IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 33683-I

June 8, 2011

Courtney Ryner, AL Coordinator
Village at Legacy Pointe
1654 SE Holiday Crest Circle
Waukee, IA 50263

RE: Final Incident Investigation Report – Village at Legacy Pointe, Waukee, IA

Dear Ms. Ryner:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of May 18, 2011, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding the enclosed Report, please contact me at 515/281-7039.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Incident Investigation Report

Assisted Living Program:

Courtney Ryner, Assisted Living Coordinator
Village at Legacy Pointe
1654 SE Holiday Crest Circle
Waukee, IA 50263

Incident Intake #:

33683-I

Date of Incident Investigation:

May 18, 2011

Monitor(s):

Joyce Kix, RN

Definitions:

The following definitions are relevant:

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 rule violations. [481 IAC 67.10(5)] The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of an Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

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.

Overview:

An incident investigation was conducted at Village at Legacy Pointe on May 18, 2011. In preparing this report, the following information was considered:

Current Program Census

Assisted Living Programs are defined by the type of population served. **Note**: The census numbers were provided by the Program at the time of the on-site.

General Population Program – A Program that is not Dementia-Specific, but may have tenants with cognitive disorder.

Number of tenants without cognitive disorder:	30
Number of tenants with cognitive disorder:	2
Total Population of Program at time of on-site	32

Accreditation Status – Not applicable

Program History – The program did not receive any regulatory insufficiencies during this certification period.

Incident Investigation – The complaint investigator made the observations detailed in the following areas:

A. Tenant Rights

Complaint Allegation: The program reported a tenant made allegations of staff providing alcohol, drugs and then sleeping with him/her.

- Monitoring Observation: Tenant #1, a 93 year old, was admitted 2-4-11 with diagnoses of: Hypertension, Weakness and Macular Degeneration. The Global Deterioration Scale (GDS) completed at admission scored the tenant at 2 which indicated very mild cognitive decline. Thirty (30) days later, the GDS indicated the tenant scored at 3 which indicated mild cognitive impairment. The tenant demonstrated increasing confusion on 3-22-11 with hallucinations for which the physician changed medications and tested for urinary tract infection. The medication changes seemed to be effective until 4-12-11 when the tenant made allegations that staff was providing alcohol and slipping pills to make him/her sleep. Family took the tenant to the emergency room and an anti-anxiety medication was prescribed. The tenant remained confused and a move to the memory care unit was planned. On 4-19-11 the tenant became totally confused and incontinent. The tenant was sent to the hospital where he/she remained at the current time.

  Interviews were completed with five staff including the two whom the tenant made allegations against. All reported they had never seen alcohol in the tenant's room. Staff reported the medications administered to the tenant were according to physician's orders. Review of the MAR revealed medications were administered as ordered.

  During interview, a family member reported no concerns with program staff. The family member reported the tenant had never made allegations like that before but since he/she had been in the hospital, he/she had made similar allegations against the hospital staff.

It was determined after review of tenant files, interview with staff and family and review of staff personnel records, that the incident reported by the tenant was in part due to confusion and not actual events that occurred.

- Regulatory Insufficiency: None noted.

Dated this 8th day of June 2011