IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

February 14, 2011

Complaint Intake #: 31063-C

Phillis Seals, Director
Gardens at Luther Park
2910 E. 16th Street
Des Moines, IA 50613

RE: Final Complaint Investigation and Recertification Report – Gardens at Luther Park, Des Moines, IA

Dear Ms. Seals:

Enclosed is the **Final Complaint Investigation and Recertification 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 completed the review of your Plan of Correction (POC) in response to the Preliminary Complaint Investigation and Recertification Report. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC. The Final report is enclosed.

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0241** with effective dates of **August 17, 2010** through **August 16, 2012**.

If you have any questions in regard to this certification, 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 Complaint Investigation and Recertification Report

Assisted Living Program: **Complaint Intake #: 31063-C**

Phillis Seals, Director
The Gardens at Luther Park
2910 E. 16th Street
Des Moines, IA 50613

Date of Investigation:

November 23 and 24, 2010

Monitor(s):

Lori Miner, RN BSN
Joyce Kix, RN

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or 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. IAC r. 481-67.10(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 a Complaint 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 chapter 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 or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at The Gardens at Luther Park on November 23 and 24, 2010. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition but may have tenants without cognitive disorder.

Current number of tenants in a DSP that serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS:	56
Current number of tenants without cognitive disorder:	9
Total Population:	65

Dementia Specific Program (DSP)* – A program that is dementia specific and provides specialized care in a dedicated setting.

Total Population of DSP:	13
Total Census of ALP:	78

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Tenant/Family Satisfaction Results – A community meeting was held on 11-23-10 with 32 tenants. The tenants reported the program staff was helpful, friendly, and available promptly. The tenants stated there were plenty of activities offered. They were generally satisfied with the program and would recommend it to family and friends.

Program History – The program received regulatory insufficiencies in the areas of: Tenant Documents, Service Plan and Medications during the prior certification period.

Complaint Investigation – The complaint investigators made the observations detailed in the following areas.

A. Evaluation of Tenant

- Monitoring Observation: Tenant #5, a 94 year-old, was admitted 7-11-09 with a diagnosis of Cardiac Arrythmia. This tenant was scored at five on Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. The clinical record included evaluations of cognition and function on 8-8-10 but lacked evidence of completion of an evaluation of the tenant's health.

  Tenant #6, a 79 year-old, was admitted 8-28-10 with diagnoses of: Insulin Dependent Diabetes Mellitus, Coronary Artery Disease, Ablation x2, Hypertension, Arthritis, Vitamin B12 Deficiency, Anxiety Disorder, Diverticulosis, Familial Dysbetalipoproteinemia, Dyspepsia, Hypercholesterolemia, Cataract removal both eyes, Left arm/shoulder pain, Candidas, and Vertigo. The clinical record included evaluations of cognition and function on 8-25-10 and 9-25-10 but lacked evidence of completion of an evaluation of the tenant's health.

  Tenant #9, an 81 year old, was admitted 12-15-06 with diagnoses of: Chronic Obstructive Pulmonary Disease (COPD), Diabetes, and Hypertension (HTN). The clinical record lacked evidence of completion of annual functional, cognitive and health status evaluation for the years of 2007, 2008, and 2009.

  Tenant #11, an 83 year old, was admitted 12-5-09 with diagnoses of: Alzheimer's Dementia, Depressive Disorder, Hyperlipidemia, Osteoarthritis, and HTN. The clinical record included evaluations of cognition and function 10-8-10 but lacked evidence of completion of an evaluation of the tenant's health.

  Tenant #22, an 87 year-old, was admitted 7-18-07 with a diagnosis of COPD. The clinical record lacked evidence of completion of annual functional, cognitive and health evaluation for the years of 2008, 2009, and 2010.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. (IAC r. 481- 69.22(2)

B. Service Plan

- Monitoring Observation: The service plan for Tenant #5 was updated and signed on 8-8-10. The tenant fell on 8-10-10, 10-14-10, and 11-9-10. On 8-31-10, the physician ordered lower leg wraps daily for edema of the lower legs. The wraps were to be put on in the morning and taken off in the evening. The order included instructions to elevate leg above heart level as much as possible. The service plan did not include fall interventions. The service plan was not updated to address tenant's need for the leg wraps or elevation of the leg. The service plan did not include specific activities for the tenant with a GDS of five.

The clinical record for Tenant #11 contained a physician's order dated 10-28-10 with additional diagnoses of: Venous Stasis, Dependent and Foot Ulcer. The order directed the tenant have compression stockings (TED hose) placed on in the am and off at night. The 24-hour report completed by staff dated 11-7-10 documented Tenant #11 did not have Ted hose on that day and also indicated Tenant #11's family had left a supplement drink if the tenant did not eat a good meal. The service plan updated 11-10-10 for Tenant #11 did not include directions for staff to assist with placement of Ted Hose or offer supplemental drink.

Tenant #20, a 96 year old, was admitted 9-6-06 with diagnoses of: HTN, Hypothyroidism and Macular Degeneration. The GDS dated 7-26-10 documented the tenant with a score of 5 which indicated moderately severe cognitive decline. The service plan of 7-20-10 directed the tenant needed assistance getting to activities but lacked specific activities based on the tenant's abilities and personal interests.

Tenant #21, a 87 year old, was admitted 9-1-10 with diagnoses of: HTN, Acute Renal Failure and Cerebral Vascular Accident. The GDS dated 10-1-10 documented the tenant with a score of 5 which indicated moderately severe cognitive decline. The service plan of 10-1-10 directed the tenant needed assistance getting to activities but lacked specific activities based on the tenant's abilities and personal interests.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate at a minimum: a. The tenant's identified needs and preferences for assistance, d. For tenants unable to plan their own activities, including tenants with dementia, planned and spontaneous activities based on the tenant's abilities and personal interests. (IAC r. 481-69.26 (4) a. and d.)

C. Medications

Complaint Allegation 31063-C: It was alleged that there were narcotics missing from both the regular and dementia unit, medication planners were not always filled properly, and staff were advised to give medications that were not on the medication administration record. (MAR)

- Monitoring Observation: On 11-23-10 at 1:50 pm, Staff #9 stated that she had been called away and not gotten back to sign the MAR. The following observations of medication documentation discrepancies were identified at 9:00 am 11-23-10 by review of the MAR:

Tenant #	Medication	Dosage/Physicians Order	Observation
#1	Lumigan 0.03%	One drop at bedtime 8:00 pm	Not signed as completed 11-22-10
#2	Gabapentin 300 milligrams (mg)	One capsule 4 times a day	11:00 am dose on 11-23-10 signed as given at 9:00 am
#3	Alendronate 70 mg	One every day 30 minutes before food	Not signed as completed 11-22-10
#3	Occuvite	1 capsule twice a day (BID)	Not signed as given 11-22-10
#4	Administer	8:00 am and 8:00 pm	Not signed as completed

	meds as set up in planner		11-22-10
#5	Administer meds as set up in planner	8:00 am, 12:00 pm 4:00 pm and 8:00 pm	12:00 dosed signed as given at 9:00 am 11-13-10
#6	Simvastatin	40 mg at 8:00 pm	Not signed as given 11-22-10
#6	Pain Relief	650 mg three times a day (TID)	12:00 noon dose signed as given at 9:00 am 11-23-10
#7	T-gel shampoo	3 times a week	Not signed as completed 11-4, 11, 14, 16, 18, or 21
#8	Furosemide	40 mg at 8:00 am	Not signed as given at 9:00 11-23-10
#8	Klor-Con	20 meq at 8:00am	Not signed as given at 9:00 11-23-10
#8	Levothyroxine	75 mcg at 8:00 am	Not signed as given at 9:00 11-23-10
#8	Omeprazole	20 mg at 8:00 am	Not signed as given at 9:00 11-23-10
#10	Oyster shell	TID	12:00 pm dose signed as given at 9:00 am
#10	Senna	2 tablets at bedtime	Not signed as given 11-22-10
#12	Cromolyn spray	1 spray both nares BID	Not signed as completed 11-8, 11, 20 or 22- 10
#14	Administer meds as set up in planner	8:00 am and 8:00 pm	Not signed as completed at 9:00 am on 11-23-10
#14	Glycolax powder	8:00 am before breakfast	Not signed as given 11-22 or 11-23-10
#15	Calcium	1 tablet BID with meals	Not signed as given 11-22-10
#15	Docusate	100 mg BID	Not signed as given 11-22-10
#15	Namenda	One tablet BID	Not signed as given 11-22-10
#15	Senna	One tablet at bedtime	Not signed as given 11-22-10
#15	Simvastatin	40 mg at bedtime	Not signed as given 11-22-10
#16	Lexapro	Every day 7:30 am	Not signed as given 11-23-10 at 9:00 am
#16	Omeprazole	20 mg, 30 minutes before meal 7:30 am	Not signed as given 11-23-10 at 9:00 am
#16	Tab-A-Vite	One tablet 7:30 am	Not signed as given 11-23-10 at 9:00 am
#16	Vitamin D	One tab 7:30 am	Not signed as given 11-23-10 at 9:00 am
#16	Ferrous Sulfate	One tab 8:00 am	Not signed as given 11-23-10 at 9:00 am
#16	Klor-Con	20 meq 8:00 am	Not signed as given 11-23-10 at 9:00 am
#16	Amlodipine	5 mg at 7:00 am	Not signed as given 11-23-10 at 9:00 am
#17	Administer meds as set up in planner	8:00 am and 8:00 pm	Not signed as given 11-23-10 at 9:00 am
#18	Ferrous Sulfate	325 mg 8:00 am	Not signed as given 11-17, 18 or 19-10
#18	Aspirin	81 mg at 8:00 am	Not signed as given 11-8 or 11-9-10
#18	Lisinopril	20 mg at 8:00 am	Not signed as given 11-8 or 11-9-10
#18	Metformin	500 mg BID	Not signed as given 11-8 or 11-9-10
#18	Vitamin D	2 tablets at 8:00 am	Not signed as given 11-8 or 11-9-10
#19	Laclotion	Apply lotion BID	Not signed as completed 11-5 or 11-7-10

The program reported the staff did not count narcotic medications and there was no policy directing to count narcotics, so it could not be determined if any medications were missing.

Staff #7 and #8 reported they had never noticed the medications planners to be set up in error. They reported they checked the MAR against the medication to verify before administration. Both staff stated they would call the nurse and verify before giving any medication from the pharmacy which was not noted on the MAR.

- Regulatory Insufficiency: When medications are administered traditionally by the program: The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced nurse practitioner registered in Iowa or by unlicensed assistive personnel in accordance with requirements in 655- Chapter 6 governing nurse delegation. (IAC r. 481-67.5 (6) a.)

Dated this 9th day of February 2011.