IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 45664-C

October 22, 2013

Ms. Kaylan Hamerlinck, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52240

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

Dear Ms. Hamerlinck:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of October 10 & 14, 2013, 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 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:

Kaylan Hamerlinck, Executive Director
Legacy Gardens
15 Silvercrest Place
Iowa City, IA 52240

Complaint/Incident Intake #: 45664-C

Date of Complaint/Incident Investigation:

October 10 & 14, 2013

Monitor(s):

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:	3
Number of tenants with cognitive disorder:	23
Total Population of Program at time of on-site	26
TOTAL census of Assisted Living Program	26

Program History – The program received regulatory insufficiencies during the Recertification and Complaint/Incident (40184-I, 40159-C, 40187-C) on-site 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. During the May 7 and 9, 2013 Complaint Investigation (43438-C), the program received a regulatory insufficiency in the area of Service Plan. During the August 26, 2013, Incident Investigation (44982-I), the program received regulatory insufficiencies in the areas of: Staffing and Policies and Procedures.

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

A. Nurse Review

Complaint/Incident Allegation: It was alleged a staff did not report a tenant's skin condition to a nursing supervisor and the tenant had never been assessed by a nurse.

- Monitoring Observation: Four tenant files (Tenants #1, #2, #3 and #4) were reviewed. Tenants #1 and #2 had skin issues.

  Tenant #1, a 92 year old, was admitted on 4-23-13 and diagnoses included: Dementia, Atrial Fibrillation, Congestive Heart Failure and Benign Prostatic Hyperplasia. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. According to the Clinical Notes dated 8-26-13, upon assessment, a nurse found a Stage 1 pressure ulcer to left heel without drainage. Tenant #1 did not voice pain or discomfort to the left heel. Measurements were approximately 1 cm x 2 cm x 0 cm. No warmth or edema to wound bed or surrounding area. On 8-28-13, Tenant #1's physician was notified and ordered home health to consult for wound care. According to the Clinical Notes dated 8-30-13, a nurse from home health was there to see Tenant #1's heel. An open area was present that measured approximately 6 cm x 2.5 cm. A Mediplex dressing was applied to the area and the home health nurse would notify the physician. According to the Clinical Notes dated 9-9-13, home health provided wound care and education to Tenant #1

concerning wound care and disease processes. A Physician Orders document dated 9-12-13 indicated Iodine to heel and change daily. This would help dry the wound and would give it an antimicrobial environment. Use gauze, gauze roll and paper tape. Moisturizing lotion applied to surrounding wound. Tenant #1 would wear yellow foam to heel at all times, may remove for bathing and transferring. An off loading shoe was ordered. Bactrim DS 800 mg-160 mg tablet, one tablet by mouth, twice per day for 10 days was ordered. According to the Clinical Notes, on 9-17-13, Tenant #1 returned from a wound clinic with new orders for Cipro 500 mg by mouth twice a day for 10 days for infection of the left heel. According to the Clinical Notes dated 9-25-13 an order from the wound clinic was received for Betadine to heel with moisturizing lotion around the wound. Cover with gauze. Wear off loading boot at all times except bathing. Change dressings on Tuesday and Friday. On 10-3-13 vital signs were blood pressure 90/40, pulse 112, respiratory rate 30, and temperature 102.3. Lung sounds were diminished with crackles noted. Tenant #1 denied difficulty breathing or pain. Emergency Medical Technician services were notified and Tenant #1 was escorted to the hospital for evaluation and treatment. On 10-7-13, a signed fax from Tenant #1's physician acknowledged Tenant #1's hospital transfer for signs and symptoms of respiratory distress. According to the Clinical Notes, dated 10-9-13, Tenant #1 reached the end of life on 10-4-13 at the hospital.

Tenant #2, a 79 year old, was admitted on 6-6-11 and diagnoses included: Dementia, Valvular Heart Disease, Coronary Artery Disease, Hypertension, Atrial Fibrillation, Glaucoma, Osteoarthritis and Hypercholesterolemia. Tenant #2 was staged at a four on the GDS which indicated moderate cognitive decline. According to the Clinical Notes dated 8-28-13, Tenant #2 went to the physician after a nurse assessment revealed hives to back and under right breast with oozing. A fax was sent to Tenant #2's physician that stated right flank and breast area with redness, blisters and pain. Tenant #2 was afebrile at 97.3 degrees, blood pressure 150/66, pulse 66, respirations 22 and oxygen saturation 97 percent. An appointment with the physician was set for 6:00 p.m. A Physician Visit Form dated 8-28-13 indicated concerns of painful rash on right breast with a diagnosis of Herpes Zoster Infection. New orders were received for Valtrev 1000 mg three times a day for seven days; Lidocaine 5% ointment, apply topically four times a day as needed; Hydrocodone Tylenol 5/325 one to two every six hours as needed; and Senna with Docusate one twice a day while on Hydrocodone, then twice a day as needed. A cooler climate would be helpful. The physician orders were noted by the Campus Director of Nursing (DON) at 7:23 p.m. on 8-28-13. According to the Clinical Notes dated 8-29-13, indicated on 8-28-13 at 12:15 p.m., Tenant #2 complained of pain to right flank area. A nursing assessment revealed the following change in condition: right flank/right breast area with pain, redness and blisters. Tenant #2 reported pain started previous day and worsened into the night. Tenant #2 was afebrile but reported feeling hot the previous evening. According to Clinical Notes dated 8-30-13 at 10:44 a.m., Tenant #2 complained of pain to right flank area (shingles) despite Hydrocodone. Family was notified. Tenant #2 would be re-evaluated by physician at 10:45 a.m. At 11:39 a.m. Tenant #2's physicians' office called and stated Tenant #2 would be admitted to the hospital for pain management. According to the Clinical Notes dated 9-16-13 at 9:57 a.m., Tenant #2's history and physical was received from the hospital that stated Tenant #2's condition. Tenant #2 was admitted to inpatient hospice with general medical service upon discharge to treat the extensive Herpes Zoster.

Staff #1 stated Tenant #1 had a wound on the heel of the foot and someone else came to the Program and cleaned and dressed it. Staff #1 stated she took care of Tenant #2 when she worked on the west side. She normally worked on the east side. She was aware that Tenant #2 had shingles but did not care for Tenant #2 directly. Tenant #2 needed help with showers and medications but dressed and toileted self and got up and ready in the morning by self. Staff #1 stated there were no current tenants with wound care.

Staff #2 stated Tenant #1 had a sore on heel that was treated by staff at first and then someone from the outside came in two times a week to treat the heel. Staff #2 stated Tenant #2 cared for self and would tell staff when Tenant #2 wanted help. Tenant #2 needed assistance with showers.

Staff #3 stated Tenant #1 had a heel wound, pressure sore. An outside home health agency came and changed the dressing. Staff checked for drainage, swelling and hot to touch in the mornings and if found would notify the nurse. Staff #3 stated Tenant #2 was pretty much independent except with bathing. Staff #3 knew Tenant #2 had shingles and staff was to wear gloves and wash hands if doing any treatments on the shingles. Staff put some ointment on the shingles on Tenant #2's back and under the breast. Tenant #2 complained of pain with it.

Staff #4 stated the third shift told her that Tenant #2 had a rash and was asking for something to put on it. Tenant #2's back was red with bubbles and just a red rash under the arm and breast. She called the Campus DON to report it. She stated she couldn't remember what happened after that.

Staff #5 stated it was pointed out to her that Tenant #2 had a shower in the morning and had a rash on back and on side. Tenant #2's family was called to look at it. Later that night Tenant #2 was in tears due to the pain. Tenant #2 went to sleep around 2:30 a.m. or 3:00 a.m. and was up at 5:00 a.m. with complaints of pain. First shift said they would call the doctor and the family. Tenant #2's family said they'd take care of it. This was the only night Staff #5 ever heard Tenant #2 complain.

The Campus DON was interviewed and stated the Nurse looked at Tenant #1's heel and sent a fax to Tenant #1's physician and asked for an appointment to see the physician or for an order for home health. Home health was notified. Tenant #1 also went to a wound clinic. Tenant #1 was hospitalized about two weeks prior for respiratory distress and died the next day. She stated she was called and told Tenant #2 had a rash and it looked like hives. Since she was pregnant she could not go into Tenant #2's apartment so she asked the Nurse to complete the assessment. Tenant #2 saw the physician the next day and a pain medication was ordered. The pain medication didn't help so Tenant #2 went for another visit to the physician and was hospitalized. Tenant #2 did not return to the Program due to Tenant #2's death. The Campus DON was not aware of Tenant #2's cause of death.

The Nurse was interviewed and stated she received a call reporting Tenant #1 had a sore on the heel, a pressure ulcer due to how Tenant #1 sat. There was a quarter sized eschar and home health was ordered to evaluate and treat. The Nurse stated she received a call from the Campus DON reporting Tenant #2 was in pain and had a rash. She assessed Tenant #2 and found blisters, some weeping on the right flank that

wrapped around to the right breast. Tenant #2 was afebrile. She thought it could be shingles. Tenant #2 saw the doctor the same day. The Nurse stated she knew Tenant #2 got an antibiotic and pain medications. She was aware the pain medication was not working as the shingles were very painful. The next time the Nurse saw Tenant #2 was at the hospital when she went to visit Tenant #2.

Review of tenant files and staff interviews indicated staff informed the Campus DON of tenant skin conditions and nursing assessments were completed as needed. The monitor was not able to determine a preponderance of evidence to substantiate the allegation.

Regulatory Insufficiency: None noted.

B. Other

Complaint/Incident Allegation: It was alleged a family called and left a message to have a nursing supervisor return the call. No return call was received.

- Monitoring Observation: Four tenant files (Tenant's #1, #2, #3 and #4) were reviewed. Notations of phone calls with physicians and families were documented within the Clinical Notes.

  An interview was held with the Campus DON. She stated incoming phone calls were not logged. Documentation of all outgoing phone calls to physicians and families were recorded within the Clinical Notes of each tenant file.

  Review of tenant files and a staff interview was conducted. The monitor was not able to determine a preponderance of evidence to substantiate the allegation.

- Regulatory Insufficiency: None noted.