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
	S0307	A. BUILDING: _____ B. WING _____	C 08/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING CREEK SENIOR LIVING MC	2607 NICKLAUS BLVD SIOUX CITY, IA 51106

(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 Program Number of tenants without cognitive disorder: 39 Number of tenants with cognitive disorder: 0 Memory Care Unit Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 12 Total Census: 51 The following regulatory insufficieny was cited during the investigation of Mandatory Report #98878-M.	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure the policy regarding incident reports was followed for 1 of 1 tenants reviewed (Tenant #2). Findings include: On 7/22/21 the program self-reported bruising noted on Tenant #2's right arm and hip. Written statements were obtained by the program during the investigation of the bruising. Review of a written statement written by Staff C	A 150	Plan of Correction is attached DS	

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A 150	Continued From page 1 revealed on the morning of 7/17/21 at 11:00 a.m. she noted a fist sized bruise on Tenant #2's upper right arm while helping her dress. On 8/24/21 at 3:17 p.m. interview with Staff C revealed she had not documented the bruising or completed an incident report until two days later on 7/19/21. On 8/25/21 review of the program's policy regarding incident reports (IRs) revealed an IR must be completed at the time of any accident or incident that affects a tenant. On 8/25/21 at 11:56 a.m. the Executive Director confirmed this finding.	A 150		
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program failed to ensure staff employed by a contracting agency received a minimum of eight hours of dementia-specific education annually. Findings include: On 8/24/21 record review revealed Staff G was hired by a contracting agency to work as a CNA	A 556		

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A 556	Continued From page 2 (certified nurse aide) on 3/04/20. Staff G worked in the program on 3/14/21, 5/29/21, 5/30/21, 6/16/21, 6/17/21, 6/26/21, 7/04/21 and 7/16/21. On 8/25/21 at 9:01 a.m. interview with the contracting agency responsible for providing staff revealed the employees sent to work at the program had not received dementia training. The agency reported they did not provide dementia training. On 8/25/21 at 9:10 a.m. the Executive Director confirmed this finding.	A 556		

October 22nd, 2021

Ms. Deb Dixon, Program Coordinator

Adult/Special Services Bureau

Iowa Department of Inspections and Appeals

Lucas State Building

321 East 12th Street

Des Moines, IA 50319-0083

RE: Whispering Creek Plan of Correction

Dear Ms. Dixon

Enclosed is the required "Plan of Correction" regarding the Mandatory Report Survey which was conducted between August 18th- August 25th, 2021. Submission of this response of the Plan of Correction is not a legal admission that a deficiency exists, or that the Statement of Deficiencies was correctly cited, and is also not to be construed as an admission against interest by the residence, or any employees, agents or other individuals who drafted or may be discussed in the response on the Plan of Correction. In addition, preparation and submission of the Plan of Correction does NOT constitute an admission of agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

IAC r 481-67.2(3) – Program Policies and Procedures

- The community leadership team held an all staff meeting on October 18th, 2021 to review the policies and procedures related to incidents and accidents.
- Caregiver chart notes to be reviewed by DON/ADON to ensure incident reports are completed as applicable.
- The ED and/or DON will audit incident reports weekly for one month, then monthly for one quarter. Continued monitoring will be ongoing.
- Regional DON will complete random chart audits to ensure incident reports are being filled out for all accidents or incidents that affect a resident.

IAC r 481-69.30(3)b – Dementia-Specific continuing education

- Three Helping Hands agency staff completed 8 hrs of Dementia training on October 14th, 2021. These will be the only agency staff working in the Memory Care unit.
- ED and DON will review current staff training to ensure that all have received the required 8 hr training and that it is up to date.
- ED and DON will conduct an audit quarterly for the next 2 quarters to ensure new staff receive the 8 hr Dementia training upon hire.
- The Leadership team will discuss quarterly in QI meeting to ensure sustained compliance.
- Completion for this Plan of correction is October 29th, 2021

Sincerely,

Jacque Kreber, ED

Executive Director/Whispering Creek

10/27/21