IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 32130-I
32131-I
32132-I
31742-I

April 8, 2011

Mr. Jim Hunter, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52240

RE: Final Incident Investigation Report – Legacy Gardens, Iowa City, IA

Dear Mr. Hunter:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of January 11, 2011, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding 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 Incident Investigation Report

Assisted Living Program:

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

Incident Intake #: 32130-I
32131-I
32132-I
31742-I

Date of Incident Investigation:

January 11, 2011

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 an Incident 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:

An on-site visit was conducted at Legacy Gardens on January 11, 2011. 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:	27
Total Census of ALP:	27

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

Program History – There were no Regulatory Insufficiencies found during this certification period.

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

A. Other

Incident Allegation #32130-I: The program reported a tenant was missing money. It was reported the money was last seen approximately two and a half weeks prior to when it was discovered.

- Monitoring Observation: Tenant #1, a 92 year old, was admitted on 10-30-10 with diagnosis of: Dementia. The tenant was staged at a Global Deterioration Scale (GDS), which indicated moderately cognitive decline.

  On 12-7-10 the tenant's family reported there was money taken from the tenant's apartment. There was money kept in the tenant's jewelry box and a purse. The family was unsure of how much was in each place and the exact total of the money. The tenant's family stated the money had gone missing in approximately the last two to three weeks. All staff working were questioned regarding the incident, according to a program document.

  A staff meeting was held on 12-16-10 and topics covered included resident rights and theft. The local police department was notified. The department was notified appropriately. An incident report was completed.

  Staff #1, #2 and #3 were interviewed. Staff were not aware of anyone who had taken anything from the tenants. Staff indicated there were tenants that wandered into other tenants' apartments. Staff reported there had not been any unusual visitors in the building; however, there had been visitors.

  The Corporate Nurse and Executive Director reported a perpetrator was not identified and there had not been any subsequent thefts.

  At the time of the investigation it could not be determined what occurred with the missing money.

- Regulatory Insufficiency: None noted.

Incident Allegation #32131-I: The program reported a tenant was missing part of the tenant's billfold. It was reported the tenant was not missing money, identification cards, checks or credit cards.

- Monitoring Observation: Tenant #2, an 87 year old, was admitted on 5-7-10 with diagnoses of: Hypertension (HTN), Hyperlipidemia, Dementia and Pedal Edema.

  On 12-8-10 the tenant reported to staff that he/she was missing a check and the tenant reported to Administrative Staff that he/she was missing money and not a check. The tenant's family was contacted and reported the tenant did not have any checks or money in the tenant's possession. The tenant's family found part of the tenant's billfold was missing; however, could not confirm anything was taken. The tenant's identification cards were with the family. All staff working were questioned regarding the incident, according to a program document.

A staff meeting was held on 12-16-10 and topics covered included resident rights and theft. The local police department was notified. The department was notified appropriately. An incident report was completed.

Staff #1, #2 and #3 were interviewed. Staff were not aware of anyone who had taken anything from the tenants. Staff indicated there were tenants that wandered into other tenants' apartments. Staff reported there had not been any unusual visitors in the building; however, there had been visitors.

The Corporate Nurse and Executive Director reported a perpetrator was not identified and there had not been any subsequent thefts.

At the time of the investigation it could not be determined what occurred with the missing part of the billfold.

- Regulatory Insufficiency: None noted.

Incident Allegation #32132-I: The program reported a tenant was missing two rings. It was reported the rings were in a nightstand when the tenant moved in to the program.

- Monitoring Observation: Tenant #3, an 82 year old, was admitted on 11-23-10 with diagnoses of: Diabetes Mellitus (DM) Type II, HTN, Hyperlipidemia, Benign Prostate Hypertrophy (BPH), Dementia, Depression and Peripheral Vascular Disease (PVD). The tenant was staged at a four on the GDS, which indicated moderate cognitive decline.

  On 12-6-10 the tenant's family reported they had placed the tenant's rings in a dresser drawer and they did not see the rings after moving the tenant in. They checked with other family members and also looked at the tenant's home to ensure the rings were not there. On 12-8-10 the tenant's family confirmed the tenant had a two rings missing from the tenant's room. All staff working were questioned regarding the incident, according to a program document.

Staff #1, #2 and #3 were interviewed. Staff were not aware of anyone who had taken anything from the tenants. Staff indicated there were tenants that wandered into other tenants' apartments. Staff reported there had not been any unusual visitors in the building; however, there had been visitors.

The Corporate Nurse and Executive Director reported a perpetrator was not identified and there had not been any subsequent thefts.

A staff meeting was held on 12-16-10 and topics covered included resident rights and theft. The local police department was notified. The department was notified appropriately. An incident report was completed.

At the time of the investigation it could not be determined what occurred with the missing rings.

- Regulatory Insufficiency: None noted.

Incident Allegation 31742-I: The program reported a tenant was missing a laptop. It was reported the laptop was last seen in June 2010.

- Monitoring Observation: Tenant #4, a 96 year old, was admitted on 6-16-10 with diagnoses of: HTN, Coronary Artery Disease (CAD), Vertigo, BPH, Hearing Loss, Aortic Stenosis, Seizure Disorder, History of Cerebral Vascular Accident (CVA), Anemia, Osteopenia, Hypothyroidism, Hypercholesterolemia, and Degenerative Arthritis in Bilateral Knees. The tenant was discharged on 11-21-10.

  On 11-12-10 the tenant's family reported the tenant's laptop was missing. The laptop was under a stack of newspapers on the desk. Staff searched the entire building to look for the laptop. According to the investigation report, the tenant was did not know the laptop was last seen. The Executive Director and the Corporate Nurse reported the tenant had not seen the laptop since June 2010.

  Staff #1, #2 and #3 were interviewed. Staff were not aware of anyone who had taken anything from the tenants. Staff indicated there were tenants that wandered into other tenants' apartments. Staff reported there had not been any unusual visitors in the building; however, there had been visitors.

  The Corporate Nurse and Executive Director reported a perpetrator was not identified and there had not been any subsequent thefts.

  A staff meeting was held on 12-16-10 and topics covered included resident rights and theft. The local police department was notified. The department was notified appropriately. An incident report was completed.

  At the time of the investigation it could not be determined what occurred with the missing laptop.

- Regulatory Insufficiency: None noted.

Dated this 8th day of April, 2011.