

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

<b>Date:</b> October 6, 2023
<b>Program Name:</b> MeadowView Memory Care Village
<b>Address:</b> 3005 F Avenue NW Cedar Rapids, IA 52405
<b>Type of Action:</b> 110880-I
<b>Date(s) of Action:</b> 8/22/2023 – 8/28/2023
<b>Citation #</b> 10056

State Rule #	State Rule	Amount of Civil Penalty
67.2(3)	<p><b><u>67.2(3) The program shall follow the policies and procedures established by the program.</u></b></p> <p>Based on observation, interview and record review the Program failed to follow established policies and procedures related to door alarms and nurse notification. This pertained to 1 of 1 current tenants reviewed who eloped (Tenant #1) and 1 of 1 discharged tenants reviewed with an attempted self-harm incident (Tenant C1). Findings follow:</p> <p>1. Review of Tenant #1's file between 8/23/23 and 8/28/23 revealed an Incident Report Form dated 5/23/23 at 6:48 p.m. indicating Tenant #1 left the building via the ice cream parlor door to the courtyard. Staff A completed the report and indicated she went to the doors but did not see anyone, then went outside the kitchen door and into the parking lot and did not see anyone. The Executive Director called and told her Tenant #1 was in the courtyard. Staff A went to get Tenant #1 who was outside by the laundry door. She was wearing a red plaid shirt, black pants and brown shoes and was carrying a gray shoe. It was noted that she did not have any visible injuries and there were no concerns with her vital signs. The incident was reported to the nurse on 5/23/23 at 6:48 p.m. and Tenant #1's legal representative on 5/23/23 at 7:00 p.m. Tenant #1's primary care provider was notified on 5/24/23.</p> <p>The Executive Director's written statement indicated she received a notification on her cell phone from a doorbell camera that there was motion detected in the courtyard. She called Staff A at 6:48 p.m. and informed her Tenant #1 was outside in the courtyard. Review of the camera footage indicated at 6:39 p.m. Tenant #1 walked outside into the courtyard area and the alarm sounded. Tenant #1 was brought back into the Program at 6:53 p.m. The temperature was 78 degrees and Tenant #1 was wearing a long sleeved shirt, black pants and brown slip on shoes. It was noted the courtyard was shaded and Tenant #1 did not sustain any injuries. Staff had been re-educated on the door alarm policy and missing tenant policies, the doors were labeled numerically and matched the numbers sent on the pager alerts, staff were re-educated on what door corresponded to each number, a lock had been added to the door in the courtyard and all staff had access to unlock if needed. Tenant #1 was placed on hourly checks. An alarm company had been working on the door alarms</p>	\$1000.00

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systems and a new mag lock was ordered for the door that Tenant #1 eloped from.

When interviewed on 8/24/23 at 1:22 p.m. Staff A said while passing medications she heard an alarm go off and went to the back and looked out the windows. She walked through the parking lot but did not walk through the courtyard. She said the key pads in that area were not lit up. She walked to the kitchen door, opened it and walked outside. She did not see anyone. She went back to passing medications and received a telephone call from the Executive Director regarding a tenant in the courtyard. She went to the courtyard and observed Tenant #1 by the laundry room door. She was locked out and had to call for staff to let them back in. She did not have her walkie-talkie but had her phone. Staff A called the Director of Nursing (DON) to let her know. She directed her to take her vital signs and fill out an incident report. Tenant #1 did not have any injuries. Staff A said she was not carrying a pager at that time as there were not enough to go around. She received re-education on going out the door (to search) and using the walkie-talkie to call for assistance. She said one of her co-workers was on break and was not in the building. The other co-worker said she called on the walkie-talkie but Staff A never heard her call.

Staff A's interview statement for the Program dated 5/24/23 indicated she heard the door alarm at approximately 6:30 p.m. and went to the hallway near the kitchen and parlor area. Staff A looked out both parlor doors but did not see anyone. She went to the kitchen door and out to the parking lot area but did not see anyone. She returned inside and was notified by the Executive Director that Tenant #1 was outside in the courtyard. She responded and brought Tenant #1 back into the building. Tenant #1 did not sustain any injuries.

When interviewed on 8/24/23 at 10:19 a.m. Staff B said she was in another tenant's apartment and received a page that indicated a door was open. She asked which door via the walkie-talkie but did not receive an answer. She stayed with the tenant she was assisting and then came out of the apartment. She was informed by Staff A that Tenant #1 had gotten outside. She said the other co-worker was on break when it occurred.

Staff B's interview statement taken on 5/24/23 indicated she was helping another tenant, she did not hear the door alarm but saw the alert on the pager that indicated "door 2" was open. Staff B said she announced on the walkie-talkie that door 2 was open. When she was finished with her cares, she went towards the medication room and saw Staff A, who confirmed Tenant #1 had gotten outside.

When interviewed on 8/28/23 at 9:56 a.m. the Executive Director she was at home and received a notification on her phone from the doorbell camera. She was able to see Tenant #1 outside in the courtyard. She called staff and they brought her back inside. Tenant #1 was outside for approximately 10 to 15 minutes. The DON was notified and she called Tenant #1's family. The Executive Director reviewed alarm records and the alarm and pagers went off but staff

**Iowa Department of Inspections and Appeals  
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did not respond appropriately. Staff A said she heard the alarm, went and looked out the door and called it good. Staff was supposed to look everywhere and if someone was not seen to start a head count. Staff B said she was helping another tenant and Staff C1 was on break and was not in the building. Staff received re-education, the mag lock was replaced on the door (for the electronic wandering monitoring system), the doors were labeled numerically and the locking system was replaced in about two weeks. She confirmed Staff A did not follow the policy and go outside and check the area. Staff B should have kept trying to walkie other staff or respond if able.

On 8/24/23 at approximately 12:00 p.m. the area of Tenant #1's elopement was observed. The courtyard appeared to be fully enclosed by either the exterior of the building or fencing or similar type materials. There was a gate, which was locked, and two doors that went into the building, including the ice cream parlor door that Tenant #1 exited. The courtyard had a concrete sidewalk and had several places to sit throughout the area. The courtyard followed around the east side of the building and the entire courtyard was not visible when looking out of the ice cream parlor door.

On 8/24/23 at approximately 11:10 a.m. the video footage from the doorbell camera was observed. On 6:38 p.m. Tenant #1 left the building. At 6:41 p.m. and 6:45 p.m. Tenant #1 came back to the door. At 6:53 p.m. Staff A arrived to let Tenant #1 back into the building. It was noted on the video Tenant #1 was wearing a long sleeved plaid shirt, pants and footwear. The Executive Director confirmed in the review of the video that it was a motion detected camera.

Review of Tenant #1's file revealed she was staged at a six on the Global Deterioration Scale, which indicated severe cognitive decline. Tenant #1's service plan dated 5/22/23 (in place at the time of the elopement) indicated she was at an increased risk for elopement. It also indicated staff were to complete checks with a.m. and p.m. cares, at meals, three times overnight and as needed.

Further record review revealed a Disciplinary Report Form dated 5/24/23 indicated Staff A failed to respond to a door alarm that resulted in an elopement. The policy was reviewed and staff were expected to follow the door alarm and missing tenant policies.

The Program's policy and procedure related to door alarms indicated staff was to check the system for the location of the alarm and immediately respond to that door. Staff was to go to the door, go outside and check the grounds to determine the source of the alarm. It was due to a tenant, staff was to assist the tenant inside and notify the nurse. If the source of the alarm was not found, staff was to account for all tenants. If a tenant was not located, staff was to start the missing tenant policy.

Staff did not follow the door alarm policy and procedure related to Tenant #1 elopement on 5/23/23.

**Iowa Department of Inspections and Appeals  
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2. Review of Tenant C1's file on 8/23/23 and 8/24/23 revealed an Incident Report Form dated 1/12/23 at 8:10 a.m. indicating staff found Tenant C1 in the shower with the shower head wrapped around his neck. Tenant C1 was sent out for evaluation.

The Executive Director's written statement indicated on 1/12/23 at about 8:30 a.m. she was notified by the DON that staff had found the tenant in the corner of his shower with the shower cord wrapped around his neck. Tenant C1 had been observed about 20 minutes prior sleeping in bed. Tenant C1 was taken to the hospital, no injuries were found and he returned the same day. Staff from the prior shift reported he had no history of suicidal thoughts prior to the incident.

A Staff Communication Report dated 1/12/23 at 6:00 a.m. was completed by Staff D who worked the third shift. She indicated Tenant C1 was more disoriented and his oxygen saturation was below 90%. The document indicated it was reported to two first shift direct care staff but not to the nurse.

Continued record review revealed the January 2023 medication administration records (MAR) reflected an order for oxygen per nasal cannula at 5 liters and to check oxygen saturation every shift and report to the nurse if below 90%. On 1/11/23 (night shift) it was 83% and on 1/12/23 (night shift) it was 82%. Both were signed off by Staff D on the MAR.

RN Notification delegation indicated staff would notify the nurse including if a tenant had a change in behavior and if vital signs were outside of parameters. Staff did not notify the nurse as needed related to the change in behavior and oxygen saturation outside of parameters for Tenant #1, which occurred on the shift prior to staff finding him with a shower cord wrapped around his neck.

When interviewed on 8/28/23 at 9:56 a.m. the Executive Director confirmed Staff D should have notified the nurse of the behavior and oxygen saturation for Tenant C1.