IOWA DEPARTMENT OF
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Complaint/Incident Intake #:
48528-I

August 19, 2014

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

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

Dear Ms. Hamerlinck:

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, following an investigation by DIA on **August 12, 2014.** The Report notes a Regulatory Insufficiency in the area(s) of: Policies and Procedures.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

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:

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

Complaint/Incident Intake #: 48528-I

Date of Complaint/Incident Investigation:

August 12, 2014

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:	2
Number of tenants with cognitive disorder:	29
Total Population of Program at time of on-site	31
TOTAL census of Assisted Living Program	31

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

A. Policies and Procedures

Complaint/Incident Allegation: The Program reported Tenant #1 had exited the building, the alarms sounded; however, staff failed to investigate according to the Program's policy.

- Monitoring Observation: Tenant #1's file was reviewed.

Tenant #1, a 95 year old, was admitted on 6-14-11 and diagnoses included: Dementia, Hypertension, Osteoporosis and Hyperlipidemia. Tenant #1 was staged at a six on the Global Deterioration Scale which indicated severe cognitive decline. According to a service plan dated 3-3-14, Tenant #1 was independent with transfers and used a four wheeled walker. Tenant #1 was independent with ambulation most times with a four wheeled walker and staff was to remind Tenant #1 to use. Tenant #1 was noted to use the walker incorrectly and would have it turned backwards and staff was to assist with getting the walker in the correct position. Tenant #1 was noted to wander and would go into the lobby. Tenant #1 liked baby dolls and staff should tell Tenant #1 the babies were left alone to redirect to go back into the west side. Tenant #1 would go into the lobby and stand and mess with papers on the desk and would also sit down in the chairs. Staff was to continue to redirect back into the west lobby (side).

According to an Incident Report dated 5-20-14 at approximately 5:45 p.m., the pager sounded "Lobby West Door" around 5:40 p.m. Staff #1 was about to check it when Staff #2 from the east side walkied and asked if Staff #1 wanted her to check the alarm. Staff #1 responded back "if you can" and continued assisting a tenant with a shower. As Staff #1 was leaving the shower room she heard Staff #2 say over the walkie "West Lobby is clear." At about 5:45 p.m. Staff #1 went to the east side to assist Staff #2 when the pager sounded "Lobby Entrance." Staff #3 walkied she was on her way to check it. Staff #3 reported Tenant #1 had exited out of the building unattended. The Director of Nursing (DON) was notified on 5-20-14 at 6:07 p.m.

Tenant #1's family was notified and Tenant #1's physician was notified by fax on 5-21-14.

According to Clinical Notes dated 5-21-14, on 5-20-14 around 6:00 p.m. Tenant #1 was found by a family member of another tenant in the parking lot. The individual brought the tenant into the building and notified staff of what happened. Tenant #1's family was notified of the situation and thanked staff for taking great care of Tenant #1. The DON was notified immediately and the Executive Director (ED) was notified. The Clinical Notes indicated Tenant #1 did not have a history of exit seeking yet did have a history of wandering into the lobby area. Service plan was appropriate and provided interventions for redirecting Tenant #1 when he/she walked into the lobby area setting off the alarms. The incident that occurred on 5-20-14 was an isolated event and had not happened in the past. Tenant #1 did not display any abnormal behavior before or after the incident occurred.

Staff #1 was interviewed and stated Tenant #1 was outside for maybe 5 or 10 minutes and appeared fine when Tenant #1 returned. There were no visible injuries. She stated Tenant #1 had not made any elopement attempts since the incident.

According to a written statement completed by the DON of a phone interview with Staff #2, Staff #2 heard an alarm go off and pager twice. She walkied Staff #1 and asked if she needed to respond and Staff #1 said yes. She went to the west lobby entrance, checked and turned off the alarm. Then she went to the lobby entrance's second door and looked out the window. Staff #2 did not see anyone so she cleared the door alarm and returned to the east side.

According to a written statement by Staff #3, around 5:45 p.m. she was in the dining room when the pager sounded and said "Lobby Entrance." She immediately went to check and saw another tenant's family by the lobby east door and Tenant #1 standing in front of the lobby entrance. The family member stated he/she had found Tenant #1 outside by the cars and helped Tenant #1 get back into the Program, but Tenant #1's walker was still outside.

The Maintenance Director was interviewed and stated he heard about the incident the day after it happened. He checked the alarms and nothing was wrong with the alarms on the doors, they functioned properly. He tested the system that morning and it also functioned correctly.

According to the DON, someone stated another tenant's family was coming to visit and found Tenant #1 in the parking lot. The family helped Tenant #1 into the building. She stated the alarm did sound but when staff responded they didn't see anyone. Staff did not go outside to check for anyone and did not do a head count before calling the "all clear" as indicated by policy.

According to the ED, the DON called her and said Tenant #1 was found in the parking lot. She stated Tenant #1 had not eloped before this incident and she was not aware of Tenant #1 showing any signs of eloping. The ED stated Tenant #1 has not had any elopement attempts since the incident.

Hourly Check Sign Off Sheets were reviewed for Tenant #1 for May 2014. The logs were consistently documented from 5-1-14 through 5-23-14 until 3:30 p.m. Documentation was not present on 5-23-14 from 3:30 p.m. through 8:30 p.m., no documentation on 5-26-14 from 3:30 p.m. through 5:30 p.m., on 5-27-14 at 2:30 p.m. and 5-31-14 from 3:30 p.m. through 8:30 p.m. The Assistant Director of Nursing (ADON)/LPN was interviewed and asked if she knew the reason for the blanks on the Hourly Check Sign Off sheets. She stated she was sure the hourly checks were completed but had just not been documented.

Thirty Minute Rounds recorded from 9:00 p.m. to 6:00 a.m. were reviewed for Tenant #1 from 4-30-14 through 6-1-14. The logs were consistently documented every 30 minutes.

According to the Qualifying Incident Listing report on 5-20-14 at 5:44:35 p.m. the Lobby West Door alarm sounded. On 5-20-14 at 5:45:45 p.m. the Lobby Entrance Door alarm sounded. At 5:48:03 p.m. the Lobby Entrance Door alarm was cleared and at 5:48:03 p.m. the Lobby West Door alarm was cleared. The response time to the Lobby West Door was 3.68 minutes and to the Lobby Entrance Door was 2.58 minutes.

The Staffing Policy indicated staff would have access to pagers in order to respond to the 24 hour personal emergency response device assigned to each tenant and all staff would be trained regarding accident, fire safety and emergency procedures and would be able to implement established procedures. Sufficient trained staff would be provided at all times to fully meet the tenant's identified needs, per state regulations. The staff would be awake and on duty 24 hours a day in the proximate area and check on tenants as indicated in the tenants' service plans.

According to Staff #1, the Community DON, ADON/LPN and ED, there was enough staff to meet the needs of the tenants.

The Alarmed Door Policy and Procedure for Locked Memory Units indicated if a door alarmed, staff was to immediately perform a physical check of the area that was outside of the door that alarmed to ensure that no tenant was outside of the building and then the staff was to perform a physical check of each tenant in the facility to ensure tenant safety and to ensure no tenant had exited through the alarmed door.

A layout of the Program was obtained. Tenant #1's apartment was two doors away from the Lobby West exit door which opened into the main lobby. The main lobby had an alarmed exit door to a foyer that connected to an unalarmed exit door. The exit door opened onto a concrete walkway that led to the parking lot.

On 5-22-14 staff was retrained on the policy and procedure for responding to alarmed doors.

According to Weather Underground on 5-20-14 at 5:52 p.m. in Iowa City the temperature was 82 degrees with a heat index of 83.8 degrees. Humidity was at 56% with overcast skies and no precipitation.

An incident report was completed and the Department was notified.

Per review of Tenant #1's file, review of the Staffing policy and Alarmed Door Policy and Procedure, review of written statements from Staffs #2 and #3, interviews with Staff #1, the DON, ADON/LPN and ED indicated Tenant #1 exited the building, the alarm functioned but staff did not respond according to the Program's policy.

- Regulatory Insufficiency: A programs' policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)