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
	S0038	A. BUILDING: _____ B. WING _____	C 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLY SPIRIT	1701 W 25TH ST SIOUX CITY, IA 51103

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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 impairment:26 Number of tenants with cognitive impairment: 14 Total census: 50 The following regulatory insufficiencies were cited during the investigation of Complaint #121682-C.	A 000		
A 115	481-69.21(2)a,b,c,d,e,f Occupancy Agreement 69.21(2) In addition to the requirements of Iowa Code section 231C.5, the written occupancy agreement shall include, but not be limited to, the following information in the body of the agreement or in the supporting documents and attachments: a. The telephone number for filing a complaint with the department. b. The telephone number for the office of long-term care ombudsman. c. The telephone number for reporting dependent adult abuse. d. A copy of the program ' s statement on tenants' rights. e. A statement that the tenant landlord law applies to assisted living programs. f. A statement that the program will notify the tenant at least 90 days in advance of any planned program cessation, which includes voluntary decertification, except in cases of emergency.	A 115	The Plan of Correction is attached	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 115	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure occupancy agreements included required information. This pertained to 3 of 3 current tenants (Tenants #1, #2, #3) and 1 of 2 former tenants (Tenants C1) reviewed. Findings follow: Record review on 10/22/24 revealed the Program's Occupancy Agreements (OA) for Tenants #1, #2, #3 and C1 failed to include the correct telephone number for the long-term care ombudsman. Further review revealed the OAs failed to clearly state Dependent Adult Abuse should be reported to the Department. The OA included the Department's telephone number to report/file complaints but did not clearly explain Dependent Adult Abuse allegations should be reported to the same telephone number. In addition, the Program failed to include a statement that tenant landlord law applied to assisted living programs. During the exit on 10/23/24 at 1:30 p.m. the administrative team acknowledged the Program failed to follow the rules regarding Occupancy Agreements.	A 115		
A 120	481-69.21(3) Occupancy Agreement 69.21(3) The occupancy agreement shall be reviewed and updated as necessary to reflect any change in services or financial arrangements.	A 120		

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A 120	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to review and update an Occupancy Agreement (OA) regarding financial arrangements. This pertained to 1 of 2 former tenants reviewed (Tenant C1). Finding follows: Record review on 10/22/24 revealed a document dated 2/1/22 explaining a change in room charges. The Program was going to start charging $6242.00 per month. Further review revealed the Program's statement for room charges for Tenant C1 dated 1/1/24 was for $6492.00 per month. Tenant C1's most recent OA before moving out on 7/29/24 was dated 1/26/22. Review of the OA revealed the tenant's room rate at admission was $6120.00 per month. The Program failed to update the OA when room charges changed. During the exit on 10/23/24 at 1:30 p.m. the administrative team acknowledged the Program failed to follow the rules regarding Occupancy Agreements.	A 120		
A 135	481-69.22(1) Evaluation of Tenant 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant's functional, cognitive and health status prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant's eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the	A 135		

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A 135	Continued From page 3 cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale (GDS) shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant's mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as required. This pertained to 1 of 3 current tenants reviewed (Tenant #3). Finding follows: Record review on 10/23/24 revealed the Program completed a Brief Interview for Mental Status (BIMS) for Tenant #3 on 11/3/23 during her intial evaluations. According to the BIMS Tenant #3 had a moderately impaired cognitive status. The subsequent cognitive evaluation completed on 5/8/24 was also a BIMS and not the required Global Deterioration Scale (GDS) evaluation. During the exit on 1/23/24 at 1:30 p.m. the administrative staff confirmed the Program failed to complete evaluations as required.	A 135		
A 215	481-69.24(1)a Involuntary Transfer from Program 69.24(1) Program initiation of transfer. If a program initiates the involuntary transfer of a tenant and the action is not the result of a monitoring, including a complaint investigation or program-reported incident investigation, by the department and if the tenant or tenant's legal representative contests the transfer, the following procedures shall apply:	A 215		

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A 215	Continued From page 4 a. The program shall notify the tenant or tenant's legal representative, in accordance with the occupancy agreement, of the need to transfer the tenant and of the reason for the transfer and shall include the contact information for the office of long-term care ombudsman. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to either notify the legal representative of the need to involuntarily transfer a tenant or include the required information in the notice. This pertained to 1 of 2 former tenants reviewed (Tenant C1). Finding follows: Record review on 10/23/24 revealed letters dated 6/11/24 and 6/25/24 provided by the Program regarding a 30 day eviction for Tenant C1. The Program failed to address the 6/11/24 letter to the legal representative and include the contact information for the long-term care ombudsman' office. The 6/25/24 letter was sent to the legal representative letter but failed to include the contact information for the long-term care ombudsman' office. Further review revealed a letter dated 7/1/24 addressed to Tenant C1 that included all of the correct information. During the exit on 10/23/24 at 1:15 p.m. when questioned about why there were three letters, the Administrative staff responded the long term care ombudsman kept "sending it back." They acknowledged they failed to provide a involuntary discharge notice that met the rules.	A 215		
A 315	481-69.25(1)n Tenant Documents 69.25(1) Documentation for each tenant shall be	A 315		

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A 315	Continued From page 5 maintained by the program and shall include: n. A copy of guardianship, durable power of attorney for health care, power of attorney, or conservatorship or other documentation of a legal representative This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure tenant records included copies of documentation of durable power of attorney information. This pertained to 1 of 1 current tenants (Tenant #2) and 1 of 1 former tenants reviewed (Tenant C1) with known powers of attorney. Findings follow: Record review on 10/22/24 revealed Tenant #2's and C1's record failed to contain copies of power of attorney documents. When interviewed on 10/23/24 the Assisted Living Manager (ALM) confirmed the Program failed to ensure tenant records included required documents.	A 315		
A 340	481-69.25(2) Tenant Documents 69.25(2) The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure tenants records were retained for three years. This pertained to 1 of 2 former tenants reviewed	A 340		

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A 340	Continued From page 6 (Tenant C1). Finding follows: Record review on 10/22/24 revealed no initial evaluations or service plan for Tenant C1. When interviewed on 10/23/24 the Assisted Living Manager (ALM) said the Program could not locate the initial evaluations or service plan for Tenant C1. She believed the former director had thrown the documents away.	A 340		
A 350	481-69.26(1) 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 consistently ensure service plans were based on evaluations. This pertained to 1 of 3 current tenants reviewed (Tenant #2) reviewed. Findings follow: Record review on 10/22/24 revealed Tenant #2's service plan was dated 8/29/24. No health evaluation for this service plan could be located. During the exit on 10/23/24 at 1:30 p.m. the	A 350		

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A 350	Continued From page 7 administrative staff acknowledged the Program failed to ensure service plans were consistently based on evaluations.	A 350		
A 385	481-69.26(3)d Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. d. The service plan updated within 30 days of the tenant's occupancy shall be signed and dated by all parties. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans were updated, signed and dated within 30 days of occupancy. This pertained to 3 of 3 current tenants (Tenants #1, #2, #3) and 1 of 2 former tenants reviewed (Tenants C2). Findings follow: Record review on 10/23/24 revealed the Program failed to update service plans and ensure signatures and dates were obtained within 30 days for: Tenant #1 occupancy date 8/1/24 Tenant #2 occupancy date 11/3/23 Tenant #3 occupancy date 11/3/23 Tenant C2 occupancy date 7/12/24 During the exit on 10/23/24 at 1:30 p.m. the administrative team confirmed the Program failed to update service plans and obtain signatures and dates within 30 days of occupancy.	A 385		

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A 390	481-69.26(3)e Service Plans 69.26(3) When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. e. The service plan shall be reviewed, updated if necessary, and signed and dated by all parties at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure service plans were signed and dated. This pertained to 3 of 3 current tenants (Tenants #1, #2, #3) and 2 of 2 former tenants reviewed (Tenants C1, C2). Findings follow: Record review on 10/23/24 revealed Tenant #1's service plan 8/1/24 (last date reviewed) was not signed or dated. Record review on 10/23/24 revealed Tenant #2's service plan 8/29/24 (last date reviewed) was not signed or dated. Record review on 10/23/24 revealed Tenant #3's service plan 9/22/24 (last date reviewed) was not signed or dated. Record review on 10/23/24 revealed Tenant #C1's service plan 6/11/24 (last date reviewed) was not signed or dated. Record review on 10/23/24 revealed Tenant #C2's service plan 7/12/24 (last date reviewed) was not signed or dated.	A 390		

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A 390	Continued From page 9 During the exit on 10/23/24 at 1:30 p.m. the administrative team confirmed the Program failed to ensure service plans were signed and dated.	A 390		
A 405	481-69.26(4)c Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: 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 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure service plans included other service providers. This pertained to 1 of 2 former tenants reviewed (Tenant C1). Finding follows: Record review on 10/22/24 revealed a note by the Assisted Living Manger (ALM) regarding the initiation of hospice services for Tenant C1 on 9/8/23. Further review revealed the Program failed to update Tenant C1's service plan to include hospice services until 5/3/24. During the exit on 10/23/24 at 1:30 p.m. the administrative team acknowledged service plan failed to include other service providers in a timely manner.	A 405		
A 410	481-69.26(4)d Service Plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum:	A 410		

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A 410	Continued From page 10 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 include planned and spontaneous activities on the service plans for 2 of 3 current tenants reviewed (Tenants #1, #2). Findings follow: Record review on 10/23/24 of tenant files revealed the following: Tenant #1's Global Deterioration Scale dated 10/10/24 revealed a score of 4 and indicated moderate cognitive decline. The service plan failed to include activities based on her preferred interests and abilities. Tenant #2's Global Deterioration Scale dated 8/29/24 revealed a score of 4 and indicated moderate cognitive decline. The service plan failed to include activities based on her preferred interests and abilities. During the exit on 10/23/24 at 1:30 p.m. the administrative team confirmed the Program failed to include spontaneous activities in the service plans.	A 410		
A 540	481-69.29(6) Staffng 69.29(6) All programs employing a new	A 540		

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A 540	Continued From page 11 delegating nurse after January 1, 2010, shall require the delegating nurse within six months of hire to complete an assisted living manager class or assisted living nursing class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living. A minimum of one delegating nurse from each program must complete the training. If there are multiple delegating nurses and only one delegating nurse completes the training, the delegating nurse who completes the training shall train the other delegating nurses in the Iowa rules and laws on assisted living. As of January 1, 2011, all programs shall have a minimum of one delegating nurse who has completed the training described in this subrule. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure the delegating nurse (DN) received required training. Finding follows: Review of the Adult Services Monitoring Entrance form on 10/22/24 revealed the Program documented the DN became the delegating nurse on 11/30/22. The Program failed to provide documentation of the delegating nurse required training. During the exit interview on 10/23/24 at 1:30 p.m. the administrative team acknowledged this finding.	A 540		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting	A 545		

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A 545	Continued From page 12 with a dementia-specific program 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 consistently ensure staff received eight hours of dementia-specific education within 30 days of employment. This pertained to 1 of 2 current staff reviewed employed for less than a year (Staff C). Findings follow: Record review on 10/22/24 revealed the Program hired Staff C on 1/3/24. Review of documentation on 10/23/24 revealed Staff C failed to complete eight hours of training. During the exit on 10/23/24 at 1:30 p.m. the administrative team acknowledged the above findings.	A 545		
A 556	481-69.30(3)b Dementia-Specific Education for Personnel 69.30(3) Dementia-specific continuing education b. Direct-contact personnel employed by or contracting with a dementia-specific program or employed by a contracting agency providing staff to a dementia-specific program shall receive a minimum of eight hours of dementia-specific continuing education annually.	A 556		

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A 556	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to consistently ensure all staff received eight hours of dementia-specific education annually. This pertained to 1 of 2 current staff employed for a year or more (Staff B). Findings follow: Record review on 10/22/24 revealed the Program hired Staff B on 10/27/99. Review of documentation on 10/23/24 revealed Staff B failed to complete eight hours of training on an annual basis. During the exit on 10/23/24 at 1:30 p.m. the administrative team acknowledged the above findings.	A 556		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the Program failed to ensure an operating door alarm was connected to each exit door. This potentially pertained to 14 of 14 tenants who scored four or more on the Global Deterioration Scale (GDS). Finding follows: Observations on 10/22/24 at 3:30 p.m. revealed the Program's main entrance and the entrance	A 635		

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A 635	Continued From page 14 labeled Assisted Living had no operating alarm. When interviewed on 10/22/24 the administrative team confirmed no operating alarms on the two doors.	A 635		

Holy Spirit Retirement Home-Assisted Living 11/26/24

A 115

The facility will ensure occupancy agreements include required information.

The telephone number for the office of the long-term care ombudsman has been updated on the occupancy agreement. All current residents and/or responsible parties have been updated with correct contact information for the long-term care ombudsman.

Staff responsible for reporting dependent adult abuse were educated on 11/25/24 on proper reporting procedures including all reports to be made to DIAL.

The program coordinator/designee will monitor for compliance monthly x 3 months.

Date of completion: 11/26/24

A 120

The facility will review and update as necessary to reflect any changes in services or financial arrangements.

Going forward, any rate changes due to annual increases or service plan updates, will have an addendum added to the occupancy agreement stating these changes and signed by the resident and/or responsible party.

The program coordinator/designee will monitor for compliance monthly x 3 months.

Date of completion: 11/25/24

A 135

The facility will complete evaluations as required.

All current residents have been reviewed and any resident requiring an assessment via the global deterioration (GDS), has been completed by the RN as of 11/25/24. Going forward, any new resident or resident with a change in condition resulting in a BIMS score indicating moderately/severe impaired cognition will have a GDS completed.

The program coordinator/designee will monitor for compliance monthly x 3 months.

Date of Completion: 11/25/24

A 215

The facility will notify the legal representative of the need to involuntarily transfer a tenant or include the required information in the notice.

For any future involuntary discharges, the facility will reach out to DIAL/program coordinator for guidance on proper completion of notification.

Date of Completion: 11/25/24

A 315

The facility will ensure tenant records include copies of documentation of durable power of attorney information when these forms have been completed by the resident/responsible party.

Upon admission, requests will be made for durable power of attorney paperwork. If available and provided by resident/responsible party, copies will be added to resident chart. For current residents, durable power of attorney paperwork has been requested from the resident/responsible party. If completed and provided, it has been added to the resident's chart.

Program coordinator/designee to monitor for compliance monthly x 3 months.

Date of Completion: 11/25/24

A 340

The facility will ensure resident records are retained for at least three years.

The program coordinator and RN were educated on record retention policies.

Program coordinator/designee to monitor for compliance monthly x 3 months.

Date of completion: 11/25/24

A 350

The facility will consistently ensure service plans are based on evaluations.

The program coordinator will assure the RN has completed a health assessment with each service plan update. All current residents have a completed health assessment included with their service plan.

The program coordinator/designee will monitor monthly x 3 months.

Date of completion: 11/25/24

A 385

The facility will ensure service plans are updated, signed and dated within 30 days of occupancy.

All current residents' service plans have been reviewed for signatures. Going forward the program coordinator/designee will monitor to ensure signatures are obtained within the required time frame.

Program coordinator/designee will monitor monthly x 3 months.

Date of Completion: 11/25/24

A 390

The facility will ensure service plans are updated within 30 days of the tenant's occupancy and as needed with any significant change and annually.

All current residents' service plans have been reviewed for signatures. Going forward the program coordinator/designee will monitor to ensure signatures are obtained within the required time frame.

Program coordinator/designee will monitor monthly x 3 months.

Date of Completion: 11/25/24

A 405

The facility will consistently ensure service plans include other service providers.

Current residents with other service providers' service plans have been reviewed to assure service plans match other provides plan of care.

Facility RN educated on requirement to assure other providers plan of care matches the facility's service plan.

Program coordinator/designee to monitor residents service plans with any added providers to ensure plan of care/service plan reflects current care needs monthly x 3 months.

Date of completion: 11/25/24

A 410

The facility will include planned and spontaneous activities on service plans.

All service plans have been updated to reflect current activity needs including spontaneous activities for all residents, including residents with a global deterioration scale (GDS) of 4 or higher. Going forward, any new resident with a GDS of 4 or higher will have their service plan reflect spontaneous activities.

Program coordinator/designee to monitor monthly x 3 months.

Date of Completion: 11/25/24

A 540

The facility will ensure the delegating nurse receives the required training.

The facility delegated nurse has registered for the Assisted Living Regulatory Class. In the event of the hiring of a new delegated nurse, the delegated nurse will immediately register for the required training.

Date of Completion: 11/25/24

A 545

The facility will consistently ensure staff receive eight hours of dementia specific education within 30 days of employment.

All current employees have completed dementia specific education. All future employees will be required to complete this training upon hire.

The program coordinator /designee will continue to monitor for compliance with all new hires.

Date of Completion: 11/25/24

A 556

The facility will consistently ensure staff receive eight hours of dementia specific education annually.

All current staff have completed the eight hours of required dementia training and have been scheduled to take the required dementia training annually.

Program coordinator/designee will monitor monthly on an on-going basis.

Date of completion: 11/25/24

A 635

The facility will ensure an operating door alarm is connected to each exit door.

The facility administrator has contacted the DIAL program coordinator and requested to have separate licenses for traditional assisted living and dementia specific assisted living. Application will be submitted by 11/27/24.

✓ 1/18/25