IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

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LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 40280-I
40282-I

September 5, 2012

Ms. Phyllis Seals, Administrator
Gardens at Luther Park
2910 E. 16th Street
Des Moines, IA 50317

RE: Final Complaint/Incident Investigation Report, Gardens at Luther Park, Des Moines, Iowa

Dear Ms. Seals:

Enclosed is the **Final Complaint/Incident 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.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint/Incident Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiency, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

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:

Phyllis Seals, Administrator
The Gardens at Luther Park
2910 E. 16th Street
Des Moines, IA 50317

Complaint/Incident Intake #: **40280-I**
40282-I

Date of Complaint/Incident Investigation:

August 14, 2012

Monitor(s):

Lori Miner, RN BSN

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 Definition	
Number of tenants without cognitive disorder:	52
Number of tenants with cognitive disorder:	8
Total Population of Program at time of on-site	60

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	1
Number of tenants with cognitive disorder:	11
Total Population of Program at time of on-site	12
TOTAL census of Assisted Living Program	72

Program History – The program did not receive any regulatory insufficiencies during this certification period.

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

A. Policies and Procedures

Complaint/Incident Allegation: On 8-10-12, the Program reported Tenant #1 eloped. (#40282-I). On 8-13-12, the Program reported Tenant #2 eloped. (40280-I)

- Monitoring Observation: Tenant #1, an 81 year-old, was admitted on 8-3-12 with a diagnosis of dementia. Tenant #1 was staged at four on the Global Deterioration Scale (GDS) which indicated moderate cognitive decline. Tenant #1 resided in the general population which was dementia-specific by definition. Functional, cognitive, and health evaluations were completed prior to admission. Tenant #1 was identified as independent with transfers and ambulation. Staff #1, a Licensed Practical Nurse (LPN), revealed Tenant #1 was admitted on the weekend and there was no indication of wandering while family members were present over the weekend. When the spouse left, Tenant #1 was observed to be wandering the building looking for the spouse. A nurse review was completed on 8-6-12 and a wander guard was placed. The service plan was updated to include the wander guard and staff interventions for wandering.

  Staff #2, LPN, stated Tenant #1 was new to the Program, and was still being evaluated. Tenant #1 was reported to wander in the building and was always with a staff person asking about the spouse. Staff #2 and #4 reported it was unusual for Tenant #1 to go to a door and unusual for Tenant #1 to walk away from staff. Staff #3, #4, and #5 stated Tenant #1 was easily redirected.

Staff #2, LPN, stated he was working the evening of 8-9-12. The Program reported at approximately 7:30 p.m. the pagers went off. Staff #2 stated the pager was reset and the staff did not communicate with each other. According to the Administrator, Staff #6 went to the outside exit doors near the Lindens dementia unit after the pager alarmed, looked out the windows, but did not follow the elopement procedure and did not go outside. According to Staff #1, LPN, Tenant #1 was a fast walker, and Tenant #1 was gone about an hour.

According to the incident report, Staff #2, LPN, received a call from Tenant #1's spouse that Tenant #1 had been picked up and was returning to the Program. The Administrator stated the police found Tenant #1 approximately three blocks from the Program; however, no police report was available. Staff #2 stated Tenant #1 was found on 16th Street, a residential area near the Program.

Upon Tenant #1's return to the Program, Staff #2, LPN, assessed Tenant #1 and Tenant #1 had no injuries. Tenant #1 was reported to be dressed for the weather and wearing shoes.

According to the State Climatologist, the weather conditions at the Ankeny Airport, the nearest reporting site on 8-9-12 at 7:35 p.m. were a temperature of 79 degrees, north winds at 14 miles per hour (mph) with gusts to 22 mph. Skies were clear. There was no heat index. Sunset was at 8:22 p.m. The clear skies would have allowed a reasonable amount of light after 8:22 p.m.

Upon return, staff members were one-to-one with Tenant #1 and began hourly safety checks. Functional, cognitive, and health assessments were completed and the service plan was updated. Tenant #1 was reported to be moving into the locked dementia unit within the week.

The policy and procedure for the wander guard alarm system identified when a tenant activated the alarm, an immediate search for the tenant was to begin. The missing resident procedure stated the building and grounds were to be searched.

An incident report was completed and the Program notified the department appropriately. The Program conducted a staff inservice on the missing tenant procedure on 8-13-12.

Tenant #2, an 87 year-old, was admitted on 9-4-10 and had diagnoses of: Dementia, Alzheimer's, Diverticulitis, Hypothyroidism, Hypertension, and Depression. Tenant #2 was staged at four on the GDS which indicated moderate cognitive decline. Tenant #2 resided in the general population which was dementia-specific by definition. According to Staff #1, LPN, Tenant #2 was disoriented "once in awhile" after an overnight visit with family, but had never attempted to leave the Program. Reminders had worked well with Tenant #2 and Tenant #2 never wandered. Tenant #2 was independent with ambulation, walked well, but slowly. Staff #3 reported Tenant #2 came out of the apartment for lunch and supper, and attended outside activities. Tenant #2 would go out to lunch with a group of tenants from the Program. Tenant #2 was reported by Staff #3 to stay with the group, and order and pay for lunch appropriately. Staff #3 reported Tenant #2 would sign out independently when

going out with family. Staff #4 stated Tenant #2 was good about letting staff members know she was leaving the building and when returning to the Program. Staff #4 was surprised to hear Tenant #2 had eloped from the Program. Staff #7 stated on 8-10-12 she had served Tenant #2 supper. Tenant #2 left the dining room and returned to the apartment. Staff #7 had never seen Tenant #2 wandering or confused. Tenant #2 usually signed self out. Staff #7 reported there had been no recent changes in Tenant #2's behavior. Staff #8 stated Tenant #2 always signed self out and someone would always be there to pick up Tenant #2.

Staff #2 reported Tenant #2 was independent with ambulation with a walker. Staff #2 had noticed no recent changes in Tenant #2's condition. Staff #2, LPN, reported on the evening of 8-10-12 Tenant #2 had gone to the dining room. Staff #2 went to Tenant #2's apartment around 7:15 p.m. to administer medications. One of the medications was a fluoride treatment. Tenant #2 was dressed and wearing shoes. Staff #2 returned to the apartment to find the fluoride trays but did not see Tenant #2. Staff #2 checked the sign-out sheet and found that Tenant #2 had signed out. Staff #2 stated it was not unusual for Tenant #2 to be out after dinner. About 9:50 p.m. Staff #2 was contacted by a hospital emergency department (ER) asking for information on Tenant #2. The ER stated Tenant #2 had been picked up by the fire department. Staff #1, LPN, documented a conversation with the ER which indicated Tenant #2 was found in the 1900 block of East 14th Street, approximately 12 blocks away. A bar attendant close by contacted the fire department according to the nurse's notes. Tenant #2 was reported to have told the fire department about going to a meeting and signing self out of the Program. An incident report was completed and the Program notified the department appropriately.

According to the State Climatologist, the weather conditions at the Ankeny Airport, the nearest reporting site on 8-10-12 at 8:35 p.m. were a temperature of 66 degrees, winds were calm with clear skies. Sunset was at 8:20 p.m. The clear skies would have allowed a reasonable amount of light after 8:20 p.m.

Tenant sign-out sheets were reviewed for two months. Tenant #2 signed self out 9 times in two months. Four of those times were late evening hours. Tenant #2 returned to the Program on 8-13-12 with a facial bone fracture and a non-displaced fracture to the left knee cap. Tenant #2 had a 24-hour a day care taker since returning to the Program and a wander guard was placed. Functional, cognitive, and health evaluations were completed and the service plan was updated. Tenant #2 was to be moved to the secured dementia unit when an apartment became available.

A tour of the building was taken. Exit doors were noted to have wander guard alarm systems on all exit doors. Keypad alarms were also being installed on all exit doors with the process expected to be completed by the end of the day 8-14-12. The Program was determined to be dementia-specific by definition in June of 2012 and according to the Administrator there had been delays in getting needed parts for the door alarm system. The Program instituted wander guards for ambulatory tenants with a GDS of at least four who resided in the general population.

Tenant #1 eloped from the Program. A staff member went to the door but did not search outside the building for Tenant #1 and did not search for Tenant #1, a known

wanderer, within the building. The Program's procedure was not followed after an elopement.

- 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 established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. (IAC r. 481-67.2)