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

Date: 2/20/2024
Program Name: Senior Star at Elmore Place Memory Care
Address: 4504 Elmore Avenue Davenport, Iowa 52807
Type of Action: 116794-C, 116795-C
Date(s) of Action: 11/14/23, 11/15/23
Citation # 10214

State Rule #	State Rule	Amount of Civil Penalty
69.32(2)	**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 all exit doors had an operating alarm system affecting 1 of 3 tenants reviewed (Tenant #2). Findings include: 1. Review of Tenant #2's record on 11/14/23 revealed an incident report dated 11/8/23. The incident report showed Tenant #2 was found outside in the courtyard on 11/8/23 at 7:21 pm laying on the ground on his right side. Tenant #2's range of motion and vitals appeared within normal limits. Tenant #2 was sent to the emergency room for evaluation due to complaints of right shoulder pain. The tenant's record also revealed he was on hospice and had a diagnosis of Alzheimer's dementia. Tenant #2's most recent scored Global Deterioration Scale (GDS) dated 9/19/23 was scored at a 6. According to Tenant #2's service plan dated 9/19/23, he self-propelled himself using a wheelchair or ambulated using his walker. 2. A nurse's note dated 11/9/23 completed by the Assistant Health Services Director revealed Tenant #2 was evaluated at the hospital and returned to the facility the same night with no injuries and no new physician's orders. The nurse's note indicated an internal investigation was completed by viewing video footage of the event. Camera footage showed Tenant #2 going to the courtyard door after it was locked by Staff A. Tenant #2 was observed pushing on the door release and the handicap accessible button at the same time for 2 minutes. This door unlocked and released for Tenant #2 and he exited into the courtyard. At some point between 5:15 pm and 7:21 pm, Tenant #2 fell onto his side while in the courtyard. The nurse's note indicated Tenant #2 was wearing a sweater, pants, socks, and slippers. The temperature outside at the time Tenant #2 was discovered was 61 degrees Fahrenheit which was	**$2000.00**

	obtained by the staff using a weather app. On 11/9/23, the door company examined the courtyard door and found a glitch in the wiring system of the door. The door was repaired immediately. 3. On 11/14/23 at 1:03 pm, Staff B stated she was in charge of Tenant #2's wing. Staff B stated she observed Tenant #2 eat supper sometime between 4:30 pm and 5:00 pm. She believed she had seen him at 6:00 pm in the front sitting area by the courtyard door which was common for Tenant #2. Staff B added another tenant looked like Tenant #2 and it could have been him. Tenant #2 was to receive normal checks which generally occurred approximately every 2 hours or during some type of care (meals, personal cares, or activities). Staff B stated after supper she assisted other residents with toileting and preparing for bed. She went to retrieve Tenant #2 from the front sitting area by the courtyard doors at around 7:00 pm to assist him in getting ready for bed. He was not there so she checked his room but he was not there. Staff B immediately asked Staff A and others to assist her in looking for Tenant #2. Staff A discovered Tenant #2 lying on the ground outside of the courtyard door. Staff B stated she was not sure if the courtyard door had an alarm on it as she had never heard one before. Staff B stated the courtyard doors were to be locked each night. 4. On 11/14/23 at 2:30 pm, Staff A stated she worked the front desk until 8:00 pm. On 11/8/23, she observed Tenant #2 come into the building from the courtyard door at around 5:00 pm. Staff A locked the courtyard door immediately after Tenant #2 came inside. At approximately 7:00 pm, Staff B asked her if she had seen Tenant #2. Staff A stated she had not recently seen Tenant #2 and assisted in looking for him in the building. She went down the hallway looking into rooms. She checked the courtyard door to see if it was locked and it was. She unlocked the door and looked outside and observed Tenant #2 laying on his right side in the dirt and grass just off the sidewalk. Tenant #2's wheelchair was sitting beside him. He was slightly moaning and looked cold. She alerted others she had found him and they covered him with blankets until Staff C arrived to assess Tenant #2. Tenant #2 was sent to the emergency room to be evaluated due to complaints of pain. Staff A stated it was very common for Tenant #2 to go outside into the courtyard. Staff A explained the courtyard door was unlocked every morning and locked every night (or when it gets dark). Tenants were allowed free access to the courtyard unless the weather was inclement. There was always a staff person at the front desk when the courtyard door was unlocked. The front desk was adjacent to the glass door to the courtyard and the glass	

	wall that overlooked the courtyard. Once the door was locked in the evening that person helped out on the unit until their shift ended. 5. On 11/14/23 at 1:21 pm, the Health Services Administrator stated the courtyard door was locked each day at dusk but the door had no alarm on it. 6. On 11/15/23 at 10:30 am, the Health Services Administrator, the Community Relations Consultant, and the Execute Director confirmed the Program had never had an operating alarm on the courtyard door before.	