STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0241	A. BUILDING: _____ B. WING _____	C 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS AT LUTHER PARK	2910 E16TH STREET DES MOINES, IA 50316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive disorder: 30 Number of tenants with cognitive disorder: 21 TOTAL census of Assisted Living Program for People with Dementia: 51 The following regulatory insufficiencies were cited during the investigation of Incidents #113878-I, #113949-I and Complaint #113948-C.	A 000	See Attached POC 11/3/23	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its policies and procedures. This pertained to 1 of 1 tenants reviewed with a history of elopement (Tenant #1). Findings follow: Record review of Tenant #1's file on 7/5/23 revealed the following: Tenant #1 was a 86 year old female with diagnoses including alzheimer's disease, delusional disorder and major depressive disorder. Tenant #1's Global Deterioration Scale dated 6/13/23 scored Tenant #1 at a 5 which indicated moderately severe cognitive decline.	A 150		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 150	Continued From page 1 Tenant #1's Incident Report dated 6/19/23 indicated she eloped from the 3rd floor locked memory care unit through the stairwell at 5:42 p.m. At 5:56 p.m. staff found her outside sitting on the curb and noted facial injuries. Staff called 911 and she was transported to the hospital. Progress Notes dated 6/19/23 noted an update from her daughter that Tenant #1 was admitted to the hospital for observation of a broken nose and hematoma above her left eye. According to timeanddate.com the weather in Des Moines on 6/19/23 around 6 p.m. was 84 degrees with 59% humidity and the sky was clear with winds out of the east at 8.7 mph. When interviewed on 7/5/23 at 3:46 p.m. Staff B stated on 6/19/23 he saw Tenant #1's wanderguard alert on the marquee and was going upstairs to turn off the alarm when it went silent. He explained he looked out the window as he walked back down the stairs and saw someone in the parking lot who appeared to have fallen. He realized it was the tenant when he reached her, observed injuries to her face, and notified another staff to call 911. He confirmed the alarm should not be turned off until all tenants were accounted for. Staff B verified all staff were retrained on door alarms and elopement procedures. Additional record review revealed Tenant #1's Incident Report dated 6/26/23, documented staff heard the north door alarm and looked down the stairs and did not see anyone. Staff completed a head count, went back downstairs, and found Tenant #1 just outside the front entrance doors with no injuries. Staff escorted her back into the building.	A 150		

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A 150	Continued From page 2	A 150		

When interviewed on 7/6/23 at 3:13 p.m. Staff A stated on 6/26/23 Staff C went on break and failed to notify any other staff she left the floor. He confirmed two staff were to be available at all times. He explained on 6/26/23 he was assisting another tenant when Tenant #1 exited the stair well after supper. He assumed Staff C would have completed the documentation of the safety checks since he was new and still learning the routine.

The Service Plan dated 6/23/23 revealed Tenant #1 required hourly safety checks due to an elopement on 6/19/23.

Tenant #1's Safety Check task list for 6/26/23 revealed staff failed to complete hourly safety checks from 11:13 a.m. to 8:33 p.m.

According to timeanddate.com the weather in Des Moines on 6/26/23 around 6:00 p.m. was 75 degrees with 62% humidity and the sky was clear with winds out of the north/northwest at 3.7 mph.

On 7/19/23 at 1:16 p.m. the Healthcare Coordinator wrote via email Tenant #1 wore slacks, three-quarter length sleeved shirt, and shoes appropriate for the weather on 6/19/23 and 6/26/23.

The Program was located between a residential and commercial area approximately a quarter mile from a heavily traveled four lane road.

Staff C was no longer employed by the Program and was not able to be reached for an interview.

Review of the Program's Door Alarm Response Policy and Procedure indicated all staff would respond immediately to all door alarms and

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A 150	Continued From page 3 always assume a tenant left the area. Review of the Program's Call Light and Pager Expectations and Clarifications signed by Staff A and Staff C on 6/22/23, noted they were to notify the other staff prior to going on a break to ensure adequate response to call lights. Review of the Program's Missing Tenant Policy and Procedure included the Director and/or Registered Nurse would contact family and the physician and determine if the situation required a report the the Department of Inspections and Appeals. When interviewed on 7/6/23 at approximately 11:09 a.m. the Administrator confirmed Tenant #1 eloped from the 3rd floor locked memory care unit on 6/19/23 at 5:42 p.m. and 6/26/23 at 5:27 p.m. She stated Tenant #1 pushed on the bar long enough for it to open to the stairwell and left the unit. She reported staff silenced the alarm prior to locating the source of the alarm. She said staff were trained to always assume it was a tenant. She stated staff were expected to document the hourly safety checks as they were completed. She confirmed staff failed to follow the policies and procedures related to door alarms, elopements, staff breaks and immediate notification of an elopement. She immediately provided re-education to all staff after 6/19/23.	A 150		
A 220	481-67.4(4) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available:	A 220		

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A 220	Continued From page 4 67.4(4) When a tenant elopes from a program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to notify the Department of Inspections, Appeals and Licensing (DIAL) when a tenant eloped. This pertained to 1 of 1 tenants with a history of elopement (Tenant #1). Finding follows: Record review on 7/5/23 of Tenant #1's file revealed the following: Incident Report dated 6/26/23 documented staff heard the north door alarm and looked down the stairs and did not see anyone. Staff completed a head count, went back downstairs, and found Tenant #1 just outside the front entrance doors with no injuries. Staff escorted her back into the building. Tenant #1 was a 86 year old female with diagnoses including alzheimer's disease, delusional disorder and major depressive disorder. Tenant #1's Global Deterioration Scale dated 6/13/23 scored Tenant #1 at a 5 which indicated moderately severe cognitive decline. Record review of a Disciplinary Notice dated 6/29/23 revealed Staff A failed to notify the nurse or the administrator when Tenant #1 eloped on 6/26/23. Review of the Program's Door Alarm Response Policy and Procedure included all staff would respond immediately to all door alarms and always assume a tenant left the area.	A 220		

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A 220	Continued From page 5 Review of the Program's Missing Tenant Policy and Procedure included the Director and/or Registered Nurse would contact family and the physician and determine if the situation required a report the Department of Inspections and Appeals. When interviewed on 7/6/23 at 3:13 p.m. Staff A stated he held a second job working with people with disabilities and it would not be considered an elopement unless the person left the property which was why he did not report the situation to management right away. When interviewed on 7/6/23 at approximately 11:09 a.m. the Administrator confirmed Tenant #1 eloped from the 3rd floor locked memory care unit on 6/26/23 at 5:27 p.m. She stated staff failed to notify management of the elopement and learned of it on 6/29/23. She said she filed the required report on 6/30/23.	A 220		
A 530	481-69.29(4) Staffing 481-69.29(231C) Staffing. 69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans. A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the	A 530		

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A 530	Continued From page 6 proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to check on tenants as indicated in the service plans. This pertained to 1 of 1 tenants with history of elopement (Tenant #1). Finding follows: Record review of Tenant #1's file on 7/5/23 revealed the following: Incident Report dated 6/19/23, indicated she eloped from the 3rd floor locked memory care unit through the stairwell at 5:42 p.m. At 5:56 p.m. staff found her outside sitting on the curb and noted facial injuries. Staff called 911 and she was transported to the hospital. Incident Report dated 6/26/23, documented staff heard the north door alarm and looked down the stairs and did not see anyone. Staff completed a head count, went back downstairs, and found her just outside the front entrance doors with no injuries. Staff escorted Tenant #1 back into the building. Tenant #1 was a 86 year old female with diagnoses including alzheimer's disease, delusional disorder and major depressive disorder. Tenant #1's Global Deterioration Scale dated 6/13/23 scored Tenant #1 at a 5 which indicated moderately severe cognitive decline. When interviewed on 7/6/23 at 3:13 p.m. Staff A stated on 6/26/23 Staff C went on break and	A 530		

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A 530	Continued From page 7 failed to notify any other staff she left the floor. He confirmed two staff were to be available at all times. He said on 6/26/23 he was assisting another tenant when Tenant #1 exited the stair well after supper. He assumed Staff C would have completed the documentation of the safety checks as he was new and still learning the routine The Service Plan dated 6/23/23, revealed Tenant #1 required hourly safety checks due to the elopement on 6/19/23. Tenant #1's Safety Check task list for 6/26/23 indicated staff failed to complete hourly safety checks from 11:13 a.m. to 8:33 p.m. When interviewed on 7/6/23 at approximately 11:09 a.m. the Administrator confirmed Tenant #1 eloped from the 3rd floor locked memory care unit on 6/26/23 at 5:27 p.m. She stated Tenant #1 pushed on the bar long enough for it to open to the stair well and left the unit. She said staff were required to document the hourly safety checks as they were completed.	A 530		

October 9, 2023

Department of Inspections and Appeals
Attn: Deb Dixon
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Dixon:

On behalf of Garden at Luther Park, I respectfully submit our Plan of Correction for your approval. This response is specific to Incident #113949-I, #113878-I and #113948-C for the onsite visit between 07/05/2023 – 07/10/2023.

Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the alleged facts or conclusions set forth in the statement of insufficiencies. The Plan of Correction is executed solely because it is required by the provisions of Iowa Law.

Policy and Procedures

1. Elements detailing how the Program will correct each regulatory insufficiency:
    - Staff will follow the policies and procedures of the community.
2. Measures taken to ensure problem does not occur:
    - All staff have been re-educated on policies and procedures related to door alarms and missing residents.
3. How the Program plans to monitor performance to ensure compliance:
    - The Director and/or designee will complete elopement drills regularly and as needed.
4. The date by which the regulatory insufficiency will be corrected:
    - The regulatory insufficiency will be corrected on or before November 3rd, 2023.

Policy and Procedures

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Staff will follow the policies and procedures of the community.
2. Measures taken to ensure problem does not occur:
    - Nursing staff were educated on the expectations of pagers and covering breaks.
3. How the Program plans to monitor performance to ensure compliance:
    - The Director of Health Services and/or designee will perform random audits to assure that pagers are being used and breaks are being covered appropriately.
4. The date by which the regulatory insufficiency will be corrected.
    - The regulatory insufficiency will be corrected on or before November 3rd, 2023.

Program Notification

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - Incidents reports will be completed for any unusual accidents, incidents involving tenants, visitors, or employees or other persons within the assisted living facility or on the premises.
    - The program will notify the Department of Inspections and Appeals of any reportable incident related to the elopement of a tenant.
2. Measures taken to ensure problem does not occur.
    - Nursing staff were educated on the policy and procedures related to accident and incident reporting and notification to the nurse/nurse on call.
3. How the Program plans to monitor performance to ensure compliance
    - Director of Health Services and/or designee will perform random audits to assure that incidents/accidents are reported to appropriate nurse/nurse on call in a timely manner.
    - Executive Director and/or designee will review each incident/accident and report required incidents/accidents to the Department.
4. The date by which the regulatory insufficiency will be corrected.
    - The regulatory insufficiency will be corrected on or before November 3rd, 2023.

Staffing

1. Elements detailing how the Program will correct each regulatory insufficiency.
    - All tenants who are unable to understand the use of emergency pendant/call light will have safety checks completed as identified on their service plan.
2. Measures taken to ensure problem does not occur.
    - Nursing staff were educated on safety check procedure and documentation of the safety checks.
3. How the Program plans to monitor performance to ensure compliance
    - The Director of Health Services and/or designee will perform random audits to assure that safety checks are being completed as identified on the tenant's service plan.
    - The Director of Health Services and/or designee will perform random audits to assure that safety checks are being documented appropriately.
4. The date by which the regulatory insufficiency will be corrected.
    - The regulatory insufficiency will be corrected on or before November 3rd, 2023.

Sincerely,

Tyffany Jackson, Director of Assisted Living
Luther Park Community
Phone: 515-261-6387
Email: tjackson@lutherparkcommunity.org