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

Date: September 1, 2026
Program Name: Copper Creek Senior Living
Address: 609 Hwy 150 North West Union, Iowa 52175
Type of Action: Investigation #131629-C, #131630-C, #131893-C, and #132258-I
Date(s) of Action: 7/13/26 – 7/15/26
Citation #11238

State Rule #		Amount of Civil Penalty
Iowa Administrative Code 481 Chapter 67.2(2)	**481—67.2(231B,231C,231D) Program policies and procedures.** **67.2(2) The program shall follow the policies and procedures established by the program.** Based on observation, interview, and record review, the Program failed to follow policies related to incident reports and door alarm response for 2 out of 4 tenants (Tenant C1, Tenant #2). Findings follow: 1. Record review on 7/13/26 revealed Tenant C1 was admitted on 8/25/25 with diagnoses of confusion, colon cancer, hypothyroidism, hyperlipidemia, and hypertension. Tenant C1 was discharged from the Program on 2/28/26. A review of Tenant C1's incident reports revealed that only one incident or accident was documented during the last week of her stay, which was an act of aggression toward a staff member on 2/28/26. However, nurse's notes from 2/25/26 revealed the following incident was documented: During the overnight shift, Tenant C1 screamed loudly because she believed the building was on fire. Tenant C1 banged on other apartment doors with her hands to wake others and tell them about the perceived fire. Tenant C1 told staff that God told her there was a fire and that others needed to evacuate. Tenant C1 then threw water on staff because she believed staff members were on fire. No incident report was on file for this incident, nor was there one for the potential injury to her hand from aggressively pounding on the doors. When interviewed on 7/13/26 at 11:00 a.m., a police officer with the West Union Police Department confirmed he received a report that Tenant C1 had bruises on her arms. The officer confirmed he	**$4500.00**

	followed up on the concerns by visiting the Program to speak with administration and staff. When interviewed on 7/13/26 at 3:08 p.m., Staff B reported she observed bruising on Tenant C1's arms during the last week or two she resided at the Program. Staff B asked Tenant C1 how she got the bruises and was told she "hit something." Staff B stated she saw no injury to Tenant C1's hand. Staff B confirmed Tenant C1 had been aggressive toward her and other tenants during her last few weeks. When interviewed on 7/13/26 at 2:39 p.m., Staff C confirmed she observed bruises on Tenant C1's arms during the last few weeks she resided at the Program. When interviewed on 7/13/26 at 2:02 p.m., Staff D reported Tenant C1 was aggressive in her last few weeks of living at the Program. Tenant C1 slammed chairs to the floor, hit staff with a flashlight, and fought staff in an attempt to elope from the premises. Staff D reported she observed a large bruise on Tenant C1's elbow area prior to her discharge. Tenant C1 indicated she did not know where the bruise came from. When interviewed on 7/13/26 at 2:55 p.m., Staff E stated Tenant C1 had a bruise on her arm. Staff E believed the bruise was likely from her banging on doors and throwing chairs. Record review of Program policies revealed a policy titled Incident Reports. The policy dictated that staff complete an accident/incident report for all unexplained bruises or abrasions, as well as all accidents or incidents where there was an injury or the potential to result in injury. When interviewed on 7/15/26 at 11:00 a.m., the Regional Director and Registered Nurse (RN) confirmed staff failed to complete an incident report on the events documented in the nurse's notes on 2/25/26, and had not completed an incident/accident report for the bruises observed by four separate staff members. 2. During the surveyor's entrance to the Program on 7/13/26 at 10:10 a.m., no one greeted the surveyor upon entry. The front desk was unstaffed, but a call button was available to alert staff for assistance. The button was pressed twice. No staff came to check the door within 10 minutes. The surveyor eventually located the RN in her office and was greeted after 10 minutes.	

	Record review on 7/14/26 revealed Tenant #2's admission date was 5/21/26. Tenant #2's initial evaluations were completed on 5/18/26, and the initial service plan was completed on 5/20/26. Tenant #2's service plan reflected the potential for exit-seeking and directed staff to provide gentle, positive diversion and distraction techniques for such behaviors. An incident report dated 5/25/26 revealed the following incident: On 5/25/26 at 12:30 p.m., Tenant #2 was observed walking out of her apartment into the hallway. At 12:45 p.m., staff went to Tenant #2's apartment to prompt her for lunch. Tenant #2 was not in her apartment. After a search of the premises, Tenant #2 could not be located, and the Director and police were notified. According to Weather Underground (wunderground.com), on 5/25/26 at 12:55 p.m., the temperature in West Union was 81 degrees Fahrenheit. Record review on 7/15/26 of the Program's log showing front entrance activity revealed the front entrance was used and alerted staff 8 times between 12:30 p.m. and 12:45 p.m. on 5/25/26. When interviewed on 7/14/26 at 9:48 p.m., Staff F reported she last observed Tenant #2 on 5/25/26 at 12:30 p.m. in the hallway. Staff F confirmed that at 12:45 p.m., Tenant #2 could not be located. Staff called the Director and police to report Tenant #2 was missing. Police returned Tenant #2 to the building at 2:30 p.m. with no injuries. Tenant #2 was found at a Dairy Queen 0.3 miles away eating a meal. Staff F reported it was believed Tenant #2 left the secured memory care area of the building by following a visitor who used the security code. Once out in the unsecured area of the building, Tenant #2 likely exited the front entrance door, which alerted staff by pager. Staff F indicated they were alerted when the front door was used, but staff did not always check it and had not done so that day. Staff F stated Tenant #2 wore pants, a short-sleeved shirt, and shoes, and carried a purse that day. When interviewed on 7/13/26 at 1:52 p.m., Staff A confirmed that when someone entered or exited using the front entrance door to the Program, staff were alerted on their pager/phone systems. When interviewed on 7/13/26 at 2:39 p.m., Staff C confirmed the front door alarm would notify staff on their pagers/phones. Staff were expected to check the door activity when alerted.	

	When interviewed on 7/13/26 at 2:02 p.m., Staff D confirmed the front door had an alarm that alerted staff when someone entered or exited. Staff were expected to check it when alerted. When interviewed on 7/13/26 at 2:55 p.m., Staff E confirmed the entrance door alerted staff when someone used it, and staff were expected to check it. Record review of policies on 7/15/26 revealed a policy titled Door Alarms. The policy directed staff to check their pager/phone system to determine the location of the alarm. Staff then had to immediately respond to all alarms. When interviewed on 7/15/26 at 11:00 a.m., the Regional Director and RN confirmed staff failed to check the front entrance door of the Program on 5/25/26 when it alerted their phones between 12:30 p.m. and 12:45 p.m.	
Iowa Administrative Code 481 Chapter 69.22(3)	**481—69.22(231C) Evaluation of tenant.** **69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation.** Based on interview and record review, the Program failed to evaluate a tenant's functional, cognitive, and health status following a significant change for 1 out of 4 tenants (Tenant #2). Findings follow: Record review on 7/14/26 revealed Tenant #2's admission date was 5/21/26. Tenant #2's initial evaluations were completed on 5/18/26, and the initial service plan was completed on 5/20/26. Tenant #2's service plan reflected the potential for exit-seeking and directed staff to provide gentle, positive diversion and distraction techniques for behaviors such as exit-seeking. An incident report dated 5/25/26 revealed the following incident: On 5/25/26 at 12:30 p.m., Tenant #2 was observed walking out of her apartment into the hallway. At 12:45 p.m., staff went to Tenant	

	#2's apartment to prompt her for lunch. Tenant #2 was not in her apartment. After a search of the premises, Tenant #2 was not located, and the Director and the police were notified. A second incident report dated 5/30/26 revealed the following incident: On 5/30/26 at 7:00 a.m., the Program received a telephone call from police asking if any tenants were unaccounted for. After a search of all apartments, it was discovered Tenant #2 was missing. Police had discovered Tenant #2 walking along the highway close to the Program. Tenant #2 was returned to the Program uninjured at 7:20 a.m. Safety checks were changed from 1-hour to 15-minute checks upon her return. Tenant #2's functional, cognitive, and health status was not assessed after either elopement. Tenant #2's functional, cognitive, and health status was not assessed until 6/17/26 for a 30-day review, at which time increased supervision was addressed for safety. According to Weather Underground (wunderground.com), on 5/25/26 at 12:55 p.m., the temperature in West Union was 81 degrees Fahrenheit. On 5/30/26 at 6:55 a.m., the temperature was 68 degrees Fahrenheit. When interviewed on 7/14/26 at 9:48 p.m., Staff F reported she last observed Tenant #2 on 5/25/26 at 12:30 p.m. in the hallway. Staff F confirmed that at 12:45 p.m., Tenant #2 could not be located. Staff called the Director and police to report Tenant #2 was missing. Police returned Tenant #2 to the building at 2:30 p.m. with no injuries. Tenant #2 was found at Dairy Queen 0.3 miles away eating a meal. Staff F reported it was believed Tenant #2 left the secured memory care area of the building by following a visitor who used the security code. Once out in the unsecured area of the building, Tenant #2 likely exited the front entrance door, which alerted staff by pager. Staff F indicated they were alerted when the front door was used, but staff did not always check it. Staff F stated Tenant #2 wore pants, a short-sleeved shirt, shoes, and carried a purse that day. When interviewed on 7/13/26 at 2:02 p.m., Staff D confirmed she worked on the morning of 5/30/26. Staff D confirmed the Program received a call from police at 7:00 a.m. Police asked staff if any tenants were unaccounted for. Staff D searched the building and discovered Tenant #2 was missing. It appeared Tenant #2 had exited the building by going through the first-floor office window, which contained no block to prevent full access as apartment windows did. Tenant #2 was returned to the Program by police at 7:20 a.m. When interviewed on 7/15/26 at 11:00 a.m., the	

	Regional Director reported Tenant #2 wore blue jeans, a sweater, and tennis shoes on 5/30/26. When interviewed on 7/15/26 at 10:35 a.m., the Registered Nurse (RN) confirmed she had not evaluated Tenant #2's functional, cognitive, and health status following the significant change of either elopement that occurred. When interviewed on 7/15/26 at 11:00 a.m., the Regional Director and Registered Nurse confirmed the above findings.	