

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: 9089		Date: April 19, 2021		
Facility Name: Calhoun House		Survey Dates: November 4, 2020 – January 25, 2021		
Facility Address/City/State/Zip 3911 Calhoun Avenue Ames, Iowa 50010				
		LK	94305A & 94330M	
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

50.7(4)	<p>481—50.7(10A,135C) Additional notification. The director or the director’s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III):</p> <p>50.7(4) When a resident elopes from a facility. For the purposes of this subrule, “elopes” means when a resident who has impaired decision-making ability leaves the facility without the knowledge or authorization of staff.</p>	II	\$500.00	Upon receipt
57.7(5)b	<p>57.7(5) The licensee shall:</p> <p>b. Be responsible for compliance with all applicable laws and with the rules of the department.</p> <p>DESCRIPTION:</p> <p>Based on interview and record review the facility failed to notify the Department of an elopement regarding 1 of 3 residents reviewed (Resident #3). Findings include:</p> <p>Record review on 11/3/20 revealed a Critical Incident Report for Resident #3 dated 9/21/20. It noted staff went to pass Resident #3 his 7:00 PM medication but he was not in his bedroom. Staff left to go to the gas station where Resident #3 was known to frequent to see if they could locate</p>			

Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: 9089		Date: April 6, 2021		
Facility Name: Calhoun House		Survey Dates: November 4, 2020 – January 25, 2021		
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	<p>him. On the way back from the gas station, staff noticed a police officer near the facility. The police officer stopped staff and gave a description of a person who matched Resident #3's description. When staff confirmed he was a resident of the facility, the officer stated they had received a call from a citizen who said there was a man in their yard holding his hand to his chest and they wanted to make sure he was okay. By that time, Resident #3 had returned to the facility. He was assessed by the officer who noted the resident's hand was bleeding. Staff and Resident #3 then returned to the facility where first aid was performed. The bleeding appeared to be caused by dry skin.</p> <p>Resident #3's Functional Assessment Part 3: Rights Restrictions dated 6/11/20 noted there was a restriction on his right to freedom of movement. The reason for this restriction was due to having been in a hospital for quite some time so the team felt it would be in his best interest to restrict his unsupervised time to two hours each day while in the community on planned outings or activities. Resident #3 was able to move around his home and bedroom freely. The document noted in the past, Resident #3 had wandered away from his home and other placements which led to the police bringing him home or Resident #3 needing to call providers to pick him up. Resident #3 also</p>			
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	<p>was in a new home and city. He was not familiar with the surrounding area which could cause a risk and safety concern if Resident #3 was not accompanied by staff or at a planned location for an outing or activity.</p> <p>The Administrator reported on 12/3/20 at 2:10 PM staff were not aware Resident #3 had left the facility on 9/21/20 and the incident was not reported to the Department.</p> <p>FACILITY RESPONSE:</p>			
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