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

Date: 2/2/17
Program Name: Lakeview Lodge
Address: 312 Southbrooke Dr.
Type of Action: Investigation #65071-I
Date(s) of Action: 1/11/17 – 1/12/17

State Rule #	State Rule	Amount of Civil Penalty
481-67.3(2)	**481-67.3 Tenant rights. All tenants have the following rights:** **67.3(2) To receive care, treatment and services which are adequate and appropriate.** Based on interviews and record review, staff failed to provide adequate and appropriate care for 1 of 1 tenant reviewed who eloped from the Program (Tenant #1). Findings include: Tenant #1 was admitted to the Program on 1/5/17 with a diagnosis of short-term memory impairment, anxiety with depression, hypertension, chronic headaches, hyperlipidemia, esophageal reflux, vitamin B-12 anemia, and Schatzki's ring S/P dilation. Tenant #1 scored a 28 on the Mini-Mental State Exam on 1/5/17. An incident report dated 1/8/17 at 11:00 a.m., revealed Tenant #1 eloped from the building. At approximately 11:15 AM, a hospital representative called the facility and reported Tenant #1 was at the hospital and a police officer would be bringing him/her back to the Program. Tenant #1 was returned and assessed for injury. No injuries were noted and a Wander Guard was put in place. A review of the nursing communication book revealed the following notes regarding Tenant #1: a. 1/5/17: Tenant #1 was admitted to the facility today. His/her niece is staying the night. He/she is forgetful and has anxiety issues - may be a problem when niece leaves. Try the cheerful/happy approach - invite to activities and introduce to others. b. 1/6/17: Tenant #1 may need some extra tender loving care and extra cheerful approaches when niece leaves - he/she has a history of anxiety. On 1/12/17 at 9:30 AM, review of the security video footage for 1/8/17 revealed Tenant #1 left the building out the front door as a visitor was holding open the door to carry out boxes at 10:20 AM. The video showed Tenant #1 quickly walked out with no coat on. Shortly after the tenant exited, Staff B went out the door and after Tenant #1. Staff D went to the entryway and observed. The video footage then showed on 1/8/17 at 10:55 AM, Tenant #1 went out the front door a second time and down the street. No one else was observed in the video. Tenant #1 appeared to wear a coat, scarf, shoes, and pants.	**$2000.00**

	Additional layers of clothing were visible beneath his/her coat.. It could not be determined how the Tenant was able to leave the front door without the alarm sounding or if the alarm had sounded and was turned off by someone. According to wunderground.com, on 1/8/17 at 10:54 a.m., the temperature was 10 degrees Fahrenheit (F) with a wind chill of -3.7 degrees F. Record review revealed the Registered Nurse (RN) documented in interdisciplinary notes, dated 1/8/17 at 3:15 p.m., at 11:30 a call was received from the front office informing them Tenant #1 was found by a good Samaritan. The good Samaritan took Tenant #1 to the local emergency room. Tenant #1 reported to the good Samaritan he/she was running away. The RN contacted the emergency room to confirm the tenant was there and was informed he/she was and would be returned to the Program by police. A head to toe assessment was completed upon the tenant's arrival. When interviewed on 1/11/17 at 3:45 p.m., Tenant #1 reported he/she was upset about moving. He/she reported he/she ran away because he/she "just had it." On 1/11/17 at 1:10 PM, Staff D stated she was one of two staff working on the floor where Tenant #1 resided on the day of the elopement. Staff D stated that on the day prior to the elopement (1/7/17) Tenant #1 had been anxious and stated he/she didn't like it there and was going to leave. The tenant's niece had stayed overnight but left on the morning of 1/8/17. Staff D stated Resident #1 was anxious all morning prior to the elopement. At one point, Tenant #1 told Staff D it was very cold in his/her room. Staff D found an open window in the tenant's apartment and shut it. Staff D took her break in the break room at 10:45 AM that morning, leaving Staff B to cover the floor. At 11:00 AM, Staff D got off break and went to give Tenant #1 his/her meds. Tenant #1 could not be located in the building. At approximately 11:15 AM, the emergency room contacted the facility and reported Tenant #1 was at the hospital and would be brought back to the facility by police. Staff D reported when Tenant #1 returned, he/she wore a coat and shoes. Staff D stated she did not hear any door alarms sound during that time frame. On 1/11/17 at 4:30 PM, Staff B confirmed she was one of two staff working on the floor where Tenant #1 resided on the day of the elopement. Staff B stated she met Tenant #1 that day. She described Tenant #1 as being anxious that morning. Prior to the elopement at 10:55 AM, Tenant #1 had walked out the front door at the same time a visitor was leaving. Staff B stated she followed the tenant out and walked with her back in the building. She found out Tenant #1 was missing at around 11 AM when Staff D asked if she had seen Tenant #1. Staff B had been at the end of the East hall in another tenant's room helping with cares at that time. Staff B did not heard any alarms sound during the time the tenant eloped. A review of nursing delegations revealed staff were trained on the	

	facility's procedures for restless or wandering tenants. Staff B was trained on 10/28/16 and Staff D was trained on 10/5/16. Neither staff member implemented strategies from this training after the first attempted elopement. Staff B went to the end of the East hallway and into a tenant's room. Staff D went on break. This left Tenant #1 alone with no staff supervision just minutes after being brought back in from attempting to leave the building.	
481-69.32(2)	**481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements.** **69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.** Based on observations and staff interview the facility failed to ensure all alarms on doors were operating correctly and were loud enough for staff to hear. Findings include: On 1/11/17 at 1:45 PM during an observation of a door alarm demonstration by the Maintenance Supervisor, the door alarm shut off as soon as the 15 second delayed egress time frame was over and the door opened. At 4:50 PM, the Maintenance Supervisor stated the alarms were to continue to sound after the door opened until shut off by a person by putting in the code on the keypad. On 1/11/17 at 1:52 PM, the surveyor stood in the staff break room with the door ajar and had the Maintenance Supervisor activate the front, main door alarm. The surveyor could not hear the alarm sounding from the break room area. On 1/11/17 at 5 PM, Staff E tested all of the alarmed doors for the surveyor. Out of 9 doors tested, 4 doors had alarms that shut off automatically after the door opened. This demonstration revealed the door alarms were not all working properly. Upon closer examination of the front door alarm, it was discovered if someone used the code on the keypad to bypass the alarm system, there was actually a 37 second window when the door remained unalarmed. This time frame could potentially provide easy access out the door without setting off an alarm if a tenant followed behind someone using the keycode. On 1/11/17 at 1:30 PM, the Maintenance Supervisor stated he had maintenance/security staff check the alarms each night to ensure they worked properly. According to alarm check documentation, the alarms were checked consistently each night. On 1/12/17 at 10:25 AM, Staff F stated he often did the alarm checks during the night shift. Staff F stated he only checked two doors in the entire building each night, the front door and a side glass door. He said he never went to the 2nd floor and checked those exits or any other doors on the 1st floor. On 1/12/17 at 12:00 PM, the Director confirmed the door alarms were not working properly. At the time of the exit, the alarm system company was at the Program making repairs.	

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