IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 33246-I

April 11, 2011

Annette Grochala, Administrator
Windsor Manor Assisted Living
608 S 15th Street
Indianola, IA 50125

RE: Final Incident Investigation Report, Windsor Manor Assisted Living, Indianola, Iowa

Dear Ms. Grochala:

Enclosed is the **Final Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231D and Iowa Administrative Code (IAC) chapters 481—67 and 481—70.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Final Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiency, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Incident Intake # 33246-I**

Annette Grochala, Administrator
Windsor Manor Assisted Living
608 S 15th St
Indianola, IA 50125

Date of Incident Investigation:

March 22 and 23, 2011

Monitor(s):

Lori Miner, RN BSN

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. IAC r. 481-67.10(5). 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 481 IAC - chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Windsor Manor on March 22 and 23, 2011. 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:	22
Current number of tenants with cognitive disorder:	5
Total Population of GPP:	27

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

Total Population of DSP:	9

Total Census of ALP: 36

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

Tenant/Family Satisfaction Results – A tenant meeting was not held in the locked dementia unit.

Program History – The program did not receive any regulatory insufficiencies during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

A. Staffing

Incident Allegation: The program reported to the department on 3-11-11 an incident that occurred with Tenant #1 on 3-10-11 around 8:00 p.m. The incident was appropriately reported within 24 hours.

Tenant #1, an 84 year-old, was admitted to the program on 1-13-07 with diagnoses of: Alzheimer's, History of Altered Mental Status, Diabetes Mellitus (DM), Hypothyroidism, Osteoporosis, Coronary Artery Disease (CAD), History of Constipation, Lethargy, Atrial Flutter with Ablation, Obstructive Sleep Apnea, History of Falls, History of Coronary Artery Bypass Graft (CABG), History of Compression Fracture L1 and L2, History of Wrist Fracture, Urinary Tract Infections (UTI), Epistaxis, Shortness of Breath (SOB) Depression, Low Back Pain, History of Syncope Episodes and Unresponsive Episodes, Skin Tears, and Right Wrist Fracture and Pain. At the time of the incident, the tenant scored five on the Global Deterioration Scale (GDS) which indicated Moderate Severe Cognitive Decline. The tenant resides in the locked dementia unit.

The program reported on 3-10-11 at approximately 8:00 p.m., Staff #1 was administering a nebulizer treatment to a tenant in the dementia unit. Staff #1 heard a noise and went out of the tenant's room to find Tenant #1 on the floor with the walker on top of him/her. The right wrist appeared to be injured and out of place. The program reported Tenant #1 was sitting and watching television with another tenant when Staff #1 went to administer the nebulizer treatment. Tenant #1 was found approximately 10 feet away from where he/she had been sitting. Staff #1 called for assistance from Staff #2. After notifying the program registered nurse, an ambulance was called. The staff reported not feeling comfortable moving Tenant #1, so staff waited with the tenant until the ambulance and crew arrived. Tenant #1 was transported to the hospital and treated for a right wrist fracture.

Incident reports were signed by Staff #1 and #2.

The service plan applicable at the time of the incident, dated 1-24-11, indicated Tenant #1 had a history of falls, lethargy, and syncopal episodes. Tenant #1 used a walker for ambulation and the service plan indicated the tenant preferred the staff to provide stand by assistance of one with ambulation for safety. Tenant #1 ambulated independently in the apartment. The service plan indicated the tenant preferred staff make frequent checks throughout each shift and remind the tenant to ask for assistance before ambulating.

The information provided by the program indicated one person staffed each shift in the dementia unit. The program also indicated one person staffed the general population unit each shift, with an additional person available from 6:30 a.m.-1:00 p.m. and 4:00 p.m.-8:00 p.m. According to the staff schedule for March 10, 2011 provided by the program, three persons were scheduled for the PM shift: Staff #1, Staff #2, and Staff #3. The program reported that Staff #1, a universal worker, was in a tenant's apartment administering a nebulizer treatment at the time of the incident. An interview was conducted with Staff #2, a universal worker. Staff #2 indicated she was working in the general population unit the evening of the incident. She was "walkied" by Staff #1 who requested assistance. Staff #2 arrived in the dementia unit to find Tenant #1 on the floor between a chair and table in the living room of the dementia unit with the walker behind him/her. The wrist was noted to be out of place, so Staff #2 did not move the tenant, but

notified the nurse, the family, gave pain medication and called the ambulance. Staff #2 reported that Staff #1 had been in a tenant's room administering a nebulizer treatment at the time of the incident. Staff #2 indicated it takes five to ten minutes to set up and give a nebulizer treatment, and the treatments are ordered three times per day. Staff #2 reported that only one person is scheduled all the time in the dementia unit. An interview was conducted with Staff #3, a universal worker. Staff #3 indicated she was working as a "float" on the 4:00 p.m.-8:00 p.m. shift on the evening of the incident. Staff #3 indicated she was in the middle of giving a shower to a tenant who resided in the general population unit when a request came for assistance. When the shower was completed, Staff #3 proceeded to the dementia unit. Staff #3 indicated there is one staff person per shift and the float person provides a break to the staff scheduled in the dementia unit. The float person is then working alone in the dementia unit. Staff #3 indicated it takes about five minutes to give a nebulizer treatment.

On the evening of the incident, Tenant #1 was not in his/her apartment. The only staff person in the dementia unit at the time of the incident was in another tenant's apartment for the purpose of administering a nebulizer treatment which took at least five minutes.

On 3-22-11 observations were made in the dementia unit. At approximately 7:30 p.m. Tenant #1 was observed sitting in the living room of the dementia unit. When the tenant was assisted in getting up, it was noted that there was no chair alarm present.
An observation was made from Tenant #2's apartment, the tenant who received nebulizer treatments. The site of the occurrence of the incident, as indicated by Staff #2, was not visible from inside Tenant #2's apartment.

- Regulatory Insufficiency: None noted.

Monitoring Observation: During the course of the investigation, the following onsite observations were made during the evening of 3-22-11. At 7:37 p.m. the staff began moving tenants from the dementia unit to the north hallway because of a tornado warning. The north hallway was part of the general population area and was not a locked area. Tenant #5 was escorted by staff to apartment N4 in the north hallway. Tenant #5 was directed to stay in the restroom of the apartment until an "all clear" was called. The tenant in apartment N4 was the spouse of Tenant #5.

Once all of the tenants and staff were gathered, there were four staff, Staff #2 a universal worker, Staff #3 a universal worker, Staff #4 dietary staff, and Staff #5 activity staff. There were 15 tenants sitting in the north hall during the tornado warning.

At approximately 8:08 p.m. staff were moving tenants back to their apartments after an "all clear" notification was received. At 8:09 p.m., there were no staff in the hallway when Tenant #5 exited apartment N4 and proceeded to leave through the closed fire doors and continue up the north hallway. The general direction of travel was away from the dementia unit and continued into the general population area. At 8:11 p.m. Staff #5 returned to the area at approximately the same time the spouse in apartment N4 opened the door and indicated that Tenant #5 had left the apartment. Staff #5 indicated to the spouse that the staff had taken Tenant #5 back to the dementia unit. At that time, this monitor informed Staff #5 that Tenant #5 was not in the dementia unit but had exited through the closed fire doors and was headed away from the dementia unit. Staff #5 then

left to locate Tenant #5. At 8:12 p.m. a staff person returned to the north hallway. At 8:19 p.m. Staff #5 returned with Tenant #5.

Staff #2, #3, #4, and #5 attended a training session on tornado drills on 3-2-11. A review of the P&P page 30 on Tornado Warnings does not give specific instructions to direct care for dementia unit tenants in the event of a warning. There are no instructions to indicate that staff should not leave tenants unattended.

- Regulatory Insufficiency: A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. (IAC r. 481-67.9(1))

Dated this 11th day of April, 2011.