IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 35559-C

October 21, 2011

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

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

Dear Ms. Seals:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of September 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 Complaint/Incident Investigation Report

Assisted Living Program: **Complaint/Incident Intake #:** 35559-C

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

Date of Complaint/Incident Investigation:

September 6, 2011

Monitor(s):

Hal L. Chase, RN BSN MPH

Definitions: ***The following definitions are relevant:***

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 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 (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the 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 statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: ***In preparing this report, the following information was considered:***

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	23
Number of tenants with cognitive disorder:	53
Total Population of Program at time of on-site	73
TOTAL census of Assisted Living Program	73

Program History – The program received regulatory insufficiencies in the areas of: Evaluations, Service Plan and Medications during the Recertification and Complaint (31063-C) visit of November 2010. During the June 2011 Incident (34504-I) and Complaint (34502-C) investigation, the program received regulatory insufficiencies in the areas of: Occupancy Agreement, Policy and Procedures, Service Plan, Tenant Rights, Nurse Review and Program Notification to the Department.

Complaint/Incident Investigation – The Complaint/Incident investigator(s) made the observations detailed in the following areas:

A. Staffing

Complaint/Incident Allegation: It was alleged Tenant #1 was lying on the floor all night and could not reach the call button to notify staff he/she had fallen. Staff #1 came in the morning to administer medications, saw the tenant on the floor but left without assisting the tenant or notifying the Nurse.

- Monitoring Observation: Tenant #1 (the Tenant), an 87 year old, was admitted on 6-20-11 and had diagnoses of: Atrial Fibrillation, a History of Falls, Vitamin B 12 Deficiency with Anemia, Coronary Artery Disease (CAD), Restless Leg Syndrome, Hypertension (HTN), Dementia, a History of Post Coronary Artery Bypass Graft (CABG) and Hypoxia. A cognitive evaluation was completed on 8-11-11, and staged the Tenant at three on the Global Deterioration Scale (GDS), which indicated mild cognitive decline.

  A service plan of 8-12-11 indicated the Tenant was independent with ambulation, transfer, toileting, grooming and needed assistance with bathing, dressing and medication administration. Two incident reports were completed on 8-19-11. The first incident report indicated the Tenant was found on the floor about 10:00 a.m. by the Licensed Practical Nurse (LPN). Vital signs and range of motion were completed and both indicted they were within normal limits. No injuries were apparent. The Tenant reported he/she had been lying on the floor all night next to the couch and wouldn't get up. The second incident report of the same date indicated care staff went into the Tenant's room, found the Tenant on the floor, but did not help the Tenant up or investigate further as to why the Tenant was lying on the floor. A

review of the Tenant's file indicated no other incidents of falls. Nurse's notes of 8-19-11, indicated the Tenant was found on the floor, next to the couch in the living room. The Tenant reported he/she fell the previous night, couldn't get up and spent the night on the floor. The Tenant was transported to a local hospital emergency room due to excessive fluid draining from the left lower leg. The Tenant had cloudy foul urine, which was noted during toileting. Hospital records indicated the Tenant was admitted on 8-19-11, with admitting diagnoses of: Status Post Fall, Lower Extremity Edema and a Urinary Tract Infection. Physical and Occupational Therapy were planned due to suspected weakness, which may have caused the Tenant's fall. The Tenant was was discharged on 8-23-11. The tenant was transferred to a local nursing rehabilitation facility.

The Tenant was interviewed at a local nursing rehabilitation facility and reported he/she remembered falling, but was unsure of the specific details of how he/she fell, how long he/she was on the floor and when staff came in and saw him/her on the floor. The Tenant didn't remember calling a family member or why he/she had been hospitalized.

Staff #1's personnel file was reviewed and indicated she had received training and returned demonstration of providing personal health directed cares to the Nurse. She was interviewed and reported she went to the Tenant's room on 8-19-11, at approximately 6:30 a.m. She found the Tenant on the floor, with pillows under his/her head and a blanket covering the Tenant. She asked the Tenant why he/she was on the floor and the Tenant reported he/she was lying on the floor and wanted to stay where he/she was for awhile. Staff #1 asked the Tenant if he/she had fallen and the Tenant said he/she hadn't. Staff #1 continued her duties and did not report to the LPN the Tenant was on the floor. At approximately 10:00 a.m. she and the LPN went to the Tenant's apartment and found the Tenant sitting up, with the phone in the Tenant's hand. The Tenant was dressed, wearing a pajama top and dress pants. The Tenant's pajama pants were folded and were lying on the couch. Staff #1 stated she was terminated from the employment because she hadn't reported to the LPN the Tenant was on the floor. Staff #1 stated if she thought the Tenant had fallen she would have helped the Tenant up and would have notified the LPN.

Staff #2 was interviewed and reported the Tenant was independent with ADLs. She stated she worked in the dementia unit of the program and hadn't worked with the Tenant for several weeks. As far as she knew, the Tenant was independent with ADLs and the only services provided were housekeeping and laundry services. She stated the Tenant had a call system, as do other tenants, hardwired in their apartments. The call system was portable and the Tenant would often carry the call system with him/her. She stated she didn't know of any other incidents of staff not providing cares to tenants.

The LPN was interviewed and reported she received a phone call from a kitchen staff that the Tenant's family member called and reported the Tenant had been on the floor throughout the night. The LPN went to the Tenant's apartment and found the Tenant as described by Staff #1. The LPN reported pillows were on the couch and a blanket was on the floor. The phone was a cordless phone and the base was on the table next to a recliner. The phone could not be reached from the floor adjacent to the couch. The Tenant reported he/she had fallen last evening. The LPN assisted the Tenant up

from the floor and accompanied him/her to the bathroom to toilet. The LPN noted the Tenant's urine had a foul smell. The LPN spoke to a family member about the incident. Family arrived at the Program and transported the Tenant to a local hospital emergency room.

- Regulatory Insufficiency: None noted.

Dated this 6th day of September, 2011.