PRINTED: 05/03/2021

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
	S0254	A. BUILDING: _____ B. WING _____	C 03/01/2021

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR MANOR VINTON	1807 WEST 5TH STREET VINTON, IA 52349

(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: 26 Number of tenants with cognitive disorder: 0 Memory Care Unit Number of tenants without cognitive disorder: 1 Number of tenants with cognitive disorder: 4	A 000	✓ 6/4/21	
A 150	Total Census: 31 No regulatory insufficiencies were cited during the onsite infection survey. The following regulatory insufficiency was cited during the investigation of Complaint #95231-C. 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 observation, interview and record review the Program failed to follow its policy and procedure related to door alarm response for 1 of 1 tenants reviewed (Tenant #2). Findings follow: 1. On 1-25-21 review of an Iowa Resident & Visitor Incident/Accident Form dated 1-21-21 at 3:20 a.m. revealed Staff B was on her way back from her break and heard "Help me." She called	A 150	481-67.2(3) Elopement policy (specifically if any door alarm sounds staff are to respond promptly and thoroughly check the areas inside and outside the alarm) reviewed with all staff. 481-67.2 (3) Disciplinary notices given to Staff A & Staff B for not following policy.	Completed 11-6-2020 & 2-10-21 Completed 1-22-2021

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

DD 6/3/21

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'ATE FORM 6899 2HIE11 If continuation sheet 1 of 9

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A 150	Continued From page 1 on her radio for Staff A to help find out where it came from. Tenant #2 was found outside on the ground by the west sunroom parking lot door with her legs blocking the door. Staff B went outside by another exit and moved the tenant's legs away from the door. Staff A called 911 and Staff B called the Executive Director (ED). Staff B got a blanket and they rolled Tenant #2 onto it and brought her inside. Pressure was held against her head with a towel until emergency medical technicians (EMTs) arrived. EMTs assessed Tenant #2, she stood up, walked to gurney and was taken to a hospital. There were no vital signs recorded on the report. The report indicated affected areas included the tenant's right eye, face and head. The injuries were indicated as a bruise/contusion, inflammation, cut/puncture/abrasion and pain. The type of incident was a fall. Staff B completed the report and Staff A was listed as a witness. Review of the Patient Care Record from the ambulance service indicated on 1-21-21 at approximately 3:23 a.m. they were dispatched to the Program for a reported fall. Staff reported Tenant #2 had fallen just outside the door. It could not be determined how long she had been outside because the door did not alarm. Staff found her and moved her inside. Her right pupil was "blown" and "appeared to be bleeding out of itself." The right eye appeared to be "cracked." Tenant #2 was secured, transferred and taken to a hospital. The vital signs recorded at 3:51 a.m. (1-21-21) indicated blood pressure was 152/77, pulse was 68, respiration rate was 16 and oxygen saturation was 92% on room air. There was no documentation of Tenant #2's temperature. Review of Tenant #2's file revealed diagnoses including history of traumatic brain injury, anxiety,	A 150	481-67.2 (3) Door sensor replaced on West Courtyard sunroom exit door. 481-67.2 (3) Door sensor put on Tenant #2 apartment exit door. 481-67.2(3) New form created for two hour visual checks on the tenant. 481-67.2(3) Random door check completed by member of management team a minimum of once a month to monitor compliance of response to activated door alarm.	Completed 1-21-2021 Completed 1-21-2021 Completed 1-21-2021 Effective immediately 5-4-2021 and ongoing

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A 150	Continued From page 2 arthritis, subretinal hemorrhage left eye, pseudophakaia both eyes and posterior vitreous detachment left eye. Tenant #2 had a Global Deterioration Scale of two, which indicated very mild cognitive decline. The service plan dated 8-25-20 indicated Tenant #2 ambulated independently with a walker. A fall history was not indicated. The Elopement Risk Assessment most recently completed on 11-19-20 did not indicate Tenant #2 was a risk of elopement based on the score provided. The service plan reflected Tenant #2 wore eyeglasses and typically went to bed at 8:00 p.m. and woke up at 7:00 a.m. Tenant #2 had one fall with no injuries documented in the Nurse's Notes on 11-30-20. 2. Observation on 1-25-21 at 10:42 a.m. of the west sunroom parking lot exit door revealed a door alarm sensor was located on the upper left corner of the door. The door led to the exterior of the building and was located in the hallway where Tenant #2 resided. 3. When interviewed on 1-26-21 at 1:04 p.m. and 1-27-21 at 3:17 p.m. Staff A stated she worked third shift on the assisted living (AL) side of the building on the night of the incident. She took her break from about 1:55 a.m. to 2:20 a.m. She completed her two tenant room checks and then went to the memory care unit. She cut through the courtyard to the other side of the building. Those door alarms showed on the pager. Staff B went for her 30 minute break around 2:30 a.m. while Staff A relieved her in the memory care unit. Staff A was sitting in the memory care unit when Staff B radioed Staff A for help. She came out of the door and they heard someone calling for help. They checked a couple of apartments and then Staff B looked out the window and Tenant #2 was outside the west sunroom parking lot door. The	A 150		

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A 150	Continued From page 3 tenant was on her side and her feet were in front of the door. Staff B ran outside and moved Tenant #2's feet. The ED was contacted and 911 was called (twice). The ED instructed staff to move her inside so they tucked a comforter under her and carried her inside the door. Tenant #2 said her eyes hurt and she had blood around her eyes and a lump on her eye. She had no other pain and was able to see. Tenant #2 had her pajama top and pants on but was not wearing socks or shoes. She did not have her walker, eyeglasses or emergency pendant. The EMTs arrived 5 to 10 minutes later. Staff A got the paperwork ready to send with Tenant #2. The ED arrived as she was getting the paperwork ready. Staff A stated she had not seen Tenant #2 that night prior to being found outside. She stated a page did not come through when the west sunroom parking lot door was opened. She was in the break room from approximately 1:55 a.m. until 2:20 a.m. taking her break. Her pager was on the table beside her and it never went off or vibrated. After Tenant #2 was found, she and Staff B exchanged pagers, and neither one had a notification of the sunroom parking lot exit door being opened. Staff A had never seen Tenant #2 awake on her shift and the tenant had never left the building on her shift before. She had no previous issues with the door alarms not functioning and said the west sunroom parking lot door had never gone off when she worked. Other doors that sent a page that night included the east door, memory care door, front door, courtyard doors, and memory care unit sunroom door. When interviewed on 1-26-21 at 3:52 p.m. and 5:12 p.m. Staff B said she worked third shift in the memory care unit on the night of the incident. It was a normal night, and she completed her checks on the tenants as scheduled and	A 150		

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A 150	Continued From page 4 completed laundry. Staff A took her break at 2:00 a.m. and came back to the memory care unit at 2:30 a.m. Staff B took her break at 2:33 a.m. and punched back in at 3:03 a.m. She stopped in the laundry room on her way back to the memory care unit. She was almost to the sunroom area when she heard someone calling for help. She called on the walkie-talkie for Staff A to come help. They checked a couple of tenant apartments near the area and then at approximately 3:15 a.m. Staff B looked out to the parking lot and saw Tenant #2 laying outside with her legs in front of the door. Staff B went outside by another exit in order to move the tenant's legs so they could open the door. Staff A called 911. Tenant #2 was wearing a pajama top and bottom. She was not wearing a coat, socks or shoes. Tenant #2 did not have her walker, eyeglasses or emergency pendant. Staff A went inside to get a comforter and tucked the comforter around Tenant #2. She also grabbed a towel and applied pressure to her head. They rolled her onto the blanket and moved her inside the building after direction from the ED via the phone. Tenant #2 knew her name and age but could not say why she was outside. The front door alarm went off and Staff A brought the EMTs to the area. The EMTs completed tests and helped her up. She took steps to the gurney without complaints of pain. Staff B said Staff A told her the pager she was using had not vibrated or sent a message indicating the west sunroom parking lot door had opened that night. When the two staff opened the door to bring the tenant inside it came across their pagers. There was no indication on her (Staff B's) pager the door had been opened prior to that. The pager held a history of 16 pages and when asked if she and Staff A checked each other's pagers, Staff B said they had not. The only issues she had ever noticed with the pagers	A 150		

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A 150	Continued From page 5 was that on occasion a pager would have message that contained just symbols. There had been no other times she had experienced the doors being opened and not receiving a page. She recalled a couple of times more than a year prior when Tenant #2 had gone to the courtyard door and opened it, but did not go outside. On 1-27-21 at 1:00 p.m. and 2:33 p.m. the ED said she received a telephone call from Staff B at 3:23 a.m. who reported Tenant #2 was found outside and bleeding. Staff A had called 911. She asked how long Tenant #2 had been outside but staff did not know. She told staff to move her inside if it could be done safely. The ED arrived to the building while the EMTs were still present. When asked by the EMTs if Tenant #2's mental status was altered she said Tenant #2 did not go outside at night, so it most likely was. The ED checked the computer monitor in the break room and then pulled the report for the door which showed it was opened at 2:14 a.m. and 3:21 a.m. She called the hospital to give them report, including the length of time outside. She visited with both staff after the EMTs left and both said the page for the door did not come across their pagers. She looked at both pagers and did not see a page for the west sunroom parking door. She believed they had gone past the history limit of 16 pages. Staff A said she was on break and eating at 2:14 a.m. (when the door was opened). Staff A said she had the pager beside her on the table. The next day she received an update from Tenant #2's legal representative and was informed the tenant had been transferred to another hospital for surgery due to a ruptured right eye globe. At 10:00 a.m. a new exit door senor was placed on the west sunroom parking lot door and a sensor was placed on Tenant #2's apartment door to alert staff when the door was	A 150		

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A 150	Continued From page 6 opened. A new form was also started for two hour visual checks on the tenant. Disciplinary actions were completed for Staff A and Staff B for failure to follow the policy regarding door alarm response. She stated there had been an issue with the west sunroom parking door in the last month not resetting when closed. The maintenance staff looked at it and replaced the sensor. On 1-26-21 at 10:16 a.m. Staff C said she worked first shift and was not aware of any calls that had not come across the pager. On 1-26-21 at 2:46 p.m. Staff D said she worked second shift and was not aware of any issues with pagers, pendants or door alarms. On 1-26-21 Staff E said she worked second shift and reported no issues with the pagers. On 1-28-21 at 8:00 a.m. Staff F said she worked third shift and she had not had any issues with the pagers and pendants. There had been no issues with a door was opened and not receiving a page. There had been one occasion approximately 3 or 4 weeks prior when west sunroom parking door did not reset after being closed. She tapped on the door alarm box and it reset. There were no other issues. When interviewed on 1-27-21 at 11:32 a.m. the Maintenance Director said a couple of weeks prior a third shift staff reported the west sunroom parking lot door would not reset. When he checked it worked fine but he changed the door alarm sensor. He had never heard of a door opening not being received on the pager. After the incident with Tenant #2, an alarm was placed on her door and a new door alarm sensor was put	A 150		

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A 150	Continued From page 7 on the exit door. 4. A review of the door alarm records from the start of third shift until the time of the incident with Tenant #2 (1-20-21 to 1-21-21) was completed. The review revealed there were 36 notifications for doors that included seven different doors from 10:32 p.m. on 1-20-21 until 3:35 a.m. on 1-21-21. One of the seven doors that was reflected on the system was the west sunroom parking lot door. The system showed the door was opened at 2:14:24 and closed at 2:14:44 a.m. The system showed the notification when Staff B went to west hallway parking door at 3:21:30 a.m. to go outside to move Tenant #2's feet. It reflected the door was opened at 3:21:51 a.m. when the staff brought the tenant in. The door was closed at 3:29:53 a.m. Video footage reviewed and timeline provided via interview from the Executive Director on 1-27-21 and 1-28-21 indicated at 2:09 a.m. Staff A exited the break room and vacuumed in the area near the activity room and salon (top of the west hall). She went around the corner to the front hallway at 2:11:17 a.m. At 2:11:53 a.m. Tenant #2 exited her apartment to the right, and walked towards the sunroom using the handrail. At 2:12 a.m. there was movement across the hall to the left (towards the west sunroom parking lot door) and Tenant #2 was out of sight. Staff A and Tenant #2 missed each other in the west hall by 36 seconds. At 2:13 a.m. Staff A returned to the break room. (The time stamp reflected on the video was ahead by one hour, the times listed above were all adjusted to reflect the actual time). Information obtained from the State Climatologist indicated local weather conditions in Vinton on 1-21-21 at 2:15 a.m. to 3:15 a.m. were as follows:	A 150		

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A 150	Continued From page 8 temperature was between 31 to 33 degrees, relative humidity was 72% at 2:15 a.m. and 68% at 3:15 a.m. The winds were from the west at 7 to 11 miles per hour. The wind chill was 24 to 25 degrees. 5. The Program's policy regarding elopement indicated if any door alarm sounded staff were to respond promptly and thoroughly check the areas inside and outside the alarm area to determine if anyone exited the building. A staff person was to stay at the door until it was locked and reset. Records revealed Staff A and Staff B attended a training on 11-6-20 which included elopement and a review of the policy. 6. On 1-28-21 at 3:11 p.m. the Executive Director confirmed Staff A and Staff B had been trained regarding the door alarm response policy but did not follow the policy regarding the incident with Tenant #2.	A 150		