

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

November 2, 2012

Complaint/Incident Intake: 40288-I

Ms. Gayla Gilliland, Manager
Windsor Manor Assisted Living
608 South 15th Street
Indianola, IA 50125

**RE: Final Incident and Recertification Monitoring Evaluation Report –
Windsor Manor Assisted Living, Indianola, IA**

Dear Ms. Gilliland:

Enclosed is the **Final Incident and Recertification Monitoring Evaluation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481–67 and 481–69.

DIA has completed the review of your Plan of Correction (POC) in response to the **Preliminary Incident and Recertification Monitoring Evaluation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiency, DIA accepts your POC. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0199** with effective dates of **November 5, 2012** through **November 4, 2014**.

LUCAS STATE OFFICE BUILDING, 321 EAST 12TH STREET, DES MOINES, IOWA 50319-0083

ADMINISTRATION
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HEALTH FACILITIES
(515) 281-4115
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INVESTIGATIONS
(515) 281-5714
FAX: (515) 242-6507

If you have any questions in regard to this certification, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Incident and Recertification Monitoring Evaluation Report

Assisted Living Program:

Incident # 40288-I

Gayla Gilliland, Manager
Windsor Manor Assisted Living
608 South 15th Street
Indianola, IA 50125

Date of Monitoring Visit:

September 12, 2012

Monitor(s):

Joyce Kix, RN
Lori Miner, RN BSN

Definitions: *The following definitions are relevant:*

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: *In preparing this report, the following information was considered:*

Current Program Census

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:	19
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	20
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	6
Total Population of Program at time of on-site	7
TOTAL census of Assisted Living Program	27

Tenant/Family Satisfaction Results – A meeting was held with 10 tenants. The best thing about the Program was the service, the food, and having assistance available when needed. Housekeeping in apartments and common areas was completed to the tenants' satisfaction. The tenants reported using a call button to request assistance. Staff members were reported to respond in five minutes or less. Staff members were described as very good. The tenants reported the staff members treated tenants kindly and with respect. The food was good with hot foods served hot. There were enough activities offered with no suggestions for additional activities. The tenants reported they felt safe at the Program, were generally satisfied, and would recommend the Program to others.

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

Complaint/Incident Investigation – The Complaint/Incident investigators made the observations detailed in the following areas:

Structural Requirements

- **Complaint/Incident Allegation:** It was reported one tenant exhibiting dementia eloped from the program without staff member knowledge through an unlocked gate in the program's outdoor courtyard.
- **Monitoring Observation:** Tenant #1, a 73 year old, was admitted to the secured memory care unit on 5-29-12 with diagnoses of Alzheimer's, Hypertension and Agitation. Tenant #1 scored 5 on the Global Deterioration Scale, which indicated moderately severe cognitive decline. The Tenant's service plan dated 8-13-12 documented the Tenant was independent with transfers and ambulation.

According to the program investigation, on 8-12-12 at approximately 2:40 p.m., the alarm sounded to the pager system indicating the front door had been opened. Staff #1 addressed the alarm and found Tenant #1 in the general population dining room at 2:43 p.m. Staff #1 notified the staff member in the secured unit that Tenant #1 had come in the front door and was presently eating ice cream in the dining room. Tenant #1 had last been observed in the enclosed outside courtyard at 2:36 p.m. when visiting family left the program.

According to the State Climatologist, the weather on 8-12-12 at Des Moines around 2:54 p.m. was 73 degrees with cloudy skies and occasional rain and wind at 12 miles per hour from the east.

Tenant #1 left the enclosed courtyard through the unlocked gate and traveled to the front door of the program which was approximately 150 yards of paved sidewalk. Tenant #1 was unobserved for approximately seven minutes.

The Manager initiated an immediate internal investigation into Tenant #1's elopement. Upon initiation of the program's investigation, the Maintenance personnel noted the outside courtyard gate was unlocked. The lock was found to be in working order.

It was determined, the gates had been unlocked on 8-10-12 to allow pest control professionals to enter through the gate and the gate had inadvertently been left unlocked following treatment. The program did not have a system in place prior to 8-12-12 to ensure the gate doors were secure prior to allowing tenants to go into the courtyard unattended.

All exit doors in the building are alarmed and signal to staff pagers when a door is opened. All universal workers carry a pager while working which indicates which door in the building has been opened. Staff members have been instructed to investigate each alarm which come over the pager to verify who entered or left the building.

The program failed to assure the gate doors exiting from the enclosed courtyard were secured. The program failed to secure the courtyard gate and left it unlocked for two days prior to Tenant #1's elopement. Staff members reported multiple tenants routinely used the courtyard unattended.

- Regulatory Insufficiency: The buildings and grounds shall be well-maintained, clean, safe and sanitary. (IAC r. 481-69.35(1)(b))