IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 33990-I

June 17, 2011

Phillis Seals, Administrator
Gardens at Luther Park
2910 E. 16th Street
Des Moines, IA 50316

RE: Final Incident Investigation Report – Gardens at Luther Park, Des Moines, IA

Dear Ms. Seals:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of June 6, 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:

Incident Intake #: 33990-I

Phillis Seals, Administrator
The Gardens at Luther Park
2910 E. 16th Street
Des Moines, IA 50316

Date of Incident Investigation:

June 6, 2011

Monitor(s):

Hal L. Chase, MPH BSN

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 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 - 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:

An on-site visit was conducted at The Gardens at Luther Park on June 6, 2011. In preparing this report, the following information was considered:

Current Program Census:

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:	11
Current number of tenants without cognitive disorder:	50

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

Total Population of DSP:	13
Total Population:	74

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

Program History – The program received regulatory insufficiencies in the areas of Evaluation, Service Plan and Medications during this certification period.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

A. Nurse Review

Incident Allegation #33990-I: The program reported on 5-6-11, a staff member was doing rounds, knocked on Tenant #1's (the Tenant) door; however, the Tenant did not answer. The staff member opened the door and found the Tenant standing behind the door. A table lamp had tipped over and landed on the Tenant's right foot. The staff member did not see any apparent injury, notified the Nurse, who evaluated the Tenant for injury. Family was notified and transported took the Tenant to a local hospital emergency room (ER) for evaluation. The Tenant was diagnosed with a toe fracture to the right foot. It was reported the Tenant had a similar incident a week earlier and sustained a sprained left ankle.

- Monitoring Observation: The Tenant, a 77 year old, was admitted on 12-16-09 and had diagnoses of: Dementia, Hypertension (HTN), Coronary Artery Disease (CAD) and Syncope. A cognitive evaluation was completed on 7-27-10 and staged the Tenant at five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. The Tenant resided in the dementia unit of the program. A service plan of 4-29-11 revealed the Tenant was independent with ambulation, used a walker intermittently and needed minimal assistance with activities of daily living (ADLs). Fall precautions were listed, including keeping pathways clear from obstruction and remind the Tenant to walk slowly.

Nurse's notes of 4-19-11 revealed the Tenant was ambulating in the hallway and reported feeling dizzy, lost balance and fell before staff could assist. A nurse review was completed and the Tenant's physician was contacted. On 4-20-11 the Tenant was admitted to the hospital with an admitting diagnosis of Hypokalemia. The Tenant returned to the program on 4-29-11.

The Tenant's family was interviewed and reported the incident occurred on 5-7-11 and not 5-6-11 as reported by the program. Family had taken the Tenant to a local hospital ER for evaluation. On 5-10-11, family took the Tenant to a local urgent care clinic for evaluation and was the Tenant was diagnosed with a metatarsal fracture of the right toe. Staff Members #1 and #2 reported the Tenant was independent with ambulation, used a walker and had a steady gait. Staff Member #1 reported the Tenant had fallen a week earlier, coming out of his/her bathroom and the Nurse evaluated the tenant. Staff #1 and #2 reported the Tenant participates in his/her ADLs and was high functioning.

Nurse's notes of 5-10-11 revealed the Tenant's physician was notified and orders were obtained for additional treatment. A physician order of 5-10-11 indicated the Tenant was to wear a boot on the right foot and could bear weight. The Nurse completed a nurse review of both incidents.

- Regulatory Insufficiency: None noted.

Dated this 15th day of June, 2011.