HEALTH FACILITIES

PAY TO THE ORDER OF PRINTED: 12/21/2017
JAN 02 2018 TREASURER STATE OF IOWA FORM APPROVED
FOR DEPOSIT ONLY
Iowa State Dept. of Inspections & Appeals

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
	S0224	A. BUILDING: _____ B. WING _____	12/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR MANOR GRINNELL	229 PEARL STREET GRINNELL, IA 50112

(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	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. General Population Number of tenants without cognitive disorder: 27 Number of tenants with cognitive disorder: 1 Memory Care Unit Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 9 TOTAL Census of Assisted Living Program for People with Dementia: 38 The following regulatory insufficiency was cited during the recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program:	A 000		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to develop service plans that reflected identified needs for 2 of 6 tenants	A 089	Service Plans Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance. Plan of Correction: The insufficiency will be corrected as follows: The RN corrected the service plan's for Tenant #1 and Tenant #4 to include the items identified in the insufficincies related to the tenants' needs.	completed 12/08/2017

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debby Cooper	Executive Director	12/28/2017

1/11/18

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
	S0224	A. BUILDING: _____ B. WING _____	12/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR MANOR GRINNELL	229 PEARL STREET GRINNELL, IA 50112

(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 089	Continued From page 1 reviewed (Tenant #1 and Tenant #4). Findings follow: 1. Record review revealed Tenant #1 was admitted on 3-7-17 with diagnoses including Parkinson's disease, hypertension, pinning of the left hand due to fall with fracture, history of stress fractures in bilateral feet and history of fractured ribs on the left side. Nursing notes dated 3-7-17 indicated Tenant #1 had a history of multiple falls at home. Nursing notes from 3-7-17 to 12-7-17 indicated Tenant #1 had 28 falls; however, none with significant injury. A physician's progress note dated 11-9-17 indicated Tenant #1 was wearing a brace on the left ankle during the visit. Interview with the Director of Health and Wellness on 12-6-17 at 1:31 p.m. revealed Tenant #1 entered the Program with the ankle brace but there was no order for him/her to wear it. Tenant #1 wore the brace at his/her discretion. Staff assisted Tenant #1 with the application and removal of the ankle brace. Further record review revealed the brace was not reflected on Tenant #1's service plan. 2 Tenant #4 was admitted on 12-28-15 with a diagnosis of Alzheimer's disease. Tenant #4 resided in the secured dementia unit and was staged at a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. During a routine interview with Staff A on 12-6-17 at 10:39 a.m. it was revealed Tenant #4 walked to the alarmed exit door one to two days per week	A 089	The following measures will be taken to ensure the problem does not recur: • Executive Director and Health and Wellness Director provided verbal education on 12/20/17 with direct care staff regarding the process of notification to HWD(RN) of changes in resident behaviors or services provided to a resident by using the Stop and Watch form. • HWD provided delegations on all braces to direct care staff and reviewed all of the resident's service plans to ensure assistive devices are included on their service plans. The program will monitor performance to ensure compliance as follows: • Executive Director will immediately begin reviewing Stop and Watch forms submitted to HWD and ensure changes are made to service plans as needed.	completed 12/20/2017

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
	S0224	A. BUILDING: _____ B. WING _____	12/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR MANOR GRINNELL	229 PEARL STREET GRINNELL, IA 50112

(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 089	Continued From page 2 and was redirected. Interview with Staff B on 12-6-17 at 3:55 p.m. revealed Tenant #4 walked to the exit door "once a week on 1st shift." Interview with the Director of Health and Wellness on 12-7-17 at 9:17 a.m. revealed she was not aware Tenant #4 had displayed exit seeking behavior. Further record review revealed Tenant #4's service plan did not address exit seeking behavior or interventions related to the behavior. The service plan did not reflect the identified needs of Tenant #4.	A 089		