IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 40044-I

August 17, 2012

Mr. LeRoy Tinnean, Administrator
Gardens Assisted Living
1000 West Washington
Jefferson, IA 50129

RE: Final Complaint/Incident Investigation Report – Gardens Assisted Living, Jefferson, IA

Dear Mr. Tinnean:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of July 25, August 1 and 2, 2012, 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 515/281-4116 or **James.Berkley@dia.iowa.gov**

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Le Roy Tinnean, Administrator
Gardens Assisted Living
1000 West Washington
Jefferson, Iowa 50129

Complaint/Incident Intake #:

40044-I

Date of Complaint/Incident Investigation:

On-site July 25, 2012 and August 1 and 2, 2012

Monitor(s):

Maribeth Freland RN

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

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.

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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

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

General Population Program	
Number of tenants without cognitive disorder:	29
Number of tenants with cognitive disorder:	4
Total Population of Program at time of on-site	33
TOTAL census of Assisted Living Program	33

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

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

Other

Complaint/Incident Allegation: The program reported dietary staff members found potentially contaminated food items in the kitchen and dining room area. Some of the items were stored in areas available to tenants on a 24-hour basis. It was unknown how the foods had been contaminated and unknown if any tenants ingested the contaminated food items.

- Monitoring Observation: On 7-12-12 Staff #1, cook, tasted a pickle off of the salad bar that was located in the program's common dining room area after the supper meal had already been served to the tenants. The pickle reportedly tasted "soapy". Staff #1 discarded the rest of the pickle and contacted the Dietary Supervisor via telephone. The Dietary Supervisor directed Staff #1 to discard the rest of the pickles located on the salad bar. Staff #1 checked other items on the salad bar and all appeared to taste normal. The staff member later began to experience nausea and was ill with vomiting and other gastrointestinal symptoms for two days, requiring medical evaluation for dehydration.

  During interview, the Registered Nurse (RN) reported no tenants experienced symptoms generally associated with ingestion of contaminated food items such as nausea vomiting, other gastrointestinal symptoms, burning mouth, mouth sores or sore throats following the supper meal on 7-12-12 or in the few days following.

  The program kept lemonade and iced tea, both prepared by staff members, in containers located on a countertop in the main dining room area. Staff members and tenants were allowed 24-hour access to both drinks. On 7-23-12 at approximately 9:15 p.m. Staff #2, universal worker (UW), filled a glass of iced tea from the container located on the countertop in the dining room.

She took a drink noting a chemical taste. Staff #2 spit out the tea and discarded the rest of the liquid in her glass. Staff #2 did not remove the iced tea container at that time. At approximately 10:15 p.m., after Staff #2 left the program, she remembered the bad tasting tea still remained on the countertop. She called into the program and reported the bad tasting tea to Staff #3, UW, who removed the iced tea container and placed the container in the sink located in the kitchen.

On 7-24-12, the Dietary Supervisor arrived at work around 6:00 a.m. to find the iced tea container sitting in the sink. The Dietary Supervisor noted the iced tea had an oily film at the top and had a thick mass of sediment at the bottom of the container when she dumped the iced tea. The Dietary Supervisor had no knowledge that the iced tea had the chemical taste the previous night.

The Dietary Supervisor prepared breakfast and then began set up of the salad bar for the lunch meal. The Dietary Supervisor noted the plastic container of apricots removed from the refrigerator had a layer of oily looking substance on the top surface and the apricots smelled "like furniture polish". She then removed a plastic container of radishes from the same refrigerator that had been sliced the day prior. The radishes were devoid of all color. She removed a plastic container of fruit cocktail from the same refrigerator. The Dietary Supervisor tasted the fruit cocktail, noting a chemical taste and felt a burning in her mouth. The Dietary Supervisor removed a plastic container of pickles from the same refrigerator. The pickles smelled normal so the Dietary Supervisor took a bite of one of the pickles. She noted a strong chemical taste and intense burning in her mouth. She immediately went to the dining room and poured a glass of lemonade, taking a drink in an attempt to dilute the chemical taste and burning. The lemonade had the same chemical taste and again burned her mouth. The lemonade container was removed from the dining room area and secured in the kitchen area. At approximately 7:30 a.m., the Dietary Supervisor contacted the program RN, who directed her to rinse her mouth with water and then milk. The Dietary Supervisor complied. She reported the burning sensation continued throughout the day on 7-24-12. During interview, the Dietary Supervisor reported she could still taste a chemical taste and had a sore throat on 7-25-12. On 7-26-12, the Dietary Supervisor reported her throat still hurt and she planned to seek medical evaluation later in the day.

On 7-24-12 Staff #4, UW, entered the kitchen area while the Dietary Supervisor tasted the above stated food items. Staff #4 smelled the food items, noting a chemical smell. Staff #4 placed her finger in the liquid surrounding the radishes and immediately noted a burning sensation. Staff #4 rinsed her finger with water. Staff #4 reported the burning sensation lasted several hours with her tongue eventually becoming numb. During interview, Staff #4 denied any ill effects on 7-25-12.

On 7-24-12 Staff #5, Activity Director, entered the kitchen after the other three staff members had already tasted the fruit cocktail. She observed the apricots had an oily film at the surface of the container and smelled of a strong chemical smell. She observed the radishes to be bleached out. Staff #5 placed her finger in the liquid of the fruit cocktail, noting a burning sensation and chemical taste in her mouth, lips and stomach. During interview, Staff #5 reported the burning sensation on her lips, tongue and stomach lasted all day on 7-24-12.

Staff #5 reported all burning sensations no longer existed on 7-25-12; however, she felt the chemical taste remained in her mouth.

On 7-24-12 the Maintenance Director entered the kitchen at the request of the Dietary Supervisor. The Dietary Supervisor asked the Maintenance Director to smell the food items in question. The Maintenance Director reported noting no smells. The Maintenance Director did not taste any of the items.

On 7-24-12, after notification of the incident from the Dietary Supervisor, the program RN immediately contacted the Administrator. After investigating the situation, the Administrator contacted the program's corporate personnel and the Department of Inspections and Appeals to report the incident. The program tasted all items before serving during breakfast on 7-24-12. The program purchased food from local restaurants and grocery stores prior to each meal for the lunch and supper meal on 7-24-12 and the breakfast, lunch and supper meal on 7-25-12. The program secured all of the potentially contaminated items. The program began having three meals daily catered into the program and served by the catering employees beginning on 7-26-12 with a plan to continue with this practice until the Department of Inspections and Appeals released the kitchen for use upon the completion of its investigation.

As the iced tea and lemonade were stored in the common dining room area, allowing tenant access to the liquids, tenants may have consumed either liquid. No tenants were identified as being observed in the area between 9:15 p.m. on 7-23-12 and 7:30 a.m. on 7-24-12. All bulk liquids were removed from the dining room area and only individual bottles of water and other liquids were left out for 24-hour consumption by tenants and staff members beginning on 7-24-12 with a plan to continue with this practice until the Department of Inspections and Appeals finished the investigation into the food concerns.

The Administrator reported Tenant #1 and Tenant #2 would often take program prepared foods to their apartment to consume at a later time. The monitor and the Administrator looked in Tenant #1 and Tenant #2's refrigerator, finding no salad bar items or any other program prepared food items in the refrigerator. The monitor noted a full glass of milk on the refrigerator shelf, identified by Tenant #1 as being brought from the dining room "a few days ago". Tenant #1 denied drinking any of the milk. Tenant #1 allowed disposal of the milk.

During interview, the RN reported no tenants had yet experienced symptoms associated with ingestion of contaminated food items such as nausea, vomiting, other gastrointestinal symptoms, burning in the mouth, mouth sores or sore throats.

During interview, the Consultant reported she is on-site at the program once weekly. The Consultant indicated no tenant illnesses resembling symptoms normally associated with consumption of contaminated food items was noted from 7-12-12 to present.

Staff members identified multiple cognitively intact tenants who routinely play cards in the program's common dining room and/or work on puzzles in the area adjacent to the dining room.

The monitor interviewed Tenants #3, #4, #5, #6, #7 #8 and #9, all identified as described above. None of the tenants reported seeing any persons in the program in the previous few weeks that looked like they didn't belong.

Tenants #5, #6 and #8 reported occasionally drinking the iced tea provided by the program on a 24-hour basis. None of the three tenants reported ever feeling the iced tea tasted any way other than normal.

Tenants #4, #6, #7, #8 and #9 reported occasionally drinking the lemonade provided by the program on a 24-hour basis. None of the five tenants reported ever feeling the lemonade tasted any way other than normal.

Tenants #3, #4, #5, #6, #7, #8 and #9 reported routinely eating items from the program's salad bar. None of the seven tenants reported noting any items tasting bad or different than usual. None of the seven tenants reported having any recent illnesses or unexplained gastro-intestinal problems.

There appeared to be a potential chemical contamination of multiple food items and liquids on 7-12-12 and 7-24-12. Tenants had access to the items placed on the salad bar on 7-12-12 and access to the liquids, which were kept available for tenant consumption on a 24-hour basis in the common dining room. The monitor identified no evidence that any tenant consumed any of the potentially contaminated items. No tenants experienced any symptoms generally associated with consumption of contaminated foods between 7-12-12 and 7-25-12. The program responded to the incident appropriately and notified the Department of Inspections and Appeals in a timely manner.

- Regulatory Insufficiency: None noted.