

**Department of Inspections and Appeals
Health Facilities Division
Citation**

Number 5977					Report date January 19, 2023
Facility name Windsor Place Senior Living Campus		Survey dates 12/05/2022 - 12/29/2022			
Facility address 900 South Stone Street					
City Sigourney		JB			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date	
58.19(2)j	<p>481—58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:</p> <p>58.19(2) Medication and treatment. <i>j.</i> Provision of accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in mental, emotional, or physical condition. (I, II, III)</p> <p>DESCRIPTION</p> <p>Based on clinical record reviews and staff interviews, the facility failed to complete a comprehensive assessment on a resident with a persistent and excruciating headache, motor skill decline, and a change in mental status for one of four residents reviewed (Resident #1). The facility reported a census of 24.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) assessment tool with an Assessment Reference Date of 10/20/22, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. Resident #1</p>	I	\$9,500.00 Held in Suspension	Upon Receipt	

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Facility Administrator

Date

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	<p>required limited assistance with transfers, mobility, dressing, toilet use, and personal hygiene needs. Resident #1's diagnoses included coronary artery disease, congestive heart failure, hypertension, and psychotic disorder.</p> <p>In an interview on 12/5/22 at 3:14 p.m. Staff A, Certified Nurse Aide (CNA), stated that on Tuesday, 11/29/22 she worked a 6:00 a.m. to 2:00 p.m. shift. That morning, Resident #1 was already up in her recliner, this was unusual as Resident #1 usually slept in until 9:00 a.m. to 10:00 a.m. Resident #1 was complaining of a headache and constantly pulling on her call light. At 6:15 a.m. Staff A reported Resident #1's complaints of a severe headache to the charge nurse who happened to also be the Administrator. The Administrator stated Resident #1 had already been given pain medication. Staff A asked the Administrator if the facility had ice packs and was told no, so Staff A got some wet washcloths and placed them on Resident #1's neck and head. Staff A stated the wet cloths helped briefly, but Resident #1 was back on her call light. One minute wanting in her bed and the next wanting back in her recliner. Staff A attempted to comfort her and told her they had given her medication that morning, but Resident #1 did not recall getting the medication. Staff A stated Resident #1 was usually cognitively alert, could carry on a conversation, was independent with</p>				

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	<p>most care, and could walk independently using her walker. Resident #1 was also a nurse. Resident #1 continued to complain of a severe headache and Staff A stated she continued to report to the Administrator that Resident #1 was having an excruciating headache and requesting to be sent to the hospital. Staff A indicated the Administrator seemed more interested in cleaning and organizing the medication room than attending to the resident. By 12:00 p.m. to 12:30 p.m. Resident #1 became even more agitated and was yelling she needed to go to the hospital. Her outbursts were so disruptive that residents including Resident #2 and Resident #3, were also commenting to the Administrator that Resident #1 was crying and wanting to go to the hospital. Staff A stated Resident #1 was crying in pain and stated I was a nurse and this is not normal. Staff A stated Staff B and Staff C also witnessed Resident #1's cries for help that day, but nothing was done. Staff A stated she returned to work at 5:30 a.m. the following day (11/30/22). In report, the night aide reported Resident #1 continued to complain of pain and rolled out of bed. Resident #1 was not disturbed once she seemed to calm down. At around 6:20 a.m. Staff A checked on Resident #1. Resident #1 was soaked in urine from her shoulders to her knees. The nurse, Staff E witnessed the residents lack of care and instructed Staff A to give her a bed bath. Staff A stated once she began attending to</p>				

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	<p>Resident #1 she knew immediately that she had had a stroke. Resident #1 was unable to talk or move her right side. There was nothing in her eyes, she was like a vegetable. Staff E had an order for a urinalysis and she assisted him with getting the urine sample. Staff A commented, I believe she has had a stroke and Staff E responded maybe. Staff A stated she changed Resident #1's bed three times that day and Resident #1 never showed any signs of improvement. Staff A stated on Monday, 11/28/22, Resident #1 was up, independent and in the dining room talking and normal and by Wednesday, 11/30/22 she was a vegetable.</p> <p>On 12/7/22 at 8:45 a.m. Staff A was contacted for clarification. Staff A stated that she gave a report to the on-coming aide (Staff G) at 2:00 p.m. on 11/29/22. Staff A stated she informed Staff G that Resident #1 had been up all night and complained of a severe headache throughout the day. Staff A stated Resident #1 was requesting to go to the hospital. Staff A explained that the Administrator knew of her condition and Resident #1 's request to go to the hospital.</p> <p>In an interview on 12/5/22 at 4:55 p.m. Staff B, CNA, stated that she worked 6:00 a.m. to 2:00 p.m. on Monday, 11/28/22. Staff B stated she remembered Resident #1 being alert, conversing with staff, independently mobile using her walker,</p>				

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	<p>and being her normal self. Resident #1 only needed assistance with incontinence cares. On Tuesday, 11/29/22, Staff B worked from 6:00 a.m. until 2:00 p.m. That morning when she arrived, Resident #1 was complaining of a headache. As the morning progressed, Resident #1's headache worsened into a migraine. Resident #1 began requesting to be sent to the hospital. The Administrator stated they had already given her something and stated that is just Resident #1 she complains, but she is fine. Staff B stated she never saw the Administrator check on Resident #1. Resident #1 continued to complain of an excruciating headache and continually pulled on her call light throughout her shift. Resident #1 would say I was a nurse, I know they can help me, but no one did.</p> <p>On 12/7/22 at 11:50 a.m. Staff B was interviewed for clarification. Staff B stated when she spoke with the Administrator about Resident #1, she informed her that Resident #1 was requesting to go to the hospital. At that time the Administrator said she already gave her something for pain. The Administrator added that she complains, but she is fine.</p> <p>In an interview on 12/5/22 at 5:10 p.m. Staff C, Marketing, stated she arrived to work around 8:30 a.m. on 11/29/22. Several of the aides approached her with concerns related to Resident #1. The aides</p>				

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Facility Administrator

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	<p>stated Resident #1 was complaining of an excruciating headache and requesting to go to the hospital. The aides indicated they had informed the Administrator several times, but she was doing nothing. Staff C stated she went to the Administrator and expressed her concern. The Administrator stated she had given Resident #1 a Tramadol (controlled pain medication) and they were getting an order for a urinalysis. Staff C stated that the Administrator never saw or assessed Resident #1 that day. Staff C stated that afternoon Resident #1 was grabbing at her head and screaming. Resident #1 wanted to go to the hospital. Staff C stated Resident #1 had been cognitively alert most of the day complaining of a headache, but by late that afternoon her speech had become garbled. She was not alert and confused. On Wednesday, 11/30/22, Resident #1's right side was flaccid, she was unresponsive, and she had no right-side vision. Staff C stated to her knowledge no one ever properly assessed Resident #1 or sought appropriate medical attention.</p> <p>On 12/7/22 at 8:08 a.m. Staff C was contacted for clarification. Staff C stated she included Resident #1's requesting to go to the hospital when informing the Administrator of Resident 1's condition that day and also reported late that afternoon when Resident #1's speech became garbled and she became confused.</p>				

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	<p>In an interview on 12/6/22 at 11:05 a.m. Staff D, Certified Medication Aide, stated she worked 6:00 a.m. to 2:00 p.m. on 11/29/22 and was assigned to pass medications. The scheduled nurse called in so the Administrator covered for the absent nurse. Staff D stated the Administrator remained in the medication room cleaning and organizing her entire shift. Staff D stated she started setting up medications when Resident #1's call light came on, so she responded. Resident #1 was complaining of a headache. Staff D assisted Resident #1 to the toilet. Resident #1 was having difficulties walking which was unusual for her. Staff D got Resident #1 to the toilet and returned to her medication cart. The call light came on again and Staff D returned and helped Resident #1 into her recliner, gave her a blanket. Moments later Resident #1 was hollering for help. Staff D gave her Tylenol at 7:14 a.m. and then again returned to her cart as Resident #1 continued to holler out and cry for help. Other aides voiced concerns. At around 9:00 a.m. Staff D asked the Administrator to check on Resident #1. Staff D stated the Administrator never checked on Resident #1 during her shift, despite being informed, and asked multiple times. Staff D stated she felt helpless because the Administrator would not do anything. Staff D stated she was on the assisted living unit setting up medications from about 10:00 a.m. until 12:00 p.m. Upon returning,</p>				

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	<p>Resident #1 was continuing to cry out in pain. Staff D said something to the Administrator and she was instructed to give Resident #1 Tramadol at 11:48 a.m. Staff D stated the Administrator did not assess Resident #1 prior to or after the administration of the controlled medication. The next day (11/30/22) an aide reported something was wrong with Resident #1. Staff D went to the room. Resident #1 was sitting in bed awake but not responsive, would not talk, and would not move. Resident #1 would not take her medications. Staff D reported her observations to Staff E. The Administrator was standing nearby, listening to the conversation, then stated the urinalysis was sent. And that she was fine. Staff F stated Staff E went to check on Resident #1.</p> <p>In an interview on 12/6/22 at 5:00 p.m. the Administrator stated on 11/29/22 the day nurse called in, so she took on the responsibilities of the licensed nurse from 6:00 a.m. to 6:00 p.m. The Administrator admitted she does not work the floor and was not familiar with the residents. The Administrator stated Resident #1 had a headache, was confused, and not acting right that day. Resident #1 was given as needed pain medication and the Administrator personally gave her pain medication at 6:02 p.m. The Administrator stated at one time that day (unable to specify the time of day) she noticed Resident #1's oxygen tubing</p>				

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	<p>knotted. She corrected it and checked the oxygen saturation which was at 91%-92%. The Administrator stated at 2:00 p.m. Staff D left, then at 6:00 p.m. Staff F arrived and took over the nursing duties. The Administrator was asked if anyone had approached her that day with concerns about Resident #1? The Administrator stated yes, they all thought she had COVID. They told her Resident #1 had a headache. The Administrator was asked if anyone told her Resident #1 wanted to go to the hospital? The Administrator stated no, if they had I would have sent her. The Administrator stated she never charted an assessment on Resident #1, consulted a physician, or notified family of Resident #1's condition.</p> <p>According to the Centers for Disease Control and Prevention (CDC) information on Stroke Signs and Symptoms dated March 4, 2022: During a stroke every minute counts, fast treatment can lessen the brain damage that stroke can cause. By knowing the signs and symptoms of a stroke, you can take quick action and perhaps save a life. Signs and symptoms of stroke include: *Sudden numbness or weakness in the face, arm, or leg, especially on one side of the body. *Sudden confusion, trouble speaking, or difficulty understanding speech. *Sudden trouble seeing in one or both eyes.</p>				

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	<p>*Sudden trouble walking, dizziness, loss of balance, or lack of coordination. *Sudden severe headache with no known cause. Call 9-1-1 right away if you or someone else has any of these symptoms.</p> <p>In an interview on 12/6/22 at 4:25 p.m. Staff G, CNA, stated she worked 2:00 p.m. to 10:00 p.m. on 11/29/22. In report she was informed that Resident #1 was not doing well, was in bed, and had a headache. Staff G stated Resident #1 was complaining of a major headache that evening and she informed Staff F, Licensed Practical Nurse (LPN). Staff G stated she assisted Resident #1 to the bathroom a couple times during her shift. Staff G stated Resident #1 was normally independent, so it was unusual for her needing assistance, but that evening she was having balance issues.</p> <p>In an interview on 12/7/22 at 10:30 p.m. Staff H, CNA, stated she worked the overnight shift (10:00 p.m. to 6:00 a.m.) on 11/28/22. Staff H recalled that Resident #1 slept through most of the night, but had slid out of bed at around 5:45 a.m. that morning. Staff H stated she noted no change in Resident #1's condition. Staff H stated she returned that evening (11/29/22) for the overnight shift and was informed in report Resident #1 had a headache that day and that they suspected she had a urinary tract infection. Staff H stated it was not unusual for</p>				

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	<p>Resident #1 to have headaches and receive Tylenol. Shortly after midnight (12:29 a.m.) Resident #1 was discovered on the floor in front of her recliner. Resident #1 was disoriented, saying what, what. Resident #1 was unable to understand or respond to staff. Staff H stated this was the first time she had noticed a dramatic change in Resident #1's condition who had been independent and required minimal assistance to now require total care, have to be checked for incontinence, and get changed as needed.</p> <p>In an interview on 12/8/22 at 12:50 a.m. Staff F stated she was an agency nurse, but has worked several shifts at the facility and was familiar with Resident #1. Staff F stated she worked the overnight shift (6:00 p.m. to 6:00 a.m.) on 11/28/22. Staff F recalled Resident #1 being fine during her shift. Resident #1 complained of a headache and was given Tylenol at 5:45 a.m. Resident #1 slid off of her bed when she sat up to take her medication. Resident #1 was not injured. On 11/29/22, Staff F returned to the facility to work another overnight shift. In report the Administrator stated Resident #1 had been acting differently and she was wanting to get a urinalysis and put in an order. The Administrator made no mention of Resident #1's complaints of headache that day or of her change in condition. Early that evening, Resident #1 was screaming help, help, help.</p>				

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	<p>Resident #1 was assisted to the bathroom and completely confused. Staff F stated she attributed the confusion to a urinary tract infection based on the information she was given from the Administrator. Staff F stated she thought the change in condition had already been discussed with a physician. Staff F stated if a resident had a change in condition, they should be assessed, have their vitals checked, and a physician notified. The assessment should be documented in the progress notes. Staff F stated she thought Resident #1's change in condition had already been reported.</p> <p>In an interview on 12/8/22 at 4:42 p.m. Staff E, LPN, stated he has taken care of Resident #1 for several years and knows the family well. Staff E stated 6 months ago Resident #1 went through a bout of pulmonary edema and hypoxia. During that time, she was hospitalized and upon returning to the facility she was placed on oxygen supplement and her condition was such that she was placed on hospice services. Resident #1 was adamant that she did not want to return to the hospital. Eventually Resident #1 recovered and about a month ago she was taken off hospice services. Resident #1 was able to toilet independently and required minimal assistance with care. Resident #1 used an oxygen supplement, but was not always compliant. Staff E stated he worked the day shift (6:00 a.m. to 6:00 p.m.) on 11/30/22. It was the first time he had</p>				

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	<p>worked in four days. In report he was informed by Staff F, that Resident #1 fell, had increased disorientation, agitation, and restlessness. Following the report, Staff E went to see Resident #1. One of the first things he noticed was a strong odor of urine. Staff E stated this was unusual as Resident #1 was normally a continent. Resident #1 was in her bed restless, grabbing her blankets, and throwing them off her bed. Resident #1 was not responding to directions and was saying words, but not every answer made sense. Staff E stated he checked her pupils which seemed equal and reactive to light, but was unable to check hand grips due to Resident #1's noncompliance. Staff E stated he also noticed Resident #1 holding her right arm into her body and her right wrist slightly contracted. Staff E stated they have a standing order for a urinalysis (UA), so he collected a urine sample to rule out a possible urinary tract infection (UTI). Meanwhile Staff E stated he knew the Advanced Registered Nurse Practitioner (ARNP) would be visiting that morning and she could assess Resident #1 further. At around 9:00 a.m. to 9:30 a.m. ARNP1 visited and started Resident #1 on an antibiotic. ARNP1 stated they would see whether Resident #1 had a UTI and if so treat accordingly. Otherwise the family needed to be consulted whether they wanted more aggressive treatment or comfort care. Staff E stated by the end of that day, Resident #1's right arm was pulled up against her</p>				

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	<p>body and right wrist contractured. At that time Staff E suspected Resident #1 had had a stroke. Staff E stated he contacted the family informing them of her condition and that she had probably had a stroke. The family stated they did not want her hospitalized and if her condition did not change they would consider hospice. Staff E explained that according to other caregivers on 11/29/22, Resident #1 had an excruciating headache, unrelieved with medication throughout the day. She was continually on her call light and requesting to go to the hospital, Staff E stated he did not know that. Staff E stated Resident #1 putting on her call light or having a headache was not unusual, but not getting relief of her headache after receiving medication was unusual. Staff E asked what he would have done given these circumstances. Staff E stated he would have assessed Resident #1 and discussed what they could do to relieve her headache. If symptoms persisted he would notify the physician and have her sent out.</p> <p>In an interview on 12/6/22 at 10:05 a.m. ARNP1 reported that on 11/30/22 she visited the facility in response to Resident #1's change in condition. ARNP1 stated this was the first time she had ever seen Resident #1 and she was not familiar with the residents past abilities and condition. ARNP1 stated she was informed by Staff E that Resident #1 had become incontinent and her urine was foul</p>				

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	<p>smelling. Staff E stated Resident #1 gets confused when she has a urinary tract infection. ARNP1 stated she seen Resident #1 sitting at her bedside, restless, and unable to respond appropriately when spoken to. ARNP1 stated she spoke with her family who indicated they did not want Resident #1 sent to the hospital. The family indicated the resident would not want to go to the hospital. ARNP1 stated she had not been informed of Resident #1 was having an excruciating headache throughout the day on 11/29/22 and that Resident #1 was requesting to go to the hospital. ARNP1 stated she did not know that prior to the day before, Resident #1 was cognitively alert, verbal, and independently mobile using her walker. ARNP1 asked if she had been contacted about a resident having an excruciating headache, crying, and requesting to go to the hospital, would she send the resident? ARNP1 stated if the resident was cognitively aware, she would not hesitate to send her to the hospital. ARNP1 asked if a resident were having an excruciating headache 24 hours before she had an adverse condition change (stroke), would there have been any benefit to sending the resident to the hospital prior to those adverse changes. ARNP1 stated yes, there are medications which can slow the progression of a stroke down.</p> <p>In an interview on 12/7/22 at 11:30 a.m. the Director of Nursing (DON) stated she was at home</p>				

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	<p>with COVID on 11/29/22. The DON stated she has only been the DON for 3 weeks, but has worked at the facility for 3-4 months. The DON stated Resident #1 required limited assistance with changing and some care. Resident #1 could ambulate with a walker and could verbalize her wants and needs, although did not talk a lot. The DON indicated new nurses and CMAs are provided a job description upon hire and provided the surveyor the job descriptions for their CMAs, LPNs, and Registered Nurses. The DON stated residents with complaints or changes in condition are to be thoroughly assessed, treated, and documented in the progress notes. If a complaint persists or is a significant change, nurses are to contact a physician and treat accordingly. Families are also to be notified and documentation of actions recorded in the progress notes.</p> <p>According to the facilities undated Licensed Vocational Nurse Position Description (LPN), licensed nurses are responsible for:</p> <ul style="list-style-type: none"> *The total nursing care of residents in their assigned unit. *Assumes responsibility for compliance with Federal, State, Local and company regulations. *Charts progress notes in an informative, factual manner that reflects the care administered as well as the resident's response to care. 				

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Facility Administrator

Date

**Department of Inspections and Appeals
Health Facilities Division
Citation**

Number 5977					Report date January 19, 2023
Facility name Windsor Place Senior Living Campus		Survey dates 12/05/2022 - 12/29/2022			
Facility address 900 South Stone Street					
City Sigourney		JB			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction Date	
	<p>*Observes residents, records significant conditions and reactions, notifies supervisor or physician of resident's conditions and reactions to drugs, treatments and significant incidents.</p> <p>*Takes temperatures, pulse, blood pressure and other vital signs to detect deviations from normal and assess the condition of the resident.</p> <p>*Responds to emergency situations based upon nursing standards, policies, procedures and protocols.</p> <p>In an interview on 12/7/22 at 3:25 p.m. Staff I, LPN, stated that she works for an agency. Staff I stated when a resident has a complaint or change in condition, they are to be assessed, including checking vital signs, rating pain, and administering as needed (PRN) medications when appropriate. The assessment should be recorded in the progress notes. If the change in condition is significant or an emergency type situation, she would first attend to the resident's needs, consult a physician, and notify emergency medical services (EMS) if appropriate. Following the event, she would record the assessment and contact details in the progress notes or on an incident report form. Staff I stated she would notify family and record the communication in the progress notes. Staff I stated when giving a PRN medication, it is recorded in the electronic medical records (EMR) system. The EMR system automatically prompts a follow up needed</p>				

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	<p>to evaluate the effectiveness of the medication. Staff I stated she would usually wait 45 minutes to an hour and a half to revisit the resident and evaluate effectiveness. Staff I stated the follow up prompt will remain on the EMR until someone addresses it.</p> <p>According to Resident #1's progress notes: 11/28/22 at 8:16 p.m. administered 50 milligrams Tramadol HL as needed for a headache by Staff F. 11/28/22 at 11:04 p.m. recorded as effective by Staff F. 11/29/22 at 7:14 a.m. administered 650 milligrams of Tylenol as needed for a headache by Staff D. 11/29/22 at 11:25 a.m. recorded as effective by Staff D. 11/29/22 at 11:48 a.m. administered 50 milligrams of Tramadol HL as needed for a headache by Staff D. 11/29/22 at 5:53 p.m. recorded as effective by the Administrator. 11/29/22 at 6:02 p.m. administered 50 milligrams of Tramadol HL as needed for pain by the Administrator. 11/29/23 at 11:31 p.m. recorded as effective by Staff F.</p> <p>In an interview on 12/6/22 at 4:18 p.m. the primary care physician's nurse stated there was no record of</p>				

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	<p>anyone from the facility calling regarding Resident #1 on 11/29/22.</p> <p>FACILITY RESPONSE:</p>				

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Facility Administrator

Date