

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

<b>Date:</b> April 18, 2022
<b>Program Name:</b> Keystone Cedars Memory Care
<b>Address:</b> 6325 Rockwell Drive NE Cedar Rapids, IA 52402
<b>Type of Action:</b> 102204-C, 102321-I, recert
<b>Date(s) of Action:</b> 2/10/22 – 2/21/22
<b>Citation # :</b> 5685

State Rule #	State Rule	Amount of Civil Penalty
67.2(3)	<p><b>481—67.2(231B,231C,231D) Program policies and procedures, including those for incident reports.</b>  <u>67.2(3) The program shall follow the policies and procedures established by the program.</u></p> <p>Based on interview and record review the Program failed to follow its policy and procedures related to the completion of incident reports and responding to door alarms. This pertained to 1 of 5 tenants reviewed (Tenant #1). Findings follow:</p> <p>1. Record review on 2-14-22 to 2-16-22 of Tenant #1's file revealed Tenant #1 had a diagnosis included late onset Alzheimer's disease with behavioral disturbance. Tenant #1 was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Observation notes indicated the following:</p> <ul style="list-style-type: none"> <li>- On 9-13-21 it was noted on 9-10-21 at approximately 7:10 p.m. staff was outside with tenant, taking him for walk and the other staff was in the sunroom fixing the television. The memory care door alarm went off and when staff left to look at the door and discovered Tenant #1 was missing. Staff left the memory care door and heard Tenant #1 talking in the kitchen with dietary staff. After a brief discussion, staff was able to redirect Tenant #1 back to the memory care unit. When staff asked why she had left, she said she was looking for her sister. Vitals were not taken and Tenant #1's family was not notified as Tenant #1 was redirected back to the memory care unit.</li> <li>- On 12-20-21 it was noted a nurse followed with on a staff communication and incident report over the weekend. The incident report indicated Tenant #1 was wandering in the hallway outside of the memory care unit and was near the kitchen. Tenant #1 was found by dietary staff, they called direct care staff to come and get Tenant #1. She was taken back to the memory care unit by direct care staff. Tenant #1 did not have any injuries.</li> <li>- On 1-26-22 it was noted nursing staff was notified on 1-25-22 at approximately 4:30 p.m. that both memory care staff were in a tenant apartment and when they came out to the common area, dietary staff was bringing Tenant #1 back to memory care. Dietary staff reported Tenant #1 was walking in the hall next to the dining room. Staff reported they did not hear the door alarm go off and were not sure how Tenant #1 left the unit. Tenant #1 was easily redirected and was looking for someone.</li> </ul>	\$2500.00

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	<p>Continued record review revealed an incident report was not completed related to the incident on 9-10-21.</p> <p>2. Record review of an Incident Report dated 12-18-21 at 9:00 a.m. indicated Tenant #1 walked out of memory care and dietary staff found her and contacted direct care staff. Tenant #1 was returned to memory care. There were not vital signs documented on the incident report. A nurse was notified at 9:30 a.m. and said to notify nursing there were any changes in her behavior. The incident report was completed by Staff G and dated 12-18-21. Tenant #1's family was notified on 12-20-21. The primary care provider (PCP) was notified on 12-20-21. The nurse follow up section on the report indicated Tenant #1 was doing well and was at her baseline, regarding mental status. When the incident was investigated care staff reported they were helping another tenant.</p> <p>Continued record review revealed door alarm records indicated a door alarm went off at the memory care door at 9:13 a.m. Another door alarm went off at the memory care door at 9:14 a.m. The incident report time was documented as 9:00 a.m.</p> <p>When interviewed on 2-21-22 at 10:21 a.m. Staff G said another staff asked for help Tenant #5's apartment. She said dietary staff notified Staff D (working on the general population side) that Tenant #1 was out of the unit and Staff D brought her back to memory care unit. Staff D said she would stay there until staff were done assisting Tenant #5. Staff saw Tenant #1, 10 to 15 minutes before she was brought back. The door alarm and pagers did not go off. Staff D was not carrying a pager.</p> <p>Further record review revealed there were no witness statements for staff involved and there were investigation notes provided related to the elopement. Vitals were not documented on the incident report and names of other staff involved were not included on the incident report. The incident report lacked detail regarding the door alarms and pagers and staff response.</p> <p>3. Record review of an Incident Report dated 1-25-22 at 4:00 p.m. indicated both memory care staff were in a tenant apartment and when staff were done in that apartment, dietary staff were brining Tenant #1 back into the memory care. Dietary staff said she was walking in the hall next to the dining room. Tenant #1 was easily redirected back to memory care and was looking for someone. There were no vital signs documented. Nurses were notified at 4:00 p.m. and staff were instructed to notify them if there were any further exit seeking behaviors. Tenant #1's family was notified on 1-26-22. The PCP was notified on 1-26-22.</p> <p>When interviewed on 2-15-22 at 3:29 p.m. Staff F said Tenant #4 had fallen. Both staff were in his apartment and Tenant #1 was in the common area. Staff F was still in Tenant #4's apartment and Staff H went back out and dietary staff was walking Tenant #1 back into the unit. Dietary staff said Tenant #1 was in the hallway by the dining room. Both staff were supposed to have a pager, she did not</p>	
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have her pager. Staff did not hear the door alarm or pager. Tenant #1 had no injuries. She said there were a few other times Tenant #1 had gotten out of the door. This was the only time they did not 'not hear door alarm or pager. She said Tenant #4's door was open and they did not hear the door alarm. She estimated it was less than five minutes from when Tenant #1 was last seen and she was back in the unit. She said nursing staff looked back at the door alarms and there was not an exact match of time. She said Tenant #1 needed one to one assistance and an incident like that only happened if there were not staff there.

When interviewed on 2-16-22 at 3:46 p.m. Staff H said she was working second shift in memory care with Staff F. She was in another tenant's apartment and then to Tenant #4's apartment to help Staff F after a fall. It was before supper, approximately 4:15 p.m. to 4:30 p.m. Tenant #4's apartment door was partially closed. Dietary staff brought Tenant #1 back to the memory care unit and said she was walking in the hallway. Tenant #1 had no injuries. She said she last saw Tenant #1 right before she went to help the first tenant and then was called to Tenant #4's apartment to help Staff F. At that time Tenant #1 was in her recliner and the door was shut to the apartment. She estimated it was five minutes at the most from when she was last seen until dietary staff brought her back. She said she did not hear the door alarm or hear a pager when Tenant #1 left the unit. She said the medication aide handled the incident reports and she did not complete a witness statement. She said memory care was understaffed related to Tenant #1. A third person was needed, if both staff were in the apartments, staff could not keep an eye on her. She said it was very difficult to stay with her and handle the other tenants. She said Tenant #1 needed a one to one assistance.

When interviewed on 2-17-22 at 4:13 p.m. Nurse #2 said she remembered Staff F reporting that dietary staff brought Tenant #1 back to memory care. There were no injuries to Tenant #1.

When interviewed on 2-21-22 at 12:38 p.m. the Executive Director said she found the incident report for the 1-25-22 incident when gathering things for the visit. She talked to nursing staff who staff was busy and dietary staff brought her back. She was not sure how long she was gone but did not have any injuries. The door alarms functioned and it would have reflected on the pager.

Continued record review revealed door alarm records indicated a door alarm went off at the memory care door at 4:06 p.m. Another door alarm at the memory care door was indicated at 4:08 p.m.

Further record review revealed there were no witness statements for staff involved and there were investigation notes provided related to the elopement. Vitals were not documented on the incident report and names of other staff involved were not included on the incident report. The incident report lacked detail regarding the door alarms and pagers and staff response.

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

4. Further record review revealed the Welcome to the Keystone Cedars Memory Care training document indicated staff would immediately respond to every alarm. If staff did not identify anyone near the door, to complete a head count of all tenants in memory care. If all tenants were not accounted for then staff was to implement the missing tenant or elopement policy. The Emergency Call System and Pagers document indicated staff would immediately respond to the apartment number or the location as indicated on the pager. Staff would designate another staff if they were unable to immediately respond to the page.

5. Record review of a written statement dated 2-18-22 by Staff E indicated on the morning of 2-12-22, Staff E witnessed Staff G "verbally abuse" Tenant #1. She also witnessed her hold the bathroom door closed so Tenant #1 could not get out. Later in the day Staff G put an ice cube down Tenant #1's back "thinking it was funny." The next morning Staff G came into the memory care unit and was angry because "I told on her" and she was removed the memory care unit. Staff G was banging and slamming things and being disrespectful.

When interviewed on 2-15-22 at 9:16 a.m. and 2-21-22 at 9:34 a.m. Staff E said Staff G was pulled out of memory care on Sunday. Staff G yelled at Tenant #1 and told her to sit down and get away. It happened on first shift on Saturday. It made Tenant #1 more angry and irritable. She it happened approximately four to six times during the shift. She also said she was in Tenant #1's apartment, sometime before 7:00 a.m. and she asked Staff G to come in. Staff G said "God dammit ...we aren't doing this today." She said Staff G tried to be funny and it was not funny. Staff E asked Tenant #1 to go to the bathroom and it took awhile for her to sit down and she kept getting up. Staff E left the bathroom and went to get Tenant #1's clothes. Tenant #1 stood up to get off the toilet and Staff G closed the bathroom door and held it shut. Staff G held the door shut with both hands on the handle. Tenant #1 was yelling. Staff G did not hold the door shut too long and Staff E said she was pretty sure she told her to stop it. Staff E said later that day at approximately 1:00 p.m. in the kitchen area of the memory care unit Staff G asked for a piece of ice and put an ice cube down Tenant #1's back when she was standing by the sink. Tenant #1 started hitting and yelling for Staff G to take it out. Staff E messaged Staff I, venting to her and Staff I told her she needed to tell one of the nurses. She called Nurse #2 after work and was told she needed to call the Executive Director. She told the Executive Director about the verbal concern and the bathroom door but forgot about the ice cube. Staff E confirmed in interview her statement dated 2-18-22 was accurate. Staff E said she did not have any conflict with Staff G.

When interviewed on 2-21-22 at 10:21 a.m. Staff G said she worked first shift with Staff E on that weekend in memory care. She said at approximately 7:30 a.m. or 8:00 a.m. she went into Tenant #1's apartment. She said Tenant #1 was in a Tenant #1 mood. Staff E was getting her clothes and Tenant #1 was on the toilet. Staff G

**Iowa Department of Inspections and Appeals  
Health Facilities Division  
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said she usually shut everyone's door when they were toileting for privacy. If a tenant needed assistance then she stayed with with them. Staff G shut the door, it was not shut for long. Staff G stood at the hinge of the door and had her hand on the handle but was not holding it. Tenant #1 was able to open the door. Staff G heard her stand up. There was no assistance provided after toileting as Tenant #1 did not go. Staff G denied any inappropriate verbal comments towards Tenant #1. She said after breakfast, approximately 10:00 a.m. to 10:30 a.m. she noticed a couple of black lines on the back of Tenant #1's neck. She got a towel wet with water from the faucet that was extremely hot and she did not want to hurt her. She took an ice cube and made a line with the ice cube on her skin and then wiped it with the towel. She said Tenant #1 was mad something cold was put on her. She turned around and hit Staff G. There was not an incident report completed related to the incident. Staff G said there was not conflict between Staff E and Staff G. She said Staff E wanted to change weekends. She said Tenant #1 liked to poke at staff.

Continued record review revealed there was not an incident report completed related to Staff E's allegations from 2-12-22 or a written statement completed by Staff G in response to the allegations. Staff E's written statement was dated 2-18-22 and the incidents allegedly occurred on 2-12-22. Staff G said Tenant #1 hit her after she made a line with an ice cube on her skin. An incident report was not completed related to that incident.

6. When interviewed on 2-21-22 at 12:38 p.m. the Executive Director all incident reports and witness statements were provided for the tenant listed above.

7. In summary, record review revealed there were no witness statements for staff involved and there were investigation notes provided related to the elopement. Vitals were not documented on the incident report and names of other staff involved were not included on the incident report. The incident report lacked detail regarding the door alarms and pagers and staff response. In both incidents staff said they did not hear door alarms or pagers. Not all staff were carrying pagers at the time of the elopements. Door alarm records showed the memory care doors alarmed within 15 minutes of the time of the elopements as indicated on incident reports. None of the staff witnessed Tenant #1 leaving the unit and video evidence could not be provided related to the dates indicated above. The memory door alarms either failed to alarm per policy and procedure or staff failed to respond to the door alarms per policy and procedure. Staff failed to complete incident reports as required.