-19.
- On 8-21-19 it was noted Tenant #3 attempted to sit on the couch but there was another tenant on the couch, which caused Tenant #3 to fall. She fell on her left knee and then sat on her buttocks.
- On 9-13-19 it was noted Tenant #3 got off the couch with the protective covering from the couch. Staff asked her to put it back on the

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A 083	Continued From page 14 couch. Tenant #3 appeared to lose her balance and fell on the floor on her buttocks. A fall follow-up revealed bruising on the upper left buttocks. - On 9-19-19 it was noted Tenant #3 was found laying on her left side in her apartment facing the door. She moved all extremities without complaints of pain. A fall follow-up indicated Tenant #3's gait was off and there was a bruise noted on the left hip area. A 90 Day Nurse Review and Assessment dated 10-7-19 reflected Tenant #3 was independent with ambulation, had a steady gait and had four falls in the past 90 days related to her ability to make good decisions. The tenant's service plan dated 10-7-19 reflected Tenant #3 was independent with ambulation. There was no mention of her history of falls or interventions to prevent falls. 3. Review of Tenant #4's file on 12-17-19 revealed a diagnosis of diabetes mellitus type II with neurological manifestations. Tenant #4 was staged at a six on the GDS, which indicated severe cognitive decline. A 90 Day Nurse Review dated 10-24-19 reflected Tenant #4 had an order for Near Beer after Tenant #4 frequently requested a beer. Tenant #4's limit was two per day. A Significant change with Nurse Review assessment dated 11-1-19 reflected there was an area to the top of his left foot that was diagnosed as pyodium gangrenosis. Treatments had been in place off and on with Prednisone. A second area was identified right next to the other area. A	A 083		

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A 083	Continued From page 15 & D ointment was ordered to the site daily for skin irritation on 10-26-19. The tenant's service plans dated 10-24-19 and 11-1-19 did not reflect the frequent requests for beer and the order for Near Beer (limit of two per day) or the diagnosis of pyodium gangrenosis and treatments ordered. 4. Review of Tenant #5's file on 12-19-19 and 1-6-20 of revealed a diagnosis of dementia without behavioral disturbance. Tenant #5 was staged at a five to six on the GDS, which indicated moderately severe to severe cognitive decline. A fax to Tenant #5's physician dated 11-15-19 indicated an order was received for physical therapy (PT) to evaluate and treat. A Program document indicated PT was discontinued on 12-19-19. A 90 Day Nurse review and Significant Change assessment dated 12-20-19 reflected Tenant #5 had a decreased appetite and at times needed assistance feeding himself. A fax to to Tenant #5's physician dated 1-3-20 reflected Tenant #5 had a nine pound weight loss from December to January. The tenant's service plan dated 10-22-19 did not reflect the initiation or discontinuation of PT services. The 12-20-19 service plan reflected both the initiation and discontinuation of PT services; however, PT had been discontinued before the date of the service plan. The 12-20-19 service plan did not reflect Tenant #5's decreased appetite and weight loss.	A 083		

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A 083	Continued From page 16 5. Review of Tenant #6's file on 1-6-20 of revealed a diagnosis of vascular dementia. Tenant #6 was staged at a six to seven on the GDS, which indicated severe to very severe cognitive decline. Fax communication documents to Tenant #6's physician indicated the following: - On 12-16-19 it was noted when being assisted by staff, the tenant's knees buckled placing all of his weight on staff. He was lowered to the ground to keep him from falling and hurting staff. Three staff assisted. - On 12-17-19 it was noted staff assisted Tenant #6 to the restroom. It took three attempts to get him to a standing position. His knees buckled under him, which caused the staff to lose her balance and fall into the wheelchair. Tenant #6 rested on the staff's leg. Three staff were needed to get the tenant into the wheelchair. - On 12-23-19 it was noted an order for physical therapy to evaluate and treat was requested and an order was given. The fax indicated Tenant #6 required additional staff with transfers and getting out of the chair. Tenant #6 would purposefully slide down in a chair or refuse to stand if up on his legs. - On 1-5-20 or 1-6-20 it was noted Tenant #6 needed four staff members to transfer him. He would not bear any weight and his knees buckled. One staff hurt her arm. Staff interviews throughout the investigation revealed the following: - Staff E said staff had been injured assisting the tenant over the past two to three months. Tenant #6 was not weight bearing very often. It was recently changed to transfer Tenant #6 with	A 083		

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A 083	Continued From page 17 two people. - Staff F said staff had been hurt transferring Tenant #6. He had been a two person assist for three to four months. Recently it had taken three to four staff at times. - Staff G said Tenant #6 took two to three staff to assist in the last month. Previously it took two to stand up and one staff to walk. On 1/7/20 at 9:56 am the Assistant Director said Tenant #6 was a light two person transfer. Two staff were used for safety purposes. On 1/9/20 at 8:55 am the Director said the family was in agreement with a move to a higher level of care when a bed was available. Tenant #6 was a two person assist with a gait belt. The tenant's service plan dated 1-6-20 reflected assistance of one staff with a walker and gait belt to transfer and ambulate. Assistance of two staff was to be used as needed for safety. The service plan did not reflect the frequent need of three staff to assist the tenant with transfers.	A 083		