Iowa Department of Inspections and Appeals
Assisted Living Program
Complaint Investigation Report

Assisted Living Program: **Complaint Intake #: 7964**

Robbie Hinz, RN, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52240

Date of Investigation:

August 31, 2004

Monitor(s):

Stephanie Cummins, SW

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to, and approved by, the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may re-visit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Legacy Gardens on August 31, 2004. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP) **–** Not applicable.

Dementia Specific Program (DSP) **–**

Current number of tenants in a DSP that holds itself out as providing specialized care in a dedicated setting:	29

Accreditation Status – Not applicable.

Complaint History – No complaints on file this certification period**.**

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Criteria for exclusion of tenants - Program does not admit or retain tenants that require a higher level of care, unless a written exception has been applied for and approved. [321 IAC 25.23(3); 25.24]

Complaint Allegation: It is the alleged the program retained a tenant that was sexually aggressive.

- Monitoring Observation: According to an interview and a written statement by the RN, Tenant #1 inappropriately touched Tenant #2. Tenant #1 had a diagnosis of Parkinson's, Dementia, Anxiety, and Constipation. Tenant #1 was evaluated at a three on the Global Deterioration Scale (GDS) on 8/23/04. Tenant #2 had a diagnosis of Parkinson's, Cellulitus, Insomnia, and Depression. Tenant #2 was evaluated as a two on the GDS on 8/5/04. Tenant #2 was admitted on 8/6/04 and was staying in one of the guest rooms until the tenant's room was prepared. According to a written statement provided by the RN, the family of Tenant #2 reported to the LPN that Tenant #1 had entered Tenant #2's room on 8/6/04, and touched the tenant inappropriately. The RN was notified and then contacted the family of Tenant #2. The family and the RN agreed to move Tenant #2 to the opposite wing of the building. The move occurred before 3:00 p.m. that day. The RN spoke with Tenant #2 to verify the incident had occurred. The tenant stated that it had happened and when the tenant asked Tenant #1 to stop, the tenant did so. Tenant #2 stated to the RN that the tenant felt safe in the other wing of the building and both the tenant and the tenant's family did not want the police involved. The RN and Staff Member #3 spoke with Tenant #1 about the incident in which the tenant acknowledged the incident had occurred. The tenant, the family of Tenant #1 and the tenant's primary physician all agreed to the admission of the tenant to the University of Iowa Geri-Psych unit. The RN reported the incident to Department of Inspections and Appeals. Tenant #1 was treated at the University of Iowa Geri-Psych unit for two weeks. The tenant returned to the program on 8/23/04, and had been placed on medications. Since starting on these medications, there have been no incidents of inappropriate sexual behavior. Additionally, the program had established another intervention, which was to assist the tenant to bed and to put the tenant's wheelchair at the nurse's station. The tenant had an emergency response system if the tenant required staff assistance through the night. The wheelchair and walker were returned in the morning and the tenant agreed to this intervention set up by program staff according to the written statement by the RN. According to progress notes on 6/30/04, a staff member reported Tenant #1 had made inappropriate behavior toward the staff member. No other incidents of inappropriate behavior have been documented. The building has two main wings, west and east. The east side of the building has tenants that are higher functioning and the west side of the building has tenants that are not as high functioning and have more advanced cognitive impairment. Tenant #1 resided on the east side of the building with the higher functioning tenants. Typically, these tenants would be more likely to verbalize any concerns to staff and would be able to remove themselves from an inappropriate situation if it were to occur. Family of Tenant #1 contacted the RN on the day of the re-certification visit and gave a 30-day notice. The family was going to try a two-week home visit. The staff member indicated this was not a result of the incident that had occurred at the program.

- Regulatory Insufficiency: None Noted.

Dated this 17th day of September 2004.