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
	S0254	A. BUILDING: _____ B. WING _____	C 12/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR MANOR VINTON	1807 WEST 5TH STREET VINTON, IA 52349

(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	481-67 Initial Comments Assisted Living Programs are defined by the type of 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: 29 Number of tenants with cognitive disorder: 3 Total Population of Program at time of on-site: 32 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 7 Total Population of Program at time of on-site: 9 TOTAL census of Assisted Living Program: 41 The following regulatory insufficiency was cited during the onsite investigation of Incident #64672-I.	A 000	HEALTH FACILITIES JAN 18 2017	
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.	A 003		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

1/18/17

A 003	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the Program failed to follow the policies and procedures regarding door alarm response protocol for 1 of 1 tenants reviewed (Tenant #1). Findings follow: 1. When interviewed on 12-20-16 at 9:40 a.m., Staff A stated she and Staff B left the building out the east service door on 12-14-16 about 10:30 a.m. to take garbage to the dumpster. They looked up and saw Tenant #1 in the east side parking lot. She put the trash down and ran over to Tenant #1 and asked what he/she was doing. The tenant stated they were trying to go home. Tenant #1 walked independently without his/her cane and held a closed can of soda. Staff A and B assisted Tenant #1 into the building and to the dementia unit. The Executive Director was notified. Tenant #1 wore blue jeans, tennis shoes, knit shirt and a flannel shirt. Staff A said it was cold outside and she had put on a jacket to take out the garbage. She did not hear any door alarms sound. Staff A worked in the AL unit that day. 2. When interviewed on 12-20-16 at 9:55 a.m., Staff B stated on the day of the incident at about 10:30 a.m. she took garbage to the dumpster with Staff A. There were cars parked in the lot near the dumpster and she told Staff A she thought she saw Tenant #1 on the sidewalk. They dropped what they were doing and went to Tenant #1 and asked why he/she was outside. Tenant #1 stated he/she was trying to find home. Staff A and B walked Tenant #1 back inside to their apartment in the dementia unit. Tenant #1	A 003	Staff training on policy & procedure regarding door alarm response protocol to be completed by 1/20/2017. Staff will sign acknowledging training completion & comprehension. ED will verify training is completed and acknowledged by staff. Staff C was disciplined for not following policy & procedure on 12/14/2016. RN will do door checks per RN discretion to ensure staff are checking pagers and alarm vicinity compliance. This will be completed by 1/27/2017. While not a structural insufficiency I think it's important to note; Alliance alarm company has been contacted and we are in the process at WM of gathering the needed information to turn into the state fire marshal to change our door locking system from a 15 second egress to a total locking system. We plan to have this information submitted to fire marshal for approval no later than 3/5/2017 (60 days from receipt of deficiencies). HStaubin/ED	1/20/2017 1/27/17 3/5/17

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A 003	Continued From page 2 wore a flannel shirt, blue jeans and tennis shoes. His/her hands were cold. Tenant #1 was confused when returned to the apartment. Staff A and B then notified the Executive Director. Staff A notified Staff C, who had been assisting a tenant with a shower, that Tenant #1 was found outside. Staff B did not hear any alarms sound however the dementia unit door alarm had shown up in her pager. She looked in the hall but didn't see anyone. She didn't think to look outside. Tenant #1 did not exhibit exit seeking before this incident and had not previously eloped. Tenant #1 was the type of person who liked to remain in their apartment. Staff B worked in the AL unit that day. 3. According to investigation notes documented by the Executive Director (ED) on 12-14-16 at 11:20 a.m., she met with Staff C who stated she was giving a shower and didn't hear the alarm. There had been numerous people in and out of the dementia unit that morning so she thought the page (reflecting the door alarm sounded) was another tenant's family leaving the unit. Tenant #1 was in another tenant's apartment when Staff C started to assist with the shower. The ED counseled Staff C for not answering/responding to the pager when a door alarmed and a tenant left the unit. 4. When interviewed on 12-20-16 at 11:18 a.m., the Executive Director stated at about 10:55 a.m. on 12-14-16, Staff A told her Tenant #1 was found outside. The first thing she did was to check the code alert computer to see when alarms sounded. Multiple dementia unit door alarms had sounded when the doors were opened. She checked the video camera and saw Tenant #1 exit the dementia unit. Tenant #1's family told her	A 003		

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A 003	Continued From page 3 that after the incident the tenant appeared confused and told them he/she had gone outside and two ten year old girls helped him/her back inside. The tenant also wanted to go upstairs (there is no upstairs in the building as it is all on one level). The ED shared the video results with the family and discussed obtaining a urine sample for possible urinary tract infection (UTI). 5. Observations on 12-20-16 at 9:48 a.m., revealed the distance from the east service door to the point where Tenant #1 was seen on the sidewalk as 25 yards. The distance from the west sunroom parking door, which is the door determined to be the exit point, to the east service door entrance was a total of 220 yards. 6. On 12-20-16 at 10:25 a.m., the Executive Director showed the monitor the video recordings of the hallways. Tenant #1 was observed in the hallway talking with another tenant as they entered each others' apartments, then walked towards the exit doors. At 10:38 a.m. on 12-14-16, the other tenant walked back to their apartment. Tenant #1 was no longer visible on the recording. At 10:50 a.m. Staff A and B were visualized entering the east service door with Tenant #1. 7. According to a pager report, the dementia unit's main doors were opened on 12-14-16 at 10:30 a.m., the west sunroom door was opened at 10:30 a.m. and the east service door was opened at 10:37 a.m., indicating Tenant #1 was outside for approximately seven minutes. 8. According to the State Climatologist, on 12-14-16 at 10:55 a.m., at the Vinton airport, it was 18 degrees with winds from the west at 20	A 003		

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A 003	Continued From page 4 miles per hour, gusting to 30 miles per hour. Wind chill was 1 degree. There was approximately a two inch snow cover on the ground from a snowfall three days prior to the incident. 9. Tenant #1, an 86 year old, resided in a locked dementia unit and had a diagnosis of dementia. Tenant #1 was staged at a five on the Global Deterioration Scale which indicated moderate severe cognitive decline. According to the Nurse's Notes dated 12-14-16, when Tenant #1 returned to the dementia unit vital signs were: Blood Pressure 136/78, Pulse 54, Respirations 16 and Temperature 98.3 degrees. Tenant #1 immediately went with family to the salon for hair grooming. On 12-15-16 a UA was collected. On 12-16-16 an antibiotic (Omnicef 300 mg.) was ordered to be administered twice a day for ten days. Tenant #1's service plan was updated to indicate exit seeking behaviors. 10. According to the Exterior Door Policy, when the door alarms on the non-memory care side was signaled the staff who carries a pager must visually check the exterior door to ensure a tenant does not need assistance at the door. If the staff required assistance they would access assistance via the walkie-talkie communication system. The assigned memory care staff would be responsible for doors within the memory care community. Staff B failed to check the west sunroom door when the dementia unit doors alarmed and Staff C failed to call for assistance when her pager indicated the dementia door alarmed.	A 003		

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

Date: January 4, 2017
Program Name: Windsor Manor Vinton
Address: 1807 West 5th Street, Vinton IA 52349
Type of Action: Investigation 64672-I
Date(s) of Action: December 20, 2016

State Rule #	State Rule	Amount of Civil Penalty
67.2	481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. Based on interviews and record reviews, the Program failed to follow the policies and procedures regarding door alarm response protocol for 1 of 1 tenants reviewed (Tenant #1). Findings follow: 1. When interviewed on 12-20-16 at 9:40 a.m., Staff A stated she and Staff B left the building out the east service door on 12-14-16 about 10:30 a.m. to take garbage to the dumpster. They looked up and saw Tenant #1 in the east side parking lot. She put the trash down and ran over to Tenant #1 and asked what he/she was doing. The tenant stated they were trying to go home. Tenant #1 walked independently without his/her cane and held a closed can of soda. Staff A and B assisted Tenant #1 into the building and to the dementia unit. The Executive Director was notified. Tenant #1 wore blue jeans, tennis shoes, knit shirt and a flannel shirt. Staff A said it was cold outside and she had put on a jacket to take out the garbage. She did not hear any door alarms sound. Staff A worked in the AL unit that day. 2. When interviewed on 12-20-16 at 9:55 a.m., Staff B stated on the day of the incident at about 10:30 a.m. she took garbage to the dumpster with Staff A. There were cars parked in the lot near the dumpster and she told Staff A she thought she saw Tenant #1 on the sidewalk. They dropped what they were doing and went to Tenant #1 and asked why he/she was outside. Tenant #1 stated he/she was trying to find home. Staff A and B walked Tenant #1 back inside to their apartment in the dementia unit. Tenant #1 wore a flannel shirt, blue jeans and tennis shoes. His/her hands were cold. Tenant #1 was confused when returned to the apartment. Staff A and B then notified the Executive Director. Staff A notified Staff C, who had been assisting a tenant with a shower, that Tenant #1 was found outside. Staff B did not hear any alarms sound however the dementia unit door alarm had shown up in her pager. She looked in the hall but didn't see anyone. She didn't think to look outside. Tenant #1 did not exhibit exit seeking before this incident and had not previously eloped. Tenant #1	$2000.00

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