

**Iowa Department of Inspections and Appeals  
Health Facilities Division  
Adult Services Civil Penalty Citation**

<b>Date:</b> September 24, 2019
<b>Program Name:</b> Windsor Manor Shenandoah
<b>Address:</b> 601 Harrison St. Shenandoah, IA 51601
<b>Type of Action:</b> 84190-C
<b>Date(s) of Action:</b> 8/19/19 – 8/21/19

State Rule #	State Rule	Amount of Civil Penalty
<b>67.9(4)f</b>	<p><u>481-67.9(231B,231C,231D) Staffing.</u></p> <p><u>67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:</u></p> <p><u>f. Services shall be provided to tenants in accordance with the training provided.</u></p> <p>Review of the Program's list of recently discharged tenants revealed Tenant #1 passed away at the hospital on 6/21/19. Review of a Nurse's Note dated 6/25/19 revealed at approximately 3:05 a.m. on 6/21/19 the nurse received a phone call from staff stating the tenant was vomiting, had loose stools and was cold and clammy. Staff was not able to obtain a blood pressure. The tenant was sent to the emergency room. The Executive Director (ED) was informed the tenant later passed away at the hospital. The son called to say the tenant died from an obstructed bowel.</p> <p>When interviewed on 8/19/19 at 4:10 p.m. Staff A said Tenant #1 had not felt well and threw up her supper. When she tried to administer medications Tenant #1 wouldn't take the medication and threw up again. Staff A admitted she did not take Tenant #1's vital signs.</p> <p>When interviewed on 8/21/19 at 12:11 p.m. Staff B said Staff A had called her back to the memory care unit to put another tenant to bed but mentioned nothing about Tenant #1 vomiting. She did not see Tenant #1. Staff B said she had been in the building since 5:00 p.m. and Staff A did not call for any help until 8:40 p.m. when she assisted Staff A to put another tenant to bed.</p> <p>When interviewed on 8/21/19 at 11:55 a.m. Staff C said Staff A called her back to memory care at 9:00 p.m. to ask if she needed to use the carpet cleaner to clean up vomit. Staff C said Staff A told her Tenant #1 had been saying she didn't feel well and was in pain. Staff C said she told Staff A to take Tenant #1's vitals and she would come back to check after she administered medications. Staff C said she never saw Tenant #1 as Staff A told her she was in bed. According to Staff C the 10:00 p.m. - 6:00 a.m. staff person who no longer worked for the Program told her Tenant #1 had vomit on her clothes when she arrived for her shift.</p>	<b>\$2000.00</b>

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	<p>When interviewed on 8/19/19 at 4:45 p.m. the Executive Director (ED) thought Staff A became upset by the vomit and how to deal with it. She said staff all knew they could call her or the nurse. On 8/21/19 the ED reiterated all staff knew they could call her or the nurse at any time.</p> <p>On 8/21/19 the nurse provided a written statement regarding the incident. Staff A told her Tenant #1 had eaten a large dinner and thrown up while seated at the table. Staff A stated she cleaned up Tenant #1 and took her to the bathroom to use the toilet then assisted her to bed per her request. At 9:00 p.m. she noted Tenant #1 had thrown up in bed. She assisted Tenant #1 to the bathroom where she had a loose stool. Staff A cleaned up Tenant #1 and she returned to bed. According to the nurse's statement it was not unusual for Tenant #1 to have loose stools but it was unusual for Tenant #1 to vomit. She talked to Staff A about reporting such things to the nurse and/or ED. During the conversation the nurse directed Staff A to take vitals before calling to report things that were out of the ordinary. Staff A indicated she was feeling overwhelmed at the time of the incident and the nurse reminded her to call herself or the ED when something out of the ordinary and/or she did not get support or assistance from coworkers. Staff A said she understood.</p> <p>Record review on 8/21/19 revealed an undated Policy and Procedure entitled Resident Illness and Incident Reporting Training provided by the ED. According to the Policy, "Associates will report all incidences of resident illness, abnormal behavior, accidents, unusual events immediately to the Nursing/Wellness group."</p> <p>Further review revealed Staff A's Nurse Delegation for Incontinent Care form signed by Staff A on 1/5/19 and the delegating nurse on 1/6/19. According to the form staff should report anything unusual to a supervisor when assisting tenants with incontinent care.</p> <p>Further record review on 8/21/19 revealed a document entitled Announcements dated 6/28/19. The document directed staff to call the nurse and/or ED if staff needed clarification, help with residents (tenants) or any other problems/questions/concerns.</p>	
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