IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

RODNEY A. ROBERTS, DIRECTOR

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 36964-I

February 10, 2012

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

RE: I. Final Complaint/Incident Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Mr. Hunter:

I. Final Complaint/Incident Investigation Report – Legacy Gardens, Iowa City, IA

Enclosed is the **Final Complaint/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. The Report notes Regulatory Insufficiency in the area(s) of: Nurse Review. **Legacy Gardens** ("Program") is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

Legacy Gardens ("Program") is being assessed a $500 civil penalty. As you note in your letter of January 20, 2012, a Request for Reconsideration is not the proper venue for reconsideration of civil penalties. The civil penalty was issued pursuant to Iowa Code section 231C.14(1)(b) and Iowa Administrative Code rule 481 – 67.12(3)a(2) for the regulatory insufficiency related to Nurse Review.

II. Civil Penalty

If, within 30 days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover

letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order in the amount of three hundred twenty five dollars ($325) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on January 20, 2012, has been reviewed and will constitute the final POC related to the on-site visit of January 4, 2012.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

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

Complaint/Incident Intake #: 36964-I

Date of Complaint/Incident Investigation:

January 4, 2012

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	2
Number of tenants with cognitive disorder:	30
Total Population of Program at time of on-site	32
TOTAL census of Assisted Living Program	32

Program History – The program received regulatory insufficiencies during the August 2011 on-site (35306-C, 35174-I) in the areas of Service Plan, Medications, Nurse Review, Staffing and Policy and Procedure.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Criteria for Admission and Retention

Complaint/Incident Allegation: The Program reported a tenant struck another tenant on the left side of the face, by the left ear, with a closed fist.

- Monitoring Observation: Tenant #1, an 84 year old, was admitted on 2-1-10 and diagnoses include Alzheimer's Disease, Migraines, Falls Frequently and Vascular Dementia. Tenant #1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #1 was discharged on 12-7-11.

  Tenant #2, a 72 year old, was admitted on 10-28-10 and had a diagnosis of Dementia. Tenant #2 was staged at a six on the GDS, which indicated severe cognitive decline. At the time of the investigation, Tenant #2 resided at the Program; however, Tenant #2 was expected to be discharged on 1-5-12.

  There were two incident reports completed related to the incident on 12-1-11. One incident report was completed for Tenant #1 and one incident report for Tenant #2. The information below was obtained from both incident reports. According to the Incident Reports, on 12-1-11 at 6:30 p.m. Tenant #2 came and asked staff for assistance and said "get … out of my room." Staff #1 went straight to the sink to wash her hands, turned and Tenant #2 was no longer waiting behind her. Staff #1 walked around the counter towards Tenant #2's apartment, at which time she saw Tenant #2 striking Tenant #1 with a closed fist in the head. Staff #1 told Tenant #2 to stop as she ran towards them. Tenant #2 continued to strike Tenant #1 until Staff #1 grabbed Tenant #2's arm to stop Tenant #2. Tenant #2 was insistent that he/she was not wrong in his/her actions and stated Tenant #1 started it. Tenant #2 did not sustain

any visible injuries from the incident. Tenant #2 continued to be verbally upset and could not be redirected. Tenant #2 did not complain of pain and first aid treatment was not needed. Tenant #2 was sent out to a hospital Emergency Room (ER) for psychiatric evaluation. An on call nurse was notified. According to the Incident Reports, on 12-1-11 at 6:30 p.m. in Tenant #2's apartment doorway, Tenant #1 was observed to be pushed up against the open door to Tenant #2's apartment. Tenant #1 had his/her hand covering up his/her face and was crying, "STOP." Tenant #2 was observed striking Tenant #1 on the head with a closed fist repeatedly, four or five times. Tenant #1 was noted to have a red unopened wound to the left side of the face (approximately .2cm x 6.0 cm) no bruising noted at that time. Tenant #1's face, forehead and head were dark pink in color and tender to the touch. No change in Tenant #1's behavior or increased confusion was noted at that time. Tenant #1's functional ability was normal and Tenant #1 ambulated without difficulty. During assessment of the face and head Tenant #1 stated not to touch and said it hurt. Tenant #1's grips were strong and equal and vitals were intact. Tenant #1's pupils were brisk and reactive to light and no change was noted. A cold compress was applied to the left side of Tenant #1's face as tolerated. An on call nurse was notified.

According to an Incident Investigation Report, on 12-1-11 at 6:30 p.m. a staff member walked into Tenant #2's apartment and witnessed Tenant #2 hitting Tenant #1 with a closed hand. The staff member immediately stepped in and split up the two tenants. Once the two tenants were separated and safe, staff called the on call nurse. Staff called Tenant #2's family member and the family member spoke with Tenant #2 while another family member was called and told he/she needed to come in to sit with Tenant #2. The Director of Nursing (DON) was notified and called the Program and advised Tenant #2 be sent to the ER for evaluation. At the time of the incident Tenant #1 was noted to have an unopened injury to the left side of his/her face by the left ear. No bruising was noted at that time. Incident reports were filled out, legal representatives for Tenant #1 and Tenant #2 were called and information was provided. An investigation report was initiated. Checks every 15 minutes were implemented when Tenant #2 returned from the ER. Checks every 15 minutes were completed for both Tenant #1 and Tenant #2.

Staff #1, a licensed practical nurse, was interviewed. Staff #1 was cleaning up after another tenant had an incontinence episode by the beauty shop door. Tenant #2 said he/she needed assistance. Staff #1 took off her gloves and washed her hands. She saw Tenant #2 in the doorway and Tenant #1 pushed up against the door. Tenant #2 hit Tenant #1 on the side of the head and face with a closed hand. She ran over and told Tenant #2 to stop and grabbed Tenant #2's hand. Tenant #2 hit Tenant #1 approximately five times. She got Tenant #1 out of the room. She requested assistance from other staff. She assessed Tenant #1 and a welt was noted on Tenant #1's face. Neurologic checks and vitals were completed. No other injuries were noted at that time. Tenant #2 was also assessed as Tenant #2 said Tenant #1 hit him/her in the stomach and kicked him/her in the leg. Tenant #2 did not have any marks or bruises. The DON was notified of the incident. Tenant #2's family member came to the Program and sat with Tenant #2. Tenant #2 was sent to the ER. Checks every 15 minutes were initiated for Tenant #1 and Tenant #2. Staff #1 felt the situation was handled appropriately and there was enough staff to meet the needs of the tenants.

The DON was interviewed. On 12-1-11 at approximately 7:00 p.m. she was notified by the on call nurse, she called the Program to ensure everyone was safe and there were no injuries. Tenant #2 was sent out to the ER. Staff #1 told her Tenant #2 struck Tenant #1's face with a closed fist. She said if Tenant #2 returned staff needed to implement 15 minute checks and Tenant #2's family member would need to stay with him/her. The family member stayed most of the night. Change of condition assessment was completed. The DON felt the situation was handled appropriately and there was enough staff to meet the needs of the tenants.

Tenant #1's file was reviewed. After the incident, evaluations were completed and the service plan was updated. The service plan reflected behaviors and interventions related to the behavior. The service plan also reflected 15 minute checks would be completed. Review of 15 minute check logs indicated checks were consistently completed until Tenant #1 moved out. Tenant #1 had previously been given notice to move out due to an increase in behaviors on 11-16-11. It was not a formal 30 day notice because Tenant #1 showed signs of exceeding level of care and family was approached about possible transfer to long term care and family agreed, according to Clinical Notes. Tenant #1 was discharged on 12-7-11.

Tenant #2's file was reviewed. After the incident, evaluations were completed and the service plan was updated. The service plan reflected behaviors and interventions related to the behavior. The service plan also reflected 15 minute checks would be completed. Review of 15 minute check logs indicated checks were consistently completed. Tenant #2's legal representative was given a verbal notice to move out. It was not a formal 30 day notice because Tenant #2 showed signs of exceeding level of care and the legal representative verbalized understanding. Tenant #2 was expected to be discharged on 1-5-12.

Incident reports were completed related to the incident and the Program notified the Department. Staff #1 immediately intervened and separated Tenant #1 and Tenant #2. Tenant #2 was sent out to the ER for evaluation. Tenant #1 and Tenant #2 were placed on 15 minute checks and the checks were completed consistently. Tenant #1 was discharged on 12-7-11 and Tenant #2 was expected to be discharged on 1-5-12. Staff #1, Staff #2 and the DON did not identify any other tenants that exceeded the appropriate level of care.

- Regulatory Insufficiency: None noted.

B. Nurse Review

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

- Monitoring Observation: According to an Incident Report, on 11-8-11 at 5:45 p.m. Tenant #2 hit Tenant #1 in the left eye. Tenant #1's grips were equal and Tenant #1 continued to be talkative and no loss of consciousness. Tenant #1 had a small purple/red area below the left eye and slight swelling around the left eye. Tenant #1 said his/her eye was sore but was unable to use a pain scale. Ice was applied to

Tenant #1's left eye area. The on call nurse was notified and Tenant #1's doctor was notified.

Tenant #1's file was reviewed. According to Clinical Notes dated 11-11-11, Tenant #1 was involved in an altercation with another tenant. Staff observed other tenant strike Tenant #1 below the left eye. Pupils were equal and reactive, grips were equal and no other changes noted. Vitals were obtained. Ice was applied to the area on the left cheek. Tenant #1's family was notified and Tenant #1's doctor was notified. No vision changes were noted.

Tenant #2's file was reviewed. There was no documentation in Tenant #2's Clinical Notes regarding the incident on 11-8-11, when Tenant #2 hit Tenant #1 in the left eye. Tenant #2 was also involved in the incident detailed above on 12-1-11, where Tenant #2 hit Tenant #1 on the side of the head and face with a closed fist. Nurse review was not completed related for Tenant #2 related to the 11-8-11 incident. Nurse review was not completed as needed.

- Regulatory Insufficiency: If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))