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

Date: March 16, 2022	
Program Name: Courtyard Estates at Hawthorne Crossing	
Address: 601 Hawthorne Crossing Dr. SE Bondurant, IA 50035	
Type of Action: Investigations 101714-A, 101735-M	
Date(s) of Action: 1/24/2022 to 3/15/2022	
Citation # 5638	

State Rule #	State Rule	Amount of Civil Penalty
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 interview and record review the Program failed to provide adequate and appropriate care, treatment, and services to 2 of 9 discharged tenants reviewed (Tenant #C1 and Tenant #C2). Findings follow: 1. Record review of Tenant #C1's file on 1-25-22 revealed the following: Incident Report dated 1-21-22 revealed at approximately 6:19 a.m. the Registered Nurse (RN) received a call from Staff B who reported Tenant #C1 was found outside of the East Garden Door in the memory care unit. Staff brought her inside and covered her with blankets and immediately called 911. They reported she failed to respond but then found a pulse. Emergency services arrived and transported Tenant #C1 to the hospital. Around 8:55 a.m. the Sheriff arrived to investigate and informed the Program Tenant #C1 passed away at the hospital. Staff noted she wore long pants, a sweater, and shoes with the temperature noted to be around 7 degrees below zero. The Service Plan dated 11-13-21 revealed she required assistance with activities, bathing, toileting, medications, and received hospice services. Continued review noted forgetfulness, mild to moderate disorientation, difficulty retaining information, wore a wanderguard for added safety, and required hourly safety checks. Further review revealed diagnoses of Alzheimer's disease, major depressive disorder, and anxiety disorder. The Global Deterioration Scale completed 8-13-21 revealed a score of 5 and indicated moderately severe cognitive decline. A 90 Day Review dated 11-13-21 revealed she continued to have episodes of anxiety, packed up her room, and attempted to leave the community. She exit seeked and wandered at times of high anxiety and had PRN (as needed) medications to assist with behavior and had been effective. A Century System had been placed on her apartment door to assist with monitoring and had been effective this quarter with no elopements.	**$10,000.00**

2. Documents and surveillance video provided by the Program confirmed the following:

Documentation Survey Reports revealed Staff A failed to complete and document hourly safety checks on December 28, 2021 at 10:00 p.m. until December 29, 2021 at 6 a.m., December 29, 2021 at 10:00 p.m. until December 30, 2021 at 6 a.m, and January 20, 2022 at 10:00 p.m. until January 21, 2022 at 6 a.m.

Device Activity Report revealed E5 East Garden Door alarmed at 9:34 p.m. on 1-20-22 until cleared at 6:12 a.m. on 1-21-22. Tenant #C1's door alarmed at 4:23 p.m. on 1-20-22 until cleared at 7:15 a.m. on 1-21-22.

On 1-20-22 video footage recorded Staff A arriving after 10 p.m. Continued review showed her walking around the unit from approximately 11:09 p.m. until 2:44 a.m. and failed to walk down the east hallway to complete safety checks. A male tenant walked around the unit and appeared to fall asleep in a chair. Further review revealed around
2:44 a.m. until 6:10 a.m. she continued to walk around the memory care unit. She walked over to the assisted living area two times, and walked past the sleeping male tenant several times. She failed to walk down the east hallway throughout the night to complete hourly checks as required.

3. Record review of the hospital's emergency room documentation revealed Tenant #C1 arrived at 7:23 a.m. on 1-21-22. The Pre-Arrival Summary noted the chief complaint to be "hypothermia, cold, stiff, ice freezing on her, responsive to pain, head and hand abrasion". Further review revealed en route her pulse was 40 beats per minute and when pulse was lost, EMS (Emergence Medical Services) performed CPR for approximately 90 seconds. Upon arrival at the hospital, EMS noted a slight pulse and when brought in to the emergency room, no pulse could be obtained. EMS stated she was too cold to obtain a temperature. Continued review revealed her temperature to be around 25 degrees Celsius (77 degrees Fahrenheit). Family was contacted and determined efforts to be ceased due to lack of expected meaningful recovery. The diagnosis was cardiac arrest and hypothermia and Tenant #C1 was deceased.

4. Record review of Polk County Medical Examiners Report of Autopsy documented pathologic diagnoses included heart failure and hypothermia due to cold exposure. Tenant #1's cause of death was documented as hypothermia (minutes) due to environmental cold exposure (hours) and the manner of death was documented as an accident.

5. According to the state climatologist the weather in Bondurant on 1-20-22 around 6:19 a.m. was -11 degrees Fahrenheit with relative humidity of 76%, the sky was clear, and the wind was calm with no windchill.

	6. Record review on 2-7-22 of Tenant #C2's Service Plan dated 11-2-21 revealed she required 24 hour supervision and hourly safety checks. Review of Documentation Survey Report revealed Staff A failed to complete and document hourly safety checks from December 21, 2021 at 10:00 p.m. until December 21, 2022 at 6 a.m. 7. Record review on 1-31-22 of the Program's policy and procedures and job descriptions confirmed the following: The Elopement Policy stated routine visual checks would be completed on tenants with confusion at or above Stage 4 on the Global Deterioration Scale. For tenants at risk of wandering, a Sentry System may be installed in individual apartments. If a tenant exited their apartment an emergency call would be activated to notify staff to check on the tenant. The system included visual checks eight times per shift. Staff were to watch for signs of wandering and confusion that may put the tenant at risk of elopement and if an exit door alarm sounds they should thoroughly check inside and outside areas triggered by the alarm. Nurse Delegation for Visual Checks required staff to enter the apartment and make visual contact of tenant, document visual check in Point of Care/Companion according to scheduled time to ensure tenant safety. If staff failed to see the tenant they were required to check the building until the tenant was located. Staff were required to ensure they completed all required documentation on all tenants. Nurse Delegation for Door Alarm Response revealed as staff received a notification to their IPAD of a door breached or opened, staff should immediately go to that door and observe inside and outside that door to find out who utilized the door. After knowing who used the door staff could push the green button, enter the code, on IPAD, etc to reset the door. The procedure included the alarms were in place to keep tenants safe. Ex. If a tenant exhibited increased confusion they may exit the community in inclement weather without being properly clothed. Nurse Delegation for Point of Care, EMAR or Companion revealed staff logged into program with individualized and confidential login information. Staff selected the specific program for correct documentation and review required tasks. Staff logged out after ensuring all tasks had been completed to prevent use from an unauthorized person. Community Manager job summary revealed the Director is on call 24/7 and maintained normal business hours 8 a.m. to 5 p.m. Monday through Friday. The Director's role included to ensure resources were in place to deliver quality essential services, to assure quality workmanship and performance was achieved by on-site staff. Continued review revealed Operational and Emergency Monitoring included to assure 24/7 coverage to carry on daily operational services and needs. Healthcare Coordinator Essential Functions included to coordinate	

	and implement the delivery of tenant care and to assure 24/7 coverage to respond to calls for urgent assistance from tenants of the Community, respond to fire alarms or other emergencies, and other duties as assigned. 8. Record review of staff files on 1-31-22 revealed the following: Staff A signed the Elopement Policy on 6-9-21, the Nurse Delegation for Door Alarm Response, Visual Checks, and Point of Care delegations on 11-22-21, and acknowledged she was competent to complete the task as trained. On 1-3-22 she received a verbal warning over the phone from the LPN for failure to document tasks performed on her shift in Point Click Care on 12-30-21 as required. Corrective action included timely charting during her shift to reflect the cares provided to the tenants. On 1-28-22 the Program mailed a letter of termination effective 1-21-22. Staff B signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-21-22 she received a written warning for failure to respond to door alarms as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants. Staff C signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-21-22 she received a written warning for failure to respond to door alarms as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants. Staff D signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-25-22 she received a written warning for failure to respond to door alarms and failure to carry an IPAD as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants. Staff E signed the Nurse Delegation for Door Alarm Response training on 11-18-21 and acknowledged she was competent to complete the task as trained. On 1-25-22 she received a written warning for failure to respond to door alarms and failure to carry an IPAD as trained. Corrective Action included carrying a functioning IPAD during her shift to monitor door alarms and pendants. 9. Staff interviews revealed the following: On 2-1-22 at 11:30 a.m. Staff A revealed the following: She started about six months ago and confirmed the Program provided training for safety checks and door alarms. Two staff usually worked in the memory care unit overnight and on 1-20-22 she was the only staff and Staff B worked in the assisted living area. She stated a male tenant yelled, banged, and attempted to exit the memory care unit at times that kept her busy throughout the entire shift. He wasn't	

	wearing a jacket and required constant supervision to prevent him from going outside the door in the lounge area for most of her shift. Her IPAD was in the TV room and another IPAD was in the laundry room. The door alerts failed to appear on either IPAD. She provided a screen shot that revealed she texted the Executive Director in December 2021 the door alarm failed to show up on her tablet. Around 4 or 5 in the morning Staff B arrived and stated the computer showed the door alarm going off. She dropped everything, searched the area,and found Tenant #C1 outside the exit door in the East Hallway. Both staff brought her in and covered her with blankets and immediately called 911. She observed clothing hung and draped on the handrail and a purse near Tenant #C1. She confirmed knowledge of the camera located in the lounge above the exit door that recorded 24 hours per day and continued to state she worked on laundry and provided supervision to the male tenant throughout her shift. She confirmed Tenant #C1 required an alarm on her apartment door because "she can leave and had a history of doing it" and stated "it is very important to check and make sure they are safe". The previous staff informed her everyone was ok and tenants were in their rooms and did not see Tenant #C1 at this time. She observed Tenant #C1's door was shut and failed to explain how she knew the door was shut when the video revealed she never walked down Tenant #C1's hallway. She failed to do rounds to check each tenant hourly as trained and continued to insist the male tenant required her full attention for the entire shift and prioritized keeping him from exiting the building. This surveyor explained the video failed to match how she described her shift and revealed the male tenant asleep around 2:53. She stated she remained in the TV room from 3:32 am to 5:23 a.m. and peaked her head out to make sure he was ok. She prioritized monitoring the male tenant because the door alarms failed to show up on the tablet at times. She stated it "slipped my mind to do safety checks" down the east hallway. She checked on one tenant in the west hallway to ensure the door was closed to prevent her from waking up from the noise the male tenant made. She stated "it did not come to my mind honestly to check on Tenant #C1" after she acknowledged the issue with the door alerts, that Tenant #C1 required a door alarm for her safety due to wandering, and Tenant #C1 slept lightly. On 1-25-22 at 10:38 a.m. Staff B reported the following: She arrived at the memory care unit around 10 p.m. on 1-20-22 and started to sanitize the equipment. Staff A arrived and wanted to work in the memory care unit so she walked back to the front to work in the assisted living part of the building. No door alert appeared on her IPAD when she opened it. The IPAD's battery died before the end of her shift and went to the office for a replacement. She noticed the desktop computer monitor had door alerts for the East Garden door and Tenant #C1's apartment door. She walked to the memory care and observed Staff A in the laundry room. She told her she was checking the alarms and Staff A did not respond. She observed	

	Tenant #C1's apartment door was open, checked inside, and yelled to Staff A "she is not in her room". Staff A arrived and both went to the exit door near her apartment. She observed Tenant #C1's clothing on the handrail and saw shoes when she opened the exit door. Both staff moved Tenant #C1 inside and got blankets to cover her. She called the Healthcare Coordinator and received instructions to call 911. Tenant #C1 made some noise but was unresponsive. Tenant #C1 wore a sweater, pants, shoes, but no coat, hat, or gloves. EMS arrived for Tenant #C1 and as they left she observed Tenant #C1 open her eyes as they exited the building. Tenant #C1 had a history of being up and down throughout the night and asked about the location of stairs, elevators, her dog, or her car. She attempted distractions to redirect Tenant #C1 when this occurred and attempted to keep her in her sight due to her history of exit seeking. The memory care residents required hourly checks with eyes on the person to confirm their presence and documented when they are done. The past few weeks Tenant #C1's door alarm continued to send alerts even when closed and at times the IPAD failed to receive door alerts once in while. She assumed the Assistant Director knew about the issue with Tenant #C1's alarm but not sure if she knew about the issues with the IPAD. On 1-24-22 at 2:17 p.m. Staff C stated the following: She worked 2 p.m. to 10 p.m. on 1-20-22 in the memory care unit and Tenant #C1 spent most the shift in her room until supper time. Tenant #C1's anxiety increased during this time and she administered medication for her anxiety. Tenant #C1 slept in her room after supper until approximately 9-9:30 p.m. when she joined Staff E, Staff C, and another tenant in the TV room. Staff E and her IPADs were charging and not with them but Staff D in the assisted living side had an IPAD. The exit door had an audible alarm and she would be able to hear it if in the area but stated it may be hard to hear it if busy with other tenants or in an apartment. They relied on the IPAD to notify staff of door alarms. During shift change no one acknowledged a door alert and Tenant #C1 remained in the TV room and she left after 10 p.m. Hourly checks are required to be done and documented on each tenant. The door alarm system "Ariel" alerts failed to appear on the IPADS occasionally and informed the previous Director of the issue. Other staff talked about this issue and new IPADs had been ordered by the new Director. The door alarm on Tenant #C1's door alarmed even when shut and had done so for at least one month. The alarm appeared on the IPAD and no one cleared it due to the continuous alarm. All staff knew the door alarm failed to work properly and the issue was discussed at team meetings. The maintenance man failed to fix the issue before he left employment. She failed to have a charged IPAD with her as required and did not think to check all exit doors knowing the IPAD failed to receive alerts on occasion. She assumed Tenant #C1 may have tried to open the exit door by her apartment prior to coming to the TV room. On 1-24-22 at 3:55 p.m. Staff D reported the following: She worked 2 p.m. to 10 p.m. on 1-20-22 on the assisted living side of the building and worked in the memory care unit at times. Tenant #C1 required medication for anxiety in the evening when the sun went	

	down and would look for her husband, her baby, and/or her car, had a history of elopement, and would exit seek at times. Tenant #C1 liked to go to bed after supper and all staff knew she required supervision to prevent elopement. Staff knew her apartment door alarm failed to work properly and alarmed every two minutes. At first staff checked every time but as it continued, the staff checked the hallway once in a while due to the continuous alarm. Tenant #C1 packed up her belongings often and would say she was going home. On 1-25-22 at 3:42 p.m. Staff D confirmed she knew neither staff in the memory care unit carried a charged IPAD and assumed responsibility to notify them if anything appeared on her IPAD. This occurred often and the only alert she observed was Tenant #C1's apartment door alarm every 2 minutes. There had been issues with "Ariel" and alerts failed to come through to the IPAD once in a while. On 1-25-22 at 1:07 p.m. Staff E stated the following: She worked 2 p.m. to 10 p.m. on 1-20-22 in the assisted living area until 7 p.m. then worked in the memory care unit until 10 p.m. Staff C completed most of the required tasks and they hung out with another tenant watching TV in the TV room around 9 p.m. She observed Tenant #C1 enter the area holding a little red purse. She gave her IPAD to Staff G who worked on the assisted living side and Staff C's battery died and was on the charger. At least one person on the shift was required to have an IPAD at all times. Four IPADS were available when fully charged and only 2 chargers worked currently. A fully charged tablet would last a shift but when given to the oncoming shift it would require charging at some point. Her IPAD died a few times on her shift and she notified the other staff to alert her if a door alarm went off. The Director was aware and new IPADS were ordered a while ago. Door alerts failed to appear on the IPAD a couple of times and she thought management had knowledge of this issue. The door on Tenant #C1's door failed to work properly and would alarm even when the door was shut. She informed the previous maintenance man sometime before Christmas but he is no longer employed. Hourly safety were required in the memory care unit to ensure everyone is accounted for and she received re-training on the door alarm policy and visual checks. On 1-24-22 at 3:31 p.m. Staff F reported the following: She worked in the memory care unit and Tenant #C1 resided in memory care for a few years. An alarm had been placed on her apartment door approximately one and half years ago and had an ankle monitor applied approximately one year ago. Tenant #C1 required these for her safety due to a history of elopement attempts and occurred more often on the 2 p.m. to 10 p.m. shifts due to her preference to sleep in. It would not be unusual for Tenant #C1 to move her belongings into the hallway in an attempt to leave and she required enhanced supervision and safety checks to be documented when completed. The system time stamps the documented checks to ensure they are completed as required. Tenant #C1 regularly approached exit doors in the unit and required the alarms and ankle monitor for safety. Tenant #C1's apartment door alarm worked as long as the door remained shut. Tenant #C1 preferred to keep the door	

open, would regularly go in/out of her apartment, and this resulted in a continuous alarm. The exit door had to be pushed for 15 seconds before it would open and required someone to push the green button by the door to clear the alarm from the IPAD.

On 2-1-22 at 3:21 p.m. Staff G confirmed the door alerts failed to appear on the IPAD at times and reported this to the Executive Director on 12-28-21.

The Executive Director (ED) revealed the following:
*On 1-24-22 at 12:55 p.m. she stated the Program has three cameras in the memory care unit. One camera was located in the common area facing the exit hallway to the assisted living portion of the building and records video 24 hours a day. The other two cameras were located at the end of each hallway above the exit doors. Those cameras did not record video but allowed staff to observe the area when accessed. New cameras were being installed to record all areas 24 hours per day. Tenant #C1 resided near the exit where staff found her. She received doors alerts on her phone via text message the East Garden Door and Tenant #C1's apartment door were breached but she failed to hear them because she was asleep. The text alert on her phone was difficult to hear and it failed to wake her up. Screenshots of her phone revealed she received the first alert at 9:44 p.m. on 1-20-22 for the East Garden Door and continued to receive them every five minutes and door alerts for Tenant #C1's apartment door alarm every 5 minutes from around 4:30 p.m. 1-20-22 until early morning 1-21-22.

*On 1-25-22 at 11:32 a.m. she confirmed Tenant #C1 propped her door open frequently and allowed the alert to go off continuously. She stated she failed to check on it each time because it occurred often.

*On 1-26-22 at 9:46 a.m. two staff informed her they had issues with the IPADs not working properly during an elopement drill on 12-28-21. The IPAD 's failed to make noise and the system for the door alarms didn't always work. She assumed staff turned down the volume at times and failed to hear the alert. On 1-21-22 the Clinical Educator checked every IPAD and found no issues. New IPADs were ordered prior to the elopement drill. The Healthcare Coordinator covered the on-call duties on 1-20-22 and didn't know why she failed to respond to the door alerts. Tenant #C1 required a door alarm for her safety and the door alarm failed to work properly for over one month. Staff reported the door alarmed constantly at times even when the door was shut. The alarm was installed with double sided tape, continued to slip out of alignment, and failed to have it securely installed to prevent this from happening.

*On 1-26-22 at 1:22 p.m. she confirmed the door must be shut to clear and reset the alarm on Tenant #C1's door.

On 1-25-22 at 9:37 a.m. the Portfolio Leader confirmed the Program recognized the need to develop a new system to alert management by a phone call instead of text to ensure they hear the alert, discussed installing a different type of exit doors, and purchased new camera systems to record 24 hours a day in all areas to be installed

	immediately. On 1-26-22 at 10:00 a.m. this surveyor and the Senior Portfolio Leader stood in the TV room and adjusted the volume on the TV to a moderate level. The Executive Director walked to the East Garden Door to open it and set off the alarm. This surveyor heard a faint alarm and confirmed with the Senior Portfolio Leader if the TV volume was increased and the staff engaged in loud conversation with the tenant present around 9:30 p.m., the alarm may not have been heard. On 2-2-22 at 11:54 a.m. the Registered Nurse (RN) reported the following: She worked 1-20-22 as the on-call nurse that evening and noticed the on-going door alerts for Tenant #C1 on her work phone. She failed to respond to them due to being with her family and was in bed around 9:30 p.m. She ignored the alerts in the past because Tenant #C1 opened the door constantly. The Program provided no training related to monitoring the phone for the door alerts and stated that wasn't part of the on-call expectations per the Executive Director. The expectation was to answer phone calls from staff and not to monitor the phone while on-call. Staff received door alerts to their IPADs and she expected them to watch for them and felt that wasn't something she needed to monitor. Tenant #C1 required an alarm on her apartment door due to wandering and exit seeking behavior and often got into other tenants belongings. Staff reported door alerts failed to come through the IPAD at times and new IPADs were ordered some time ago. She should have called the staff to check on things but assumed the staff would take care of it. She delegated all staff on visual checks, door alarms, and POC during a skills fair in November 2021. They understood the training and signed the paperwork acknowledging competency. She delegated Staff A one on one and signed off on the training. On 2-2-22 at 3:37 p.m. the Clinical Care Coordinator stated she completed a Quality Assurance review with the RN on 12-20-21 and included to "continue to monitor Pendant and Security Response times-Escalating Call". She explained the Escalating Call sent the door alerts to the cell phones provided to the Director and Nurse to monitor as part of their job. The Senior Portfolio Leader confirmed these findings on 3-14-22 at 3:10 p.m.	