IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 34502-C
Incident Intake #: 34504-I

August 10, 2011

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

RE: I. Final Incident & Complaint Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Ms. Seals:

I. Final Incident & Complaint Investigation Report – Gardens at Luther Park, Des Moines, IA

Enclosed is the **Final Incident & Complaint 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. The Report notes Regulatory Insufficiencies in the area(s) of: Occupancy Agreement, Program Policies & Procedures, Service Plan, Tenant Rights, Nurse Review and Program Notification to Department. **Gardens at Luther Park** ("Program") is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

II. Civil Penalty

If, within 30 days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order

in the amount of six hundred and fifty dollars ($650) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.11 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on August 5, 2011, has been reviewed and will constitute the final POC related to the on-site visit of June 28, 2011.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Incident & Complaint Investigation Report

Assisted Living Program:

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

Incident Intake #: 34504-I
Complaint Intake#: 34502-C

Date of Incident Investigation:

June 28, 2011

Monitor(s):

Hal L. Chase, MPH BSN
Rose Boccella, MA

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 28, 2011. In preparing this report, the following information was considered:

General Population Program (GPP)* – A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	59
Current number of tenants with cognitive disorder:	5
Total Population of GPP:	64

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:	77

***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 during the recertification visit of November 23 and 24, 2010 in the areas of : Evaluation, Service Plan and Medications.

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

A. Occupancy Agreement

During the course of the investigation, the following information was obtained:

- Monitoring Observation: Tenant #1, (the Tenant) a 78 year old, was admitted on 8-1-08 and had diagnoses of: Alzheimer's Disease, Hypothyroidism, Glaucoma and Arthritis. The Tenant resided in the general population. A Global Deterioration Scale (GDS) was completed on 6-15-11 and staged the Tenant at six, which indicated severe cognitive decline. Nurse's notes of 6-17-11 revealed the tenant left with family and did not return to the program.

  The Tenant's occupancy agreement of 1-9-10 had not been updated to include all the required information, including but not limited to: criteria for admission and retention, tenant rights, involuntary transfer and policies and procedures related to addressing grievances between the assisted living program and tenants.

- Regulatory Insufficiency: An assisted living program occupancy agreement shall clearly describe the rights and responsibilities of the tenant and the program. The occupancy agreement shall also include but is not limited to inclusion of all of the following information in the body of the agreement or in the supporting documents and attachments: Occupancy, involuntary transfer, and transfer criteria and procedures, which ensure a safe and orderly transfer, the internal appeals process provided relative to an involuntary transfer. The program's policies and procedures for addressing grievances between the assisted living program and the tenants, including grievances relating to transfer and occupancy. (231C.5(2)(h,i,j))

B. Program Policies and Procedures

Incident Allegation #34504-I: The Program reported Tenant #1 (the Tenant) had eloped on 6-13-11. The Tenant was sitting behind the steering wheel of a parked car in the program's parking lot. The Tenant was confused as to the reason he/she was sitting in the car and had to be coaxed back into the building. The Tenant was placed on one-hour checks for the rest of the evening and overnight hours.

- Monitoring Observation: Program photos of 6-13-11, showed the Tenant leaving the program on three separate occasions. The Tenant had left the Program at 6:27 p.m., returning through the front entrance at 6:31 p.m. At 7:10 p.m. the Tenant was seen leaving the Program and returning to the front entrance way, between the outside and inside door at 7:13 p.m. The Tenant went outside again, through the front entrance at 7:15 p.m. At 7:34 p.m., staff went outside to look for the Tenant and returned with the Tenant at 7:36 p.m.

  Nurse's notes of 6-17-11 revealed staff was instructed to check on the Tenant, who had a GDS of six, every hour to maintain safety. The Nurse stated task sheets were not used to show the date and time(s) staff checked on the tenant. The Nurse stated she didn't know if the Tenant was checked on hourly by staff. Program documentation revealed a 24-hour report/change of condition report (staff communication record) of 6-13-11 the Tenant was found in a visitor's car in the parking lot. The Tenant had been redirected into the program without incident. The Administrator, Nurse and family had been notified. No other notations were made. Staff communication record of 6-14-11, revealed the Tenant sat by the front door "a lot."

  Staff #1 stated the Tenant had regularly gone outside of the program and would walk in front of the Program and sit outside the front entrance. Staff #1 stated she didn't recall being directed by the Nurse to do any "special checking" on the Tenant. Staff #1 stated staff didn't use task sheets and she didn't know what they were. Staff #2 stated task sheets were used in the dementia unit for safety checks only, but were not used anywhere else. Staff #2 stated the Nurse told her to check on the Tenant every two hours, but didn't remember when she was told to complete the two-hour checks. The Administrator and Nurse stated an incident report had not been completed despite a program policy to do so.

  Nurse's notes of 6-17-11 revealed the program called local police related to physical aggression exhibited toward the Administrator by the Tenant's family member. The Administrator reported she had met with the Tenant's family member on 6-16-11 to discuss the Tenant's service plan and elopement of 6-13-11. The meeting began cordialy, but escalated. The Administrator stopped the meeting and walked away. The Tenant's family member blocked the entry to the elevator and pushed the Administrator. Staff called police, who arrived 30-minutes later, spoke to both the Administrator and the Tenant's family member. Police escorted the Tenant's family member from the program. The Administrator stated an incident report had not been completed.

- Regulatory Insufficiency: A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. The program's policies and procedures on incident reports, at a minimum shall include the following: All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. (IAC r. 481-67(2)(1)(e))

C. Service Plan

Complaint Allegation #34502-C: It was alleged the Program told a tenant's family the Program could no longer meet the tenant's needs and family needed to provide 24-hour care, until the family found alternative placement.

Monitoring Observation: Tenant #1's (the Tenant) nurse's notes of 2-7-11, revealed the Tenant asked staff how to get back to his/her apartment and Staff assisted the Tenant; however upon arrival to the Tenant's apartment, the Tenant could not find the key, despite having the key on a necklace the Tenant was wearing. On 2-8-11, the Tenant needed staff assistance with dressing. On 2-18-11 and 2-23-11, the Tenant had had put on multiple layers of incontinent undergarments and clothing and needed staff assistance with changing. On 2-28-11 the Tenant needed redirection when leaving the dining room and assistance with clothing choices.

Nurse's notes of 5-24-11, revealed the Tenant needed additional prompting from staff with morning cares, as the Tenant was unable to put on his/her shoes. On 5-27-11, staff reported the Tenant was unable to dress and required assistance every morning with activities of daily living (ADLs). On 5-31-11, the Tenant was seen walking the hallways without shoes. On 6-6-11 staff reported the Tenant had increased agitation, was yelling at staff and needed frequent redirection. On 6-13-11 staff found the Tenant in a visitor's car parked in the parking lot.

Staff #1 stated the Tenant believed he/she lived in another apartment located on the first floor of the program. Beginning in March 2011, the Tenant wandered the hallways, not knowing which hallway he/she was in. The Tenant would become agitated and angry in the afternoon. Staff #1 stated the Tenant had regularly gone outside of the program and would walk in front of the Program and would sit outside the front entrance. Staff #2 stated in May of 2011, she had noticed a decline in the Tenant's cognition. The Tenant was having a harder time following directions, had increased confusion and became lost inside the program. Staff #2 was not aware the Tenant had been allowed to be outside alone.

The service plan of 3-11-11, did not include interventions related to staff assisting with cares, staff escort or stand by assist to and from meals and going outside independently despite having impaired decision making ability. The service plan of 6-15-11did not establish interventions directing staff to respond to the Tenant's wandering, potential elopement, increased agitation and 24-hour care needs. Both service plans did not identify activities that were planned and spontaneous, specific to the Tenant's ability and personal interest.

- Regulatory Insufficiency: The service plan shall be individualized and shall indicate, at a minimum, the tenant's identified needs and preferences for assistance. For tenants who are 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)(d))

D. Tenant Rights

During the course of the investigation, the following information was obtained.

Monitoring Observation: Tenant #1's (the Tenant) nurse's notes of 2-7-11, revealed the Tenant asked staff how to get back to his/her apartment. Staff assisted the Tenant to his/her apartment. Upon arrival to the Tenant's apartment, the Tenant could not find the key to his/her apartment, despite having the key on a necklace the Tenant was wearing. On 2-8-11, the Tenant needed staff assistance with dressing. On 2-18-11 and 2-23-11, the Tenant had had put on multiple layers of incontinent undergarments and clothing and needed staff assistance with changing. On 2-28-11 the Tenant needed redirection when leaving the dining room and assistance with clothing choices.

The Nurse indicated the service plan was updated on 3-11-11, due to increased level of care and needed redirection due to increased cognitive decline and confusion. The Tenant needed additional prompting with all ADLs. Staff was to provide the Tenant with reminders/directions on how to get to and from meals and to and from activities, as the Tenant would often become lost. The Nurse recommended the Tenant transfer to the program's locked dementia unit when an apartment became available.

Nurse's notes of 5-24-11, revealed the Tenant needed additional prompting from staff with morning cares, as the Tenant was unable to put on his/her shoes. On 5-27-11, staff reported the Tenant was unable to dress and required assistance every morning with ADLs. On 5-31-11, the Tenant was seen walking the hallways without shoes. On 6-6-11 staff reported the Tenant had increased agitation, was yelling at staff and needed frequent redirection. On 6-13-11 staff found the Tenant in a visitor's car parked in the parking lot.

Staff #1 stated the Tenant believed he/she lived in another apartment located on the first floor of the program. Beginning in March 2011, the Tenant wandered the hallways, not knowing which hallway he/she was in. The Tenant would become agitated and angry in the afternoon. The Tenant would go outside and walk in front of the program and would sit on a bench next to the front entrance. Staff #2 stated in May of 2011, she had noticed a decline in the Tenant's cognition. The Tenant was having a harder time following directions, had increased confusion and became lost inside the program. Staff #2 was not aware the Tenant had been allowed to be outside alone. The Tenant's service plans of 3-11-11 and 6-15-11 did not establish The program did not receive services which are adequate and appropriate.

The service plan of 3-11-11, did not include interventions related to staff assisting with cares, staff escort or stand by assist to and from meals and going outside independently despite having impaired decision making ability. The service plan of 6-15-11did not establish interventions directing staff to respond to the Tenant's

wandering, potential elopement, increased agitation and 24-hour care needs. Both service plans did not identify activities that were planned and spontaneous specific to the Tenant's ability and personal interest.

- Regulatory Insufficiency: All tenants have the following rights. To receive care, treatment and services which are adequate and appropriate. (IAC r. 481-67.3(2))

E. Nurse Review

During the course of the investigation, the following information was obtained:

Monitoring Observation: Tenant #1's (the Tenant) nurse's notes of 2-7-11, revealed the Tenant wanted to know how to get back to his/her apartment. Staff assisted, but the Tenant could not find the key to his/her apartment. The Tenant's key was on a necklace he/she was wearing. On 2-8-11, the Tenant needed staff assistance with dressing. On 2-18-11 and 2-23-11, the Tenant had had put on multiple layers of incontinent undergarments and clothing and needed staff assistance with changing. On 2-28-11 the Tenant needed redirection when leaving the dining room and assistance with clothing choices.

Nurse's notes of 5-24-11, revealed the Tenant needed additional prompting from staff with morning cares, as the Tenant was unable to put on his/her shoes. On 5-27-11, staff reported the Tenant was unable to dress and required assistance every morning with ADLs. On 5-31-11, the Tenant was seen walking the hallways without shoes. On 6-6-11 staff reported the Tenant had increased agitation, was yelling at staff and needed frequent redirection. On 6-13-11 staff found the Tenant in a visitor's car parked in the parking lot.

The Program did not complete a nurse review with a significant change in the tenant's condition as reported in nurse's notes of 2-7-11 through 2-28-11 and 5-24-11 through 6-13-11.

- Regulatory Insufficiency: 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 and 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(4))

F. Program Notification to the Department

Incident Allegation #34504-I: On 6-17-11, the Program reported Tenant #1 (the Tenant) had eloped on 6-13-11. The Tenant was sitting behind the steering wheel of a parked car in the program's parking lot. The Tenant was confused as to the reason he/she was sitting in the car and had to be coaxed back into the building.

Complaint Allegation #34502-C: It was alleged a tenant had eloped from the program on 6-13-11 at 7:00 p.m.

- Monitoring Observation: Tenant #1 was staged at six on the GDS, on 3-11-11 and 6-15-11, which indicated severe cognitive decline. Program photos of 6-13-11, showed the Tenant leaving the program on three separate occasions. The Tenant had left the Program at 6:27 p.m., returning through the front entrance at 6:31 p.m. At 7:10 p.m. the Tenant was seen leaving the Program and returning to the front entrance way, between the outside and inside door at 7:13 p.m. The Tenant went outside again, through the front entrance at 7:15 p.m. At 7:34 p.m., staff went outside to look for the Tenant and returned with the Tenant at 7:36 p.m.

  The Program notified the Department on 6-17-11 of the Tenant's elopement of 6-13-11. The Program did not notify the Department with 24-hours.

- Regulatory Insufficiency: The director or the director's designee shall be notified with 24 hours, or the next business day, by the most expeditious means available when a tenant elopes from a program. (IAC r.481-67(4)(4))

G. Other

Complaint Allegation #34502-C: It was alleged a tenant should have been in the memory care unit. The tenant had been on a waiting list for some time, but the Program had admitted other tenants. The tenant had greater needs and should have been admitted first.

- Monitoring Observation: Tenant #1 (the Tenant) was admitted to the Program on 8-1-08. The service plan of 3-11-11, revealed the Nurse recommended the Tenant transfer to the program's locked dementia unit when an apartment became available. Program documentation revealed the dementia unit can only accommodate 13 tenants. Program census revealed there was 13 tenants in the dementia unit and the last two admissions occurred on 1-7-11 and 2-10-11.

- Regulatory Insufficiency: None noted.

Dated this 9th day of August, 2011.