

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

Date: November 1, 2024
Program Name: Meadowview Memory Care Village
Address: 3005 F Avenue NW
Type of Action: recert, 123134-I
Date(s) of Action: 9/25/24, 9/26/24
Citation #: 10654

State Rule #	State Rule	Amount of Civil Penalty
69.32(2)	<p><u>69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.</u></p> <p>Based on observation, interview, and record review the program failed to ensure there was an operating alarm system on each exit door, affecting 1 of 3 tenants reviewed (Tenant #3). Findings follow:</p> <p>Record review on 9/25/24 revealed an undated program investigation of an incident which occurred on 8/19/24. The Activity Director called the Executive Director at approximately 6:28 PM to inform her Tenant #3 was outside her home, approximately 1.5 miles from the program. Tenant #3 told the Activity Director he had money and was waiting for the bus to take him home. The Assistant Director of Nursing (ADON) arrived to assess Tenant #3. He was dressed in jeans, a polo shirt and slip-on tennis shoes. He had no visible signs of distress with no sweating noted. His vitals and neurological checks were completed and were within normal limits. It was approximately 74 degrees outside and sunny according to the investigation report. Tenant #3 was transported back to the program via a program vehicle at 7:15 PM. The report revealed Tenant #3 was seen exiting the program at 5:27 PM when a visitor was entering through the front door. He had last been seen by staff at dinner less than 30 minutes prior to leaving the building.</p> <p>An observation of the layout of the building on 9/26/24 at 1:26 PM revealed a set of side by side doors which led to the memory care unit. These doors were alarmed. There was a keypad that was utilized by staff and family members to disarm the alarm in order to enter or exit the memory care unit. There was a sign posted on either side of the doors alerting people to make sure they, or the group they came in with, were the only ones exiting.</p> <p>There was a vestibule that lead out to the parking lot consisting of an interior and an exterior glass door. Neither of these doors had an alarm system.</p> <p>A review of Tenant #3's service plan dated 6/27/24 revealed he moved to the program on 6/19/24. He had diagnoses of Alzheimer's disease with late onset and generalized anxiety disorder. Tenant #3 had a Global Deterioration Score of 6, indicating severe cognitive decline, and was known to display wandering and exit-seeking behaviors requiring routine safety checks every two hours.</p>	\$4000.00

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	<p>During an interview with the Executive Director (ED) on 9/26/24 at 1:05 pm, she stated she was at home on 8/19/24 when she received a Facetime call from the Activity Director who said she was with Tenant #3 on the front porch of her home. The ED placed a call to the ADON and directed her to go directly to the Activity Director's home and assess Tenant #3. The ED arrived at the program, reviewed the camera footage and discovered another tenant's family member went to the memory care unit door, punched in the code to disarm the alarm in order to open the door, and held the door open for Tenant #3 to leave the locked portion of the program. The camera footage then showed Tenant #3 exiting the building through the unlocked, unalarmed, automatic sliding front doors of the vestibule. The ED stated she later spoke with the family member who stated they were unaware Tenant #3 was a tenant of the program. The ED confirmed there had not been an alarm system on the front vestibule doors since she started working at the program approximately 3 years earlier.</p>	
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