IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 42598-C

April 1, 2013

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

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

Dear Ms. Seals:

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

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. The Report notes Regulatory Insufficiencies in the area(s) of: Policies and Procedures, Service Plans and Nurse Review.

Gardens at Luther Park is being assessed a $500 civil penalty pursuant to Iowa Code section 231C.14(1)(c) and 481 IAC 67.12(3)(a)(3). The Program prevented or interfered with or attempted to impede a duly authorized representative(s) of DIA in the lawful enforcement of Iowa Code chapter 231C and IAC chapters 481—67 and 481—69. Upon entering the building to begin its investigation, numerous program staff, including the Administrator, told DIA representatives there had been no elopements. Later, the Administrator presented a written statement verifying a tenant had exited the building. The Program's failure to immediately disclose elopements to DIA representatives interfered with DIA's investigation and impeded DIA representatives from conducting a timely investigation.

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 to the State of Iowa in the amount of three hundred twenty five dollars ($325) 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 $500 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on March 27, 2013, has been reviewed and will constitute the final POC related to the on-site visit of February 19 and 20, 2013. The Request for Reconsideration has been denied. The Program did not submit sufficient additional information to document compliance with regulation at the time of the onsite.

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 Complaint/Incident Investigation Report

Assisted Living Program:

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

Complaint/Incident Intake #: 42598-C

Date of Complaint/Incident Investigation:

February 19th and 20th, 2013

Monitor(s):

Lori Miner, RN BSN
Rose Boccella, MS

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.

General Population Program	
Number of tenants without cognitive disorder:	46
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	49
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	12
Number of tenants with cognitive disorder:	9
Total Population of Program at time of on-site	21
TOTAL census of Assisted Living Program	70

Program History – The program received a regulatory insufficiency in the area of Policy and Procedure during the August 14, 2012 Incident Investigation (40280-I, 40282-I).

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

A. Program Reporting to the Department

Complaint/Incident Allegation: It was alleged Tenant #1 and Tenant #2 eloped from the building and the program did not report it.

- Monitoring Observation: Upon entering the Program, the monitor asked to see incident reports from November1, 2012 forward. There was one incident report for November 2012 which related to a tenant fall. There were no incident reports for February 2013, and there were no incident reports relating to elopements. The Licensed Practical Nurse (LPN) was interviewed.

  The LPN stated there had been no elopements since August 2012 when Tenant #1 eloped and was investigated by the department. The clinical record was opened and the LPN found documentation in the nurse's notes dated 11-16-12 and timed 5:00 p.m. and then recalled that Tenant #1 attempted to leave the building. The LPN reported that Tenant #1 wanders after being told of an upcoming appointment or outing, or has a night out of the building. The LPN stated family was now showing up unannounced to take Tenant #1 to appointments or out of the building and that has lessened Tenant #1's wandering.

The LPN reported Tenant #2 wanted to go home and went from room to room. Tenant #2 was up all night and slept all day, and was agitated. Seroquel was started in December 2012 and the agitation and wandering decreased.

The LPN reported Tenant #1 and #2 were moved from the first floor secured dementia unit to the third floor dementia unit on 2-8-13. The LPN stated the third floor door alarms were in place when the tenants moved to the third floor. The first floor dementia unit was converted to general population rooms. The third floor was previously in the general population.

Staff #1, Universal Worker (UW), was interviewed and stated no tenants have gotten out of the building. Staff #1 reported generally working in the dementia unit. Staff #1 stated Tenants #1 and #2 have not gotten out of the building. If Tenants #1 and #2 were found wandering, they were redirected.

Maintenance was interviewed and stated three to four weeks ago he was asked to double check records to make sure wander guards and egress doors were working in the first floor dementia unit. No problems were identified with the wander guards or egress doors. Maintenance stated he was asked to check the doors by his supervisors. Maintenance stated he had heard that someone had gotten out of the building through the dining room door during the evening shift. Maintenance stated the event occurred before tenants were moved from first to third floor. Maintenance was not able to identify who got out of the building. Maintenance stated he had not viewed any video tapes.

Staff #2, UW reported she generally worked in the general population. Staff #2 reported Tenant #1 got out of the building in November but did not recall the date. Staff #2 stated she was not working at the time. Staff #2 had no knowledge of Tenant #2 leaving the building.

The Administrator was asked to provide video tape from the exterior building for the end of January 2013. The Administrator stated the person with the knowledge of the video tapes was out of town and not available. The Administrator reported the assistant was unable to access the information. She also stated video was good for about 10 days and was then recorded over. The Administrator asked the monitor the purpose of the monitoring visit. The monitor responded the purpose was to look into elopements.

On 2-19-13, the Administrator stated there had been no elopements.

On the morning of 2-20-13 the Administrator presented to the monitors a letter dated 2-20-13 which stated on 1-28-13 during the evening hours she was notified by staff members a tenant, later identified as Tenant #2, had exited the building. The Administrator went to the Program to find staff members followed protocol and the tenant was back in the building. The Administrator instituted one-hour checks. The Administrator reported the incident to the family. The Administrator stated she did not report the incident to the department because of the brevity of the incident. The Administrator also stated an incident report was not completed.

The Administrator also provided a witness statement signed by Staff #2 and #4 and dated 1-28-13 which indicated a door alarm went off and staff responded. Room checks were done and Tenant #2 was missing. Staff responded by looking inside and outside the building. Tenant #2 was found outside a few minutes later. Staff #2 stated in interview she had no knowledge of Tenant #2 leaving the building.

Staff #3, UW, was interviewed on 2-20-13 and stated she was working the night Tenant #2 got out of the building. Staff #3 saw the alarm on the marquee on the wall, notified another staff member and went to look for the tenant. Another staff member brought Tenant #2 inside. One-hour checks were done and Staff #3 reported Tenant #2 was "fine."

The State Climatologist reported the following weather conditions on 1-28-13 between 6 p.m. and 8 p.m. on 1-28-13 at the Ankeny Airport, the closest reporting station to the Program: Temperature 39 degrees, with a wind chill of 33 degrees, and foggy.

The clinical record for Tenant #1 documented Tenant #1 attempted to leave the building on 11-16-12. Staff responded to the alarms and found Tenant #1 pushing the door open. Tenant #1 was redirected and one-hour checks were initiated. Two staff members (LPN, Staff #1) stated no tenants got out of the building. One staff member (#2) stated Tenant #1 got out of the building in November, but was not working at the time of the incident. Staff #3 did not identify Tenant #1 as a person that eloped, but did identify Tenant #2. Maintenance heard someone got out of the building within the last few weeks, but did not know who it was. There was no documentation to suggest Tenant #1 eloped from the program.

Tenant #2 was reported to have left the building on 1-28-13. Alarms sounded and staff members responded. A UW reported Tenant #2 was "fine." The staff members at the Program were aware the tenant left the building and responded and Tenant #2 was returned to the building. Because the alarm system notified the staff members, and the staff responded, the Program was not required to report to the department the incident as an elopement.

- Regulatory Insufficiency: None noted.

B. Policies and Procedures

Complaint/Incident Allegation: It was alleged Tenant #1 actually eloped from the Program but was documented as a near elopement. It was alleged there was no documentation of the elopement of Tenant #2. It was alleged the actions were deliberate.

- Monitoring Observation: The clinical record for Tenant #2 did not contain any entries for 1-28-13, and there was no documentation which indicated Tenant #2 left the building. The 24-hour report dated 1-28-13 indicated Tenant #2 was on one-hour checks in the evening, but no reason for the checks was given. The Administrator provided a written statement and documentation that Tenant #2 had gotten out of the building on 1-28-13. The Administrator stated an incident report was not completed.

The Administrator also provided a witness statement signed by Staff #2 and #4 and dated 1-28-13 which indicated a door alarm went off and staff responded. Room checks were done and Tenant #2 was missing. Staff responded by looking inside and outside the building. Tenant #2 was found outside a few minutes later. Staff #2 stated in interview she had no knowledge of Tenant #2 leaving the building.

Staff #3, UW, was interviewed on 2-20-13 and stated she was working the night Tenant #2 got out of the building. Staff #3 saw the alarm on the marquee on the wall, notified another staff member and went to look for the tenant. Another staff member brought Tenant #2 inside. One-hour checks were done and Staff #3 reported Tenant #2 was "fine."

The State Climatologist reported the following weather conditions on 1-28-13 between 6 p.m. and 8 p.m. on 1-28-13 at the Ankeny Airport, the closest reporting station to the Program: Temperature 39 degrees, with a wind chill of 33 degrees, and foggy.

The clinical record for Tenant #1 documented Tenant #1 attempted to leave the building on 11-16-12. Staff responded to the alarms and found Tenant #1 pushing the door open. Tenant #1 was redirected and one-hour checks were initiated. Two staff members (LPN, Staff #1) stated no tenants got out of the building. One staff member (#2) stated Tenant #1 got out of the building in November, but was not working at the time of the incident. Staff #3 did not identify Tenant #1 as a person that eloped, but did identify Tenant #2. Maintenance heard someone got out of the building within the last few weeks, but did not know who it was. There was no documentation to suggest Tenant #1 eloped from the program.

Tenant #2 was reported to have left the building on 1-28-13. Alarms sounded and staff members responded. A UW reported Tenant #2 was "fine." The staff members at the Program were aware the tenant left the building and responded and Tenant #2 was returned to the building. Because the alarm system notified the staff members, and the staff responded, the Program was not required to report to the department the incident as an elopement.

- Regulatory Insufficiency: None noted.

B. Policies and Procedures

Complaint/Incident Allegation: It was alleged Tenant #1 actually eloped from the Program but was documented as a near elopement. It was alleged there was no documentation of the elopement of Tenant #2. It was alleged the actions were deliberate.

- Monitoring Observation: The clinical record for Tenant #2 did not contain any entries for 1-28-13, and there was no documentation which indicated Tenant #2 left the building. The 24-hour report dated 1-28-13 indicated Tenant #2 was on one-hour checks in the evening, but no reason for the checks was given. The Administrator provided a written statement and documentation that Tenant #2 had gotten out of the building on 1-28-13. The Administrator stated an incident report was not completed.

The Administrator did provide a witness statement. Incident reports were reviewed from 11-1-12 to current as provided by the Program, and there was no incident report to document Tenant #2 leaving the building. Tenant #2 leaving the building, an unusual occurrence on the premises, was not documented with an incident report.

- Regulatory Insufficiency: The program's policies and procedures on incident reports, at a minimum, shall include the following: (e) 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 Plans

During the course of the investigation, the following was noted:

- Monitoring Observation: Tenant #1, an 87 year-old, was admitted on 9-4-10 and had diagnoses of: Alzheimer's dementia, Diverticulitis, Hypothyroidism, Hypertension, and Depression. Tenant #1 was staged at five on the Global Deterioration Scale (GDS) which indicated moderately severe cognitive decline. Tenant #1 resided in the secured dementia unit. Tenant #1 eloped from the Program on 8-13-12 and attempted to leave the building on 11-16-12 according to the nurse's notes. Tenant #1 was moved to the secured dementia unit after the elopement. The current service plan was updated on 11-19-12 to include assistance with hygiene. The service plan indicated Tenant #1 needed assistance with dressing including application of an immobilizer. Nurse's notes of 10-3-12 indicated the immobilizer was discontinued. The service plan was not updated when the immobilizer was discontinued. The service plan indicated Tenant #1 had eloped in August 2012, however, the service plan did not identify interventions related to elopement. In an interview with the LPN, she stated Tenant #1 wandered less when not told of upcoming appointments or reasons to leave the building. The service plan did not identify that particular intervention, nor staff response to Tenant #1 when attempting to leave the building. The service plan did not meet the identified needs of Tenant #1.

  Tenant #2, an 80 year-old, was admitted on 12-27-11 and had diagnoses of: Hyperthyroidism, Hyperlipidemia, Atrial Fibrillation, Osteoporosis, and Questionable Dementia. Tenant #2 was staged at five on the GDS which indicated moderately severe cognitive decline. Tenant #2 resided in the secured dementia unit. Tenant #2 eloped from the Program on 1-28-13 as identified by the Administrator. The clinical record lacked documentation of an elopement. The LPN stated Tenant #2 was checked for wandering. Staff #1 stated Tenant #2 was redirected when wandering.

  The Program provided 24-hour reports upon request. The reports were not part of the permanent tenant record. The 24-hour report documented the following for Tenant #2:

  12-15-12: Tenant #2 struck another tenant in the arm. Tenant #2 was combative and stated he/she was going to hit a staff member
  12-24-12: Tenant #2 kicked a staff member in the head while applying support stockings

1-5-13: Tenant #2 was very confused, yelling at people, trying to hit, making other tenants uncomfortable, tried to go out door
1-6-13: Tenant #2 was very confused, yelled at staff, sat in dining room chair pounding fist, other tenants bothered by yelling and outburst.

The current service plan for Tenant #2 dated 3-5-12 did not identify behaviors or elopement, nor specific interventions related to elopement or behaviors. The service plan did not meet the identified needs of Tenant #2.

Tenant #3, a 79 year-old, was admitted on 1-4-13 and had diagnoses of: Dementia, Hypertension, Depression, and Diabetes. Tenant #3 was staged at four on the GDS which indicated moderate cognitive decline. Tenant #3 resided in the secured dementia unit. Evaluations completed prior to admission identified Tenant #3 was agitated and paranoid. Staff members were to provide reassurance when Tenant #3 was upset and thinking the spouse was having an affair. An incident report dated 1-7-13 indicated Tenant #3 tried "forcefully" for three hours to leave the building in the middle of the night. Staff members tried redirection without success. The service plan did not identify interventions when Tenant #3 was upset and thought the spouse was having an affair. The service plan was not developed based on the evaluations. The service plan was not updated to include interventions when Tenant #3 wanted to leave the building and redirection was unsuccessful. The service plan did not meet the identified needs of Tenant #3. Tenant #3 was discharged on 1-15-13.

Service plans were not based on evaluations conducted prior to admission, did not meet the specific service need of tenants, and were not updated when changes were needed.

- Regulatory Insufficiency: A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26(1))

D. Nurse Review

During the course of the investigation, the following was noted:

- Monitoring Observation: A 90-day nurse review was completed for Tenant #1 on 2-11-13. Nurse's notes dated 11-28-12 documented Tenant #1 required hot compresses and eyelid scrubs at bedtime. Current physician's orders continued the eyelid scrub after hot compresses. The 90-day health assessment indicated Tenant #1 had impaired vision but did not address the condition of the eyes related to the scrubs and compresses. Tenant #1 was administered medications by the Program. The 90-day nurse review did not review medications for effectiveness or side effects.

  Tenant #2 was prescribed Seroquel at bedtime on 12-18-12. The nurse's notes dated 12-28-12 indicated the Seroquel was ordered for behavioral changes, but did not identify the behaviors. A 90-day nurse review was completed on 1-11-13 which indicated Tenant #2 did not sleep much of the night, was restless, confused, and

agitated at times. The 90-day nurse review did not indicate the effect of Seroquel on behaviors. The 90-day review identified the Program as administering medications but did not identify any other medications as to effectiveness or side effects.

- 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 or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: To monitor, at least every 90 days, or after a significant change in the tenant's condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders. (IAC r. 481-69.27(1))