IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

October 16, 2009

Incident: #24769-I
24885-I

Annette Grochala, Administrator
Windsor Manor Assisted Living
608 South 15th Street
Indianola, IA 50125-2981

RE: Complaint Investigation Report, Windsor Manor Assisted Living, Indianola, IA

Dear Ms. Grochala:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Complaint Investigation Report dated August 26 & 27, 2009. Based on the information provided, DIA accepts the POC. No further action on the part of the program is necessary.

We appreciate your prompt action in correcting the Regulatory Insufficiency. If you have questions, please contact me at 515-281-5003.

Sincerely,

Connie Schaffer

Connie Schaffer
Certification Coordinator – Central Iowa
Health Facilities Division
Adult Services Bureau
Connie.Schaffer@dia.iowa.gov

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Incident Investigation Report

Assisted Living Program:

Annette Grochala, Administrator
Windsor Manor Assisted Living
608 South 15th Street
Indianola, IA 50125-2981

Incident Intake #: 24769-I
24885-I

Date of Incident Investigation:

August 27, 2009

Monitor(s):

Hal L. Chase, RN BSN MPH

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to, and approved by, the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of an Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Windsor Manor Assisted Living on August 27, 2009. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	25
Current number of tenants with cognitive disorder:	7
Total Population of GPP:	32

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	10

Total Census of ALP: 42

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Program History – There was a substantiated Regulatory Insufficiency in the area of Medications during this recertification period.

Incident Investigation – The investigator(s) made the observations detailed in the following areas.

A. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Incident Allegation #24769-I : It is alleged Tenant #1 left the program and "flagged" a lady down and asked her for a ride in her convertible. The tenant reportedly stated he/she was lost.

Monitoring Observation: Tenant #1, an 85 year old, was admitted on 4-29-09 and has diagnoses of: Alzheimer's Disease, Dementia, Anxiety and Hyponatremia. A cognitive evaluation of 8-10-09 staged the tenant at four on the Global Deterioration Scale, which indicated moderate cognitive impairment. The tenant resided in the general population. Nurse's care notes of 7-23-09 indicated a managed risk agreement was implemented as the tenant had hid his/her security pendent, the pendent was never found and the tenant refused to wear the second pendent. The Administrator stated the "Sentry System" was initiated on 6-19-09, which included staff to check on the tenant's safety when the alarm system sounded. Nurse's care notes of 6-19-09 indicated staff will check on the tenant visually every eight times per shift for safety sake. Service plans of 6-19-09 and 7-23-09 indicated interventions related to safety checks. The tenant's file indicated "resident hourly checks" sheet were completed beginning 4-30-09, with the last entry recorded on 6-3-09. No other records of hourly checks were found. An incident report of 8-9-09 indicated the tenant was found by a passerby down the street from the program. The incident report also indicated two staff were busy with other tenants and did not realize the tenant had left the program until a passerby returned the tenant to the program. The program did not have staff available to check on the tenant when the sentry system alarmed.

- Regulatory Insufficiency: The program did not have sufficiently trained staff available at all times to meet tenants' identified needs. (25.33 (1))

Incident Allegation #24885-I: It is alleged Tenant #2 reported an unknown quantity of Percocet 7.5mg/500mg Tylenol was missing between 10:00 am and 2:00 pm on 8-13-09.

Monitoring Observation: Tenant #2, an 81 year old, was admitted on 2-25-08 and has diagnoses of: Angina, Status Post Coronary Stent, Diabetes Mellitus, Arthritis, Osteoarthritis of the Knees, Pedal Edema, Status Post Angioplasty, Status Post Cataract Surgery, Hypertension, Gastro Esophageal Reflux Disease, Status Post Hysterectomy and Hypothyroidism. Service plan of 7-20-09 indicated the tenant was independent with medication administration, but received other services. The tenant was interviewed and stated he/she believed medications were missing on 8-13-09 between 10:00 am and 2:00 pm but could not identify who may have taken the medication. A Dependent Adult Abuse Investigation is ongoing as of this writing. Iowa Administrative Code Chapter 25 for Assisted Living does not have regulations related to missing medications from tenants who are self-medicating.

- Regulatory Insufficiency: None noted.

Dated this 16th day of October, 2009.