IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

Complaint Intake: 30562-C
Incident Intake: 29728-I
Complaint Intake: 30563-A

October 5, 2010

Mr. Jim Hunter, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52245

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

Dear Mr. Hunter:

Enclosed is the **Final Complaint Investigation & Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint Investigation & Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiency, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Jim Hunter, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52245

Complaint Intake #: 30562-C
Incident Intake#: 29728-I
Complaint Intake # 30563-A

Date of Investigation:

September 7, 8, 9 & 13, 2010

Monitor(s):

Stephanie Cummins, MA

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. IAC r. 481-67.10(5). 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 481 IAC chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Legacy Gardens on September 7, 8, 9 & 13, 2010. In preparing this report, the following information was considered:

Current Program Census:

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	31
Total Census of ALP:	31

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

Program History – There were no substantiated regulatory insufficiencies found during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

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

A. Staffing

Complaint Allegations #30562-C, 30563-A: It was alleged staff saw a tenant pick up a metal bowl and carry it around. It was alleged a staff walked up to the tenant, wrapped her arms around the tenant, grabbing the tenant's arms and tried to pull them apart. It was alleged the staff pulled on the metal bowl and tried to pry the tenant's fingers off of the bowl. It was alleged staff pushed on the bowl, the tenant was hanging onto the bowl and it knocked the tenant over and the tenant fell to the ground. It was alleged the tenant started crying and the staff member walked away and left the tenant on the floor after she pushed the tenant over. It was alleged this was reported to Administrative Staff and an investigation was not completed.

- Monitoring Observation: Tenant #1, an 83 year old, was admitted on 2-17-10 and diagnoses include: Alzheimer's Disease, Migraines and Vascular Dementia. The tenant was staged at five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive impairment.

  According to an incident report dated 8-3-10 at 3:30 p.m. Tenant #1 went into the kitchen area and grabbed the bowl of chips and Staff #6 tried to take the bowl of chips claiming the tenant already had plenty of bags in the tenant's room. Staff #6 continued to grab the bowl, according to the incident report. The tenant let go after saying Staff #6 had scratched and hurt his/her arm. Staff #6 left and the tenant fell to the floor by the piano and cried, according to the report. The tenant stated his/her arm hurt. There was no physical harm other than the tenant statement of his/her arm hurting, according to the incident report. The tenant became very agitated, emotional and cried. The tenant indicated he/she was shocked someone would do that to him/her. The tenant complained his/her arm hurt and felt as though his/her skin had been torn, according to the incident report. The incident report was completed by Staff #10.

  The on-call nurse was notified on 8-3-10 at 3:30 p.m. Staff #8 notified the on-call nurse and reported there was an incident involving a staff member and tenant concerning a bowl of chips. Staff #8 told the on-call nurse the staff member and tenant both had a hold of the bowl and the tenant let go of the bowl and the tenant stated he/she was scratched. The tenant lay down on the ground and was very emotional. There were no injuries and no pain noted and the tenant was no longer emotional at the time the call was made to the on-call nurse. Staff was instructed to fill out incident reports. On 8-5-10 family was notified of the incident and family did not have a concern. The on-call nurse felt in her opinion, there was no need for further action. On 8-9-10 the DON received a call from the Department regarding the incident and was directed to do a full investigation and file a self complaint. A full investigation was completed. The program provided copies of all investigation materials to the monitor. The program's conclusion was there had been no abuse or neglect and it was a customer service based issue. Retraining on appropriate interventions and redirection were to be completed for all staff involved by August 13, 2010...

  Staff #7 indicated Staff #6 and the tenant had their hands on the bowl and there was no skin contact. The tenant let go of the bowl after redirection from Staff #7. The tenant got red in the face and sat down on the ground. Staff #7 stated she did not feel

Staff #6 caused the tenant to go to the ground. Staff #7 did not feel there was any physical or verbal abuse. Staff #7 felt the issue should have been handled differently and indicated Staff #6 should have let go of the bowl and redirected the tenant later.

Staff #8 indicated she entered the common area and the tenant was lying on the floor by the piano and was crying. She was told there was an incident involving the tenant and Staff #6 over a bowl of chips. Staff #8 called the on-call nurse and she reported there were no injuries. Staff #8 reported the tenant was no longer emotional.

Staff #9 indicated she had come out of the kitchen and Staff #6 and the tenant had a bowl of chips and were "tugging" on it. The tenant said "She ripped off her arms." The tenant then let go of the bowl, walked over to the piano and laid herself down on the ground and started crying. Staff #9 stated Staff #6 could have hurt her arms by pulling on the bowl.

Staff #6 indicated the tenant grabbed a metal bowl off of the counter and she intervened and asked the tenant to place the bowl on the counter. She indicated the tenant was agitated and she was trying to talk to the tenant and get the tenant to put the bowl back. Staff #6 put her hand on the bottom of the bowl and as the tenant walked away she grabbed the edge of the bowl to prevent the tenant was taking it to the tenant's room. Staff #6 indicated she tried to tell the tenant the chips were for everyone and also the bowl was sticky and needed to be washed and she would bring it right back. Staff #6 stated her hands never left the bowl and did not make contact with the tenant. Staff #6 stated two staff were beside her watching and did not offer any assistance. The tenant gave Staff #6 the bowl and she had asked a staff to open the kitchen door; however, the staff walked into the kitchen without holding the door and left the situation. The tenant then grabbed the bowl again trying to get it away from Staff #6. The tenant had become more agitated and she asked other staff watching the situation to assist and they asked the tenant to put the bowl down. The tenant started smacking Staff #6's arms and hands to release the bowl. The tenant let go of the bowl and raised his/her voice at Staff #6 as the tenant walked away. Staff#6 indicated the tenant was upset but she figured the tenant would calm down in a few minutes and not necessarily remember the situation. She placed the bowl on the counter and walked past the tenant to collect her things to leave. Staff #6 stated she forgot a coffee mug and returned and saw the tenant on the ground by the piano. She asked staff if the tenant was alright and they said yes and the tenant was upset and sat down onto the ground. Staff #6 indicated the situation could have been handled differently by her letting go of the bowl; however, she was concerned about the tenant eating the chips and getting a stomach ache.

Staff #6 involved in the incident with the tenant and the chip bowl, was a trainer for Mandatory Dependent Adult Abuse and Dementia.

The tenant was not treated with consideration, respect, and full recognition of personal dignity and autonomy related to the incident on 8-3-10.

- Regulatory Insufficiency: All tenants have the following rights: To be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481-67.3(1))

B. Other

Incident Allegation #29728-I: The program reported a tenant had a fractured humeral shaft. The tenant was sent to the hospital for evaluation. The origin of the injury was unknown.

- Monitoring Observation: Tenant #2, an 89 year old, was admitted on 4-22-10 and diagnoses include: Allergies, Arrhythmias, Constipation, Dementia, Fatigue, Hypertension (HTN), Hypothyroidism and Pain. The tenant was staged at five on the GDS, which indicated moderately severe cognitive impairment. The tenant received Hospice services. The tenant was discharged on 6-30-10.

  According to Clinical notes, the tenant's private caregiver assisted the tenant with am cares and the tenant was taken to the dining room table for breakfast. At 11:40 a.m. staff assisted the tenant with toileting and the tenant assisted with grabbing the bar in the bathroom. After toileting the tenant was brought out to the dining room. Staff #2 approached the tenant on the right side to give the tenant his/her medication. Staff #2 placed his hand on the tenant's right upper arm and felt it was deformed. Staff #2 pulled up the tenant's sleeve and visualized a deformity. Staff #2 called the on-call nurse. According to Clinical Notes dated 6-19-10, the on-call nurse received a call from staff stating the tenant's right arm looked funny and bowed when moved by the shoulder. The on-call nurse was on the campus and assessed the tenant. The on-call nurse indicated it appeared the tenant's shoulder was dislocated as evidenced by abnormal movement in the joint. The tenant's shoulder was malformed and the tenant was not able to perform Range of Motion (ROM). The tenant voiced complaints of pain when physically manipulated. The notes indicated no falls were witnessed and it was not noticed when the tenant was assisted with toileting. The tenant's family member was notified and family stated she knew it was going to be the tenant's right arm since so much had gone wrong in the past with that arm. The tenant was taken to the Emergency Room (ER). According to Clinical Notes dated 6-21-10, the tenant was diagnosed with a Right Proximal Humeral Fracture. Notes dated 6-21-10 indicated the tenant's family was contacted and indicated the tenant had a broken humerous and it had broke in the same spot as it did a couple years ago.

  Staff # 1 stated she assisted the tenant with toileting prior to the injury being discovered. She helped the tenant transfer to the toilet and back into the wheelchair with assistance from another staff. She stated there was nothing unusual during the transfer and the tenant did not complain of pain. The tenant grabbed the bar, according to Staff #1. She took the tenant to lunch and Staff #2 noticed the tenant's arm. Staff #2 asked Staff #1 if she had noticed anything. The tenant did not complain of pain at that time and the nurse was called to assess the tenant.

  Staff #2 was administering noon medications and put his hand on the tenant's shoulder and said the tenant's name to ensure the tenant knew what side the staff was on before administering the medications. He could feel the area was lowered and looked at the area and it looked out of place. He called the nurse and she assessed and sent the tenant out for evaluation. He said the tenant did not complain of any pain when it was discovered.

Staff #5, the on-call nurse stated she received a call from Staff #2 and he said the tenant's arm looked abnormal. She assessed the tenant and observed the upper arm was bowed inwards. Initially the tenant did not complain of pain. When the tenant's arm was moved more the tenant said "ouch." There was no bruising observed at that time. She called the tenant's family and they came and took the tenant to the hospital for evaluation. Family arrived approximately 20 minutes after the call was made. Family did not have any concerns regarding abuse.

The DON stated she was called by the on-call nurse to let her know the tenant had been sent to the ER. The tenant was assessed by the DON for return to the program; however, the tenant did not return. She did not have any concerns regarding abuse.

The Hospice nurse did not observe any deformity to the area and the tenant did not complain of arm pain. The Hospice nurse did not have any concerns regarding abuse.

According to an Investigation Report, an outside service provider (private caregiver) assisted with am cares and dressing and did not observe any pain or deformity.

The tenant was re-assessed on 6-22-10; however, did not return to the program.

The tenant's service plan addressed interventions related to history of falls including a low bed and bed and chair alarms.

Review of the tenant's file indicated nurse review, evaluations and service plans were updated as needed.

Review of Incident Reports indicated the tenant was found on the floor on 4-27-10 (twice), 5-18-10, 5-29-10 and 5-31-10. On 4-27-10 at 2:00 a.m. the tenant complained of bilateral knee pain and on 5-29-10 the tenant complained of buttock pain. There were no visible injuries with the incidents.

Staff #1, #2, #3 and #4 had appropriate nurse delegation training regarding mobility and transfers. Staff #1, #2, #3 and #4 had eight hours of dementia training.

- Regulatory Insufficiency: None noted.

Dated this 5th day of October 2010.