IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
43438-C

June 12, 2013

Ms. Kris Ward, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52240

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

Dear Ms. Ward:

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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/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 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Complaint/Incident Intake #:** 43438-C

Kris Ward, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52240

Date of Complaint/Incident Investigation:

May 7 and 9, 2013

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:	20
Total Population of Program at time of on-site	22
TOTAL census of Assisted Living Program	22

Program History – The program received regulatory insufficiencies during the Recertification and Complaint/Incident (40184-I, 40159-C, 40187-C) on-sit of August and Sept, 2012 in the areas of: Service Plan, Medications, Nurse Review, Staffing, Policy and Procedure, Tenant Rights and Tenant Documents. During the April 2013 Incident Investigation (43251-I), the program received regulatory insufficiencies in the areas of: Life Safety, Program Reporting to the Department, Criteria for Admission and discharge and Tenant Documents.

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

A. Medications

Complaint/Incident Allegation: It was alleged a tenant had to use a different pharmacy.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

  Tenant #1, an 87 year old, was admitted on 2-24-12 and diagnoses included: Dementia, L1 Fracture and Cellulitis. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #1's service plan reflected staff administered medications and treatments based on the Medication Administration Record (MAR). The service plan reflected medications were ordered through the Veterans Administration (VA) and a pharmacy if (VA) was unable to fill.

  Tenant #2, a 94 year old, was admitted on 2-19-13 and diagnoses included: Congestive Heart Failure, Dementia, Coronary Artery Disease, Pacemaker, Degenerative Joint Disease and High Blood Pressure and Benign Prostate Hypertrophy. Tenant #2 was staged a six on the GDS, which indicated severe cognitive decline. Tenant #2's date of discharge was 4-15-13. Clinical Notes reflected Tenant #2 moved out on 3-15-13. According to the service plan staff

administered Tenant #2's medications and Tenant #2 needed assistance with storage, preparation and reminders. The service plan reflected pharmacy.

Tenant #3, a 90 year old was admitted on 5-7-10 and diagnoses included: Dementia, Hypertension, Hyperlipidemia, Pedal Edema, Renal Insufficiency, Atrial Fibrillation and Left Hip Fracture. Tenant #3 was discharged on 4-8-13. According to a service plan dated 9-14-12, staff administered medications; staff followed all orders as stated on the MAR; medications stored in locked cart. The service plan reflected the pharmacy.

Tenant #4, a 79 year old, was admitted on 1-31-11 and diagnoses included: Dementia, Parkinson's Disease and Hypothyroid. Tenant #4 was staged at a five on the GDS, which indicated moderately severe cognitive decline. According to the service plan, staff administered medications and Tenant #4 received assistance with ordering medications/supplies. The service plan reflected the medications could be crushed (except for those unable to be crushed) and were placed in applesauce, yogurt, jelly, ice cream and pudding. The service plan also reflected the pharmacy

Tenant #5, an 84 year old was admitted on 2-29-12 and diagnoses included: Dementia, Atrial Fibrillation and Benign Prostatic Hyperplasia. A hospice diagnosis was Debility. Tenant #5 was staged at a six on the GDS, which indicated severe cognitive decline. According to a service plan dated 4-16-13, staff administered medications and treatments on the MAR; medications stored in a locked medication cart. The service plan reflected the pharmacy.

The Executive Director (ED) stated when a new tenant chose a pharmacy, the pharmacy was notified by fax and a follow up phone call was made, if needed. Insurance information and a copy of the Medicare card were sent to the pharmacy. Tenants were notified of the special packaging needs for medications through the marketing process and during the admission assessment made by the nurse. The ED said tenants were not required to use a certain pharmacy. New people were asked to use bubble packs, except those that received VA medications. She had not heard any complaints regarding the issue.

The Registered Nurse (RN) stated when a new tenant chose a pharmacy a phone call was made to the pharmacy to find out what information the pharmacy needed. Then a copy of the Medicare card, insurance card and prescription were sent to the pharmacy.

Two family interviews were conducted and there were no complaints or concerns regarding pharmacy and the packaging method for medications.

According to a document, the Program administered medications to 22 tenants. There were different pharmacies selected and two tenants had VA medications.

Review of tenant files, family interviews, an interview with the ED and RN and a Program document indicated tenants could use a pharmacy of choice.

- Regulatory Insufficiency: None noted.

B. Staffing

Complaint/Incident Allegation: It was alleged the pendant system did not work. It was alleged equipment was not working.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

Tenant #2's file was reviewed. According to an incident report on 3-3-13 at 2:30 p.m. staff heard Tenant #2 yelling and found Tenant #2 on the floor in front of the chair. There were no injuries. Vitals were taken and were as follows: blood pressure was 120/70, pulse was 70, respirations were 13 and temperature was 98.9. Personal emergency response device records indicated the wall mount device was activated on 3-3-13 at 2:33 p.m. and was cleared on 3-3-13 at 2:33 p.m. According to an incident report on 3-6-13 at 6:15 p.m. Tenant #2 was found on the floor in the apartment between the recliner and bed. Tenant #2 had a visible skin tear on the left forearm and one on the lower back. Vitals were taken and were as follows: blood pressure was 82/60, pulse was 54, respirations were 20 and temperature was 96.7. Tenant #2 was transported to the hospital. Personal emergency response device records indicated Tenant #2's pendant was activated on 3-6-13 at 10:42 a.m. and was reset at 10:45 a.m.; however, was not activated at the time the incident. According to an incident report dated 3-8-13 at 3:45 p.m. Tenant #2 was found on the knees at bedside by staff. No injuries were noted. Vitals were obtained and were as follows: blood pressure was 98/66, pulse was 68, respirations were 16 and temperature was 97. According to personal emergency response device records Tenant #2's pendant was activated on 3-8-13 at 6:11 p.m. and reset at 6:17 p.m. and at 8:02 p.m. and reset at 8:03 p.m. Tenant #2's wall mount device was activated on 3-8-13 at 7:44 p.m. and was reset at 7:45 p.m. The personal emergency response devices were activated on 3-8-13; however, not at the time of the incident. Review of Tenant #2's personal emergency response device records indicated Tenant #2's wall mount device had 20 incidents, including 10 cleared alarms with an average response time of 1.5 minutes. The pendant from 2-19-13 to 3-11-13 had 22 incidents, including 11 cleared alarms with an average response of 3.3 minutes. Clinical Notes dated 3-12-13 indicated a new pendant was issued to Tenant #2; however, the notes did not indicate the pendant did not function. Vitals were taken and were recorded on the incident reports.

Tenant #3's file was reviewed. According to Clinical Notes on 3-21-13 a fax was sent to the attending physician regarding early that morning around 2:15 a.m., Tenant #3 was found on hallway floor with Tenant #3's walker, complained of lower back pain, a 4 on a 10 scale. Tenant #3 was able to get back up. Tenant #3 complained in the morning of lower back pain as well. Vital signs were as follows: blood pressure 84/70, pulse 73, respirations 28 and temperature 98.7. Tenant #3 did not activate the personal emergency response device at the time of the incident. The personal emergency response device records for Tenant #3 reflected activation from 2-15-13

through 3-20-13 a total of 120 incidents, including 60 cleared alarms with an average response time of 1.1 minute. Vitals were taken and were documented in Clinical Notes.

Tenant #4's file was reviewed. According to an incident report on 4-12-13 at 11:00 p.m. Tenant #4 pushed the call light as staff was on the way to get Tenant #4. Staff heard the alarm going off as staff ran toward the apartment. Tenant #4 lost Tenant #4's balance and fell backwards. Tenant #4 had a small abrasion on the left arm under the elbow. Vitals were taken and were as follows: blood pressure 116/70, pulse 70, respirations were 20 and temperature was 97.6. Personal emergency response device records indicated a device was activated on 4-12-13 at 11:06 p.m. and reset at 11:07 p.m. For the time period provided Tenant #4 had 144 incidents, including 72 cleared alarms with an average response of 1.7 minutes. Vitals were taken and were recorded on the incident report.

The personal emergency response devices in apartments for Tenants #1, #2, #3, #4 and #5 were tested. The devices checked for these apartments functioned appropriately at the time of the investigation.

According to the ED, pendants and call cords were part of the system which showed a low battery or if one was missing. Staff knew when the walkies were not working and pagers were battery operated.

According to the RN, maintenance did weekly testing on all equipment. Staff would alert if there were issues with walkies and pagers. She had back up pagers, approximately four or five. Walkies were sent out for repair if needed. According to the RN, she had not been at the Program long enough to know the process for maintenance since she just began working there in April. She had ordered two or three new blood pressure cuffs. In cleaning them she noticed several weren't holding due to the elastic.

According to Staff #1, every morning a walkie check was completed. If pagers did not work the batteries were changed by giving the walkie to the nurse to fix. The walkies were used enough during the day to let staff know if they were not working. Blood pressure cuffs were maintained by looking to make sure the level was set at zero on the dial. If not, it was given to the nurse to fix.

Two family members were interviewed. One family member did not have any issues regarding personal emergency response devices. Another family member said on the day of the interview the personal emergency response device did not work when a tenant requested Tylenol; however, it was reported to the Program and the Program was working to resolve the issue. The family member said it was the only time there had been an issue with the personal emergency response device.

According to the Program's Staffing Policy and Procedure, it was the policy of the Program to maintain competent staff at all times who were able to implement the accident, fire safety and emergency procedures. Staff was given access to pagers in order to respond to the 24 hour personal emergency response device assigned to each tenant. Each tenant had access to the 24 hour personal emergency response system

that automatically identified the tenant in distress and could be activated with one touch.

Review of tenant files and incident reports, a staff interview, family interviews, an interview with the ED and RN, a test of personal emergency response devices and review of the personal emergency response device records did not reveal any concerns with the personal emergency response devices or equipment.

- Regulatory Insufficiency: None noted.

C. Service Plans

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

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

  Tenant #1's file was reviewed. According to Clinical Notes dated 4-2-13, a change of condition evaluation was completed related to a new diagnosis of Thrush. A service plan was developed on 4-2-13 and at the time of the investigation was not signed by the tenant or tenant's legal representative or by a health or human service professional. The service plan had gone out for signature and at the time of investigation was not signed. According to an incident report dated 4-11-13, staff received a page regarding the east lobby door, responded and heard the front door alarm go off. Tenant #1 started going out the front outside door. Staff tried to redirect Tenant #1. Tenant #1 walked to another building on the campus and staff went with Tenant #1. Tenant #1 walked back to the Program with staff and stayed in the office until family arrived. Tenant #1 had no injuries. The service plan was updated on 4-11-13 and was signed by a health professional on 4-11-13. The service plan was not signed by Tenant #1's family member until 5-10-13. Service plans updated as needed with a change in condition were not signed by the tenant or tenant's legal representative and a health or human service professional.

  Tenant #2's file was reviewed. The initial service plan was not signed by Tenant #2 or Tenant #2's legal representative. Clinical Notes dated 3-8-13 indicated had a fall, was sent to the hospital for evaluation on 3-6-13, reopened a skin tear and obtained a new skin tear. A change of condition evaluation was completed related to the skin tears and treatment. The service plan was updated as needed on 3-8-13 and was not signed by Tenant #2 or Tenant #2's legal representative or a health or human service professional. The service plan prior to taking occupancy and as needed was not signed by the tenant or tenant's legal representative and a health or human service professional.

  Review of tenant files indicated service plans were not signed by the tenant or tenant's legal representative or a health or human service professional.

- Regulatory Insufficiency: Prior to the tenant's signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by

health care professional or human service professional 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. All persons who develop the plan and the tenant or the tenant's legal representative shall sign the plan. (IAC r. 481-69.26(2))

- Regulatory Insufficiency: When a tenant needs personal care or health-related care, the service plan shall be updated within 30 days of the tenant's occupancy and as needed with significant change but not less annually. If a significant change triggers the review and update of the service plan, the updated service plan shall be signed and dated by all parties. (IAC r. 481-69.26(3)(a))

D. Activities

Complaint/Incident Allegation: It was alleged there was not enough stimulation and tenants were not taken to activities.

- Monitoring Observation: Five tenant files (Tenants #1, 2, #3, #4 and #5) were reviewed. The service plans for Tenants #1, #2, #3, #4 and #5 reflected activities for those unable to plan their own activities.

  An activity calendar for May 2013 was provided. The activity calendar reflected daily activities, including evening and weekend activities. The calendar also announced new activities for the month and outings. The calendar indicated activities were subject to change. In addition to the monthly calendar, daily activities were written on a board on each side of the building.

  Monitor observations of activities were completed on 5-7-13 and 5-9-13. Observations included: chapel service, reminiscing card game, exercises and a craft activity with wooden cars. The activities had between four and six tenants in attendance.

  The Activity Director stated usually there were some tenants sitting on the couch and she would tell them about 15 minutes before an activity when one would start. Ten minutes before the activity she would go from room to room to notify tenants. If a tenant needed help to get to an activity she would ask an aide to get them. The tenants that were most willing to attend an activity were ambulatory. Everyone was invited to all activities. She stated she had not necessarily had any complaints regarding activities. When she started an activity, if tenants were not engaged she would switch to another activity they would like to do. When group activities were over she provided one on one activities.

  The RN stated tenants were notified about activities through activity calendars, activity staff and other staff provided reminders. Activity boards were also posted within the units. Tenants were assisted to activities by staff and the Activity Director. She had not received any complaints regarding activities.

  The ED stated tenants were notified of activities by reminders from staff, the posted boards, calendars and staff went to the tenants they knew enjoyed that activity.

Tenants were assisted to activities by direct care staff and activity staff. There were two activity staff in February and March and both worked 40 hours per week. The ED said she had not received any complaints regarding lack of activities.

Staff #1 stated a tenant was notified about activities by staff saying something to the tenant and staff went from room to room to notify tenants. The Activity Director informed tenants and the tenants could look at the daily board that listed the activities. Usually the Activity Director or staff assisted the tenants to the activities.

Two family members were interviewed. One family member said there were no issues with activities. Another family member indicated there were exercises, sing-a-longs, music class with instruments and church. Staff came to the room to get the tenant if not at an activity. The family member said the Program was trying to work on activities. There was a suggestion for more craft or project oriented activities for some of the tenants.

The Activities Policy and Procedure indicated it was the policy of the Program to provide each tenant with activities and lifestyle choices which were appropriate, stimulating and enjoyable and met tenant needs.

Review of the activity calendar, review of the activity policy, family interviews, review of tenant files, monitor observations, a staff interview and interviews with the ED, RN and Activity Director indicated there were sufficient activities provided.

- Regulatory Insufficiency: None noted.

E. Nurse Review

Complaint/Incident Allegation: It was alleged physician orders were not followed.

- Monitoring Observation: Five tenant files (Tenants #1, #2, #3, #4 and #5) were reviewed.

  Tenant #1's file was reviewed. A physician's order dated 3-29-13 indicated Fish Oil, Miralax, Sennakot were discontinued. A new diagnosis of Thrush was added. Nystatin swish and spit two teaspoons four times daily continue for 48 hours after symptoms improved. Metamucil one tablespoon daily as bulking agent was ordered. The orders were reflected on the MARs and the MARs indicated medications and treatments were administered consistent with such orders. Physician orders were followed.

  Tenant #2's file was reviewed. The Admission Orders reflected medication orders, diagnosis, activity and allergies. The orders reflected an Influenza Vaccine could be administered annually. There were no labs listed on the Admission Orders. The medications ordered were reflected on the MARs and the MARs indicated medications were administered consistent with such orders. On 3-11-13 an order for Debrox AU for three days, Aquaphilic to lower to extremity every day as needed for dryness and barrier cream twice daily to irritated skin was received. On 3-11-13 an order was also received for a C-Diff toxin. The order was noted and the lab was

completed and the results indicated it was negative. The physician was informed of the result of the lab. Physician orders were followed.

Tenant #4's file was reviewed. On 2-8-13 a Urine analysis (UA) was ordered. On 2-11-13 the lab results of the UA were sent to the physician and Cipro 250 mg was ordered twice daily for seven days. The order was noted. On 2-28-13 a fax was sent to the physician requesting a UA. A UA was ordered and noted on 2-28-13. The results of the UA were faxed to the physician on 3-4-13 and no new orders were received. Physician orders were followed.

Review of tenant files indicated physician orders were consistently followed.

- Regulatory Insufficiency: None noted.

F. Other

Complaint/Incident Allegation: It was alleged tenant supplies were missing.

- Monitoring Observation:

  Two family interviews were conducted. There were no issues identified with supplies.

  According to the RN, when a tenant was discharged, supplies purchased by the family were sent home with the family because it was their property. She would call and remind them if they had left supplies behind for about four months. If the supplies had been opened, they were never used for other tenants.

  According to the ED, personal supplies were sent with the tenant when they were discharged. The ED indicated families provided any personal supplies, including: soap, toothpaste and protective undergarments. She said there were no concerns with supplies, she was not aware of any missing supplies and did not have complaints regarding this issue from tenants or families.

  According to Staff #1, when a tenant was discharged personal supplies were taken by the family. If the family said they didn't want the supplies they were put in the shower room or laundry room or housekeeping threw them out.

  Review of family interviews, a staff interview, and interview with the ED and the RN did not reveal any concerns with supplies.

- Regulatory Insufficiency: None noted.