IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
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RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #: 52444-I

July 7, 2015

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

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL COMPLAINT/INCIDENT INVESTIGATION REPORT - LEGACY GARDENS
II. Reduction of Civil Penalty
III. Informal Conference
IV. Conclusion

Dear Ms. Hamerlinck:

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

Enclosed is the **Final Complaint/Incident Investigation Report ("Report")** issued 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 **June 23 - 25, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation of Tenant, Tenant Documents and Service Plans.

Legacy Gardens ("Program") is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

Pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC rule 67.17(1)(b), the continued failure or refusal to comply within a prescribed time frame with regulatory requirements that have a direct relationship to the health, safety, or security of tenants may result in a civil penalty of up to $5,000.

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.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The Report reflects that the Program failed to comply with regulatory requirements which have been cited previously by the Department. The Program previously received Regulatory Insufficiencies in the areas of Service Plans.

The determination of a **$500 civil penalty** is based upon repeated in the area(s) of: Service Plans. As the enclosed Report details, the Program failed to complete service plans as required.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service 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 481−67.17(5). 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 to the **State of Iowa** in the amount of **three hundred twenty five dollars ($325)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

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.

IV. Conclusion

The Program is being assessed a **$500 civil penalty** pursuant to Iowa Code section 231C.14(1)(b) and 481 IAC 67.17(1)(b).

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 as provided in IAC rule 481-67.14.

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

Sincerely,

Jim Friberg

Jim Friberg, Bureau Chief
Adult Services Bureau

Enclosure

cc: Jean Herrity, Legal Assistant
Disability Rights Iowa

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0163	A. BUILDING: _____ B. WING _____	C 06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY GARDENS	15 SILVERCREST PLACE IOWA CITY, IA 52240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 33 Total Population of Program at time of on-site: 33 TOTAL census of Assisted Living Program: 33 An investigation of Incident #52444-I was completed. There were regulatory insufficiencies identified related to Incident #52444-I and during the course of the investigation of Incident #52444-I.	A 000		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant ' s functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant ' s continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change.	A 037		

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A 037	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of tenant files and Program documents the Program failed to evaluate each tenants' functional, cognitive and health status as needed with significant change for three of seven tenant files reviewed (Tenants #5, #6 and #7). Evaluations were not completed as needed with significant change for three tenants. (During the course of the investigation of Incident #52444-I) 1. Tenant #5, a 75 year old, was admitted on 10-5-13 and diagnoses included: dementia (Alzheimer's type) and aggressive behavior. Tenant #5 was staged at five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. According to Clinical Notes dated 5-18-15, the on-call nurse was notified on 5-17-15 at 9:15 a.m. that Tenant #5 tried grabbing the newspaper out of the hands of another tenant and a verbal confrontation began at 9:00 a.m. Tenant #5 picked up silverware and threw it at another tenant. As the other tenant stood up, Tenant #5 took a step back and knocked down another tenant. Staff escorted Tenant #5 from the dining area and Tenant #5 began yelling at the tenant sitting on the floor. Tenant #5 was sitting with staff in the lobby waiting to be transferred to the emergency room (ER) for evaluation. Upon transport arrival, Tenant #5 pushed staff twice and the police officer stepped forward causing a redirection of behavior. Tenant #5 remained agitated and combative and Tenant #5 was transferred to the ER for an evaluation. Tenant	A 037		

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A 037	Continued From page 2 #5 returned on 5-17-15 with new orders for Haldol 2 milligrams (mg) by mouth twice daily for agitation. According to Clinical Notes dated 5-18-15, an incident report was received from 5-15-15, which indicated Tenant #5 grabbed the chair of a family member who was sitting doing puzzles on 5-15-15 and began yelling and pointing at them. Tenant #5 threw the puzzle box across the table. Staff intervened and apologized to the family. According to Clinical Notes dated 5-19-15, a verbal order was received to change the time of the administration of Haldol 2 mg by mouth twice daily from 8:00 a.m. and 8:00 p.m to 8:00 a.m. and 6:00 p.m. Clinical Notes dated 5-21-15 indicated an order was received to start Cipro 250 mg by mouth twice daily for five days (pending culture) and to decrease Haldol to 1 mg twice daily in one week. Tenant #5 had a history of urinary tract infections (UTIs) and a discretionary change was made to the service plan to identify the antibiotic for the UTI. Clinical Notes dated 5-28-15 indicated Tenant #5 was agitated, walked in the dining room and tried to take other tenants' cups and dishes. Tenant #5 refused the scheduled Haldol, spit it out and mixed it with Tenant #5's food. Tenant #5 ate the food, took the pill and approximately 30 minutes later became agitated and aggressive towards staff and other tenants. On 5-25-15 Tenant #5 was agitated and aggressive. According to Clinical Notes dated 5-30-15, Tenant #5 went to the ER last evening (5-29-15) due to violent behaviors and aggression towards other tenants and staff. A new order for Haldol 2 mg twice daily was received.	A 037		

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A 037	Continued From page 3 On 6-3-15 Tenant #5 was involved with another altercation with another tenant. Tenant #5 walked up to another tenant and shoved the other tenant. According to Clinical Notes dated 6-3-15, a new order to increase Setraline from 125 mg to 150 mg daily was received. According to Clinical Notes dated 6-15-15, on 6-13-15 a staff communication report was received regarding Tenant #5 attempting to punch another tenant. According to Clinical Notes dated 6-22-15, on 6-19-15 Tenant #5 spit on another tenant. The other tenant reacted and punched Tenant #5 in the shoulder. Staff immediately redirected the other tenant away from the living room. Cognitive, health and functional evaluations were not completed as needed regarding the aggressive incidents with Tenant #5 towards other tenants and staff, two ER visits due to aggressive behaviors, new orders for antipsychotic medication and an increased dose of an antidepressant medication. Evaluations were not completed as needed with significant change. 2. Tenant #6, an 84 year old, was admitted on 6-8-13 and diagnoses included: hypertension, major depressive disorder, history of UTIs, anxiety and lymphocytic colitis. Tenant #6 was staged at a four on the GDS, which indicated moderate cognitive decline. According to Clinical Notes dated 4-30-15, an order was received for Cipro 250 mg by mouth twice daily for five days. According to Clinical Notes dated 6-5-15, a staff communication report received on 6-3-15 indicated Tenant #6 had a weight loss and seemed to be more paranoid than normal. Tenant #6 was seen in a behavioral	A 037		

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A 037	Continued From page 4 health clinic on 6-3-15 and Tenant #6's weight remained steady per their records. The Clinical Notes indicated Tenant #6 continued to take nutritional supplements twice daily. According to Clinical Notes dated 6-12-15, the doctor stated to ensure Tenant #6 got all meals, ate all or most food and to continue the nutritional supplements twice daily. According to Clinical Notes dated 6-22-15, Tenant #6 had a small round, red area noted to Tenant #6's vertical gluteal crease. No open areas were noted and the doctor was made aware. Cognitive, health and functional evaluations were not completed as needed regarding, a UTI with antibiotic therapy, increased paranoia, the doctor's instructions regarding meal intake and the red area to Tenant #6's vertical gluteal crease. Evaluations were not completed as needed with significant change. 3. Tenant #7, a 76 year old, was admitted on 10-25-12 and diagnoses included: Parkinson's disease, anxiety, depression, memory disorder and constipation. Tenant #7 was staged at a five on the GDS, which indicated moderately severe cognitive decline. According to Clinical Notes dated 6-12-15, Tenant #7 had five teeth pulled and new orders were received. Tylenol 325 mg, take two tablets by mouth every six hours for four days was ordered. Chlorhexidine Gluconate 0.12% rinse, rinse with 10 milliliters for 30 seconds twice daily, spit out excess and nothing by mouth for 30 minutes was ordered. The Clinical Notes indicated a discretionary change was made to the service plan to include care instructions. The service plan reflected Tenant #7 had teeth	A 037		

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A 037	Continued From page 5 pulled and staff was to apply moist warm packs to the outside of the face for 20 minute intervals if swelling (was observed). It was normal for swelling to peak two to three days after surgery and bruising could occur and would gradually disappear over a week or two. The service plan indicated to rinse Tenant #7's mouth with warm water with enough salt added so the water barely tasted salty. That was to be done after each meal or snack and before bed for one week following the procedure. The service plan indicated the teeth could be brushed normally but to avoid the extraction sites. A cool, soft diet for 36 hours was indicated and to offer soft foods such as cottage cheese, yogurt, scrambled eggs and drink plenty of fluids. Staff was to notify the nurse if increased pain that did not subside with as needed medication or signs and symptoms of infection. Cognitive, health and functional evaluations were not completed regarding the care instructions and orders for Tenant #7 after the extraction of five teeth. Evaluations were not completed as needed with significant change. 4. According to the Program's policy and procedure regarding evaluations, tenant evaluations would be reviewed and updated if applicable within 30 days of admission, annually and with a significant change of condition.	A 037		
A 071	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include i. When any personal or health-related care is delegated to the program, the medical	A 071		

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A 071	Continued From page 6 information sheet; documentation of health professionals ' orders, such as those for treatment, therapy, and medication; and nurses ' notes written by exception This REQUIREMENT is not met as evidenced by: Based on review of tenant files and Program documents the Program failed to maintain documentation for each tenant including: nurses' notes written by exception for two of seven tenant files reviewed (Tenants #1 and #5). Nurses' notes were not documented by exception for two tenants. (Incident #52444-I and during the course of the investigation of Incident #52444-I) 1. Tenant #1, an 81 year old, was admitted on 3-8-15 and diagnoses included: Parkinson's disease, hypotension and stroke. Tenant #1 was staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #1 was discharged and the date of discharge provided was 3-17-15. According to Clinical Notes dated 3-16-15, on 3-15-15 at 5:47 p m. Tenant #1 was sitting in the apartment watching television with family and Tenant #1 tried to stand up and fell to the floor. Staff reported Tenant #1 hit Tenant #1's head and shoulder. On 3-16-15 Tenant #1 was taken to the emergency room (ER). Clinical Notes dated 3-18-15 indicated Tenant #1's family said Tenant #1 was at the hospital and they were working on finding placement in a skilled nursing facility to help get Tenant #1's strength back with a goal to return to the Program.	A 071		

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A 071	Continued From page 7 According to a Major Injury Determination Form, Tenant #1 had a right scapula fracture and the right third rib fracture. It was not indicated as a major injury and was signed by the physician, designee of physician or physician extender on 3-16-15. Clinical Notes dated 3-23-15 indicated Tenant #3 had a hairline fracture of the scapula and was at a another facility. The Clinical Notes dated 3-23-15 indicated Tenant #1's family gave an update on Tenant #1's condition on 3-16-15 and stated the rib fracture was an old injury. Clinical Notes dated 3-31-15 indicated Tenant #1's family and movers picked up Tenant #1's belongings. Tenant #1 had fallen a couple of times at the other facility and was not progressing as they would have liked. According to the Incident Summary on the Program's self report to the Department, Tenant #1's family reported Tenant #1 had a hairline fracture. Tenant #1's doctor was contacted for confirmation of the hairline fracture and the Program was notified late on 3-23-15 that it was a fracture. It was then reported to the Department. The Clinical Notes did not document the change from hairline fracture of the right scapula to a fracture of the right scapula. Nurses' notes were not written by exception regarding Tenant #1's injury. 2. Tenant #5, a 75 year old, was admitted on 10-5-13 and diagnoses included: dementia (Alzheimer's type) and aggressive behavior. Tenant #5 was staged at five on the GDS, which indicated moderately severe cognitive decline. According to Clinical Notes dated 5-30-15, Tenant	A 071		

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A 071	Continued From page 8 #5 went to the ER last evening (5-29-15) due to violent behaviors and aggression towards other tenants and staff. A new order for Haldol 2 milligrams (mg) twice daily was received. According to an Incident Report dated 5-29-15, Tenant #5 was hitting another tenant with Tenant #5's fist and a purse. According to an Incident reported dated 5-29-15, staff was trying to stop the fighting and separate the tenants and was hit in the face. There was no documentation in Clinical Notes regarding the specifics of the incident on 5-29-15, which resulted in the completion of incident reports, the transfer of Tenant #5 to the ER and Tenant #5 returning to the Program with an order for Haldol 2 mg twice daily. Nurses' notes were not documented by exception for Tenant #5.	A 071		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on review of tenant files and Program documents the Program failed to develop service	A 083		

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A 083	Continued From page 9 plans based on evaluations, update service plans when changes were needed and design service plans to meet the specific service needs of the individual tenant for five of the seven tenant files reviewed (Tenants #3, #4, #5, #6 and #7). Service plans were not based on evaluations, were not updated as needed with significant change and were not designed to meet the service needs of the tenants. (During the course of the investigation of Incident #52444-I) 1. Tenant #3, an 82 year old, was admitted on 1-3-15 and diagnoses included: hypertension (HTN) and hypothyroid Tenant #3 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline According to Clinical Notes dated 5-1-15, on 5-1-15 at approximately 9:15 a.m. staff informed a nurse that Tenant #3 was found in another tenant's apartment sitting in the recliner. The other tenant was sitting on the edge of the bed, with pants on and shirt in the other tenant's hands covering the other tenant's chest. Tenant #3 was talking to the other tenant and the other tenant had asked Tenant #3 to leave. Tenant #3 was easily redirected out of the apartment. According to Clinical Notes dated 6-22-15, on 6-20-15 at approximately 10:55 p.m. Tenant #3 wandered into another tenant's apartment and the door was closed Tenant #3 was wearing a shirt and a protective undergarment. Tenant #3 stood next to the other tenant's bed and Tenant #3 ran Tenant #3's finger on the other tenant's cheek. Staff immediately redirected Tenant #3 out of the other tenant's apartment. No visible injuries were	A 083		

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A 083	Continued From page 10 noted. The service plan reflected Tenant #3 might need supervision at night as Tenant #3 got up and might need cueing to Tenant #3's apartment. The service plan did not reflect Tenant #3 wandered into other tenant apartments and interventions related to the behavior. The service plan did not reflect the specific service needs of Tenant #3. 2. Tenant #4, an 82 year old, was admitted on 1-31-11 and diagnoses included: dementia and Parkinson's disease. Tenant #4 was staged at a five to six on the GDS, which indicated moderately severe to severe cognitive decline. According to Clinical Notes dated 5-21-15, a signed fax from the doctor was received regarding blood pressure parameters for Tenant #4. The parameters to notify the doctor were as follows: if Tenant #4's blood pressure was less than or equal to 100/50 or greater than or equal to 180/95. The blood pressure parameters were not reflected on the service plan. The service plan did not reflect the specific service needs of Tenant #4. 3. Tenant #5, a 75 year old, was admitted on 10-5-13 and diagnoses included: dementia (Alzheimer's type) and aggressive behavior. Tenant #5 was staged at five on the GDS, which indicated moderately severe cognitive decline. According to Clinical Notes dated 5-18-15, the on-call nurse was notified on 5-17-15 at 9:15 a.m. that Tenant #5 tried grabbing the newspaper out of the hands of another tenant and a verbal confrontation began at 9:00 a.m. Tenant #5 picked up silverware and threw it at another tenant. As the other tenant stood up Tenant #5	A 083		

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	S0163	A. BUILDING. _____ B. WING _____	C 06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY GARDENS	15 SILVERCREST PLACE IOWA CITY, IA 52240

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A 083	Continued From page 11 took a step back and knocked down another tenant. Staff escorted Tenant #5 from the dining area and Tenant #5 began yelling at the tenant sitting on the floor. Tenant #5 was sitting with staff in the lobby waiting to be transferred to the emergency room (ER) for evaluation. Upon transport arrival Tenant #5 pushed staff twice and the police officer stepped forward causing a redirection of behavior. Tenant #5 remained agitated and combative and Tenant #5 was transferred to the ER for an evaluation. Tenant #5 returned on 5-17-15 with new orders for Haldol 2 milligrams (mg) by mouth twice daily for agitation. According to Clinical Notes dated 5-18-15, an incident report was received from 5-15-15, which indicated Tenant #5 grabbed the chair of a family member who was sitting doing puzzles on 5-15-15 and began yelling and pointing at them. Tenant #5 threw the puzzle box across the table. Staff intervened and apologized to the family. According to Clinical Notes dated 5-19-15, a verbal order was received to change the time of the administration of Haldol 2 mg by mouth twice daily from 8:00 a.m. and 8:00 p.m. to 8:00 a.m. and 6:00 p.m. Clinical Notes dated 5-21-15 indicated an order was received to start Cipro 250 mg by mouth twice daily for five days (pending culture) and to decrease Haldol to 1 mg twice daily in one week. Tenant #5 had a history of urinary tract infections (UTIs) and a discretionary change was made to the service plan to identify the antibiotic for the UTI. Clinical Notes dated 5-28-15 indicated Tenant #5 was agitated, walked in the dining room and tried to take other tenants' cups and dishes. Tenant #5	A 083		

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A 083	Continued From page 12	A 083		

refused the scheduled Haldol, spit it out and mixed it with Tenant #5's food. Tenant #5 ate the food, took the pill and approximately 30 minutes later became agitated and aggressive towards staff and other tenants. On 5-25-15 Tenant #5 was agitated and aggressive. According to Clinical Notes dated 5-30-15, Tenant #5 went to the ER last evening (5-29-15) due to violent behaviors and aggression towards other tenants and staff. A new order for Haldol 2 mg twice daily was received.

On 6-3-15 Tenant #5 was involved with another altercation with another tenant. Tenant #5 walked up to another tenant and shoved the other tenant. According to Clinical Notes dated 6-3-15, a new order to increase Setraline from 125 mg to 150 mg daily was received. According to Clinical Notes dated 6-15-15, on 6-13-15 a staff communication report was received regarding Tenant #5 attempting to punch another tenant. According to Clinical Notes dated 6-22-15, on 6-19-15 Tenant #5 spit on another tenant. The other tenant reacted and punched Tenant #5 in the shoulder. Staff immediately redirected the other tenant away from the living room.

The service plan was not updated as needed regarding the aggressive incidents with Tenant #5 towards other tenants and staff, two ER visits due to aggressive behaviors, new orders for antipsychotic medication and an increased dose of an antidepressant medication. The service plan was not updated as needed.

4. Tenant #6, an 84 year old, was admitted on 6-8-13 and diagnoses included: HTN, major depressive disorder, history of UTIs, anxiety and lymphocytic colitis. Tenant #6 was staged at a four on the GDS, which indicated moderate

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A 083	Continued From page 13 cognitive decline. According to Clinical Notes dated 4-30-15, an order was received for Cipro 250 mg by mouth twice daily for five days. According to Clinical Notes dated 6-5-15, a staff communication report received on 6-3-15 indicated Tenant #6 had a weight loss and seemed to be more paranoid than normal. Tenant #6 was seen in a behavioral health clinic on 6-3-15 and Tenant #6's weight remained steady per their records. The Clinical Notes indicated Tenant #6 continued to take nutritional supplements twice daily. According to Clinical Notes dated 6-12-15, the doctor stated to ensure Tenant #6 got all meals, ate all or most food and to continue the nutritional supplements twice daily. According to Clinical Notes dated 6-22-15, Tenant #6 had a small round, red area noted to Tenant #6's vertical gluteal crease. No open areas were noted and the doctor was made aware. The service plan was updated with changes (noted as discretionary changes) regarding the UTI and antibiotic therapy, for staff to ensure Tenant #6 was offered all meals and encouragement to eat all or most of the food. The service plan was updated to reflect those changes; however, was not based on evaluations. A nutritional supplement twice daily was ordered and the supplement was not reflected on the service plan. The service plan was not based on evaluations and did not meet the specific service needs of Tenant #6. 5. Tenant #7, a 76 year old, was admitted on 10-25-12 and diagnoses included: Parkinson's disease, anxiety, depression, memory disorder and constipation. Tenant #7 was staged at a five on the GDS, which indicated moderately severe	A 083		

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A 083	Continued From page 14 cognitive decline. According to Clinical Notes dated 6-12-15, Tenant #7 had five teeth pulled and new orders were received. Tylenol 325 mg, take two tablets by mouth every six hours for four days was ordered. Chlorhexidine Gluconate 0.12% rinse, rinse with 10 milliliters for 30 seconds twice daily, spit out excess and nothing by mouth for 30 minutes was ordered. The Clinical Notes indicated a discretionary change was made to the service plan to include care instructions. The service plan reflected Tenant #7 had teeth pulled and staff was to apply moist warm packs to the outside of the face for 20 minute intervals if swelling (was observed). It was normal for swelling to peak two to three days after surgery and bruising could occur and would gradually disappear over a week or two. The service plan indicated to rinse Tenant #7's mouth with warm water with enough salt added so the water barely tasted salty. That was to be done after each meal or snack and before bed for one week following the procedure. The service plan indicated the teeth could be brushed normally but to avoid the extraction sites. A cool, soft diet for 36 hours was indicated and to offer soft foods such as cottage cheese, yogurt, scrambled eggs and drink plenty of fluids. Staff was to notify the nurse if increased pain that did not subside with as needed medication or signs and symptoms of infection. The care instructions and orders reflected a change that would require cognitive, health and functional evaluations to be completed prior to the service plan update. The service plan was updated; however, it was not based on evaluations.	A 083		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 083	Continued From page 15 6. According to the Program's policy and procedure regarding service plans, the service plan would be the basis for coordination of services and would be tailored to each individual's specific needs. Individualized service plans would be developed for each tenant based on functional, cognitive, health status and lifestyle.	A 083		

Plan of Correction for Legacy Gardens
In Response to
Complaint/Incident Investigation Report
Dated June 25, 2015

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared is prepared and/or executed solely because it is required by the provisions of state law.

Regulatory Insufficiency: Evaluation of tenant - IAC r. 481-69.22(231C) Evaluation within 30 days of occupancy and with significant change. - IAC r. 481-67.22(2) A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional of human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change.

1. **Elements detailing how the program will correct the insufficiency.**
   Significant change evaluations, including service plan changes, were completed for the tenants identified on the following dates: Tenant # 5 – 7/6/15, Tenant #6 – 7/13/15, Tenant # 7 – 7/13/15. All other tenant charts have been reviewed by the Dial Retirement Communities Health Services RN, and will be updated with significant change evaluations as needed by July 24, 2015.
2. **What measures will be taken to ensure the problem does not recur.**
   The DON, delegating RN, Jen Miller, has received training with Regional RN, Emily Buckles, on the parameters for significant change evaluations and recognizing when to complete an evaluation vs. nurse review. Jen will also attend the Regulatory Nurse Class in August for additional training. The Assistant DON has also received additional training on indications of significant change and when to notify RN of need for significant change assessment from nurse review, and a communication process has been put in place with both DON and Regional RN being notified by ADON when significant change evaluation is indicated.
3. **How the program plans to monitor performance to ensure compliance.**
   Quality Assurance audits will be performed monthly by the Dial Retirement Communities Health Services RNs to ensure compliance in the future. Assisted Living Partners Consultants will also monitor during regularly scheduled quarterly audits.
4. **The date by which the regulatory insufficiency will be corrected.**
   Regulatory Insufficiency was corrected on residents identified in report by 7/13/2015.

Regulatory Insufficiency: Tenant Documents – IAC r. 481-69.25 (1)i Documentation for each tenant shall be maintained by the program and shall include: when any personal or health-related care is delegated to the program, the medical information sheet;

documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception. IAC r. 481-69.25(1)

1. **Elements detailing how the program will correct the insufficiency.**
   Tenant #1 is no longer a resident at the program, and RN who completed documentation is no longer employed. For Tenant #5, a complete significant change evaluation has been completed, as well as service plan. DON has received training on 7/6 regarding charting by exception and documentation requirements.
2. **What measures will be taken to ensure the problem does not recur.**
   The DON and ADON have received additional training on documentation requirements and charting by exception. The DON will attend the ICAL Nurse Regulatory Class in August for additional training.
3. **How the program plans to monitor performance to ensure compliance.**
   Quality Assurance audits will be regularly performed by the Dial Reirement Communities Health Services RNs and Assisted Living Partners consultants to ensure compliance in the future.
4. **The date by which the regulatory insufficiency will be corrected.**
   Regulatory Insufficiency was corrected on 07/06/2015.

Regulatory Insufficiency: Service Plans – 481-69.26(231C) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. – 481-69.26(1)

1. **Elements detailing how the program will correct the insufficiency.**
   Tenant #3 service plan has been updated on 7/03/15 to include interventions needed for wandering into tenant's apartment (has sig change been done, and if so, please include date.) Tenant #4 service plan has been updated (7/02/15) to include blood pressure parameters and staff interventions needed. Tenant #5 service plan has been updated (7/06/15) to reflect tenant behaviors and in conjunction with significant change evaluation as noted above. Tenant #6 service plan has been updated (7/13/15) to include supplements and based on significant change evaluation as noted above. Tenant #7 service plan was reviewed and updated (7/13/15) based on significant change evaluations as noted above. All service plan insufficiencies were corrected by 7/13/15.
2. **What measures will be taken to ensure the problem does not recur.**
   The DON responsible for service plan development have reviewed regulations and service plans, and a system has been put in place to review all tenant documentation on a regular basis to ensure each tenant have identified needs and preferences for assistance. The DON will also attend the ICAL Nurse Regulatory Class in August for additional training. The Regional RN and Dial Retirement Communities Health Services RNs, as well as Assisted Living Partners Consultants, will review files on a regular basis to ensure that the problem does not recur.
3. **How the program plans to monitor performance to ensure compliance.**
   Quality Assurance audits will be regularly performed by the Dial Retirement Communities Heath Services RN, and Assisted Living Partners consultants to ensure compliance in the future.
4. **The date by which the regulatory insufficiency will be corrected.**

The insufficiency has been corrected as of July, 13 2015.

Respectfully Submitted,

Kaylan Hamerlinck, Executive Director

July 13, 2015