VK 1/11/17

PRINTED: 12/28/2016
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
	S0335	A. BUILDING: _____ B. WING _____	C 12/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR MANOR ALGONA	512 FINN DRIVE ALGONA, IA 50511

(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: 34 Number of tenants with cognitive disorder: 0 Total Population of Program at time of on-site: 34 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 8 Total Population of Program at time of on-site: 10 TOTAL census of Assisted Living Program: 44 The following regulatory insufficiencies were cited during the investigation of Complaint #64568-C.	A 000		
A 081	481-69.25(2) Tenant Documents 481-69.25(231C) Tenant documents. 69.25(2) The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the Program failed to maintain all records regarding 1 of 3 tenants reviewed (Tenant #1). Findings include:	A 081	See attached Plan of Correction DD 1/9/17	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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
	S0335	A. BUILDING: _____ B. WING _____	C 12/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR MANOR ALGONA	512 FINN DRIVE ALGONA, IA 50511

(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 081	Continued From page 1 On 11/05/16 Tenant #1 presented with stroke like symptoms. Tenant #1 was later transferred to the local hospital and diagnosed as having had a CVA (cerebrovascular accident). The tenant was admitted to a long term care facility and did not return to the Program. On 12/12/16 at 4:15 p.m. interview with the Program's RN (Registered Nurse) revealed Staff C had completed a full set of vitals on Resident #1 prior to calling her for assistance. The results of these vitals were documented on the communication sheet. The RN also completed a full set of vitals and documented the results on the Vital Signs flow sheet. According to the RN, only nurses were allowed to document on the Vital Signs sheet. All other staff were to document in the communication log. On 12/13/16 at 10:10 am interview with Staff C confirmed she took Tenant #1's vitals on 11/05/16 and documented them in the communication log. She did not know what happened to the communication log. On 12/12/16 at 6:00 p.m. interview with the Administrator and the RN revealed the vitals Staff C had completed on Tenant #1 had been documented in the communication logs. Both confirmed the record of Tenant #1's vitals as recorded by Staff C had been destroyed along with the rest of the communication log for November. It was standard Program practice to destroy communication logs of previous months.	A 081		
A 094	481-69.27(1)a Nurse Review 481-69.27(231C) Nurse review. If a tenant does	A 094		

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
	S0335	A. BUILDING: _____ B. WING _____	C 12/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR MANOR ALGONA	512 FINN DRIVE ALGONA, IA 50511

(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 094	Continued From page 2 not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse: 69.27(1)a To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the Program failed to complete a 90 day review for 1 of 3 tenants reviewed (Tenant #2). Findings include: Record review on 12/13/16 at 12:40 pm revealed Tenant #2 relied on the staff of the Program to administer his/her medication. The tenant's most recent nurse's review had been completed on 5/13/16. A new review should have been done in August 2016.	A 094		

1/11/17

Windsor Manor Algona – Provider Identification Number S0335

Provider's Plan of Correction in reference to Complaint #64568-C

A 081 – Tenant Documents

The communication log referenced is not a tenant specific medical tool and will no longer be utilized. Going forward the communication form that is used between the RN and resident assistants is called the "Stop and Watch" which is a resident specific tool and is used to record and convey information about changes in a specific tenant. This form will be used for the resident assistants to document what they observe until the nurse can assess the resident. The nurse makes her recommendations for the tenant's care and records it on the form.

All staff will be in-serviced on the use Jan 12, 2017. Stop and Watch forms will be kept and retained per 69.25(2) for a minimum of three years after the transfer of death of a tenant.

A 094 – Nurse Review

The missing assessment has been completed, and an audit of all assessment due dates has been completed to ensure that no other assessments show incorrect due dates. Facility will implement dual tracking systems maintained by the administrator and the RN. Significant Changes will be discussed between RN and administrator, assessments completed, and next due dates updated to reflect any changes. Schedules will be reviewed as needed to ensure that assessments are timely. Completed on 1/4/17.

1/9/17