IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #:
61094-I
60831-C

July 14, 2016

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 28 & 29, 2016.**

Based on review of tenant files, review of incident reports, review of policies and procedures, staff interviews, nurse interview, interview with Executive Director (ED) and monitor observations in reference to Complaint #60831-C, the following was found:

1. Allegation: Staffing—It was alleged staff caused injury to tenants, did not provide services as needed and left tenants to care for themselves during a fire.
   Findings: Not Substantiated
   Comments: Review of tenant files and incident reports indicated there were no tenants with staff inflicted injuries. Staff, nurse and ED interviews indicated services were provided as indicated and there were plenty of staff to meet the needs of the tenants. Staff and management interviews indicated there

had never been a fire in the program and if the fire alarm sounded, staff knew the steps to implement to address the emergency and to keep the tenants safe. No concerns with staff were identified,

2. Allegation: DIA Notification—It was alleged the program did not notify DIA when indicated.
   Findings: Not Substantiated
   Comments: Review of tenant files and incident reports indicated proper notification of DIA was implemented when required. No concerns with DIA Notification were identified.

3. Allegation: Tenant Rights—It was alleged staff did not answer tenant call lights or remove wet clothing and bedding.
   Findings: Not Substantiated
   Comments: Review of tenant files, review of incident reports, staff interviews, nurse interview and interview with the ED indicated cares were provided as indicated and were appropriate for individual tenant needs. No concerns with tenant rights were identified.

4. Allegation: Service Plans—It was alleged staff did not follow tenant service plans.
   Findings: Not substantiated
   Comments: Review of tenant files, review of incident reports, staff interviews, nurse interview and interview with the ED indicated services were provided as indicated. No concerns with service plans were identified.

5. Allegation: Level of Care—It was alleged tenants exceeded level of care.
   Findings: Not substantiated
   Comments: Review of tenant files and interviews with staff, nurse interview and ED interview indicated there was one tenant who exceeded level of care but that tenant had been given a 30 day notice. No other tenants exceeded level of care. No concerns with level of care were identified.

The Report notes a Regulatory Insufficiency in the area(s) of: Program policies and procedures.

Legacy Gardens ("Program") is being assessed a **$2,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.17(1)(a), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

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 determination of a **2,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, a 93 year old tenant with dementia eloped from a locked unit. Staff failed to follow the program's policy on elopements.

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 **one thousand three hundred dollars ($1,300)** 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 **$2,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

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 Rose Boccella, your Program Coordinator, at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

Linda Kellen

Linda Kellen, MS, RN
Bureau Chief
Adult Services/Special Services
Health Facilities Division
Linda.Kellen@dia.iowa.gov

Enclosure

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 06/29/2016

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: 3 Number of tenants with cognitive disorder: 32 Total Population of Program at time of on-site: 35 TOTAL census of Assisted Living Program: 35 No regulatory insufficiencies were cited during the investigation of Complaint #60831-C. The following regulatory insufficiency was cited during the investigation of Incident #61094-I.	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program ' s 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. This REQUIREMENT is not met as evidenced by: Based on review of a tenant file, review of incident reports, review of staff statements, interviews with staff, nurse interview and the Executive Director (ED) interview, staff did not follow the program's policy regarding door alarms	A 003		

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A 003	Continued From page 1 when a tenant eloped. Tenant #1, a 93 year old, admitted on 10-28-15, had diagnoses of: depression, post traumatic stress disorder, dementia, gastric esophageal reflux disease, urinary retention, hypertension, back pain and aspiration pneumonia. Tenant #1 was staged at a four on the Global Deterioration Scale which indicated moderate cognitive decline. Tenant #1 resided in a locked dementia unit. According to an incident report dated 6-26-16 at 4:45 p.m., Tenant #1 had eloped. According to Charting Notes dated 6-27-16, on 6-26-16 at approximately 4:45 p.m. Tenant #1 was returned with paramedic team to program after being gone for an estimated time of 30 minutes based upon alarm records. The nurse went to the program at the time of report to assess Tenant #1. Tenant #1 was eating dinner when the nurse arrived. Tenant #1 was wearing clothing appropriate for weather outside, including shoes, sock, short sleeved shirt and pants. Vital signs were completed and upon physical assessment Tenant #1 seemed to be free of injuries, was in good spirits and denied pain. Tenant #1 joked about how it was hot outside that day. According to the Aerial Report for Device Activity (door alarms), on 6-26-16 at 4:15:26 p.m. the west lobby door alarmed. At 4:17:27 p.m. the lobby door alarmed. The front door bell alarm sounded at 4:30:19 p.m. and 4:43:15 p.m. According to the ED, based on her investigation, she felt Tenant #1 exited into the lobby at 4:15 p.m., then exited the building at 4:17 p.m. and returned at 4:43 p.m. Staff A was interviewed and stated several alarms were going off between 3:30 and 4:00 p.m. on 6-26-16. He went outside and looked in the	A 003		

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A 003	Continued From page 2	A 003		

parking lot and didn't see anyone. He told the west staff he had gone outside. He did a head count and all tenants were accounted for on the west side. He did not tell the staff on the east side as he figured they would have responded to the alarm also. At 4:45 p.m. he received a call from the paramedics stating Tenant #1 had been found near the street. Tenant #1 seemed fine, was confused and a little hot. Staff A stated an individual saw Tenant #1 along the sidewalk and brought Tenant #1 to the building. The individual called the paramedics because no one answered the door bell. Tenant #1 was wearing a red shirt, green hat, blue slacks, socks and shoes.

According to a written statement by Staff B, indicated at 3:15 p.m., she went to get Tenant #1 from Tenant #1's apartment and took to the west side for exercise class. Tenant #1 returned to the east side around 3:45 p.m. She did not hear any alarms.

According to a written statement by Staff C, dated 6-26-16, Tenant #1 was at an exercise activity that started at 3:15 p.m. and stayed for the whole class. Afterwards Tenant #1 moved to the dining room table. At some time between 3:45 p.m. and 4:15 p.m., Tenant #1 went to the east side and Staff C cleared the alarms on the computer. She later noticed on the computer in the lobby that the doorbell had gone off. She looked out the window and saw no one there and saw a car pulling away. She went ahead and cleared the doorbell alarm at that point. She did not have her pager on, thus, she never heard the front entrance alarm go off.

According to a written statement by Staff D, dated 6-26-16, at about 4:00 p.m., she saw Tenant #1 on the west side. She and another staff went to

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A 003	Continued From page 3	A 003		

care for another tenant. Tenant #1 was in the hallway while they assisted the other tenant. Her pager went off and said "Lobby East." As soon as she was finished with the other tenant, she went to check the doors. Another tenant and that tenant's friend were in the entryway. Staff D noticed on the lobby computer three alarms had gone off around 4:13 p.m. to 4:15 p.m. She immediately went to check the outside and saw no one and no cars so she came back inside. She assisted a tenant and then continued to get tenants ready and assisted them from one unit to the other. About 4:40 p.m. or 4:45 p.m., she went to get Tenant #1 to eat and Tenant #1 wasn't in room. She assumed Tenant #1 was on the other side already. She continued to take another tenant to the other side where she looked for Tenant #1. When Tenant #1 wasn't there, she immediately asked another staff if they had seen Tenant #1 but they had not. She went out the west door to check the alarm when she found Tenant #1 sitting in the lobby with Staff A and the paramedics.

The ED was interviewed and stated she received a phone call from the on call nurse who stated Staff A had notified her Tenant #1 was dropped off after being gone for about 30 minutes. She called Staff A and requested the alarm report be printed. At 4:10 p.m. the lobby door alarm went off and one minute later the exit door alarm went off. Staff A responded and completed a head count on the east unit and everyone was there. Staff A did not notify the west unit. The ED called the nurse and requested she go to the program and assess Tenant #1, get statements from staff and notify Tenant #1's power of attorney.

An aerial view map of the community was provided. It was assumed Tenant #1 exited the

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A 003	Continued From page 4 front door of the program and walked through the parking and possibly the sidewalks in a northwest direction to where Tenant #1 was found, still on the property, but near the west entrance/exit to the program. The distance walked was approximately one tenth of a mile. On 6-28-16, the ED provided a written statement indicating a passerby was headed west on the highway and saw Tenant #1 in the driveway of the property headed toward the road, thus the passerby intervened. According to the Alarmed Door Policy and Procedure for Locked Memory Unit, if a door alarmed, staff was immediately perform a physical check of the area that is outside of the door that alarmed to ensure no tenant was outside of the building and then staff were to perform a physical check of each tenant in the program to ensure tenant safety and to ensure no tenant had exited through the alarmed door. According to the ED, staff did not follow the policy. According to the State Climatologist, on 6-26-16 at the Iowa City airport at 3:52 p.m., it was 87 degrees, winds out of the west at 10 miles per hour, clear skies and a heat index of 89 degrees. The Program completed an incident report and notified the Department appropriately.	A 003		

In Response to
Final Complaint/Incident Investigation
Dated July 19th, 2016

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.

Evaluation

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 allegation of dependent adult abuse. (IAC r. 481-67.2)

1. Elements detailing how the program will correct each regulatory insufficiency.
   - Facility will continue to monitor residents with a history or current risk for elopement
   - Staff will report any elopement or suspected elopement to Director of Nursing and Executive Director immediately. RN/LPN will report to facility immediately after an incident of elopement occurs and perform head to toe assessment, document the incident, and provide safety checks following each episode of elopement.
   - Nursing staff will be re-trained on alarm response and procedure by July 28th 2016
   - RN/LPN will continue to monitor response times on door alarms in Arial systems

2. What measures will be taken to ensure the problem does not recur.
   - In-service took place with Legacy Gardens nursing staff on July 7th, 2016 to review alarm policy and missing persons policy
   - Staff will secure parameter of facility whenever the front door alarm activates when family or visitors are not noted in the front lobby.
   - Staff to provide resident head count whenever front door alarm is activated and family or visitors are not present to verify who activated the alarm door.
   - Documented safety checks to continue at minimum each hour for every Garden's resident, or more depending on the needs of the resident.
   - Staff will carry pagers with them at all times when working

3. How the Program plans to monitor performance to ensure compliance.
    - Documented safety checks will be monitored for completion and accuracy on a routine basis.
    - Staff will continue to be trained and educated on alarm response policies and missing person's policy.
    - Alarm response times will be monitored regularly on Arial System.
    - All documentation will be reviewed on a regular basis by DON, and Regional RN. Any inconsistencies noted or training needed will be addressed by DON and reported back to the Executive Director, Regional RN to ensure follow through and adherence to established policies.

4. The date by which the regulatory insufficiency will be corrected.
    - The regulatory insufficiency is corrected as of July 28th 2016.

Respectfully Submitted,

Kaylan Hamerlinck,
Executive Director

Jill DeVoll,
Director of Nursing