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 04/25/2019

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. Memory Care Unit (if applicable) Number of tenants without cognitive disorder: 3 Number of tenants with cognitive disorder: 19 TOTAL Census of Assisted Living Program for People with Dementia : 22 The following regulatory insufficiency was cited during the investigation of Complaint #82523-C.	A 000	See attached POC 6/18/19	
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to ensure 1 of 5 tenants received appropriate care (Tenant #3). Findings follow: Record review on 4/25/19 revealed the following: a. On 3/28/19 at 2:45 p.m., Nurse A documented: "Per staff update, (Tenant #3) was not acting her norm, had bowel movement in common area and not ambulating. (Nurse A) spoke with (Tenant #3's) POA (Power of Attorney) and discussed getting UA (urine analysis). (ADON) called	A 013		

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A 013	Continued From page 1	A 013		

(physician) to request UA..."

b. On 3/28/19 at 3:46 p.m., Nurse A documented in charting notes, "Received verbal order for (physician) for UA. Staff to obtain UA, and contact (lab) for pickup."

c. On 3/29/19 at 11:43 a.m., the Assistant Director of Nursing (ADON) documented a Nurse Review in charting notes, which noted: "On 3/28/19 at 2:05pm (Tenant #3) got up from (dining) room chair and lost her balance. Staff assisted resident down to floor. Resident states, 'I feel weak.' Resident did not hit her head and has no apparent injury observed as resident was assisted to floor. Able to move all extremities per norm, able to bear full weight, and denies pain... (ADON) assessed resident today. She was resting gin bed. Alert and talkative. Denies pain, able to move all extremities per norm, and no apparent injuries observed. Received order yesterday to check UA for possible UTI. Will obtain and send to lab..."

d. On 4/15/19, the ADON sent an email to staff indicating a UA needed to be completed on Tenant #3.

e. On 4/16/19, the ADON documented a conversation with the nurse of Tenant #3's Primary Care Provider (PCP) in charting notes, as follows: "discussed with PCP's nurse that staff has been attempting to collect a UA on resident with little success. Resident has a tendency to dump urine from collection hat into toilet or contaminate the specimen with toilet paper. Per PCP's nurse, a new order is not needed for the UA. The order received on 3/28/19 is still active."

f. On 4/16/19 the ADON again sent an email to

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A 013	Continued From page 2 staffing asking for them to get a urine sample from Tenant #3. g. Per charting notes, on 4/18/19, Tenant #3's POA notified the ADON she had spoken with the PCP about the difficulties in getting a UA from Tenant #3. The PCP agreed to write out a prescription for an antibiotic but requested the program attempt to get the UA. The program received the order for the antibiotic, Ciprofloxacin, 500 MG., one tablet twice daily for five days and faxed the order to the pharmacy. h. Tenant #3's Medication Administration Record (MAR) reflected she began taking the medication on 4/18/19; however Tenant #3 refused to take four of the ten pills, on 4/21, 4/22, 4/23 and 4/24. i. The ADON sent emails to staff on 4/19/19, 4/22/19 and 4/24/19 asking them to get a UA from Tenant #3. j. Charting Notes dated 4/24/19 reflect Tenant #3 completed the antibiotic as ordered however she continued to have disruptive behaviors as evidenced by yelling and cursing at staff. It was noted staff continued to have difficulties with obtaining a UA due to the resident not allowing staff into the room while attempting to toilet and taking the urine collection hat out of the toilet. The ADON sent a fax to the doctor informing him of this. Tenant #3's service plan noted she had a history of urinary tract infections (UTI) but made no mention of her refusing to give urine samples. The service plan did note Tenant #3 tended to become more irritable and verbally combative when she had a UTI.	A 013		

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A 013	Continued From page 3 An interview conducted with Staff A on 4/25/19 at 8:55 AM revealed she had not had difficulty in getting a urine sample from Tenant #3. Staff B reported in an interview on 4/25/19 at 10:15 AM she tried four or five times to get a urine sample from Tenant #3 but the tenant kicked her out of the bathroom and removed the urine collection hat. Staff B reported these failed attempts to the nurse as well as to the second shift staff. On 4/25/19 at 11:45 AM, Staff C reported she had tried to get Tenant #3 to give a urine sample when she worked on the unit without success. During an interview with the ADON on 4/25/19 at 11:55 AM, she reported she attempted to contact the doctor during the period of 3/29/19 and 4/15/19 to inform them they could not collect a urine specimen, but had no documentation to reflect this.	A 013		

OK 6/24/19

✓6/26/19

Plan of Correction for Legacy Gardens
In Response to
Complaint Visit
Dated 5/28/2019

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: Tenant rights- IAC r. 481-67.3(2)
Tenant rights. All tenants have the following rights: (2) To receive care, treatment and services which are adequate and appropriate

1. **Elements detailing how the program will correct the insufficiency.**
   a. Resident care plans without notes regarding difficulty in obtaining or refusal to provide a urine sample to be updated to reflect this behavior, if appropriate
   b. Physician to be contacted within 72 hours as appropriate for direction if resident refusing to submit or interrupting the process of obtaining a urine sample
2. **What measures will be taken to ensure the problem does not recur.**
   a. Nursing management staff meeting to be held on June 12, 2019 to review the need to include details on care plan regarding refusals or difficulty with obtaining urinalysis samples as appropriate.
   b. This meeting also to include reminders to contact physician within 72 hours if resident is refusing or unable to provide a urine sample.
3. **How the program plans to monitor performance to ensure compliance.**
   a. Annual and as needed review by regional/corporate nursing team of random resident care plans to ensure they reflect accurate behaviors and services.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. June 18th, 2019

Respectfully Submitted,

Leah Donald, Executive Director

June 5, 2019