IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

April 7, 2015

Complaint Intake #: 51432-C

Ms. Kaylan Hamerlinck, Executive Director
Legacy Pointe
1020 S. Scott Blvd.
Iowa City, IA 52240

RE: Final Complaint Investigation & Recertification Monitoring Evaluation Report – Legacy Pointe, Iowa City, IA

Dear Ms. Hamerlinck:

Enclosed is the **Final Complaint Investigation & Recertification Monitoring Evaluation 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, following a survey by DIA on **March 24 - 26, 2015.** A recertification visit and the investigation of Complaint #51432-C were completed. There were regulatory insufficiencies cited related to the recertification and Complaint #51432-C. The regulatory insufficiencies are indicated on the enclosed report.

The following allegation was investigated in regards to Complaint #51432-C:

Allegation: Admission/Discharge
Findings: Unsubstantiated
Comments: Based on eight tenant file reviews, review of Program documents and staff interviews there were no concerns identified regarding admission/discharge.

The Report notes Regulatory Insufficiencies in the area(s) of: Record Checks, Tenant Documents, Service Plans and Nurse Review. Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.

3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

The recertification process has not been completed as the application, policies and procedures and fee for recertification have not been received. In addition, the State Fire Marshal's (SFM) inspection report has not been received for your program. The certificate will be sent when the process has been completed.

If you have any questions in regard to this 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

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
	S0116	A BUILDING: _____ B WING _____	C 03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY POINTE	1020 S SCOTT BLVD 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	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Definition Number of tenants without cognitive disorder: 56 Number of tenants with cognitive disorder: 6 Total Population of Program at time of on-site: 62 TOTAL census of Assisted Living Program: 62 A recertification visit and the investigation of Complaint #51432-C were completed. There were regulatory insufficiencies cited related to the recertification visit and Complaint #51432-C.	A 000		
A 118	481-67.19(3) Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3) Requirements for employer prior to employing an individual. Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. This REQUIREMENT is not met as evidenced by: Based on review of staff files, a timecard record and Program documents the Program failed to complete a criminal history background check with the Department of Public Safety (DPS) prior	A 118		

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A 118	Continued From page 1 to employment for one of eight staff files reviewed (Staff A). Staff A did not have a criminal history background check completed by the DPS prior to beginning employment. (Recertification) 1. Staff A, a certified nursing assistant, was hired on 1-20-15 and an abuse registries background check was completed on 1-19-15. The check indicated no results were found in the abuse registries. A Background Screening Report document was found in Staff A's file. The order date was 1-16-15 and the report date was 1-19-15. The document indicated searches were completed including: federal criminal records, county criminal records and multi-state criminal search and government watch list. According to the Background Screening Report document, no reportable records for the searches indicated above were found for Staff A. The searches were completed by a background check and pre-employment screening firm. The criminal history background check was not completed by the Department of Public Safety. 2. A Single Contact License and Background Check was completed for Staff A on 3-25-15 using the single contact repository (SING). A criminal history background check and abuse registries background were completed and did not reveal any records found. 3. According to Staff A's timecard records, Staff A worked on 1-20-15. Staff A worked prior to the completion of the criminal history background check with the DPS. 4. According to the Program's Staffing Policy and Procedure, background checks (criminal history	A 118		

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A 118	Continued From page 2 check), dependent adult abuse checks and child abuse checks would be completed on all employees providing direct services to tenants prior to employment. If a prospective employee had a criminal history or an abuse history, the prospective employee should not be employed by the Program unless the Department of Human Services had performed an evaluation and determined the record did not warrant employment prohibition. Proof of the pre-employment background check would be maintained in the Program's employee file.	A 118		
A 071	481-69.25(1)i Tenant Documents 481-69.25(231C) Tenant documents. 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals ' orders, such as those for treatment, therapy, and medication; and nurses ' notes written by exception This REQUIREMENT is not met as evidenced by: Based on review of tenant files and Program documents the Program failed to document by exception in nurses' notes for one of eight tenant files reviewed (Tenant #7). There were no nurses' notes documented for Tenant #7 after 9-9-14 despite events that would have required documentation by exception. (Complaint #51432-C) 1. Tenant #7, a 64 year old, was admitted on	A 071		

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A 071	Continued From page 3 7-3-14 and diagnoses included: hypertension, hypoglycemia, restless leg syndrome, optic atrophy, pain and diabetic retinopathy. Tenant #7 was discharged on 12-8-14. The last entry in Clinical Notes (nurses' notes) was dated 9-9-14. 2. According to a Physician Orders document, Tenant #7 had blood sugar checks ordered daily at 7:00 a.m. and blood sugar checks below 100 and greater than 400 were to be reported to the nurse. According to a medication/treatment record for November 2014, there were blood sugar readings below 100 on 11-8-14, 11-13-14, 11-14-14 and 11-16-14. There were no entries in the nurses' notes regarding the blood sugar readings below 100. 3. According to Staff B's written statement, on 11-20-14 a staff called for assistance in Tenant #7's apartment. Tenant #7's temperature was high and Tenant #7 was dry heaving. Staff B called the Former Director of Nursing (DON) and was told to send Tenant #7 to the hospital. The family was contacted first to see if family could take Tenant #7 or meet Tenant #7 at the hospital. Family said to take Tenant #7 to the hospital and family would meet Tenant #7 as soon as possible. The statement indicated Tenant #7 had not been feeling well prior to the 20th (11-20-14). Staff was toileting Tenant #7 and brought meals to Tenant #7 several times a day. There were a few times Tenant #7 refused to shower or participate in activities of daily living (ADLs). Staff brought fluids to encourage Tenant #7 to drink and staff got Tenant #7 a liter of a lemon-lime flavored non-caffeinated soft drink. Staff B's statement indicated up until the 20th (11-20-14) staff was meeting Tenant #7's needs to the best of their ability.	A 071		

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A 071	Continued From page 4 There were no entries in Tenant #7's nurses' notes regarding Tenant #7's not feeling well prior to 11-20-14, the refusals of ADLs and staff encouragement to drink fluids. There were no entries in the nurses' notes regarding 11-20-14 when staff found Tenant #7 with a high temperature, dry heaving or documentation regarding Tenant #7 going to the hospital. 4. According to email correspondence from the Former DON to Tenant #7's family dated 11-6-14, the Former DON notified Tenant #7's family that Tenant #7 had not been out of bed that day and had not elected to attend meals or have a room tray delivered. Tenant #7 was experiencing hip pain and did not have an appetite. There were no entries in Tenant #7's nurses' notes regarding the issues reported to Tenant #7's family including: Tenant #7 not getting out of bed and the election to not attend meals or have a room tray delivered. There were no entries in nurses' notes regarding the hip pain and Tenant #7 not having an appetite. 5. According to email correspondence from the Former DON to Tenant #7's family dated 11-18-14, they were becoming increasingly concerned with Tenant #7's ability to self-administer Tenant #7's medications and asked if the Program could begin to administer Tenant #7's medications. Staff found medications scattered on the floor and Tenant #7 reported they often fell out of Tenant #7's hands due to contracture. There were no entries in nurses' notes regarding the issues reported to Tenant #7's family including concerns with Tenant #7 taking Tenant #7's medications independently, finding	A 071		

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A 071	Continued From page 5 medications on the floor and medications falling out of Tenant #7's hands. 6. According to email correspondence from the Executive Director (ED) to Tenant #7's family on 1-2-15, there were findings after investigating Tenant #7's hospitalization. On 11-6-14 the Former DON notified Tenant #7's family that Tenant #7 complained of hip pain and had a decrease in appetite. It was the first complaint of pain with Tenant #7 the staff had received and family was made aware. On 11-7-14 Tenant #7's family emailed back and reported a history of sciatic nerve pain three years ago. Tenant #7's family asked about meal delivery and asked if staff could see if Tenant #7 needed assistance with toileting. According to the document, staff began delivering Tenant #7 a room tray regularly and Tenant #7 was a one person assist with transfers. On 11-18-14 the Former DON expressed concerns to Tenant #7's family regarding medication administration. Tenant #7's family was agreeable to have the Program administer medications and inquired about the cost. The Former DON replied and told Tenant #7's family there would be an update in the next couple of days. It was noted medication administration took a minimum of one business day to coordinate since physician communication was required as well as a change to the service plan and medication administration records. On 11-20-14 Tenant #7 went to the hospital. On 12-10-14 Tenant #7 died at the hospital. The email correspondence indicated according to information gathered a few days prior to Tenant #7's hospitalization Tenant #7 said Tenant #7 was not feeling well. Tenant #7 refused most meals and refused bathing. Staff met Tenant #7's needs by bringing Tenant #7's favorite foods/liquids and	A 071		

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A 071	Continued From page 6 bathing Tenant #7 in bed. Staff was also assisting with toileting and perineal care. Staff felt Tenant #7's needs were being well taken care of until the morning of the 20th (11-20-14). Tenant #7 was observed in bed and had been perspiring a great deal. The sheets were damp with sweat and Tenant #7's temperature was higher than normal. The Former DON was contacted and recommended Tenant #7's family be called immediately and Tenant #7 go to the hospital. Staff escorted Tenant #7 to the emergency room. There were no entries in the nurses' notes the regarding the days prior to 11-20-14 when Tenant #7 was not feeling well, the events of 11-20-14 and Tenant #7's discharge from the Program.	A 071		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant ' s identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on review of tenant files, Program documents and a staff interview the Program failed to develop a service plan that reflected the identified needs and preferences for one of eight tenant files reviewed (Tenant #7). Tenant #7's service plan did not reflect the identified needs and preferences for assistance. (Complaint #51432-C)	A 089		

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A 089	Continued From page 7 1. Tenant #7, a 64 year old, was admitted on 7-3-14 and diagnoses included: hypertension, hypoglycemia, restless leg syndrome, optic atrophy, pain and diabetic retinopathy. Tenant #7 was discharged on 12-8-14. 2. According to email correspondence from the Former Director of Nursing (DON) to Tenant #7's family dated 11-6-14, the Former DON notified Tenant #7's family that Tenant #7 had not been out of bed that day and had not elected to attend meals or have a room tray delivered. Tenant #7 was experiencing hip pain and did not have an appetite. 3. According to Staff B's written statement, on 11-20-14 a staff called for assistance in Tenant #7's apartment. Tenant #7's temperature was high and Tenant #7 was dry heaving. Staff B called the Former DON and was told to send Tenant #7 to the hospital. The family was contacted first to see if family could take Tenant #7 or meet Tenant #7 at the hospital. Family said to take Tenant #7 to the hospital and family would meet Tenant #7 as soon as possible. The statement indicated Tenant #7 had not been feeling well prior to 11-20-14. Staff was toileting Tenant #7 and brought meals to Tenant #7 several times a day. There were a few times Tenant #7 refused to shower or participate in activities of daily living (ADLs). Staff brought fluids to encourage Tenant #7 to drink and staff got Tenant #7 a liter of a lemon-lime flavored non-caffeinated soft drink. Staff B's statement indicated up until the 20th (11-20-14) staff was meeting Tenant #7's needs to the best of their ability. 4. According to an interview with the Executive Director (ED) on 3-26-15 at 12:18 p.m., Tenant #7	A 089		

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A 089	Continued From page 8 was not coming out to meals but it was not a significant change for Tenant #7. Tenant #7 was staying in Tenant #7's apartment which was a typical routine for Tenant #7. Tenant #7 was a very independent and private person. Staff brought meals to Tenant #7 on a routine basis. 5. Tenant #7's service plan dated 8-4-14 was updated on 9-4-14 to reflect a discretionary change. The change indicated staff assisted Tenant #7 with toileting every two hours to decrease the risk of falls. Tenant #7 had a history of toileting independently which resulted in falls. Tenant #7 was to push the pendant if additional assistance was needed between the toileting program. Tenant #7 was not to transfer without staff assistance. The service plan reflected Tenant #7 had a history of spilling/dropping medications on the floor due to poor hand grips. Staff was to notify the nurse of any observed medications on the floor, pick up the medications and turn in to the nurse for disposal. If Tenant #7 was agreeable, staff to assist with administering medications from the medication planner to prevent missed medication doses and/or spilled medications. The service plan reflected Tenant #7 had chronic hip pain. The service plan indicated Tenant #7 ate independently, conversed (in the dining room) and Tenant #7 typically ate all of Tenant #7's meal. The service plan did not reflect Tenant #7 was not feeling well prior to 11-20-14, the refusals of ADLs, staff brought meals to Tenant #7 and staff encouragement to drink fluids. The service plan did not reflect Tenant #7 had a decreased appetite and the election to not attend meals or have a room tray delivered. The service plan did not reflect Tenant #7 stayed in Tenant #7's apartment. The service plan did not reflect the	A 089		

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A 089	Continued From page 9 identified needs of Tenant #7. 6. According to the Program's Service Plan Policy and Procedure, the service plan should be individualized and should indicated a minimum of: the tenant's identified needs, requests for services, interventions and expected outcomes.	A 089		
A 096	481-69.27(3) Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant ' s condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(3) To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant ' s health status This REQUIREMENT is not met as evidenced by: Based on review of tenant files and a Program document, the Program failed to complete a nurse review every 90 days for one of eight tenant files reviewed (Tenant #7). Tenant #7 received personal and health- related care and did not have a nurse review completed every 90 days. (Complaint #51432-C) 1. Tenant #7, a 64 year old, was admitted on 7-3-14 and diagnoses included: hypertension,	A 096		

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A 096	Continued From page 10 hypoglycemia, restless leg syndrome, optic atrophy, pain and diabetic retinopathy. Tenant #7 was discharged on 12-8-14. A 30 day evaluation was completed on 8-4-14. Tenant #7 received personal and health-related care and the last entry in Clinical Notes (nurses' notes) was dated 9-9-14. Review of Tenant #7's file indicated a 90-day nurse review was not found. A nurse review was not completed every 90 days for Tenant #7. 2. According to the Program's Tenant/Resident Assessments Policy and Procedure, a nurse review would be conducted every 90 days that included but was not limited to: review of tenant's health, functional, cognitive status, medication orders, medication administration records, as needed medication usage, incidents and managed risk/negotiated risk agreement as applicable. A nurse review would be conducted to assess and document the health status of each tenant and to make recommendations and referrals as appropriate.	A 096		

Plan of Correction for Silvercrest Legacy Pointe
In Response to
Preliminary Complaint/Incident Investigation Report
Dated March 24 - 26, 2015

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: Requirements for employer prior to employer prior to employing an individual in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state. (IAC r. 481-67.19(3)

1. **Elements detailing how the program will correct the insufficiency.**
   The insufficiency regarding failing to complete a criminal history background check with the Department of Public Safety (DPS) prior to employment for one of eight staff files reviews (Staff A) was completed on 03/25/2015. All other employee background checks have been reviewed for completed record checks by the Administrative Assistant on 03/31/2015.
2. **What measures will be taken to ensure the problem does not recur.**
   The Administrative Assistant responsible for record checks has reviewed regulations and a system has been put in place to ensure their timely completion. Assisted Living Partners Consultants will review files on a regular basis to ensure that the problem does not recur.
3. **How the program plans to monitor performance to ensure compliance.**
   Quality Assurance audits will be regularly performed by Assisted Living Partners consultants to ensure compliance in the future. The Administrative Assistant will maintain records for compliance.
4. **The date by which the regulatory insufficiency will be corrected.**
   Regulatory Insufficiency was corrected on all existing staff by 03/31/2015 and process has been corrected with 3rd Degree Background Check Company for all future background checks include criminal background checks completed using the Iowa DCI process.

Regulatory Insufficiency: The service plan shall be individualized and shall indicate at a minimum: The tenant's identified needs and preferences for assistance.(IAC r. 481-69.26(231C) 69.26 (4))

1. **Elements detailing how the program will correct the insufficiency.**
   Nurse training regarding service plan reviews including individualizing and detailing identified needs and preferences for assistance of each tenant will be completed by 04/10/2015.

2. **What measures will be taken to ensure the problem does not recur.**
   The RNs who are responsible for service plan development have reviewed regulations and service plans, and a system has been put in place to review all tenant documentation on a regular basis to ensure each tenant have identified needs and preferences for

assistance. The Regional Heath Services Resource Nurse and Regional Director, as well as Assisted Living Partners Consultants, will review files on a regular basis to ensure that the problem does not recur.

3. **How the program plans to monitor performance to ensure compliance.**
   Quality Assurance audits will be regularly performed by the Regional Heath Services Resource Nurse, Regional Director of Dial Retirement Communities, and Assisted Living Partners consultants to ensure compliance in the future.
4. **The date by which the regulatory insufficiency will be corrected.**
   The insufficiency has been corrected as of April 10, 2015.

Regulatory Insufficiency: Documentation for each tenant shall be maintained by the program and shall include: when any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for treatment, therapy, and medication; and nurses' notes written by exception. (IAC r. 481-69.25(1)

1. **Elements detailing how the program will correct the insufficiency.**
   All tenant charts were audited by Regional Health Services Resource Nurse, Regional Director, and Assisted Living Partners on 11/28/2014. The RNs responsible will document by exception in nurses' notes for all tenants as required. Nurse training regarding tenant documentation pertaining to nurses notes being written by exception for each tenant has been completed as of 04/10/2015.
2. **What measures will be taken to ensure the problem does not recur.**
   The Regional Health Services Resource Nurse will review tenant documentation periodically and as needed and Assisted Living Partners Consultants will review tenant documentation on a regular basis to ensure that the problem does not recur.
3. **How the program plans to monitor performance to ensure compliance.**
   Quality Assurance audits will be regularly performed by the Regional Health Services Resource Nurse and Assisted Living Partners consultants to ensure compliance in the future.
4. **The date by which the regulatory insufficiency will be corrected.**
   Regulatory Insufficiency was corrected on 04/10/2015.

Regulatory Insufficiency: If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation to assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3)

1. **Elements detailing how the program will correct the insufficiency.**
   All tenant charts were audited by Regional Health Services Resource Nurse, Regional Director, and Assisted Living Partners on 11/28/2014. All tenants of the program have completed nurse reviews dated at least every 90 days and whenever there are changes in their health status.
2. **What measures will be taken to ensure the problem does not recur.**
   Assisted Living Partners will review tenant nurse reviews on a regular basis to ensure that the problem does not recur. The Regional Health Services Resource Nurse will also complete an audit of nurse reviews regularly.
3. **How the program plans to monitor performance to ensure compliance.**

Quality Assurance audits will be regularly performed by the Regional Health Services Resource Nurse and Assisted Living Partners consultants to ensure compliance in the future.

4. **The date by which the regulatory insufficiency will be corrected.**
   Regulatory Insufficiency was corrected on 04/10/2015.

Respectfully Submitted,

Kaylan Hamerlinck, Executive Director

April 10th, 2015