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

Assisted Living Program: **Complaint Intake #15998**
#16029

Jim Hunter, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52240-2951

Date of Investigation:

February 11 & 12, 2008

Monitor(s):

Stephanie Cummins, SW MA
Lincoln Newsom, RN

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 revisit 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 February 11 & 12, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* **–** A program that is a Dementia Specific Program by definition or holds itself out as providing specialized care in a dedicated setting but may have tenants without cognitive disorder.

Current number of tenants in a DSP that holds itself out as providing specialized care in a dedicated setting:	18
Current number of tenants without cognitive disorder:	1
Total Population:	19

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Complaint History – There were substantiated complaints this certification period in the areas of: Evaluation of Tenants, Tenant Documents, Service Plan, Medications, Nurse Review, Staffing, Dementia-Specific Education for Program Personnel, Life Safety, Record Checks, Exit Door Alarm System and Other.

The complaint history during this certification period includes the complaint investigations of: April 19, 20, 23, 24 & 25, 2007 and June 11, 12, 13 & 14, 2007. The April 19, 20, 23, 24 & 25, 2007 complaint investigation resulted in a fine of $5000.00, the issuance of a Conditional Certification through July 17, 2007, a directive to not admit any tenants while under the Conditional Certification and the requirement that the Nurse and Director attend management classes.

The June 11, 12, 13 & 14, 2007 complaint investigation resulted in a fine of $7,500.00, the issuance of a Conditional Certification through September 17, 2007, documentation that the Director and Nurse have completed the assisted living program management training, weekly updates submitted to the DIA regarding staff training and nurse delegation, 30 day nurse reviews, and a delay in software implementation of tenant files until completion of the Conditional Certification.

The August 27 - 28, 2007 revisit resulted in a fine of $10,000 dollars, an extension of the Conditional Certificate to continue no longer than May 17, 2008, a continuation of the restriction on admissions to an occupancy of 22 tenants, weekly updates submitted to DIA to include current staffing levels, 30 day nurse reviews and no new software implementation.

The November 26-28, 2007 revisit resulted in a fine of $10,000.00 dollars, an extension of the Conditional Certificate to continue no longer than May 17, 2008, a restriction of no more than 22 tenants in the program, weekly updates to the DIA that will include current staffing levels, 30 day nurse reviews, specific documentation of PRN nurse reviews and a restriction on implementing the new software system.

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

A. Evaluation of Tenant - The program evaluates each tenant's functional and cognitive abilities and health status and the determination of needed services as required. [321 IAC 25.23(1) and/or (2)]

During the course of the investigation, the following information was obtained.

Monitoring Observation: Tenant #1, an 85 year old, was admitted on 1-3-08 and diagnoses include: Depression, Dementia, Agitation, Congestive Heart Failure (CHF), Scoliosis, Back Pain, Gastric Reflux and Hypertension (HTN). The tenant was staged at a six on the Global Deterioration Scale (GDS) completed on 1-2-08, which indicated severe cognitive impairment. The tenant died on 2-3-08. According to a fax to the physician dated 1-22-08, the tenant had a dime size Stage II open area on the buttock. An order for Duoderm to be changed every three days and as needed was requested on the fax and the order was received 1-24-08. The nurse review dated 1-28-08, indicated the area had become larger in circumference and involved the upper layers of the dermis. Cognitive, health and functional evaluations were completed on 1-28-08. Evaluations were not completed as needed.

- Regulatory Insufficiency: The program did not consistently evaluate each tenant's functional, cognitive and health status as needed, to determine the tenant's continued eligibility for the program and to determine any modifications to needed services. (25.23(2))

B. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. [321 IAC 25.28]

During the course of the investigation, the following information was obtained.

Monitoring Observation:

Tenant #1 had an order for Duoderm to be changed every three days and as needed, on 1-24-08, due to a Stage II open area on the tenant's buttock. The service plan was updated on 1-28-08. The service plan dated 1-28-08, indicated staff were to position the tenant every two hours around the clock, toilet the tenant, use pro shield on the tenant's perineum area, have the tenant use a pressure reduction cushion when sitting, attempt to have the tenant sleep in the bed and apply Duoderm to the tenant's buttock. The service plan was updated four days after the order was noted. The nurse review dated 1-28-08 indicated the area had become larger in circumference and involved the upper layers of the dermis. The nurse's notes indicate use of the pressure cushion, staff assist with repositioning, the pro shield, the Duoderm and the nutritional supplement began on 1-24-08; however, it was not documented on the service plan until 1-28-08. The service plan was not updated as needed and did not reflect the needs of the tenant and the requests for assistance.

- Regulatory Insufficiency: The program did not consistently update a tenant's service plans as needed, when a tenant needs personal care or health–related care, as needed, by a multidisciplinary team that consists of no fewer than three individuals, including a health care professional and other staff appropriate to meet the needs of the tenant,

in consultation with the tenant and, at the tenant's request, with other individuals identified by the tenant, and, if applicable, with the tenant's legal representative. (25.28(3))

- Regulatory Insufficiency: The program did not consistently develop a service plan that was individualized and indicated, at a minimum, the tenant's identified needs and the tenant's requests for assistance and expected outcomes. (25.28 (4) a))

C. Medications – Program has a comprehensive written medication policy that allows tenant self-administration, but accommodates the need for tenant medication assistance via nurse delegation. The medication assistance is appropriately supervised and administered. Medications are appropriately stored. [231C.16A]

During the course of the investigation, the following information was obtained.

Monitoring Observation: Tenant #1 and Tenant #2's Medication Administration Records (MARs) were reviewed. This table includes information related to medications and treatments for these tenants.

Tenant #1	Docusate Sodium 100mg once daily 8:00 p.m.	1-11-08, 1-13-08, 1-22-08, 1-29-08 and 1-31-08, not given or not signed
Tenant #1	Digoxin 0.125 mcg Sun, Tues, Thur, Sat 8:00 a.m.	1-20-08, not given or not signed
Tenant #1	Ativan 0.5 mg twice a day 8:00 a.m. and 8:00 p.m.	1-29-08, not given or not signed
Tenant #1	Trazadone 100mg at bedtime	1-29-08, not given or not signed
Tenant #1	Oxygen two liters a min. check each shift 7-3, 3-11 and 11-7	1-29-08, not checked or not signed on 3-11 shift, 1-31-08, not checked or not signed on 11-7 shift
Tenant #1	Check water bottle on oxygen concentrator each shift and fill if needed using distilled water only 7-3, 3-11 and 11-7	1-29-08, not checked or not signed on 3-11 shift, 1-31-08, not checked or not signed on 11-7 shift
Tenant #1	Bed and chair alarm, check each shift 7-3, 3-11 and 11-7.	1-29-08, not checked or not signed on 3-11 shift, 1-31-08, not checked or not signed on 11-7 shift.
Tenant #1	Tylenol 325mg three times a day at 8:00 a.m., 2:00 p.m., 8:00 p.m.	1-29-08, not given or not signed
Tenant #1	Aspirin 325mg once daily at 2:00 p.m.	1-23-08, not given or not signed
Tenant #1	Nabumetone 500mg twice a day at 8:00 a.m. and 8:00 p.m.	1-13-08, 1-29-08, not given or not signed or documentation of refusal
Tenant #1	Metoprolol 25mg twice a day at 8:00 a.m. and 8:00 p.m.	1-29-08, not given or not signed

Tenant #1	Oyst-Cal D 500mg, three times a day at 8:00 a.m., 2:00 p.m. and 8:00 p.m.	1-23-08, 2:00 p.m. dose not given or not signed, 1-29-08, 8:00 p.m. dose not given or not signed
Tenant #1	Potassium 10 meq, twice a day, 8:00 a.m. and 8:00 p.m.	1-29-08, 8:00 p.m. dose not given or not signed
Tenant #2	Tylenol #3, one tab, three times a day at 6:00 a.m., 2:00 p.m. and 10:00 p.m.	1-15-08 and 1-21-08, 10:00 p.m. doses not given or not signed. 1-17-08, 10:00 p.m. dose does not have documentation indicating why the initials are circled.
Tenant #2	Alprazolam 0.5mg, three times a day at 6:00 a.m., 2:00 p.m. and 10:00 p.m.	1-17-08 10:00 p.m. dose does not have documentation indicating why the initials are circled. 1-21-08, 10:00 p.m. dose not given or not signed.
Tenant #2	Exelon 3mg twice a day 8:00a.m and 5:00p.m	1-13-08, 5:00 p.m. dose does not have documentation indicating why the initials are circled.
Tenant #2	Namenda 10mg, twice a day. 8:00 a.m. and 5:00 p.m.	1-13-08, 5:00 p.m. dose does not have documentation indicating why the initials are circled.

- Regulatory Insufficiency: The program did not consistently administer medications by an Iowa–licensed registered nurse or advanced registered nurse practitioner registered in Iowa or the authorized agent in accordance with 655—subrule 6.2(5) and 655—subrule 6.3(1) and Iowa Code chapter 155A. (25.29(2)a)

D. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Complaint Allegation #16029: The following information was self reported by the program. On 1-31-08 Staff #1 yelled at Tenant #1 and put her hand on the tenant's face and pushed it aside. The program called the police and the police arrested and charged Staff #1 with simple assault. The program terminated the employee. The Department of Human Services (DHS) was notified of the assault, investigated and indicated the situation was handled appropriately. The police report and the program indicated the tenant had no injuries.

Complaint Allegation #15998: It was alleged Tenant #1 died and there was suspicion the program did not report the death to the Department of Inspections and Appeals (DIA). It was alleged Staff #1 back handed the tenant and is scheduled to appear on assault charges related to the assault. It was alleged the program had a history of not reporting information to Iowa Department of Inspections and Appeals.

Monitoring Observation: Staff #1, a medication manager, was hired on 4-26-06 and was terminated on 1-31-08. Staff #1 had six hours of dementia training on 1-31-07 and mandatory dependent adult abuse training on 1-12-07 and 3-15-07. Criminal background and dependent adult abuse checks were completed appropriately.

Staff #1 had received a Performance Deficiency Notification which dated 1-23-07 which indicated the staff had received a written warning related to failing to perform duties or job assignments satisfactorily and efficiently.

A summary of events related to the alleged incident was provided. The Executive Director (ED) was told by Staff #3 on 1-30-08 that he needed to come into the program and observe Staff #1's behaviors toward the tenants as Staff #1 was rude and loud towards the tenants. On 1-30-08 at approximately 7:15 a.m. the ED entered the east side of the program and heard a loud voice which sounded like Staff #1. As the ED walked to the living room he saw Staff #1 bending over Tenant #1 and indicated he had a side visual of Staff #1's face and a full visual of the tenant's face. Staff #1 was yelling loudly "I told you to shut up!" and "I'm trying to put on your oxygen, knock it off." The tenant yelled at staff to shut up and tried to spit in Staff #1's face. Staff #1 then back handed the right side of the tenant's face yelling very loudly and with piercing words "Don't you ever spit in my face again." The ED stated, "Don't you ever hit a resident again." Staff #1 then saw the ED looking at her and said "did you see … spit in my face?" The ED said "I don't care, you don't ever touch a resident that way again." Staff #1 walked away from the tenant and the ED took the tenant's hand and asked how the tenant was doing that morning and the tenant said he/she was fine. Another med aide assisted the tenant with his/her oxygen. The ED notified the Director of Operations, who was on campus. Staff #1 was removed from the unit to the lobby and the tenant was taken to the dining room table for breakfast. At 7:30 a.m. the Director of Operations, assessed the tenant and noted no injury to the tenant's face. The police were called and Staff #2 and Staff #3 provided written and signed statements. Staff #1 was instructed to stay in the lobby and was found in a tenant's room changing a garbage bag; however, no tenants were in the area. At 8:00 a.m. the police arrived and the nurse was notified at 8:26 a.m. The police officer charged Staff #1 with simple assault. Staff #1 was immediately terminated and was not allowed back on campus. Family, the DHS and the DIA were notified of the alleged incident.

According to nurse's notes dated 1-31-08 at 7:40 a.m., the tenant showed no signs of injury upon facial assessment and the tenant states "no that does not hurt" as tenant's face was touched in all quadrants. On 1-31-08 at 8:00 a.m. the nurse's notes indicated the tenant was taking breakfast and medications well. On 1-31-08 at 9:00 a.m. the nurse's notes indicated the tenant was sitting in the recliner with the oxygen on and was calm and had no verbalizations. The tenant's eyes were closed and there was no facial redness. A call was made to the tenant's family on 1-31-08 at 12:05 p.m. and the family returned this call at 2:15 p.m. On 1-31-08 at 2:00 p.m. the tenant's physician was contacted regarding the tenant's condition. Nurse's notes dated 1-31-08, indicated the nurse discussed with the family the progress they had made on locating an alternative facility for the tenant.

A police report pertaining to the alleged incident was obtained. Staff #1 was charged with simple assault which is an act that is intended to cause pain or injury or physical contact that could be considered offensive. The report indicated the tenant sustained no injury. Staff #1 and the ED provided voluntary statements regarding the incident and the

report had handwritten statements from Staff #2 and Staff #3. In the police report it was noted Staff #2 and Staff #3 are friends and Staff #2 stated the alleged incident was not appropriate.

The ED stated in an interview that when Staff #3 reported to him on 1-30-08, it was the first time any behavior with Staff #1 was reported by anyone and he would not allow such behavior.

The nurse indicated she was called and told about the alleged incident; however, she did not witness the alleged incident. The nurse reported she arrived at approximately 8:30 a.m. and observed Tenant #1 at 9:30 a.m. The nurse stated the tenant's face was not red, he/she was calm, took his/her medications and was not agitated. The nurse indicated there was no visible sign on the tenant and no pictures were taken after the alleged incident. The nurse called the tenant's family the day of the alleged incident.

According to the ED the staffing schedule on 1-31-08, the date of the alleged incident included: Staff #1, Staff #2, Staff #3 and Staff #4 as direct care staff on first shift. The nurse arrived at approximately 9:00 a.m. and the ED arrived at 6:55 a.m. The ED indicated on first and second shifts there are three to four employees and on third shift there are two to three employees. There was also 120 hours of RN staffing per week. Staff #3 and Staff #4 indicated the staffing was sufficient to meet the needs of the tenants.

- Regulatory Insufficiency: The program did not consistently provide sufficient trained staff available at all times to fully meet tenants' identified needs. (25.33 (1))

- Regulatory Insufficiency: The program did not establish and maintain a safe and homelike environment for individuals of all income levels who require assistance to live independently but who do not require health-related care on a continuous twenty-four hour per day basis. (231C.1(2)a)

Complaint Allegation #15998: It is alleged the death of the Tenant #1 was related to an assault.

Monitoring Observation: According to an interview with the nurse, she did not notice a cough or anxiety with Tenant #1 on 2-1-08. At 5:00 p.m. staff reported a change in condition to the nurse. The nurse indicated the tenant's condition had changed. The tenant was taken to the hospital on 2-1-08 and on 2-2-08 family reported to the nurse, the tenant had declined and family decided to provide comfort measures only. According to the nurse, the tenant died a couple of days after being hospitalized, related to respiratory distress.

Nurse's notes of 2-1-08 at 5:00 p.m. indicate the tenant was pale and diaphoretic. A copy of a do not resuscitate order was noted in the tenants file. Vital signs were obtained, oxygen was turned up, the tenants' daughter was called and an ambulance was called. The tenant was taken to a local hospital for further care.

An Emergency Medical Services (EMS) report indicates the tenant was on oxygen, pale, diaphoretic, and responsive only when spoken to. The tenant was hypotensive with suspected pulmonary fluid and cardiac monitoring indicating Supra Ventricular Tachycardia (SVT) with multi-focal Premature Ventricular Contractions (PVC's).

History and Physical report from the hospital indicate the tenant expired with the following discharge diagnoses: Probable pneumonia with hypoxia, Congestive Heart Failure and probable Acute Myocardial Infarction.

A copy of the certificate of death stated the tenant's death was due to respiratory insufficiency due to (or as a consequence of) pneumonia. The certificate of death indicated the approximate interval between onset and death was seven days. The tenant died on 2-3-08.

- Regulatory Insufficiency: None noted.

Dated this 7th day of April, 2008.