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

Date: October 6, 2026
Program Name:Courtyard Estates at Hawthorne Crossing
Address: 601 Hawthorne Crossing Dr Bondurant, Iowa 50035
Type of Action: Investigations #131762-C, #131794-C, #131808-C, #132368-C, #132407-C, #132636-C, #132640-C, #132658-C & 132751-C
Date(s) of Action: 7/30/26 - 8/13/26
Citation #11265

State Rule #		Amount of Civil Penalty
Iowa Administrative Code 481 Chapter 69.32(2)	**481—69.32(231C) Life safety—emergency policies and procedures and structural safety requirements.** **69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.** Based on interview and record review the Program failed to ensure an operating alarm system connected to all exit doors. This pertained to 2 of 2 tenants (Tenant #4 and #5) who eloped through an unalarmed door and potentially all tenants who resided in the memory care unit. Finding follows: Observations on 7/30/26 revealed Staff H took out the trash using the south memory care door. He propped open the alarmed gate while placing items in the dumpster. He could not visualize the open gate while he loaded the dumpster. During an interview on 8/5/26 at 12:58 p.m. the Director confirmed two tenants eloped when staff propped the south memory care unit door open to take the trash out. She confirmed a former staff admitted to propping the door open. Record review on 8/12/26 revealed the Program's internal investigation dated 3/21/26. The investigation report noted former staff propped open the alarmed door/gate and two tenants walked outside unsupervised. Staff statements taken during the investigation detailed two separate former staff members observed Tenant #4 and Tenant #5 outside dining room of the assisted living part of the building. Tenant #4 and Tenant #5 approached the dining room door and	**$2500.00**

	attempted to re-enter the building. The dining room door was located 50 - 75 yards from the door the tenant's used to exit. Observations on 8/11/26 revealed a farm field within 50 yards South of the unalarmed door. The Program sat .2 miles from Iowa Highway 330 which had a 55 mile per hour speed limit. Record review on 8/12/26 revealed the Program's Dementia Specific Program policy, dated 6/15/25, mandated each exit door possess an operating alarm system. On 8/25/26 review of Underground Weather historical data revealed a measured temperature of 86 degrees Fahrenheit at 1:15 p.m. on 3/21/26. Record review on 8/12/26 revealed a Global Deterioration Scale score of four (moderate cognitive decline) for both Tenant #4 and Tenant #5. Tenant #4's service plan dated 11/25/25 noted a history of occasional disorientation to person, place or situation even in familiar surroundings and require supervision, oversight for safety, difficulty remembering/using information and required some directions from others. Both tenants resided in the memory care unit. Record review on 8/12/26 revealed a counseling documentation final warning form with a recorded occurrence date of 3/21/26. In this document, the Program noted Staff E propped open the secured/alarmed door. When interviewed on 8/11/26 the Director confirmed the Program failed to ensure an operating alarm system when staff propped open the door in the memory care unit to take trash to the dumpster.	