DEPARTMENT OF INSPECTIONS AND APPEALS

4/22/19 OK 4/19/19

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 _____	12/17/2018

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	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 23 TOTAL Census of Assisted Living Program for People with Dementia: 25 The recertification visit conducted to determine compliance with certification for a Dedicated Dementia Specific Assisted Living Program resulted in regulatory insufficiencies.	A 000	See attached POC 2/15/19	
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 interview and record review the Program failed to ensure completion of incident reports for all incidents in accordance with	A 003		

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A 003	Continued From page 1 Program policy and procedure. This pertained to 2 of 4 tenants reviewed (Tenants #1 and #3). Findings follow: 1. Record review on 12-13-18 of Tenant #1's file revealed diagnosis of depression. Charting Notes indicated the following: a. On 11-7-18 it was noted Tenant #1 had a difficult time sleeping during the night for the past few nights. Tenant #1 also talked about "wanting to die and seems to be depressed." b. On 11-29-18 it was noted staff overheard Tenant #1 tell another tenant that he "wanted to die." Tenant #1 said he had become more confused and "was tired of it and is going to end it all." Continued record review revealed no incident reports completed related to the incidents noted above for Tenant #1. 2. Record review on 12-13-18 of Tenant #3's file revealed Charting Notes indicated the following: a. On 10-31-18 it was noted Tenant #3 was "really agitated" when receiving a whirlpool bath. Tenant #3 threw water at staff, cried and yelled she wanted to go home. b. On 11-11-18 it was noted Tenant #3 became very upset when staff tried to give her medication and she tried to push staff out of her apartment. c. On 11-18-18 it was noted Tenant #3 became agitated and swung her arms when staff attempted to assist with toileting.	A 003		

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A 003	Continued From page 2 Continued record review revealed no incident reports completed related to the incidents noted above for Tenant #3. 3. Further record review revealed the Program's policy and procedure regarding the completion of incident reports indicated an incident report would be completed at the time of any accident or incident that affected a tenant while at the Program or a Program sponsored activity. All accidents or incidents including: a fall, abrasion, observed on the floor, bruising, elopement (perceived), laceration, skin tears, burn or tenant conflict would be reported as incidents to the DON or designee and the responsible party as applicable. The staff who was in charge, witnessed it, or was the first informed of the incident would complete the form. 4. When interviewed on 12-17-18 at 2:22 p.m. the Director of Nursing (DON) confirmed incident reports were not completed regarding these incidents.	A 003		
A 061	481-67.9(4)d Staffing 481-67.9(231B,231C,231D) Staffing. 67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives	A 061		

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A 061	Continued From page 3 and the acuity of the tenants' health, cognitive or functional status. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure staff received training on the administration of medications. This pertained to 1 of 2 staff reviewed that administered medications (Staff A). Findings follow: Record review on 12-12-18 of Staff A's file revealed Staff A was a universal worker hired on 1-23-18. Staff A did not have documented nurse delegated training on the administration of medications. When interviewed on 11-17-18 at 11:47 a.m. the Director of Nursing confirmed Staff A administered medications and no documented nurse delegated training regarding the administration of medications was found.	A 061		
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.	A 083		

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A 083	Continued From page 4	A 083		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the Program failed to ensure service plans were updated as needed and reflected specific service needs of the tenants. This pertained to 4 of 4 tenants reviewed (Tenants #1, #2, #3, and #4). Findings follow:

1. Record review on 12-13-18 of Tenant #1's file revealed diagnosis of depression. Charting Notes indicated the following:

a. On 11-7-18 it was noted Tenant #1 had a difficult time sleeping during the night for the past few nights. Tenant #1 also talked about "wanting to die and seems to be depressed."

b. On 11-8-18 it was noted Tenant #1 was seen by his primary care provider (PCP) for a wellness visit. The PCP was made aware by the Director of Nursing (DON) that Tenant #1 had increased difficulty sleeping at night. A new order was received for Trazodone 50 milligram (mg), take a 1/2 tablet at bedtime as needed for insomnia.

c. On 11-29-18 it was noted staff overheard Tenant #1 tell another tenant that he "wanted to die." Tenant #1 said he had become more confused and "was tired of it and is going to end it all."

d. On 12-10-18 (late entry for 11-30-18) it was noted the DON was notified by staff that Tenant #1 told another tenant he wanted to die on 11-29-18. Tenant #1 said he had become more confused and wanted to end it all. Tenant #1

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A 083	Continued From page 5 received safety checks every hour during the day and every half hour during the evening. Tenant #1 had no weapons or medications in his apartment and did not have a plan. Tenant #1 said he had no intention on following through and he was feeling sad. Tenant #1 had increased frustration and confusion and the doctor was aware. Continued record review revealed the most current service plan signed on 11-8-18 was not updated as needed and did not reflect Tenant #1's comments regarding wanting to die and interventions related to the behavior. 2. Record review on 12-13-18 of Tenant #2's file revealed Tenant #2 staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Tenant #2 received Hospice services. The Hospice Certification and Plan of Care dated 10-3-18 reflected Tenant #2 required a pivot transfer of two staff. When interviewed on 12-17-18 at 2:14 p.m. the Hospice Nurse reported she recommended a two person assist and a gait belt for transfers for Tenant #2. Most of the time Tenant #2 did not bear weight well. When interviewed on 12-17-18 at 2:22 p.m. the DON reported two staff transferred Tenant #2 on 12-17-18 from a chair to the wheelchair for the lunch meal. Continued record review revealed the service plan dated 12-10-18 reflected Tenant #2 required assistance of one staff with transfers. The	A 083		

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A 083	Continued From page 6 service plan was not updated as needed and did not reflect Tenant #2's current needs for transfers. 3. Record review on 12-13-18 of Tenant #3's file revealed Charting Notes indicated the following: a. On 10-22-18 it was noted Tenant #3 became agitated and upset when staff assisted with toileting and changing Tenant #3 for bed. b. On 11-11-18 it was noted Tenant #3 incontinent of urine through her pants and "never likes to be toileted anymore." c. On 11-18-18 it was noted staff attempted to toilet Tenant #3 and she became agitated and swung her arms. d. On 11-29-18 it was noted Tenant #3 was very aggressive when staff assisted with toileting needs or getting ready for bed. Continued record review revealed the service plan dated 11-8-18 reflected staff was to inform Tenant #3 of what they were doing when assisting with activities of daily living to help reduce stress and anxiety. The service plan reflected staff assisted with toileting every two hours; however, did not reflect Tenant #3 refusals or resistance with toileting and interventions. 4. Review of Tenant #3's record revealed the following: a. On 11-12-18 it was noted Tenant #3 had increased swelling to the right lower extremity (RLE). Family took Tenant #3 to the emergency room (ER) and she returned with an order for	A 083		

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A 083	Continued From page 7 Cephalexin for family report of cellulitis. b. On 11-19-18 it was noted Tenant #3 had a red rash to the right shin/leg. The DON assessed and noted increased swelling to the right leg and redness discoloration. Tenant #3 reported pain the the right leg. c. On 11-20-18 it was noted Tenant #3's right leg was swollen and red. Tenant #3 complained of pain and refused to walk to the bathroom. d. On 11-21-18 it was noted Tenant #3 finished the antibiotic and Tenant #3's right leg was still swollen, warm and red. Tenant #3 still complained of pain. Family took Tenant #3 to urgent care. Tenant #3 returned from urgent care and the doctor noted stasis dermatitis in chronic venous occlusion. New orders were received for aspirin 81 mg daily and Lasix 20 mg every day for five days. e. On 12-7-18 it was noted Tenant #3 was seen by the PCP on 12-5-18 and received new orders for anti-embolism hose, staff to put them on in the morning and remove in evening. Family had picked up the new anti-embolism hose and would bring them in on 12-7-18. New orders were also received for antibiotic ointment and non-stick dressing to the right shin legions daily until healed. Continued record review revealed the service plan dated 11-8-18 reflected Tenant #3 wore compression stockings and staff was to administer/complete skin treatments as indicated on the medication administration record/treatment administration record. The service plan did not reflect the issue with Tenant #3's RLE and treatment.	A 083		

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A 083	Continued From page 8	A 083		

5. Observation on 12-17-18 at approximately 11:40 a.m. revealed staff transferred Tenant #4 with a gait belt and one person assist from the wheelchair to the dining room chair. When observed on 12-17-18 at 12:15 p.m. (lunch meal) staff provided assistance with eating including the placement of the utensil in Tenant #4's hand and assistance bringing the utensil to Tenant #4's mouth.

Record review on 12-17-18 of Tenant #4's file revealed diagnoses included: lewy body dementia and Parkinson's disease. Tenant #4 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #4 received Hospice services. Charting Notes indicated the following:

On 12-16-18 it was noted Tenant #4 needed a two person assist for transfers and assistance at meals.

Review of Tenant #4's record revealed on 12-15-18 it was noted when Tenant #4 was transferred from the bed to wheelchair and Tenant #4 needed a two person assist for transfers.

When interviewed on 12-17-18 at 2:14 p.m. the Hospice Nurse revealed when she last observed a transfer for Tenant #4, two people were used to transfer her. She also reported a geriatric chair was brought in for Tenant #4 for safety.

When interviewed on 12-17-18 at approximately 2:30 p.m. the DON reported Tenant #4 had a geriatric chair and it was used for safety when Tenant #4 was leaning. Tenant #4 had used the

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A 083	Continued From page 9 chair two to three times. Continued record review the service plan dated 8-1-18 reflected Tenant #4 was able to transfer independently and on weaker days might require stand by assistance. It indicated Tenant #4 ambulated independently and typically used a walker. Tenant #4 would use a wheelchair on weaker days and staff propelled the wheelchair. The service plan reflected Tenant #4 was independent with dining. The service plan was not updated as needed and did not reflect Tenant #4's current needs for transfers, ambulation, the use or need for the geriatric chair, or assistance with eating. 6. When interviewed on 12-17-18 at 11:47 a.m. the DON revealed the current service plans for the tenants indicated above were provided. The DON confirmed the service plans failed to identify the specified needs of tenants.	A 083		

OK 2/14/19

Plan of Correction for Legacy Gardens
In Response to
Recertification Visit
Dated 1/16/2019

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: Program Policies and Procedures- IAC r. 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 the program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.

1. **Elements detailing how the program will correct the insufficiency.**
   The program will ensure all incident reports are completed according to policy and procedure for all incidents. Additional education for nursing staff regarding appropriate items to report using the incident report process to take place, including but not limited to resident behaviors and risk-associated thoughts and conversations.
2. **What measures will be taken to ensure the problem does not recur.**
   As applicable, all incident reports will be completed in entirety and signed in accordance to incident report policy and procedure. Nursing departmental meeting scheduled to discuss incidents that are to be reported to the DON or responsible party, more specifically risk-associated behaviors or thoughts as well resident conflict that may involve staff and/or other residents on February 11, 2019.
3. **How the program plans to monitor performance to ensure compliance.**
   Follow-up of incident reports, nurse to evaluate incident report form for completeness and inclusion of necessary supporting documents including witness statements and additional descriptions as applicable. Nurse to consciously evaluate communication from RN/LPN determining if incident report is necessary and provide education as appropriate. Quality Assurance audits will be performed annually and as needed by the Dial Retirement Communities Director of Health Services RN and home office nurses to ensure compliance in the future.
4. **The date by which the regulatory insufficiency will be corrected.**
   Regulatory Insufficiency to be corrected on or before February 15, 2019.

Regulatory Insufficiency: Staffing- IAC r. 481-67.9 (231B, 231C, 231D)

67.9 (4) Nurse Delegation Procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:

d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance

with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status.

1. **Elements detailing how the program will correct the insufficiency.**
   Specific staff member interviewed during program recertification has been re-delegated on medication administration with appropriate documents noted. Employee file updated. Facility policy and procedure regarding nurse delegation reviewed with delegating RN for property on 1/23/2019. All current and incoming nursing staff to have documented delegations in their files on February 15, 2019 and moving forward. Audit of randomly selected delegations completed annually by Dial Retirement Communities Health Services RNs to check for appropriate documentation.
2. **What measures will be taken to ensure the problem does not recur.**
   Employee delegation files to be maintained for each nursing staff member; all documents reflecting delegations to be filled out and placed in these files by delegating RN. Annual review of employee delegation files by Dial Retirement Communities Health Services RNs to ensure compliance moving forward.
3. **How the program plans to monitor performance to ensure compliance.**
   Annual and as needed review of employee files to occur from February 15, 2019, and beyond. Delegations to be placed in employee file by delegating RN; review of these files to occur annually by Dial Retirement Communities Health Services RNs. Any new delegating RNs to complete assisted living nurse class within 6 months of hire, as well as view facility policy/procedure on nurse delegation.
4. **The date by which the regulatory insufficiency will be corrected.**
   Regulatory Insufficiency to be corrected on or before February 15, 2019.

Regulatory Insufficiency: Service Plans- IAC r. 481-69.26 (231C)
69.26 (1) Service plans. 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.

1. **Elements detailing how the program will correct the insufficiency.**
   All service plans noted in report for tenants 1-4 to be reviewed by Legacy and Dial nursing teams and updated to reflect current resident needs. Baseline assessments for all residents residing at facility to be completed so all service plans are updated and accurately reflect current needs and services by February 15, 2019. Service plan policy and procedure reviewed with property Director of Nursing on January 23, 2019. Dial Retirement Communities Health Services RNs to review randomly selected service plans annually and as needed for accuracy and completeness.
2. **What measures will be taken to ensure the problem does not recur.**
   Dial regional nurse to assist with facility nursing team in reviewing communication from nursing staff, reviewing current service plan, and updating in accordance to facility policy and procedure. Annual and as needed review of service plans to take place by Dial Retirement Communities Health Services RNs and facility RNs. New RNs to review policy and procedure for Service Plans prior to completing assessment.
3. **How the program plans to monitor performance to ensure compliance.**
   Annual and as needed review of service plans for accuracy and completeness to be done by Dial Retirement Communities Health Services RNs. Director of Nursing to maintain scheduled assessments to ensure regular review of tenant chart in accordance to regulations.

4. **The date by which the regulatory insufficiency will be corrected.**
   Regulatory Insufficiency to be corrected on or before February 15, 2019.

Respectfully Submitted,

Greg Ernst, Regional Executive Director

January 25, 2019