IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

September 10, 2008

Incident #19153-I
Complaint #19152

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

RE: Incident & Complaint Investigation Report, Legacy Gardens, Iowa City, IA

Dear Mr. Hunter:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Incident & Complaint Investigation Report dated August 7, 2008. Based on the information provided, DIA accepts the POC. No further action on the part of the program is necessary.

We appreciate your prompt action in correcting the Regulatory Insufficiencies. If you have questions, please contact me at 515-281-4116.

Sincerely,

Chris Nothaft
Certification Coordinator – Eastern Iowa
Adult Services Bureau

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

Assisted Living Program:

Complaint Intake #: 19152
19153-I

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

Date of Investigation:

August 7, 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 and incident investigation on-site visit was conducted at Legacy Gardens on August 7, 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:	13
Current number of tenants without cognitive disorder:	1
Total Population:	14

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

Accreditation Status – Not applicable.

Program History – There were substantiated Regulatory Insufficiencies 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.

The February 11-12, 2008 complaint resulted in a fine of ten thousand ($10,000.00) dollars, an extension of the Conditional Certificate to continue no longer than May 17, 2008, and a restriction on admissions, The program is also required to continue with weekly updates to the DIA that will include current staffing levels, 30 day nurse reviews, specific documentation of PRN nurse reviews with tenant names protected and they will need to have the Director of Nursing (DON) complete weekly Medication Administration Record (MAR) reviews. The new software system, in regard to MARs only, may be implemented at this time.

The March 4-5, 2008 complaint revisit resulted in a fine of ten thousand ($10,000.00) dollars, a continuation of the Conditional Certificate, continuation of the restriction on new admissions, continuing weekly updates to the DIA on current staffing levels, 30 day nurse reviews, specific documentation of PRN nurse reviews with tenant names protected, weekly reviews of the MARs by the nurse and the approval of the program to implement the new software system in regard to MARs.

The April 15, 2008 revisit resulted in a Regulatory Insufficiency free report, a standard certificate being issued and no sanctions or fines.

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

A. 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 #19152: It was alleged one week prior to 08-06-08, Tenant #1 fell and sustained a fractured hip. The tenant was normally independent with ambulation.

Incident Allegation #19153: It was alleged, by the program, that on 8-1-08 at 7:25 p.m. Tenant #1 got himself/herself out of bed. The tenant took approximately five steps and fell, fracturing his/her hip. The program reported all applicable fall preventions were in place at the time of the tenant's fall. It was alleged on 8-4-08 at 12:30 a.m. the tenant died of unknown causes.

Monitoring Observation: Tenant #1, a 94 year old, was admitted on 4-5-08 and diagnoses include: Cystocele, Dementia, Hypertension (HTN) and Urinary Tract Infections (UTI), Recurrent. The tenant was staged at a five to six on the Global Deterioration Scale (GDS), which indicated moderately severe to severe cognitive impairment.

According to an incident report dated 8-1-08 at 1940 in Tenant #1's apartment, the tenant had been seated on the sofa, personal alarm was in place, and apparently the tenant attempted to get up unassisted and was found on the floor. There were no witnesses to the incident. The tenant complained of left hip and leg pain and it was noted the tenant was lucid during the conversation. The nurse was notified at 1940 and the tenant was transported to the hospital on 8-1-08 at 2040. Staff #1 and Staff #2 were involved in the original incident or complaint. According to the report, staff heard the personal alarm and Staff #2 responded within 15 to 30 seconds of the alarm. The Executive Director timed the amount of time needed to get to the tenant's apartment from the location of staff, at the time of the occurrence, and staff could not have prevented the tenant from falling. A staff meeting scheduled for 8-8-08 included a discussion of fall prevention and tenant safety. According to nurse's notes dated 8-4-08, the orthopedic surgeon informed the family that the tenant was a poor surgical risk and the decision was made to provide comfort measures only with no surgical intervention. According to hospital medical records, the findings included a subcapital left hip fracture with associated foreshortening. According to nurse's notes dated 8-7-08, the tenant's doctor stated the fracture may very easily have been caused when the tenant stood up. The notes also refer to reports from x-rays, which indicated visualized osseous structures were osteopenic. According to nurse's notes dated 8-5-08 at 1000, the nurse received a call from the tenant's DPOA who informed the program the tenant died in the hospital around midnight.

- Regulatory Insufficiency: None noted.

Complaint Allegation #19152: It was alleged approximately two weeks prior to 08-06-08, Staff #1 served hot soup as an "intervention (not at a meal)" to Tenant #1. It was alleged Tenant #1 spilled the soup on his/her lap and was burned. It was alleged Staff #2 was also on duty when the tenant burned his/her lap.

Monitoring Observation: According to a copy of the schedule, an incident report and interviews with Staff #1, Staff #3 and Staff #4, Staff #2 was not working on 7-14-08, the evening when Tenant #1 spilled soup in his/her lap and sustained a burn.

The following information was obtained from the incident report and incident investigation report related to the 7-14-08 incident. On 7-14-08 at 1700, Tenant #1 spilled soup in his/her lap that had been served in a Styrofoam cup. The witnesses were Staff #1 and Staff #3. The tenant was sitting at the evening meal, Staff #1 was administering medications and Staff #3 was with the tenant. The tenant thought the soup was something to drink and picked up the soup, dropped the cup, spilling the cream soup on the tenant's lap. Staff wiped the excess soup from the tenant's clothes and the tenant finished his/her meal. After the evening meal, the tenant was assisted back to his/her apartment. Staff noticed reddened areas on the anterior surface of the tenant's thighs when they were getting him/her ready for bed. The nurse was notified at 2000, according to the report. First aid treatment was not administered at the time.

Staff #1 stated on 7-14-08 Staff #3 reported Tenant #1 had spilled his/her soup and she went to get a rag to clean it off. The tenant did not complain of pain and Staff #3 sat between Tenant #1 and another tenant at the dining table. Staff #1 stated staff decided to keep Tenant #1 at the table so he/she could finish his/her meal and he/she was not complaining of any pain. According to Staff #1, the tenant was not eating much lately and if he/she was removed from the table he/she would not finish eating. Staff #1 reported the tenant was eating well that evening. Tenant #1 wanted to sit with the other tenants in the common area after the meal. At approximately 7:00 p.m. the tenant wanted to get ready for bed and go to the restroom. Staff #3 took the tenant to his/her apartment and placed him/her on the toilet. Staff #3 noticed red areas on the tenant's inner thighs and reported this to Staff #1. Staff #1 viewed the area and called the nurse. Staff #1 stated there were not any blisters at that point and the nurse told staff to clean the area. Staff #1 cleaned the area with baby wipes. Staff assisted the tenant with bedtime clothing and incontinence products and kept the area clear. The tenant did not complain of any pain and slept the rest of the shift. Staff #1 stated, to the best of her knowledge, no other tenants have had any burns from food.

Staff #3 stated she was sitting in the dining room at the table assisting a tenant to eat; she noted that Tenant #1 spilled soup on her lap at about 1730 hours. After observing the tenant spill, Staff #3 cleaned the tenant up by wiping the soup off the tenant's lap. She stated the tenant spilled the majority of the soup on her lap and then placed the cup on the table. After Staff #3 cleaned the tenant the tenant said thank you and continued eating. The tenant did not complain of pain. After dinner, the staff assisted the tenant with cares at approximately 1800-1830 hours. At approximately 1930 to 2000 hours she assisted the tenant with getting ready for bed. At that time she noted the tenant's inner thighs were reddened with the left leg area being greater than the right. Staff #3 got Staff #1 who looked at the area and called the nurse. The nurse stated to clean the area with a "baby" wipe. The tenant did not complain of pain and was placed in his/her night gown. At 2000 hours the area was just red, like something hot had been on it, but there was no blistering that staff noted at this time. When asked why she did not change the tenant's clothes right after the incident, Staff #3 stated that after she cleaned the soup up she didn't think the clothes needed to be changed. After the tenant was assisted to bed, there was no complaint of pain and the tenant slept. Staff #3 stated all tenants were served soup in Styrofoam cups that evening.

Staff #4 (dietary staff), stated he began serving the evening meal at 4:15 p.m. and ended at 5:15 p.m. on 7-14-08. The staff indicated a server was not scheduled that evening and he was the only dietary staff. Staff #4 indicated the nursing staff included: Staff #1 and Staff #3. The soup was served in Styrofoam cups and the food on Styrofoam plates. Staff #4 was informed about the burn incident with Tenant #1 a day or two after it occurred. Staff #4 did not witness the incident and did not see much of the tenant after the food service. Staff #4 stated it was not common practice to serve on Styrofoam products and it was a poor judgment call on his behalf. He stated it was not common practice to take temperatures of soups and this was the first time a tenant had been burned by food during his tenure.

The nurse indicated at approximately 1700 to 1730 Tenant #1 was eating the evening meal and picked up the Styrofoam cup containing hot cream soup and dropped it. The soup spilled on the tenant's lap and staff immediately wiped soup off the tenant's clothes. At 1730 staff took the tenant to his/her apartment and noted an area of skin on the upper anterior thighs was reddened. At 1930 staff assisted the tenant with putting on pajamas and noted blistering on the skin. At 2000 staff called the nurse to report this and the nurse examined these sites the next morning. The nurse assessment was done first thing in the morning and staff reported that the tenant had a small blister to right thigh only, at the time staff called. Staff reported to the nurse the blister was still intact. The usual treatment of burns is to treat people with products such as Silvadene when burns are open. The nurse stated she did not get the impression that the burned area required a home visit.

The tenant's doctor was contacted by the monitor on 8-7-08, and stated that she felt she was notified of the burn in a timely manner. The doctor stated she felt the care for the burn prior to her knowledge was handled appropriately. The tenant's doctor stated she felt the burn was cared for and treated appropriately.

The incident report stated the corrective action included: no hot beverages to be served in Styrofoam containers, dietary staff member to review the six hour dementia training videos and a staff meeting was to be scheduled for 8-8-08. According to a Mandatory Staff Meeting bulletin, the agenda included: basic first aide measures.

Staff #4 received a written warning and an additional six hours of dementia training. Staff #4 had dementia training documented on 2-10-08 and 7-17-08 and food safety and sanitation training documented. Staff #1 and Staff #3 had six hours of dementia training documented.

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

B. Dementia-specific education for program personnel – A dementia-specific program shall employ or contract with personnel who have received appropriate dementia-specific education and training. [321 IAC 25.34]

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

Monitoring Observation: The following information was obtained from the incident report and incident investigation report related to the 7-14-08 incident. On 7-14-08 at 1700, Tenant #1 spilled soup in his/her lap that had been served in Styrofoam cups. The witnesses were Staff #1 and Staff #3. The tenant was sitting at an evening meal, Staff #1 was administering medications and Staff #3 was with the tenant. Tenant #1 thought the soup was something to drink and picked up the soup, dropped the cup, spilling the cream soup on to the tenant's lap. Staff wiped the excess soup from the tenant's clothes and the tenant finished his/her meal.

Staff #4 (dietary staff), stated he began serving at 4:15 p.m. and ended at 5:15 p.m. on 7-14-08. He indicated a server was not scheduled that evening and he was the only dietary staff. Staff #4 indicated the nursing staff included: Staff #1 and Staff #3. The soup was served in Styrofoam cups and the food on Styrofoam plates. Staff #4 was informed about the burn incident with Tenant #1 a day or two after it happened. He did not witness the incident and did not see much of the tenant after the food service. He stated it was not common practice to serve on Styrofoam products and it was a poor judgment call on his behalf. Staff #4 stated it was not common practice to take temperatures of soups; however this was the first time a tenant had been burned by food during his tenure.

Staff #4 received a written warning and an additional six hours of dementia training. He had dementia training documented on 2-10-08 and 7-17-08 and also had documented food safety and sanitation training. Staff #1 and Staff #3 had six hours of dementia training documented.

- Regulatory Insufficiency: The program did not consistently provide adequate training related to dementia specific education or the program personnel. (25.34))

Dated this 10th day of September, 2008.