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
	S0241	A. BUILDING: _____ B. WING _____	C 09/03/2025

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 population served. The census numbers were provided by the Program at the time of the on-site. Number of tenants without cognitive impairment: 25 Number of tenants with cognitive impairment: 30 Total census: 55 The following regulatory insufficiencies were cited during the investigation of Incident #130272-I and Complaint #130274-C.	A 000	Plan of Correction for the Gardens at Luther Park regarding complaint survey exiting 9/3/2025 This serves as the credible allegations of compliance for the Gardens Assisted Living of Luther Park. We assert that all correctives on this plan of correction have been implemented. Regarding the specific deficiencies, we have outlined our corrective actions and continued interventions to ensure compliance with regulations and our plan of action. The staff at the Gardens Assisted Living are committed to delivering high quality health care to its tenants to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that the Gardens Assisted Living facility is in substantial compliance as set forth below. We are confident that we will be found in substantial compliance upon re-survey.	
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 established policy and procedure regarding Door Alarm Response for 1 of 1 tenant (Tenant #1) who eloped from the program. Findings follow: Record review on 9/2/25 revealed Tenant #1 admitted to the program 8/20/21 and currently resided on the locked/secured 3rd floor memory care unit. Tenant #1's diagnoses included dementia of unspecified severity with mood disturbance, major depressive disorder, thrombocytopenia, atherosclerotic heart disease, hyperlipidemia, and hypertension. A service plan with a review date of 8/20/24 identified Tenant #1	A 150		

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A 150	Continued From page 1 had exit-seeking behaviors at times and staff were to redirect these behaviors with activities of snacks, drinks, wellness activities, going for walks (date initiated 4/9/24). Tenant #1 wore a Wanderguard band, of which staff were to check placement and functioning each shift (date initiated 4/8/24). Tenant #1 required staff to perform Safety Checks four times per shift (date initiated 8/20/24). Under the Cognition section of the service plan, it noted Tenant #1 displayed deficits in judgement and had severe disorientation and difficulty recalling information or inability to recall information at all. A census list with Global Deterioration Scores (GDS) provided by the program identified Tenant #1 had a GDS score of 6, indicating Severe Cognitive Decline. An elopement incident report dated 8/27/25 and reviewed on 9/3/25 revealed 3rd floor staff informed the Assisted Living (AL) Director at 5:24pm they were unable to locate Tenant #1. The program began to search the building and grounds, called further staff from other buildings on campus for assistance, and emergency services (911) were called (time not noted in the incident report). During an initial interview on 9/2/25 at 9:25am with the CEO/Director of Operations, he stated multiple members of the staff/leadership team reported to the campus to assist with the search and police dogs had picked up Tenant #1's scent near the railroad tracks in the vicinity of Delaware Avenue and Morton Avenue (approximately 1.6 miles from the program). The CEO/Director of Operations stated he located Tenant #1 on a slight slope down from the railroad tracks in a grassy area. The program's internal investigation	A 150	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The Gardens Assisted Living of Luther Park has completed the following interventions as a result of the complaint self-reported survey ending 9/03/25. The facility was in substantial compliance on 9/4/25.	

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A 150	Continued From page 2 revealed Tenant #1 was located at 11:34pm. Review of some of the program's camera footage with the Executive Director on 9/2/25 at 3:20pm revealed the 3rd floor elevator doors randomly opened and closed, and then opened again as Tenant #1 approached the area and entered the elevator. Tenant #1 was then seen on camera exiting the elevator on the 2nd floor and entering an unlocked apartment by the elevator (Apt 230) belonging to another tenant. Footage then revealed Tenant #1 exited the apartment after a few minutes and wore a coat he found inside the apartment. They then pushed the stairway exit door and exited. Tenant #1 was next observed on camera approaching the North exit doors on 1st floor and forcefully pushed on the door until he was able to exit the doors. Another tenant was observed sitting in the general vicinity and observed Tenant #1 push through the door and exit. The tenant was seen observing Tenant #1 as he walked off through the parking lot. Further camera footage revealed Tenant #1 later returned back to the North doors and attempted to re-enter the building. Unsuccessful, Tenant #1 then turned and walked through the grass next to the building to get to the sidewalk. Review on 9/2/25 of written statements from staff obtained by the program as part of their internal investigation revealed: Staff A's written statement, dated 8/28/25, noted Tenant #1 had been in the dining room for supper after Staff A had assisted Tenant #1 to the bathroom and changed his clothes. She noted Tenant #1 had been agitated during the assistance with cares and had provided a prn (as needed) medication. She noted she assisted other tenants and "(Tenant #1) must have left the	A 150	A 150 481-67.2(3) PROGRAMS POLICIES AND PROCEDURES The Gardens Assisted Living of Luther Park shall follow the policies and procedures as established by the program. The following items were implemented immediately PRIOR to survey: 1. All staff were educated on the revised policies and procedures which now include ZONES for searching in case of a missing resident. Staff have been re-educated to respond to all door alarms per policy and procedure. 2. The door locking device which had broken was a 600 lb. magnet which was replaced with a 1200 lb. magnet. 3. Air Tags were ordered and added to the wristbands of those wearing Wander Guards. In the event a tenant may elope, this allows for quicker identification of the tenant.	

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A 150	Continued From page 3 dining room and I didn't see him leave. By the time I noticed, I went to his room to check. The alarm was going off and it was north entrance alarm and then say 319 (Tenant #1) after." The written statement did not include any times. Staff B's written statement dated 9/2/25 noted he was notified by program staff at approximately 5:24pm Tenant #1 was not in his room and could not be located. Staff B noted the 1st floor entrance (alarm) went off, indicating a possible unauthorized exit and he instructed staff to conduct a thorough search of all resident rooms in the facility. He noted program staff checked all the floors of the program, while he began searching the premises, including outside. Staff B's statement noted he contacted additional staff at another of the buildings on campus at 5:36pm for additional assistance. Staff B's written statement then noted he contacted the local police to report the missing tenant at 5:53pm (nearly one hour after Tenant #1's suspected exit). Staff B's written statement then noted "Upon their (police) arrival, we convened in my office to review the security camera footage." Staff C's written statement dated 8/29/25 noted "It was around five something can't remember the actual time when my co-worker (Staff A) notified me that the alarm was going off downstairs and the marquee was saying (Tenant #1). Staff C further noted that Staff C called him after a few minutes and said she had searched but couldn't locate Tenant #1. The written statement noted Staff A returned to the 3rd floor to further search room by room, while Staff C went downstairs to check and notified Staff B. During an interview with Staff C on 9/2/25 at	A 150	4. Elopement drills will be conducted randomly on all shifts to ensure ongoing compliance with policy and procedure of a missing tenant. 5. Wander Guard protection has been added to the stairwell and fixed on the elevator. 6. Quarterly inspections will be completed on Wander guards/doors.	

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A 150	Continued From page 4 2:32pm, Staff C stated he and Staff A worked on the evening of the incident. He observed Tenant #1 in the dining room. He stated Tenant #1 wandered regularly and last noted Tenant #1 was "all the way down, at the end of the hall" by the North elevator area. He stated the area had an elevator and stairway door and both were supposed to alert if Tenant #1 got near one of the doors, but it didn't go off. He stated he noticed Tenant #1 missing after a few minutes after the marquee alerted showing Tenant #1's name and possibly an exit door on 1st floor. He was then notified by Staff A she believed Tenant #1 had exited and they began to search. Staff D's written statement dated 8/28/25 noted he was unaware of the elopement until after the resident was gone and stated his pager was not working properly. He was not getting notified of any call lights or alarms. Staff D further stated the 3rd floor alarm did not go off at all once the resident got on the elevator as told by supervisor (nurse). Staff D stated "I think the system should have been updated." A review on 9/3/25 of the Wanderguard dashboard alarm report revealed Tenant #1's bracelet alarm triggered the alert system at the 3rd Floor North Elevator at 4:46pm and then the 1st floor North Entrance at 4:55pm. Further review of the (revised) timeline provided by the program on 9/3/25 and reportedly based on the program's internal camera footage review as well as staff statements obtained during the course of the program's internal investigation revealed the following (but not limited to and listed in military times by the program): 1650-(Tenant #1) Got into North Elevator on 3rd	A 150	Concerns identified will be reported and addressed in the facilities ongoing Quality Assurance Program.	

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A 150	Continued From page 5 floor. (Doors open and shut-no one gets off) 1650:48-(Tenant #1) Got off elevator on 2nd floor-went into apartment 230 1656-(Tenant #1) Came out of apartment 230 with a blue jacket went down stairs 1658-(Tenant #1) Went out North door (pushes door open) walked towards Trinity Center parking lot. 1703-(Tenant #1) Walked back to North door, attempting to get back inside. Was unable to open the door as it locked. 1703-(Tenant #1) Went back out North door and walked down a grassy slope to sidewalk 1704-(Tenant #1) Walked past Gardens East patio and crossed street. 1705-Alarms sounded and (Staff A) checked door. It was locked. She contacted staff and completed an immediate search of in-house including the parking lot. 1717-(Staff B) Went outside on north door in search of (Tenant #1) possibly being outside 1733-Cameras were reviewed and it was determined (Tenant #1) left facility 1736-Several staff members deployed to search for (Tenant #1) once in-house check completed. 1753-Police contacted and took a picture of missing tenant and description. Police posted a "silver alert" on TV and alerted businesses, neighbors to be aware. Police brought in dogs to track via scent. Dogs had scent until end of Hull (Ave) by railroad tracks. 2334-(Tenant #1) was found safe in a grassy area near Morton by the Director of Operations. A review of nursing progress notes on 9/2/25 noted the following: 8/28/25 at 02:30 noted the incident, and included the tenant wore black pants, a gray polo shirt, a blue jacket, and black slippers at the time of the	A 150		

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A 150	Continued From page 6	A 150		

elopement incident. It further noted "At 11:47pm police and ambulance arrived at the scene (of the area Tenant #1 was located). The police escorted him safely back to the facility. Family members chose for no ER (emergency room) evaluation and requested he stay at the facility. A head-to-toe assessment was completed by ADON (Assistant Director of Nursing) upon return. Physician was notified of tenant leaving and his safe return to the facility."

8/28/25 at 01:00 note included "A full head-to-toe assessment was completed. Assessment and vitals completed in PCC (Point Click Care). Skin issues as follows: right medial upper leg noted with small 0.5cm x 0.5cm abrasion with dried blood. Left lateral forearm 1cm x 1cm reddened area with skin intact. Left hand lateral 0.5cm x 0.5cm abrasion. Right lateral lower arm bruising 2cm x 1.5cm. Two pustules noted to left upper chest. Bruising to bilateral buttock at gluteal cleft 3cm x 4cm. Pustule noted to right posterior thigh 1cm x 1cm. Abrasion to right medial malleolus 0.5cm x 0.5cm. Abrasion to right upper shin lateral 0.5cm x 0.5cm. Skin tear to right superior patella 0.3cm x 1.5cm. All skin areas present with no signs or symptoms of infection. Tenant denies pain. Tenant resting in bed with CMA (certified medication aide) present when this nurse exited the apartment. On-call provider was notified of assessment findings."

8/28/25 noted at 00:00 noted "Follow-up Elopement" signed by Tenant #1's Nurse Practitioner, noted "Today, patient is fatigued but says he is feeling well. Nursing noted today patient complaining of back pain. Note patient does have bruising to coccyx area. Patient able to ambulate without assistance as usual. Patient

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A 150	Continued From page 7	A 150		

is calm and content" and "Patient has new bruise to buttocks, nursing states was not there at time of body check last night. Area is tender to touch, patient unable to tell me if he fell. Nursing is monitoring skin condition."

On 9/2/25, the State Climatologist provided as weather conditions report for the date of the elopement incident with suspected time of likely exit from the program at 4:55pm through the time Tenant #1 was located (11:34pm per the program's timeline) and EMS/police arrived on scene at located area and returned Tenant #1 to the program (11:47pm per the program's timeline). The temperature at 4:54pm was 81 degrees Fahrenheit with winds out of the South/Southwest at 15mph and mostly cloudy conditions. Conditions at 10:54pm were noted at 68 degrees Fahrenheit with winds out of the South at 7mph with Fair conditions. Conditions at 11:54pm were noted at 65 degrees Fahrenheit with winds out of the South/Southwest at 5 mph with Fair Conditions.

A review on 9/2/25 of the program's Door Alarm Response policy dated 4/25 revealed the following (but not limited to) procedural step/s:
*Staff must immediately respond to all door alarms.
*Attempt to determine what the alarm is indicating (i.e. did the tenant exit building, did a visitor enter or exit without disengaging the alarm, etc.)
*Open the door and look to see if the tenant is in sight. Look outside and quickly scan the area. Talk to anyone you see to determine if they set off the alarm or then saw someone come through the door.
*If the alarm was activated by a wander guard

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A 150	Continued From page 8 bracelet, then immediately locate your tenants who have these bracelets. As the program's Wanderguard alert system/marquee alerted Tenant #1 triggered the north entrance door at 4:55pm, staff should have immediately responded to this door. Rather, the timeline provided by the program and reportedly based on the program's camera footage revealed Tenant #1 pushed through the 1st floor North exit door at 4:58pm and further showed staff failed to respond timely and responded to the door at 5:05pm (approximately 10 minutes after the door alerted, and 7 minutes after Tenant #1 exited the doors). On 9/3/25 at 3:17pm, the Executive Director (and Chief Executive Officer/Director of Operations via phone) confirmed the above findings.	A 150		