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
	S0352	A. BUILDING: _____ B. WING _____	C 01/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR MANOR ESTHERVILLE	2015 3RD AVENUE NORTH ESTHERVILLE, IA 51334

(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 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: 20 Number of tenants with cognitive disorder: 1 Memory Care Unit Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 8 Total census: 31 The following regulatory insufficiences were cited during the investigation of Incident #101389-I.	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 policy and procedures regarding elopement for 1 of 1 tenants reviewed (Tenant #1). Findings follow: Record review of Tenant #1's file on 12-29-21 revealed the following: - Progress Notes dated 12-13-21 documented an initial assessment completed for admission to the locked memory care unit due to elopements from previous assisted living programs.	A 150	Policy and Procedures were reviewed with all staff on 2/14/22 to ensure that all were familiar with the Elopement, Elopement Prevention, Door Alarm and pendant procedures. Doors are to be visually checks on all alarms. All visitors are directed to only use the front entrances minimizing the number of alarms from opening doors. Training will be completed by all new hires prior to any shift assignments. The Administrator will ensure compliance to the POC,	

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

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A 150	Continued From page 1	A 150		

Diagnoses included Alzheimer's disease, anxiety, and depression.
- A Garden's Note Sheet dated 12-14-21 revealed Tenant #1 moved in on 12-14-21. She required no assistance with her activities of daily living (ADLs) but needed staff to administer her medications.
- A Global Deterioration Scale completed 12-13-21 revealed a score of 4 which indicated moderate cognitive decline.
- An Elopement Assessment completed 12-13-21 revealed a score of 28. A score of 12 or above indicated an elopement risk and prevention protocols were to be followed and documented on the service plan.
- The tenant's service plan completed on 12-14-21 revealed she required assistance with medication administration and was independent with all other ADLs. She resided in the locked memory care unit and required hourly checks for safety due to previous elopements from an unlocked assisted living facility.

Review of the Policy and Procedure for Emergency Pendent System Alarm Training revealed staff were to watch for signs of wandering and confusion and if any door alarm sounded they were to check alarms promptly and check inside and outside areas triggered by the alarm.

On 12-30-21 at 9:33 a.m. Staff A stated she worked in the memory care unit the morning of 12-23-21 and went into an empty apartment to pump breast milk. This was her break even though no other staff provided supervision to the unit during this time. Staff used to cover her break but they complained it left the assisted living side unattended so it was expected for her to continue to cover the memory care unit during

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A 150	Continued From page 2 this time. She believed she heard the kitchen staff and Staff C talking while she was in the closed apartment. She stated she heard the key pad being used and assumed it was those staff exiting the unit. She heard the alert for the memory care and the west door (located in the AL hallway) on the pager but failed to check to ensure it was the staff. Staff A stated staff were to check the doors when they heard the alert and this included the memory care door. She confirmed she was on her break and did not check the memory care door when it alerted because she assumed it was the staff she had heard talking. On 12-29-21 at 3:58 p.m. Staff B stated she was assisting a tenant with a shower when she heard the door alerts on her phone. She assumed it was a tenant going in and out of the side door in the AL unit as they frequently did. She stated if staff checked the doors every time they alerted they would not have time to provide cares. On 12-30-21 at 10:02 a.m. the RN (Registered Nurse) stated staff could not possible check every door each time an alert went off. She stated family and/or tenants used the side doors in the AL unit frequently.	A 150		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced	A 160	All resident assessments and prior knowledge indicated that the resident was an elopement risk, and resident was placed in our secure Memory Care area. However, we underestimated her ability to memorize the key pad code. Facility has changed the code and placed a locking box over the key pad for adequate protection from elopement effective 12/30/21. Only staff have access to the key.	

ok 3/8/22

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A 160	Continued From page 3 by: Based on interview and record review the Program failed to provide adequate and appropriate care, treatment, and services for 1 of 1 tenants reviewed (Tenant #1). Findings follow: Record review of Tenant #1's file on 12-29-21 revealed the following: - Progress Notes dated 12-13-21 documented an initial assessment completed for admission to the locked memory care unit due to elopements from previous assisted living programs. Diagnoses included Alzheimer's disease, anxiety, and depression. - A Garden's Note Sheet dated 12-14-21 revealed Tenant #1 moved in on 12-14-21. She required no assistance with her activities of daily living (ADLs) but needed staff to administer her medications. - A Global Deterioration Scale completed 12-13-21 revealed a score of 4 which indicated moderate cognitive decline. - An Elopement Assessment completed 12-13-21 revealed a score of 28. A score of 12 or above indicated an elopement risk and prevention protocols were to be followed and documented on the service plan. - The tenant's service plan completed on 12-14-21 revealed she required assistance with medication administration and was independent with all other ADLs. She resided in the locked memory care unit and required hourly checks for safety due to previous elopements from an unlocked assisted living facility. - A Nurse's Note dated 12-23-21 at 9:30 a.m. revealed the tenant was spotted outside of the building by staff. Staff immediately went outside and brought her back in without difficulty. She was wearing a winter coat, scarf, gloves and was carrying her purse. After they escorted her back	A 160	Staff have received additional training on Elopement Prevention, Elopement Policies and Procedures, Door Alarms, and Pendants on 2/14/22.	

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A 160	Continued From page 4	A 160		

to the memory care unit, staff were discussing how the tenant could have gotten out of the locked unit into the assisted living (AL) hallway. At that time. the tenant walked up, opened the memory care door and started to go onto the AL unit. She had figured out the code and let herself out. Tenant #1 was redirected back to the memory care unit. The incident was reported to the Executive Director, and a locked box was put over the keypad. Only staff had keys to the lock box.

According to the state climatologist the weather in Estherville on 12-23-21 at 9:30 a.m. was 31 degrees with a windchill of 23 degrees and relative humidity of 79%. The sky was clear with winds from the northeast at 9 mph and no precipitation was reported at that time.

On 12-30-21 at 9:33 a.m. Staff A stated she worked in the memory care unit the morning of 12-23-21 and went into an empty apartment to pump breast milk. This was her break even though no other staff provided supervision to the unit during this time. Staff A stated staff used to cover her break but they complained it left the assisted living side unattended so it was expected for her to continue to cover the memory care unit during this time. She believed she heard the kitchen staff and Staff C talking while she was in the closed apartment. She stated she heard the key pad being used and assumed it was those staff exiting the unit. She heard the alert for the memory care and the west door but failed to check to ensure it was the staff. The day of the elopement Tenant #1 appeared happy and no issues were noted. She stated while she was pumping the Registered Nurse (RN) came over the radio and asked if she had eyes on this tenant and Staff A replied no and the RN informed her of

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A 160	Continued From page 5	A 160		

what happened. Staff A stated after Tenant #1 returned to the memory care unit she observed the tenant go to the keypad, enter the correct code and walk out the door. She followed Tenant #1, walked with her, and got her to go back to the unit. Staff B and the RN witnessed this also. Staff A stated staff were to check the doors when they heard the alert and this included the memory care door. She stated she was on her break and did not check the memory care door when she heard the key pad being utilized as she believed it was staff.

On 12-29-21 at 3:58 p.m. Staff B stated she was assisting a tenant with a shower when she heard the door alerts on her phone on 12-23-21. She assumed it was a tenant going in and out of the side doors in the AL unit as they frequently did. She stated if they checked those doors every time they alerted they would not have time to provide cares. After the elopement she stood outside the memory care unit in the hallway and observed Tenant #1 walk out the door into the AL unit. She confirmed this door could only be opened by entering the code as it did not have a push bar with a delayed open. She walked with Tenant #1 and escorted her back into the memory care unit.

On 12-29-21 at 3:49 p.m. Staff C stated she entered the memory care unit on 12-23-21 to take something to her mother who resided there. She did not see Staff A. She checked a few apartments, including Tenant #1's, but did not find Staff A. She exited the memory care unit and walked down the hallway and observed Tenant #1 outside the building. She stated another staff had already gone out to get her.

On 12-29-21 at 3:15 p.m. the RN stated she was

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A 160	Continued From page 6	A 160		

in her office with another staff when they observed Tenant #1 outside the building on 12-23-21. The RN sent the staff to get Tenant #1 and she headed back to memory care. Review of the door alarm sheets revealed the memory care door was opened at 9:19 a.m. The west door (located in the AL hallway near the memory care door) was opened at 9:20 a.m. She saw the tenant outside at approximately 9:25 a.m. from her office. Staff A had told her she assumed it had been staff who went through the memory care door because she heard them talking while she was in the apartment pumping. She stated Staff A knew of the tenant's elopement history and that she required hourly checks.

On 12-30-21 at 10:02 a.m. the RN stated she felt staff could not possible check every door in the AL each time an alert went off. She stated family and/or tenants used those side doors frequently. The RN confirmed she witnessed staff say the code to the memory care door out loud to at least 2 visitors when they wanted to exit locked unit. Tenants had been present and staff most likely thought the tenants would not remember the code.

On 12-30-21 at 10:22 a.m. the Director stated Staff A used her break time to pump and another staff covered the memory care unit during this time. Staff started to complain the assisted living side no longer had appropriate supervision and she asked Staff A to use an empty apartment during her break time to pump and also provide supervision to the unit. The Director confirmed they needed to figure out a better way to cover breaks and developed an immediate plan of correction.

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A 325	Continued From page 7	A 325		
A 325	481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide a sufficient number of staff to fully meet the identified needs of 1 of 1 tenants reviewed (Tenant #1) and potentially all 31 tenants of the program. Findings follow: Review of Tenant #1's file on 12-29-21 revealed the following: - Progress Notes dated 12-13-21 documented an initial assessment completed for admission to the locked memory care unit due to elopements from previous assisted living programs. Diagnoses included Alzheimer's disease, anxiety, and depression. - A Global Deterioration Scale completed 12-13-21 revealed a score of 4 which indicated moderate cognitive decline. - An Elopement Assessment completed 12-13-21 revealed a score of 28. A score of 12 or above indicated an elopement risk and prevention protocols were to be followed and documented on the service plan. - The tenant's service plan completed on 12-14-21 revealed she resided in the locked memory care unit and required hourly checks for safety due to previous elopements from an unlocked assisted living facility. - A Nurse's Note dated 12-23-21 at 9:30 a.m. revealed the tenant was spotted outside of the building by staff. Staff immediately went outside and brought her back in without difficulty. She	A 325	Per our Immediate Plan of Correction for staffing dated 12/30/21, we added an additional 3 hours of evening float and assigned duties for relieving working staff on all shifts for breaks so that bathroom, meal, and personal breaks are always covered by trained staff. Staff are to alert replacement when breaks are pending so that a staff is always visually supervising residents. These new assignments have been reviewed by all staff ensuring that staff are always visually aware of residents. This was corrected effective 1/5/2022.	

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A 325	Continued From page 8	A 325		

was wearing a winter coat, scarf, gloves and was carrying her purse.

On 12-30-21 at 9:33 a.m. Staff A stated she worked in the memory care unit the morning of 12-23-21 and went into an empty apartment to pump breast milk. This was her break even though no other staff provided supervision to the unit during this time. Staff used to cover her break but they complained it left the assisted living side unattended so it was expected for her to continue to cover the memory care unit during this time. She believed she heard the kitchen staff and Staff C talking while she was in the closed apartment. She stated she heard the key pad being used and assumed it was those staff exiting the unit. She heard the alert for the memory care door but failed to check to ensure it was the staff. Staff A stated staff were to check the doors when they heard the alert and this included the memory care door. She confirmed she was on her break and did not check the memory care door when it alerted because she assumed it was the staff she had heard talking.

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A 325	Continued From page 9 alarm. On 12-30-21 at 10:02 a.m. the RN (Registered Nurse) stated staff could not possible check every door in the AL unit each time an alert went off. She stated family and/or tenants used the side doors frequently. On 12-30-21 at 10:22 a.m. the Director stated Staff A used her break time to pump and another staff covered the memory care unit during this time. Staff started to complain the assisted living side no longer had appropriate supervision and she asked Staff A to use an empty apartment during her break time to pump and also provide supervision to the unit. The Director confirmed they needed to figure out a better way to cover breaks and developed an immediate plan of correction.	A 325		
A 545	481-69.30(1) Dementia Specific Education for Personnel 69.30(1) All personnel employed by or contracting with a dementia-specific program shall receive a minimum of eight hours of dementia-specific education and training within 30 days of either employment or the beginning date of the contract, as applicable. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide 8 hours of dementia training within 30 days of employment for 1 of 1 new staff reviewed (Staff A). Findings follow: Review of Staff A's file on 12-30-21 revealed no	A 545	Staff A was rehired on 11/18/21, and had not completed her 8 hours of Dementia Training prior to this incident when our policies and procedures state that they must complete this training within 30 days of hire. A review of the employee's prior folder indicated that she had last completed training in June 2020. Staff A completed this training on 1/10/22. All staff trainings were reviewed for documentation of 8 hours of dementia training within 30 days of hire and annually. Staff are now required to complete all trainings prior to working on an assigned shift.	

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A 545	Continued From page 10 dementia training completed within 30 days of employment could be located. The Director confirmed these findings on 12-30-21 at 10:22 a.m.	A 545		