Iowa Department of Inspections, Appeals & Licensing
Health & Safety Division
Adult & Special Services Unit
Civil Penalty Citation

Date: February 24, 2025
Program Name: Ashbrook Assisted Living
Address: 1121 Fremont Street Iowa Falls, Iowa 50126
Type of Action: 126059-C
Date(s) of Action: 1/22/25, 1/23/25
Citation #: 10750

State Rule #	State Rule	Amount of Civil Penalty
67.2(3)	**67.2(3) The program shall follow the policies and procedures established by the program.** Based on observation, interview and record review, the program failed to ensure staff followed the door alarm policy regarding 1 of 1 former tenants reviewed (Tenant C1). Findings include: On 1/22/25 at 1:10 p.m. record review revealed an incident report dated 1/13/25. At 5:37 a.m. Tenant C1 was observed by Staff D in the parking lot sitting next to a van in the handicapped parking spot. Tenant C1 had a large gash on the right side of his forehead. He stated he had left the building but was not sure why and had fallen off of the curb. Tenant C1 was assisted up by 2 staff and brought back into the building by wheelchair. It was noted the temperature at the time of this incident was 7 degrees Fahrenheit. The tenant was wearing only a thermal shirt over a tee shirt, sweatpants and slip on shoes. Review of Tenant's C1's file revealed a Global Deterioration Scale score of 2 signifying very mild cognitive decline. He had no history of exit seeking or elopement. Progress notes revealed Tenant C1's vitals at the time of this incident were as follows: blood pressure 143/90, pulse 104, respirations 22. His temperature only registered as "low" on the thermometer. Several bruises to his arms and hands were noted. Blankets were applied and 911 called. Tenant C1 was transported by ambulance to the emergency room (ER). ER records revealed Tenant C1's temperature was noted as low at 35.1 degrees Celsius (95.1 degrees Fahrenheit). ER records revealed a soft tissue laceration with hematoma overlying the right forehead, periorbital region and cheek. There were no acute fractures noted. It was decided by family and the program it would be safer for the tenant to be admitted to the attached long term care facility instead of returning to the assisted living program. On 1/22/25 at 1:57 p.m. interview with Staff C revealed she was working the overnight shift alone on the early morning of 1/13/25. She was in the laundry room on the garden level folding laundry when she heard her pager notification beeping at 5:05 a.m. and saw the pager	**$2000.00**

	showing the South exit door. She heard the maintenance office door shut. The laundry room was just down the hall from the maintenance room and the door to the laundry room was open. Staff C said maintenance always came in around that time and when the door to the maintenance room shut she was sure it had been the Maintenance Director who had set off the alert on the pager when coming in the door. She didn't think anything of it and continued with her laundry. At 5:37 a.m. a second maintenance man, Staff D, found her to report he found Tenant C1 outside in the parking lot and needed her to help. On 1/23/25 at 8:37 a.m. interview with Staff D revealed he arrived to work on 1/13/25 at approximately 5:35 a.m. and parked his car on the lower level. When he exited his parked vehicle, he heard someone yelling for help. The sound came from the Main entry level parking lot above where he had parked. He investigated the origins of the sound and located Tenant C1 sitting on the ground in the parking lot of the main entry level sitting against a van. He told him he was going to get help, found Staff C, and returned with her to help the tenant. On 1/22/25 at 2:25 p.m. interview with Staff C and the Administrator reported on the morning of the incident Staff C did not scroll over on the pager she was using as there was more than one arrow on the pager's screen. Had Staff C scrolled over to the second arrow on the screen she would have realized that the main entry door on the Main level and the South door to the Garden level were opened at the same time. The Administrator reported they tested the doors that same morning of the incident to be sure they alerted the pagers and confirmed both doors were working. Staff C reported she had not seen the arrow when she looked at the pager at 5:05 a.m. when the Maintenance Director came in. Staff C, who had worked at the Program on the overnight shift for several years, said it was very unusual to have two door alerts at the same time in the morning. The Administrator reported the doors were alarmed to alert the pagers when opened between the hours of 10:00 p.m. and 6:00 a.m. On 1/23/25 at 10:45 a.m. review of the Door Security Policy revealed if an assisted living exit door is opened after the programmed time, the nurse call system will signal a door alert with the location. The following will occur: a.) Staff responds to door location. b.) staff determines reason for door alert and clears the alert from the nurse call system. On 1/23/25 at 12:04 p.m. a review of video revealed on 1/13/25 at 5:05 a.m. and 43 seconds, Tenant C-1 could be seen leaving the main entry way door out of the facility with his rolling walker. He was seen falling in the parking lot at 5:06 a.m. and 41 seconds. At 5:38 a.m. and 15 seconds, Staff D arrived at Tenant C1's side and ran for help. At 5:40 a.m. Staff D and Staff C returned to help Tenant C1 back inside the Program. On 1/23/25 at 3:30 p.m. the Director of the AL Program and the Administrator confirmed Staff C failed to scroll her pager to see if any	

	other door had alerted at the same as the South door when the Maintenance Director entered the building at 5:05 a.m. on 1/13/25. If she had she would have realized the Main door on the first floor opened at the same time the South door on the lower level. The Administrator saw it as a fluke as it was very unusual to have the doors both opened at the same time. The alarms were tested immediately and were working and alerting the pagers as intended.	