IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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Complaint/Incident Intake #:
44887-C

September 6, 2013

Ms. Angie Eppert, RN Manager
Village at Legacy Pointe
1654 SE Holiday Crest Circle
Waukee, IA 50263

RE: Final Complaint/Incident Investigation Report, Village at Legacy Pointe, Waukee, Iowa

Dear Ms. Eppert:

Enclosed is the **Final Complaint/Incident Investigation Report** 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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiencies. DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Village at Legacy Pointe
Angie Eppert, RN Manager
1654 SE Holiday Crest Circle
Waukee, IA 50263

Complaint/Incident Intake #:

44887-C

Date of Complaint/Incident Investigation:

August 12 and 13, 2013

Monitor(s):

Joyce Kix, 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:	32
Number of tenants with cognitive disorder:	1
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 made the observations detailed in the following areas:

A. Program Reporting to the Department

Complaint/Incident Allegation: It was alleged the program failed to report an elopement to the department.

- Monitoring Observation: Incident reports for the prior three months were reviewed. It was determined that there were no tenants with impaired decision making ability who had left the program grounds without staff member knowledge.

- Regulatory Insufficiency: None noted.

B. Tenant Rights

Complaint/Incident Allegation: It was alleged that a tenant was not allowed to leave the program of their own free will and was forced to sign a negotiated risk agreement.

- Monitoring Observation: Tenant #5, a 70 year old, was admitted 8-2-13 with diagnoses of: Hypertension (HTN), Wernike's Disease, Diabetes, and Dementia. The cognitive assessment (Short Portable Mental Status Questionnaire) completed 8-2-13 documented only one question missed which indicated intact intellectual functioning. According to documentation in the Resident note dated 8-8-13. Tenant #5 left the program on foot and went to a restaurant about 2 blocks away and returned to the program approximately 7:00 p.m. On 8-8-13 a meeting was held with the Tenant, tenant's family member and administrative staff. The tenant ultimately signed a Negotiated Risk Management agreement which required Tenant #5 to sign in and out when leaving and returning to the program, to obtain a consultation with a

psychologist, to become a member of 12 step support group, and to not have any alcoholic beverages in his/her apartment. The program provided a copy of a Durable Power of Attorney (DPOA) dated 10-4-2005 which designated a family member to make health care decisions for Tenant #5 only if Tenant #5 was unable, in the judgment of the attending physician, to make those health care decisions. The clinical record lacked documentation from the current physician that the DPOA was in effect.

According to the Sign-Out sheet, Tenant #5 left the program 8-9-13 at 8:05 a.m. and returned at 8:45 a.m. signing in and out correctly. Tenant #5 signed out of the program again at 11:10 a.m. but did not sign back in. Tenant #5 signed out again on 8-9-13 at 5:00 p.m. and signed in at 7:20 p.m. At 1:45 p.m. when Tenant #5 was noted to be out of the facility, a family member was notified, located Tenant #5 at the same restaurant and returned him/her to the facility. At that time the Interim Administer of the program felt it was necessary for Tenant #5 to have a companion with him/her 24 hours a day due to risk to the tenant and failure to follow the risk agreement. The family hired a caretaker who remained with Tenant #5 from 7:30 p.m. on 8-9-13 to present time.

During interview 8-13-13, the monitor noted Tenant #5 to be present in his/her apartment with the companion also present. Tenant #5 was well dressed, alert and pleasantly responsive to conversation. Tenant #5 said he/she had not been aware of a requirement to sign in and out of the program. Tenant #5 was packing personal possession and stated that although he/she felt safe at the program, family wanted him/her to move to a different place Tenant #5 transferred out of the program on 8-13-13.

Tenant #5 was admitted to the program 8-2-13 with a cognitive assessment completed by the RN as intact intellectual functioning. The DPOA was not invoked by the signature of the current physician. The program was un-necessarily restrictive to apply the components of the risk agreement and 24 hour supervision as a requirement to staying at the program.

- Regulatory Insufficiency: All tenants have the right to be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481-67.3(1))

C. Medications

Complaint/Incident Allegation: It was alleged that medications were not appropriately administered and treatments were completed without physician's orders.

- Monitoring Observation: Clinical record review was completed for five tenants, #1, #2, #3, #4, and #5.

Tenant #1, a 78 year old, was admitted 5-16-13 with diagnoses of: Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Depression, HTN, and Diabetes. The service plan completed 8-7-13 documented Tenant #1 was receiving care from a home health agency for treatment to a wound of the inner buttock. The Resident Note dated 7-

11-13 documented Tenant #1 had a pea sized open area on the left inner buttock. Tenant #1 stated the physician had told him/her to apply Betadine twice a day to the area. Tenant #1 asked Staff #6, Registered Nurse (RN) to complete the treatment because the area was hard to reach. The note documented an order was received 7-12-13 to treat the wound with Betadine twice a day. During interview on 8-13-13, Staff #6, Certified Medication Aide (CMA), stated that Tenant #1 asked him to complete the treatment that the RN had been doing. Staff #6 stated he could not find an order for the treatment and advised the RN who got the order from the physician the next day. Staff #6 stated that the RN had been doing the treatment without an order for about a week.

During interview, Staff #3, #4 and #6 reported the procedure to administer medications included ensuring the tenant has taken and swallowed the medications. Staff #3 and #4, who provide medication administration at the program, stated that they had found medications multiple times left sitting out in med cups in rooms of tenants who were supposed to be supervised with administration of medications.

The following medication administration errors were identified by the program.

Tenant #	Medication	Physician's order	Discrepancy
#6	Namenda	5 milligrams (mg) every day	Medication not given on 6-9 and 6-10, 2013
#7	Carbidopa/Levodopa	25/100 mg Three times a day (TID)	Medication not given on 7-12-13
#7	Gabapenten	400 mg at mid-day	Medication not given on 7-12-13
#8	Lisinopril	40 mg every a.m.	Medication not given 7-12-13
#8	Isosorbide	20 mg at mid-day	Medication not given 7-12-13
#8	Sulfazine	500 mg at mid-day	Medication not given 7-12-13
#8	Reglan	5 mg at mid-day	Medication not given 7-12-13
#9	Lyrica	50 mg twice a day	Medication not taken by tenant 7-12-13, All doses found in tenant's room by Universal Worker 7-13-13

Multiple staff reported finding medications in tenant's rooms that should have been observed being swallowed and staff reported a treatment for wound care had been completed for several days prior to obtaining a physician's order to do so.

- Regulatory Insufficiency: When medications are administered traditionally by the program, the administration of medications shall be provided by a registered nurse, a licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by

unlicensed personnel in accordance with requirements in 655-Chapter 6 governing nurse delegation. (IAC r. 481-67.5(6) a)

D. Staffing

Complaint/Incident Allegation: It was alleged that administrative staff was not available by phone.

- Monitoring Observation: Staff #3 and #4 reported that they did not have a problem getting in touch with the nurse when they needed to. Staff #6 reported that if he was not able to get in touch with the RN Manager, the other RN always answered her phone.

- Regulatory Insufficiency: None noted.

E. Service Plans

Complaint/Incident Allegation: It was alleged a tenant was working for the program without pay.

- Monitoring Observation: Tenant #4, a 93 year old, was admitted 12-18-12 with diagnoses of: HTN, Macular Degeneration and Diabetes. Tenant #4 scored 2 on the Global Deterioration Scale (GDS) completed 12-18-12 which indicated very mild cognitive decline. The service plan dated 3-14-13 documented the tenant liked to keep busy and often helped in the dining room clearing tables and setting tables. During interview, Tenant #4 stated that he/she enjoyed doing things like pouring coffee and juice. Tenant #4 said there was no pay but he/she didn't mind. Staff #6 reported that Tenant #4 often asked to help with tasks and he had let her wash and fold kitchen cloths. He felt she enjoyed being helpful.

- Regulatory Insufficiency: None noted.

F. Other

Complaint/Incident Allegation: It was alleged that a tenant was admitted without admission assessments completed.

- Monitoring Observation: Five clinical records were reviewed. Tenant #1, #2, #3, #4, and #5 all included admission assessments and service plans accordingly. Staff #5, RN stated that the program did not have a policy regarding respite patients because all tenants were treated the same with admission assessment and evaluations as required.

- Regulatory Insufficiency: None noted