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 _____	C 01/05/2023

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. Number of tenants without cognitive impairment: 15 Number of tenants with cognitive impairment: 19 Total census: 34 The following regulatory insufficiencies were cited during the investigation of Complaints #105322-C, #106761-C, #109634-C and the recertification visit conducted to determine compliance with certification of a Dedicated Dementia Specific Assisted Living Program:	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its policies and procedures regarding incident report completion, abuse reporting and head injuries for 4 of 4 current (Tenants #1, #2, #3 and #4) and 1 of 2 former (Tenant C2) tenants reviewed. Findings follow: 1. The Program's policy and procedure related to incident reports indicated staff would notify the Executive Director or Nurse if a tenant had fallen, was ill, had abnormal behavior or an unusual event occurred. An incident report form would be completed by the Executive Director or Nurse or	A 150	The Plan of Correction is attached.	

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A 150	Continued From page 1	A 150		

they would indicate a person in charge in their absence. Incident reports would be factual and completed in detail. Witnesses of the incident would also complete a statement on the incident report form. The incident report would be submitted to the Nurse "as soon as possible." The Nurse would follow up with a nurse review within 24 hours of the incident.

a. A Resident & Visitor Accident/Incident Form for Tenant C2 indicated the tenant fell and hit her head on trim on the door. The incident report lacked the date and time of the incident; however, it indicated the notification date was 7/10/22.

b. When interviewed on 12/20/22 at 11:49 a.m. Staff D said at approximately 11:45 a.m. on 12/17/212 she was working on the front hall and Staff E (float) asked for help with Tenant #3. Staff D responded and observed Tenant #3 seated on the toilet in an unoccupied apartment. Tenant #3 was unclothed and scrubbing her skin like she was trying to cleanse it. She kept saying "he's going to do it again." Staff D and Staff E got her dressed and reassured her she was safe. Tenant #3 was then seated in a chair in the common area. Staff D called the Executive Director and reported what she had witnessed and wrote a statement. She had not noticed that behavior with Tenant #3 previously. She said she did not complete an incident report.

c. On 12/20/22 at 3:49 p.m. Staff G stated that on 12/1/22 she saw Staff I grab Tenant #4 by the face resulting in bruising. Staff I said she did it to get the tenant's attention. Staff G said Staff I also yelled at tenants. She said she did not complete an incident report because they had been thrown away previously by the former Director of Health and Wellness. She had shredded incident reports

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A 150	Continued From page 2 regarding Resident #3. d. On 12/20/22 at 3:49 p.m. Staff G said Tenant #2 appeared to feel unsafe, did not want to go to her apartment alone and was afraid of the "boy hurting her one night." She said Tenant #3 had bruises on both of her wrists. No incident report could be located. 2. The Program's policy and procedure related to Adult Abuse Reporting Training indicated if staff suspected a dependent adult was abused they were required to report it to the Executive Director or Nurse "immediately." Within 24 hours of an oral report a Suspected Dependent Adult Abuse Report would be completed. a. On 12/20/22 at 3:49 p.m. Staff G stated that on 12/1/22 she saw Staff I grab Tenant #4 by the face resulting in bruising. Staff I said she did it to get the tenant's attention. Staff G reported it to the nursing staff. Staff G said Staff I also yelled at tenants. When interviewed neither the nurse or ED were aware of these allegations. b. On 12/21/22 at 2:35 p.m. Staff F said twice in one night in November Tenant #1 made comments about "being masturbated." It was not like Tenant #1 to talk like that. She said Tenant #1 was concerned about a man and asked if they were safe from the man. Staff F also stated Staff H told second shift staff of a time when Staff A grabbed both of Tenant #1's wrists and put them behind her back and would not release them. That incident occurred in November. Staff F said she had written a statement but had not filled out an incident report. Staff H was unavailable for interview. A statement written by Staff F could not be located.	A 150		

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c. On 12/20/22 at 3:49 p.m. Staff G said Tenant #2 appeared to feel unsafe, did not want to go to her apartment alone and was afraid of the "boy hurting her one night." She said Tenant #2 had bruises on both of her wrists. Staff G gave no specific dates or timeframes of these incidents.

d. Review of an unsigned statement by Staff G on 11/6/22 revealed two memory care tenants brought up being assaulted or hurt "by the boy at night." Tenant #2 had told staff twice that she wanted to be somewhere safe and away from that "man/boy." She said she did not feel safe staying there. It was noted it was not a prior behavior for Tenant #2. The statement indicated in the previous week Tenant #1 had mentioned masturbation multiple times. Tenant #1 had not previously spoken about that subject or anything similar. The statement alleged these behaviors started occurring after Staff A worked on the unit. The statement ended by noting a few of the memory care tenants were "popping up" with bruises on their cheeks, wrists, arms and legs.

e. When interviewed on 12/22/22 at 11:21 a.m. the Business Office Manager said a couple of tenants in the memory care unit had displayed unusual behaviors. Staff had been pulled and retraining was completed. About a month prior Staff G reported Tenant #1 and Tenant #2 had new behaviors and made comments about "they were hurt by some boy." It was first reported to her verbally and she asked Staff G to write it up. She reported the concerns to the Executive Director.

There was no indication staff immediately reported any of these allegations to a nurse or the Executive Director as directed by the Program's policy.

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A 150	Continued From page 4 3. The Program's policy and procedure related to head injuries indicated when a tenant reported they hit their head or there was a potential for a head injury, staff would notify leadership staff "immediately." The Executive Director or Nurse was to be called promptly related to any head injury due to falls or other incidents (after first aide was provided). Tenants with a head injury were asked to "seek emergency attention immediately." If the tenant declined, it would be documented. If a tenant had an activated legal representative, including a guardian, they would be notified and could make the determination regarding treatment. If the activated legal representative or guardian declined to seek medical attention it would be documented. The primary care provider was "always called directly regarding head injury falls once the Nurse has been notified." The refusal to transport or treat form would be completed for anyone who declined to seek medical attention. A Resident & Visitor Accident/Incident Form for Tenant C2 indicated the tenant fell and hit her head on trim on the door. The incident report lacked date and time of the incident; however, it indicated the notified date was 7/10/22. Vitals were taken and her Ativan was held. There was no documentation on the incident report indicating Tenant C2 was encouraged to seek medical attention due to falling and hitting her head or that Tenant C2 or her legal guardian declined to seek medical attention.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights:	A 160		

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A 160	Continued From page 5 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide adequate and appropriate services to 1 of 4 tenants reviewed (Tenant #3). Findings follow: 1. When interviewed on 12/20/22 at 11:49 a.m. Staff D said at approximately 11:45 a.m. on 12/17/212 she was working on the front hall and Staff E (float) asked for help with Tenant #3. Staff D responded and observed Tenant #3 seated on the toilet in an unoccupied apartment. Tenant #3 was unclothed and scrubbing her skin like she was trying to cleanse it. She kept saying "he's going to do it again." Staff D and Staff E got her dressed and reassured her she was safe. Tenant #3 was then seated in a chair in the common area. Staff D called the Executive Director (ED) and reported what she had witnessed and wrote a statement. She had not noticed that behavior with Tenant #3 previously. She said she did not complete an incident report. On 12/20/22 at 11:22 a.m. Staff E said one day, she thought between 12:00 p.m. and 12:30 p.m., she found Tenant #3 in the bathroom of an unoccupied apartment. She was unclothed and seated on the toilet. Tenant #3 said "he's going to do it again." She called Staff D to assist. Staff E said Staff D called the Executive Director. Staff E wrote a statement regarding the incident.	A 160		

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Staff D and Staff E's written statements substantially corroborated their interviews.

When interviewed on 12/20/22 at 2:50 p.m., 12/22/22 at 9:52 a.m. and 1/5/23 at 1:03 p.m. the Executive Director said she received a telephone call on Saturday (12/17/22) from Staff D. She told her Tenant #3 was found unclothed in an unoccupied apartment. The tenant was rubbing on her skin with toilet paper and she was very upset. Tenant #3 said "He'll do it again." She told the staff to write up statements. She spoke with the person in charge at the time (Staff I) and Staff I said it seemed liked she was going in and out of apartments and appeared to almost be hiding. The Executive Director spoke with Tenant #3's spouse and asked about prior trauma and he reported an issue that occurred in her first year of college. The Executive Director explained what had occurred and told the spouse that staff had reassured her. The Executive Director completed a head to toe assessment on Sunday and there were no injuries. She did not assess her immediately on Saturday as she was not at the Program that day. She confirmed Tenant #3 did not have a history of making those statements.

Review of the Executive Director's statement dated 12/18/22 indicated on 12/17/22 she received a telephone call from staff indicating Tenant #3 was found unclothed in an unoccupied apartment. Tenant #3 was very upset, rubbing her skin and saying repeatedly "He is going to do it again." The Executive Director told both staff to write out a statement regarding the incident. On 12/18/22 the Executive Director completed a head to toe assessment of Tenant #3. She was "in good spirits, smiling at me, mumbling word salad." Tenant #3 did not want her to look her over but did allow her to look her skin. There was

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A 160	Continued From page 7 no visible bruising or abrasions observed. The Executive Director received a call from Tenant #3's spouse. He had called earlier and said he was coming to visit Tenant #3, but had called back to say he was not coming after all. The Executive Director asked if Tenant #3 had any prior trauma. She told the spouse what occurred the day prior and the spouse told her about an incident from long ago. He was told staff reassured her and told her she was safe. The spouse said he thought the staff handled it the best they could. Tenant #3 was not assessed by a nurse until the day after this incident occurred.	A 160		
A 345	481-67.9(4)b Staffing 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s). This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide nurse delegated training within 30 days for 3 of 6 staff reviewed (Staff A, B and C). Findings follow: 1. Record review on 12/20/22 of Staff A's training documents revealed a hire date of 7/19/22. Nurse delegation training was documented on 8/26/22.	A 345		

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A 345	Continued From page 8 2. Record review on 12/20/22 of Staff B's training documents revealed a hire date of 5/19/22. Nurse delegation training was documented on 6/21/22. 3. Record review on 12/20/22 of Staff C's training documents revealed a hire date of 11/11/22. Nurse delegation training was not documented as completed when the training files were reviewed on 12/20/22. 4. Continued record review revealed the former Director of Health and Wellness was employed from 1/28/22 to 10/17/22. 5. When interviewed on 1/5/23 at 12:41 p.m. the Executive Director confirmed all nurse delegations documents for the staff listed above were provided.	A 345		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change.	A 145		

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A 145	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as required for 2 of 4 current (Tenants #1, #4) and 1 of 2 former (Tenant C2) tenants reviewed. Findings follow: 1. Review of Tenant #1's file on 12/20/22 revealed a Resident Comprehensive Assessment dated 10/26/22. The functional assessment section was not completed. A nurses note dated 10/26/22 reflected annual evaluations were completed. 2. Review of Tenant #4's file on 12/21/22 revealed a nurses note dated 12/13/22 indicating a new order was received for Calmoseptine, three times per day, to the coccyx for redness. Continued record review revealed evaluations for Tenant #4 were last completed on 3/7/22 (annual) and were not completed as needed with the redness noted to Tenant #4's coccyx and a new order for Calmoseptine. 3. Review of Tenant C2's file on 12/21/22 revealed nurses notes indicated the following: - On 9/9/22 hospice visited but unable to start services due to lack of someone to sign for Tenant C2. The next court date was 9/26/22 regarding assignment of a new power of attorney (POA) being assigned. - On 9/14/22 it was noted Tenant C2 was on comfort cares. - On 9/26/22 a new POA was appointed. End of life cares were continuing for Tenant C2. - On 9/29/22 the POA signed the paperwork for hospice. Hospice would arrive the next day. - On 10/7/22 medications were administered in liquid form as Tenant C2 was not swallowing.	A 145		

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A 145	Continued From page 10 - On 10/13/22 Tenant C2 died. A Routine Physician Progress Note (acute visit) dated 9/13/22 indicated Tenant C2 had increased confusion, slept most of the time and developed pressure sores. The plan indicated for a hospital bed and frequent repositioning to avoid a decubitus ulcer. It indicated Tenant C2 was a high risk for aspiration and the head of her bed needed to be elevated. The order indicated Mepliex could be applied to areas on her back. A fax to the PCP dated 9/29/22 indicated Tenant C2 had two ulcers: one ulcer on her coccyx that looked like a Kennedy ulcer and one ulcer on her lower back. An order was received for hydrophilic wound cream and sacral Mepliex, to change every 3 days or when soiled. A second fax to the PCP dated 9/29/22 indicated Tenant C2 cried out in pain when turning and changing her. The "kennedy ulcer on her coccyx is growing very fast." Tenant C2 only had Tylenol for pain and additional pain medications were requested. A new order was received for Tramadol 50 mg, twice daily and as needed. Resident & Visitor Incident/Accident Forms reflected Tenant C2 had falls on 7/5/22, 7/10/22, 7/10/22, 8/16/22 and 8/22/22. Tenant C2 sustained injuries with the two falls on 7/10/22. With one of the falls on 7/10/22 it was noted her ankle was swollen and she could not walk very well. With the other fall on 7/10/22 she hit her head on the door trim. Regarding the incident on 8/16/22, Tenant C2 complained of pain. Continued record review revealed evaluations were completed on 6/18/22 (30 day) and on 9/30/22 upon Tenant C2's admission to hospice.	A 145		

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A 145	Continued From page 11 Evaluations were not completed when changes occurred with Tenant C2 including falls and falls with injuries, the initiation of end of life cares, crying out in pain with repositioning, administration of medications in liquid form due to not Tenant C2 being able to swallow, two skin ulcers and treatment of the ulcers, increased confusion and increased sleeping. 4. When interviewed on 1/5/23 at 12:41 p.m. the Executive Director confirmed all of the current evaluations for the tenants listed above were provided.	A 145		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to document nurses notes by exception for 3 of 4 tenants reviewed (Tenants #1, #2, #3). Findings include: 1. When interviewed on 12/21/22 at 2:35 p.m. Staff F said twice during one night in November Tenant #1 made comments about "being masturbated" which was unusual.	A 290		

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On 12/22/22 at 11:21 a.m. the Business Office Manager stated about a month prior Staff G reported Tenant #1 and Tenant #2 had new behaviors and made comments about being hurt by some boy. It was first reported to her verbally and then she asked Staff G to write a statement. She reported the concerns to the Executive Director.

Review of an unsigned statement by Staff G dated 11/6/22 revealed 2 tenants brought up being assaulted or hurt "by the boy at night." In the previous week Tenant #1 had mentioned masturbation multiple times. Tenant #1 had not previously spoken about that subject or anything similar.

Review of the Executive Director's written statement dated 11/7/22 indicated she received a screen shot from the Business Office Manager regarding Tenant #1 and Tenant #2. She visited with Tenant #1 and completed a head to toe assessment with no visible bruising or redness (except a chronic issue). She was asked if she felt safe and Tenant #1 said yes. She was asked if anyone mistreated her and she said no.

A nurses note regarding the above could not be located.

2. When interviewed on 12/21/22 at 2:35 p.m. Staff F said Tenant #2 was concerned about a man and asked if they were safe from him.

On 12/22/22 at 11:21 a.m. the Business Office Manager said a couple of tenants in the memory care unit had behaviors, staff was pulled and retraining was completed. About a month prior Staff G reported Tenant #1 and Tenant #2 had new behaviors and made comments about "they

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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 290	Continued From page 13	A 290		

were hurt by some boy." It was first reported to her verbally and then she asked Staff G to write a statement. She reported the concerns to the Executive Director.

When interviewed on 12/20/22 at 3:49 p.m. Staff G said Tenant #2 felt unsafe, did not want to go to her apartment alone and she was afraid of the "boy hurting her one night."

Review of an unsigned statement by Staff G dated 11/6/22 indicated two memory care tenants brought up being assaulted and or hurt "by the boy at night." Tenant #2 had told staff twice that she wanted to be somewhere safe and away from that "man/boy." Tenant #2 said she did not feel safe staying there. This was not a prior behavior for Tenant #2.

Review of the Executive Director's statement dated 11/7/22 revealed she received a screen shot from the Business Office Manager regarding Tenant #1 and Tenant #2. She visited with Tenant #2 and asked her if she was hurt or mistreated by staff. Tenant #2 said no. Tenant #2 had no visible bruising or redness and no complaints of pain.

A nurses note regarding the above could not be located.

3. During interviews on 12/20/22 at 2:50 p.m., 12/22/22 at 9:52 a.m. and 1/5/23 at 1:03 p.m. the Executive Director said she received a telephone call on Saturday (12/17/22) from Staff D. She told her Tenant #3 was found unclothed in an unoccupied apartment. The tenant was rubbing on her skin with toilet paper and she was very upset. Tenant #3 said "He'll do it again." She told the staff to write up statements. She spoke with the person in charge at the time (Staff I) and Staff

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A 290	Continued From page 14 I said it seemed liked she was going in and out of apartments and appeared to almost be hiding. The Executive Director spoke with Tenant #3's spouse and asked about prior trauma and he reported an issue that occurred in her first year of college. The Executive Director explained what had occurred and told the spouse that staff had reassured her. The Executive Director completed a head to toe assessment on Sunday and there were no injuries. Although there was a nurses note regarding this incident, the note did not indicate any type of assessment occurred.	A 290		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed for 4 of 4 current (Tenants #1, #2, #3 and #4) and 2 of 2 former (Tenants C1 and C2) tenants reviewed. Findings follow: 1. Review of Tenant #1's file on 12/20/22 revealed a Resident Comprehensive Assessment dated 10/26/22 (annual) reflected the functional section was not completed. The service dated 10/26/22	A 350		

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A 350	Continued From page 15 was not based on the functional evaluation as it was not completed. When interviewed on 12/21/22 at 2:35 p.m. Staff F said twice in one night Tenant #1 made comments about "being masturbated." She said it occurred in November. She said it was not like Tenant #1 to talk like that. When interviewed on 12/22/22 at 11:21 a.m. the Business Office Manager said about a month prior Staff G reported Tenant #1 and Tenant #2 had new behaviors and made comments about "they were hurt by some boy." It was first reported to her verbally and then she asked her write it up. She reported the concerns to the Executive Director. An unsigned written statement from Staff G indicated two memory care tenants brought up being assaulted and or hurt "by the boy at night." The statement indicated in the last week approximately, Tenant #1 had mentioned masturbation multiple times. It was noted Tenant #1 had not previously spoken about that subject or anything similar. When interviewed on 12/20/22 at 2:50 p.m. and 12/22/22 at 9:52 a.m. the Executive Director said Tenant #1 did not have a history of making comments of a sexual nature. Tenant #1's most current service plan was dated 10/26/22. The service plan was not updated as needed related to the incidents and allegations noted above, including when Tenant #1 made comments of a sexual nature about "being masturbated." Tenant #1 did not have a known history of making those comments.	A 350		

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A 350	Continued From page 16	A 350		

2. On 12/21/22 at 2:35 p.m. Staff F said Tenant #2 was concerned about a man and asked if they were safe from the man.

When interviewed on 12/22/22 at 11:21 a.m. the Business Office Manager said about a month prior Staff G reported Tenant #1 and Tenant #2 had new behaviors and made comments about "they were hurt by some boy." It was first reported to her verbally and then she asked her write it up. She reported the concerns to the Executive Director.

When interviewed on 12/20/22 at 3:49 p.m. Staff G said Tenant #2 felt unsafe, did not want to go to her apartment alone and she was afraid of the "boy hurting her one night."

An unsigned written statement from Staff G indicated two memory care tenants brought up being assaulted and or hurt "by the boy at night." Tenant #2 had told staff twice that she wanted to be somewhere safe and away from that "man/boy." Tenant #2 said she did not feel safe staying there. It was noted it was not a prior behavior for Tenant #2.

Review of Tenant #2's file on 12/20/22 revealed the service plan was completed on 9/20/22. The service plan was not updated as needed and did not reflect the incident and behaviors as noted above.

3. When interviewed on 12/20/22 at 11:49 a.m. Staff D said at approximately 11:45 a.m. on 12/17/212 she was working on the front hall and Staff E (float) asked for help with Tenant #3. Staff D responded and observed Tenant #3 seated on the toilet in an unoccupied apartment. Tenant #3 was unclothed and scrubbing her skin like she

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A 350	Continued From page 17	A 350		

was trying to cleanse it. She kept saying "he's going to do it again." Staff D and Staff E got her dressed and reassured her she was safe. Tenant #3 was then seated in a chair in the common area. Staff D called the Executive Director (ED) and reported what she had witnessed and wrote a statement. She had not noticed that behavior with Tenant #3 previously.

On 12/20/22 at 11:22 a.m. Staff E said one day, she thought between 12:00 p.m. and 12:30 p.m., she found Tenant #3 in the bathroom of an unoccupied apartment. She was unclothed and seated on the toilet. Tenant #3 said "he's going to do it again." She called Staff D to assist. Staff E said Staff D called the Executive Director. Staff E wrote a statement regarding the incident.

A Routine Physician Progress Note dated 12/20/22 reflected Tenant #3 refused medications as times. She had episodes of anxiety, hiding and undressing.

Nurses notes reflected the following:
- On 11/8/22 an order for Macrobid 100 milligram (mg) capsules twice daily for 5 days was received for a urinary tract infection (UTI).
- On 12/19/22 Tenant #3 was noted to take her pants down and genital irritation was noted. An order would be requested for a urinalysis to check for a UTI.

Tenant #3's most current service plan, dated 7/21/22, was not updated as needed related to the incident on 12/17/22. Additionally, the service plan was not updated as needed related to Tenant #3's refusals of medications, behaviors and the UTI with antibiotic therapy.

4. Review of Tenant #4's file on 12/21/22

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A 350	Continued From page 18	A 350		

revealed a nurses note dated 12/13/22 indicating a new order was received for Calmoseptine, three times per day, to the coccyx for redness.

A Quarterly Nursing Summary dated 12/1/22 indicated Tenant #4 was toileted every two hours and did better with a pureed diet.

Tenant #4's most current service plan was dated 3/7/22. The service plan reflected staff assisted Tenant #4 with toileting needs, and he ate meals with verbal prompts from staff. The service plan was not updated as needed related the redness noted to Tenant #4's coccyx and a new order for Calmoseptine, the frequency of the toileting assistance every two hours, and the pureed diet.

5. Review of Tenant C1's file on 12/21/22 revealed a fax to the PCP dated 4/30/22 referencing labs and a prescription drug interaction document. The PCP was asked if the PCP wanted to continue warfarin, change the dose or change to aspirin 325 mg daily. An order was received to discontinue the warfarin.

Further record review revealed Tenant C1's service plan was updated on 4/27/22, when Tenant C1 was admitted to hospice. The service plan reflected Tenant C1 was prescribed warfarin and staff administered her medications. It was not updated to reflect the discontinuation of warfarin the warfarin.

6. Review of Tenant C2's file on 12/21/22 revealed nurses notes indicated the following:
- On 9/9/22 hospice visited but unable to start services due to lack of someone to sign for Tenant C2. The next court date was 9/26/22 regarding assignment of a new power of attorney (POA) being assigned.

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A 350	Continued From page 19	A 350		

- On 9/14/22 it was noted Tenant C2 was on comfort cares.
- On 9/26/22 a new POA was appointed. End of life cares were continuing for Tenant C2.
- On 9/29/22 the POA signed the paperwork for hospice. Hospice would arrive the next day.
- On 10/7/22 medications were administered in liquid form as Tenant C2 was not swallowing.
- On 10/13/22 Tenant C2 died.

A Routine Physician Progress Note (acute visit) dated 9/13/22 indicated Tenant C2 had increased confusion, slept most of the time and developed pressure sores. The plan indicated for a hospital bed and frequent repositioning to avoid a decubitus ulcer. It indicated Tenant C2 was a high risk for aspiration and the head of her bed needed to be elevated. The order indicated Mepliex could be applied to areas on her back.

A fax to the PCP dated 9/29/22 indicated Tenant C2 had two ulcers: one ulcer on her coccyx that looked like a Kennedy ulcer and one ulcer on her lower back. An order was received for hydrophilic wound cream and sacral Mepliex, to change every 3 days or when soiled.

A second fax to the PCP dated 9/29/22 indicated Tenant C2 cried out in pain when turning and changing her. The "kennedy ulcer on her coccyx is growing very fast." Tenant C2 only had Tylenol for pain and additional pain medications were requested. A new order was received for Tramadol 50 mg, twice daily and as needed.

Resident & Visitor Incident/Accident Forms reflected Tenant C2 had falls on 7/5/22, 7/10/22, 7/10/22, 8/16/22 and 8/22/22. Tenant C2 sustained injuries with the two falls on 7/10/22. With one of the falls on 7/10/22 it was noted her

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A 350	Continued From page 20 ankle was swollen and she could not walk very well. With the other fall on 7/10/22 she hit her head on the door trim. Regarding the incident on 8/16/22, Tenant C2 complained of pain. Tenant C2's service plans were updated on 6/18/22 (30 day) and on 9/30/22 with admission to hospice. The service plan was not updated when changes occurred with Tenant C2 including falls, falls with injuries, the initiation of end of life cares, crying out in pain with repositioning, administration of medications in liquid form due to Tenant C2 not being able to swallow, two skin ulcers and treatment of the ulcers, increased confusion and increased sleeping. 7. When interviewed on 1/5/23 at 12:41 a.m. the Executive Director confirmed all current service plans for the tenants listed above were provided.	A 350		

WINDSOR MANOR®

Assisted Living Community

Monday, March 20, 2023

Deb Dixon
Adult Services Bureau
Iowa Department of Inspections and Appeals
Health Facilities Division
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083

Re: Recertification visit, Complaints #105322-C, #106761-C, #109634-C

Dear Ms. Dixon,

Thank you for the opportunity to improve the quality of our services.

Attached, please find our responses to the regulatory insufficiencies that were observed between 12/19/22 to 1/5/23, during a state observation.

I am committed to continued staff training, as outlined in the attach, and to providing excellent care to those in our community.

Sincerely,

Amy Steffen, LPN

Amy Steffen, LPN
Executive Director
Windsor Manor
229 Pearl St
Grinnell, IA 50112

Enc

WINDSOR MANOR™

Assisted Living Community

Iowa Department of Inspections and Appeals

Windsor Manor Grinnell Plan of Correction 3/20/23

Please accept the following as the plan of correction for Windsor Manor Grinnell. This plan is for Complaints #105322-C, #106761-C, #109634-C and Recertification visit.

A 150 481-67.2 (3) Program Policies and Procedures

67.2(3) The program shall follow the policies and procedures established by the program.

Corrective action:

- Per our POC sent on 12-22-22 all Windsor Manor Grinnell Staff were retrained on incident reporting protocols and abuse reporting protocols including head injuries to ensure resident safety. This training included review of our incident reporting policy, our abuse reporting policy, and our head injury policy. All this retraining was reviewed again on 1-4-23 with all staff. These policies will be reviewed twice yearly going forward. Nurse will review incident reports on a weekly basis to ensure completion, and accuracy of final report.

Date of completion: 12/22/22 and ongoing

A160 481-67.3(2)

481-67.3 Tenant rights. All tenants have the following rights: To receive care, treatment, and services which are adequate and appropriate.

Based on record review the program failed to assess the resident until the day after the incident.

Corrective action:

- When an incident happens that is out of the norm, the resident will be assessed as soon as possible. If the Nurse is unable to assess the Resident and Family will be encouraged to be seen in Emergency Room by a physician as soon as possible. The RN/DHW and the Executive Director/LPN are on call 24/7 for any emergent situations.

Date of completion: Immediate 3/20/23 and ongoing

A345 48-67.9 (4)b Staffing

67.9(4) Nurse delegation procedures. The program's RN shall ensure certified and noncertified staff are competent to meet the individual needs of tenants, Nurse delegation shall at a minimum include the following: Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse.

Corrective action:

- The Windsor Manor RN will delegate staff within 30 days of beginning employment. The Executive Director or Business office manager will ensure that all staff delegations are completed within 30 days of beginning employment. An audit spreadsheet has been established to ensure timely completion.

Date of completion: 3/20/23

A145 481-69.22(3) Evaluation of Tenant

69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually.

Corrective action:

- When any change occurs with a resident and is reported to the Windsor Manor RN, an evaluation will be completed. This will include all status changes including falls, falls with injury, pain, increased confusion, changes in sleeping habits. A comprehensive assessment will include health, cognitive, and functional evaluation and will be completed in their entirety.

Date of completion: Immediate 3/20/23 and ongoing.

A290 481-69.25(1)l Tenant Documents

69.25 Documentation for each tenant shall be maintained by the program and shall include when any personal or health-related care is delegated to the program, the medical information sheet, documentation of health professional orders, such as those for treatment, therapy, and medication: and nurse's notes written by exception.

Corrective Action:

Corrective Action:

- A note will be documented any time there are incidents that are out of the normal for the tenant. This may include skin changes, changes in behaviors, sleep patterns, and anytime any assessment or evaluation is completed. A nurses note will be entered into the resident chart any time any assessments or evaluations are performed.

Date of completion: Immediate 3/20/23 and ongoing

A350 481-69.26(1) Service Plans

69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.

Corrective action:

- The service plans developed by the RN at Windsor Manor Grinnell will be based on the evaluation completed. The RN will ensure the ISP meets the needs identified in the evaluation. When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change, but not less than annually. If a significant change does not exist, the program will do a nurse review and add changes to the service plan without comprehensive evaluation and without obtaining signatures on the service plan. If a significant change happens that is a recurring or chronic condition, changes to the service plan will be made with Nurse review to institute the previously written evaluation and service plan. The service plan will include identified needs, preferences for assistance, any services and care to be provided pursuant to the occupancy agreement and will include any service provided by all providers of hospice care, home health care, occupational, and physical therapy.

Date of completion: immediately 3/20/23 and ongoing