Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation

Date: March 20, 2019
Program Name: Whispering Creek
Address: 2607 Nicklaus Blvd. Sioux City, IA 51106
Type of Action: Incident 81275-I
Date(s) of Action: March 4, 2019 to March 6, 2019

State Rule #	State Rule	Amount of Civil Penalty
67.2	**481-67.2(231B,231C,231D)** Program policies and procedures, including those for incident reports. 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. Based on interview and record review the Program failed to follow the policy and procedures for door alarms for 1 of 1 tenants identified in self-reported incident 81675-I (Tenant #1). Findings follow: On 2-15-19 the facility self-reported Resident #1 (age 84) exited the dining room door in the memory care unit on 2-14-19. Although the door alarm sounded staff did not respond as she believed it was an alarm in the general population area of the Program. A second staff who returned from break a few minutes later heard the alarm and found Tenant #1 outside on the sidewalk. The tenant was outside for approximately 5 to 10 minutes. Review of an Incident Report dated 2-14-19 revealed Tenant #1 exited the building through a dining room door in the memory care unit and was found by staff at 6:10 pm. A physical assessment revealed vitals were within normal limits and no injuries were noted. Review of Tenant #1's file indicated he resided in the memory care unit. Record review of Global Deterioration Scale dated 9-20-18 revealed a score of 5 and indicated an inability to survive without assistance. The tenant's care plan dated 9-20-18 revealed he exhibited exit seeking behaviors and required redirection. Charting Notes and Behavior Reports indicated 2 episodes of exit seeking on 2-14-19. On 3-5-18 at 6:00 p.m. Staff A stated she had worked in the memory care unit previously but 2-14-19 was the first time she was assigned as medication manager. She stated she became flustered looking for supplies for a nebulizer treatment. She was in a tenant's room approximately 75 feet down the hall from the dining room when she heard a faint alarm. She assumed it was the front door for the general population area and failed to respond to it as trained. Staff B radioed a couple of minutes later on the walkie that Tenant #1 had exited the	**$2000.00**

dining room door and eloped. She admitted she should have responded to the alarm or at least called for assistance on her walkie to alert other staff to check the alarm.

On 3-5-19 at 1:45 p.m. Staff B stated he returned from break and heard an alarm in the memory care unit. He immediately checked the dining room door and observed Tenant #1 outside approximately 50 feet away. He approached Tenant #1 and asked him to come back inside then radioed for assistance. Staff B stated it was very cold and icy and Tenant #1 wore a shirt, pants, socks, shoes, but no coat.

According to the state climatologist the weather on 2-14-18 at 6:00 p.m. in Sioux City was 10 degrees F with a wind chill of -9 degrees F, relative humidity 66%, wind speed 21 miles per hour (mph) out of the north-north west (NNW) with peak gusts of 30 mph.

Review of the Program's Alarmed Door Policy and Procedure for Locked Memory Unit revealed staff were required to immediately respond to any alarm to perform a physical check of the area to ensure no tenant had exited the unit.

Review of Acknowledgement of Review Form dated 4-11-18 revealed Staff A received training on Alarm Door Policy and Procedures.

On 3-5-19 at 2:10 p.m. the Assistant Director of Nursing (DON) stated the policy and procedure for door alarms required staff to respond immediately to ensure all tenants were accounted for. She stated if a staff could not leave a tenant they were to radio for assistance and not ignore any alarm. She assessed Tenant #1 after he eloped and vitals were within normal limits and his skin and extremities appeared normal. She stated he wore a t-shirt, flannel shirt, pants, socks and shoes.