IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Incident Intake #: 35367-I

August 23, 2011

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

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

Dear Ms. Seals:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of August 15, 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 #: 35367-I**

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

Date of Incident Investigation:

August 15, 2011

Monitor(s):

Hal L. Chase, RN BSN MPH

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 Gardens at Luther Park Assisted Living on August 15, 2011. 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:	22
Current number of tenants without cognitive disorder:	47
Total Population:	69

***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.

During the complaint (34502-C) and incident (34504-I) investigation of June 28, 2011, the program received regulatory insufficiencies in the areas of: Service Plan, Non-Notification of Elopement, Occupancy Agreement, Tenant Rights, Policy and Procedure and Nurse Review

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

A. Staffing

Incident Allegation: The program reported Tenant #1 eloped from the program on 8-7-11.

- Monitoring Observation: Tenant #1, (the Tenant) a 74 year old, was admitted on 8-6-10 and had diagnoses of: Alzheimer's Dementia and Depression. A cognitive evaluation was completed on 8-9-11 and staged the tenant at five on the Global Deterioration Scale, which indicated moderately severe cognitive decline. The service plan of 8-9-11 revealed the Program did not provide personal and/or health-related cares to the Tenant. The Tenant's spouse was the primary caregiver and assisted the Tenant as needed.

  Nurse's notes of 8-8-11 revealed the Tenant was with his/her spouse for supper the evening of 8-7-11. After supper, the Tenant's spouse used the restroom. The Tenant went to look for his/her spouse and went through a door leading to the outside. Another tenant watched the Tenant leave and reported the Tenant had left the building. Staff immediately brought the Tenant back to the program. Two-hour safety checks began immediately after the elopement, beginning at 8:00 p.m. on 8-7-11 until 10:00 a.m. on 8-9-11 when a personal alarm device was placed on the Tenant. This device alarms and notifies staff when the Tenant comes in close

proximity to exterior doors. Program documentation revealed safety checks were done every two-hours, beginning at 8:00 p.m. on 8-7-11 through 10:00 a.m. on 8-9-11. Staff was to complete a check placement and function of the device at every shift change. The Tenant's service plan of 8-9-11 revealed the emergency device had been placed on the Tenant. A review of the Tenant's file revealed no history of wandering or prior elopements.

- Regulatory Insufficiency: None noted.

Dated this 22nd day of August, 2011