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

Date: May 8, 2024
Program Name: Parker Place Retirement Community
Address: 707 Highway 57 Parkersburg, IA 50665
Type of Action: 114823-I, 116471-I
Date(s) of Action: 3/27/24 – 4/4/24
Citation #: 10356

State Rule #	State Rule	Amount of Civil Penalty
67.2(3)	**67.2(3) The program shall follow the policies and procedures established by the program.** Based on observation, interview and record review the Program failed to follow established policies and procedures related to door alarms, elopement and visual checks. This pertained 1 of 7 current (Tenant #1) and 1 of 2 former (Tenant C1) tenants reviewed. Findings follow: 1. On 3/28/24 review of an incident report indicated on 9/23/23 at 2:48 p.m. staff reported the interior memory care door alarm went off and then an exit door alarm went off. Staff in the memory care unit completed a head count and noted Tenant #1 was missing. A search was completed in the general population area and outside around the building. When Tenant #1 was not found, the Community Director called emergency services. At 3:59 p.m. police arrived with Tenant #1 sitting in the front seat. Vital signs were taken and no injuries were noted. The weather was noted as 75 degrees and partly cloudy. An electronic wandering monitoring device was placed on Tenant #1's left ankle. An Internal Investigation indicated on 9/23/23 Tenant #1 exited the building at 2:48 p.m. The M2 (memory care) door alarm sounded at 2:46 p.m. Staff responded but noted two other tenants inside the memory care door. At 2:48 p.m. the E1 (exterior) door sounded. Staff responded but did not locate a tenant outside of the door. Staff completed a head count, noted Tenant #1 was missing and started a search. Tenant #1 was returned by the local police department at 3:59 p.m. A full assessment was completed and no injuries were noted. The investigation noted the M2 alarm alerted staff and they saw two tenants standing by the door, looked down the hallway and saw no tenants. Two minutes later the E1 alarm sounded and it was noted Tenant #1 was missing. Staff searched the general population area and outside of the building. The Community Director was called. After she arrived, she called 911 and Tenant #1 was returned to the building by police. Employee statements from Staff C, J and F were part of the packet. a. Staff C's document indicated prior to the elopement Tenant #1 had said he wanted to get out of that place and walked towards the exit door. He was redirected away from the door. She said she heard M2 (memory care) door alarm go off but did not see Tenant #1 there. Later on she heard the E1 (exterior) door alarm go off and knew she had not seen Tenant #1 in awhile. She said Staff J and her both went	**$3500.00**

	to the M2 door alarm, after E1 alarm went off. She said Staff J opened the M2 door and did not see Tenant #1. After the E1 door alarm went off she walked outside the door and did not see Tenant #1. She said a head count was not completed. b. Staff J's document indicated Staff C heard the E1 door alarm going off after Staff C and Staff J had both run to get M2 door alarm shut off. Staff J said they did not start a head count as they thought it was the other two tenants until Staff C heard the E1 door alarm going off. c. Staff F's document indicated Staff C met him in the office to ask about the code for the door. He was not aware of any alarms that went off when Tenant #1 exited the building. He walked outside the door after he was told about a tenant. He said a head count was not completed and they focused in on one particular tenant. He indicated when asked if there was anything to know that the tenant could have been long gone before his absence was noticed. All three received Counseling Documentation Forms for not following the policy and procedure for door response/visual checks on 9/23/23 which resulted in an elopement. When interviewed on 3/28/24 at 3:40 p.m. Staff C stated she worked second shift and floated back and forth on both sides of the building administering medications. She said earlier in the day, about 2:30 p.m. Tenant #1 said he wanted to get out of the building. She was in memory care when she first heard the M2 door alarm go off. There were two tenants standing in front of the door and it was thought they had set off the alarm. She did not see Tenant #1 by the door. Staff went to door M2 and opened it but did not see him. Approximately five minutes later the second door alarm was heard. She thought back to the comment Tenant #1 had made earlier. She told Staff J and they went through every apartment in memory care. The Community Director was called and she sent Staff F out to look for Tenant #1 in a car. The police were also contacted. The police found him down the highway and brought him back with no injuries. The time gone from the building was an hour to an hour and a half. She said the door alarms functioned as they should. The tenant had worn had shorts, a t-shirt and shoes. He did not use an assistive device. When interviewed on 4/4/24 at 11:22 a.m. the Community Director said she received a telephone call from staff stating they could not find Tenant #1. They had walked through the unit and checked closets and apartments. The M2 door alarm had gone off, staff had checked and saw two other tenants there. She did not recall if the staff had reported they opened the door. The exit door in the general population then went off and Staff C had a feeling (regarding Tenant #1). She went to the door and cleared it and started looking. Tenant #1 was not found and staff called the Community Director. She advised them to look outside and she came to the building. She called the nurse on-call and the police department. On the phone the police stated they believed they had just found him and were bringing him back to the building. The police reported Tenant #1 had said he was looking for his car. He was located east of town by the golf course. An assessment was completed and there were no injuries. They gave	

	him some water as he was warm. He was wearing shorts and t-shirt with shoes and socks. His gait was steady but he appeared to be worn out. The alarms functioned on both the M2 and E1 doors. The second door alarm was within minutes of the first alarm. She would have expected to be called sooner, but the staff checked everywhere and then called her after. Staff were expected to do a head count at the first alarm (M2) when it was noted the two other tenants were located. However, staff did not complete a head count until after the E1 alarm. She did not recall if staff looked outside the E1 door after it alarmed. She said if the policy had been followed completely staff should have found him outside the exterior door. On 4/1/24 review of Tenant #1's file revealed he was staged at a five on the Global Deterioration Scale (GDS) and resided in the memory care unit at the time of the elopement. The service plan in place at the time reflected Tenant #1 received eight visual checks per shift for safety and he was independent with ambulation. The driving directions from Google Directions indicated from the Program to Orchid Lane where Tenant #1 was located was a distance of 1.8 miles and three minute drive by car. On foot it was 1.7 miles and an estimated time of 37 minutes. When observed on 4/3/24 at approximately 5:10 p.m. to 5:30 p.m. the building was located on highway 57, with a posted speed limit of 35 miles per hour (mph) in front of the building. It was a two lane road, that was west/east, with a sidewalk located on the north side of the road. The highway crossed several driveways, business entrances and cross streets. It changed to 45 mph as it traveled to the east toward the highway 57/highway 14 intersection. That intersection was a two way stop from the north and south. Traffic from the west and east did not stop. Highway 14 turned to the south and highway 57 continued to the east. After the intersection the speed limit increased to 55 mph. There was no sidewalk and minimal shoulder on the road. It was a two lane highway with a speed limit of 55 mph. The highway went up hill and Orchid Lane was a turn north off of the highway. There were no markings on Orchid Lane and no posted speed limit sign was observed. The road was paved where it turned off of highway 57. Driving distance was 1.4 miles driven by car. This was a possible route that Tenant #1 took when he eloped. The State Climatologist provided the following weather conditions at the time of the elopement: the temperature was 84 degrees, the relative humidity was 52%, the heat index was 86%, the winds were from the southeast at 18 mph gusting to 30 mph and there were low clouds but no precipitation. 2. Review on 4/1/24 of an incident report indicated on 7/1/23 at 11:30 a.m. staff found Tenant C1 in another tenant's apartment and tried to redirect him. He got up and left the apartment of the other tenant. Staff reported Tenant C1 was angry. The Program received a telephone call from a person in the community who observed Tenant C1 walking past their house. The person from the community escorted him back	

	to the building. There was no injury and vital signs were within normal limits. The weather was 78 degrees and partly cloudy. An Internal Investigation indicated on 7/1/23 at 10:30 a.m., Tenant C1 exited the memory care unit, the door alarm sounded. He then went through the front door of the building at 10:30 a.m. unattended. Staff responded to the door alarm, searched outside the memory care door, did not see anyone and shut off the door alarm. A local community member observed Tenant C1 near the bank (later clarified as a church) in Parkersburg at 11:14 a.m. The community member assisted him back to the building at 11:17 a.m. During that time the nurse was called and was alerted by another local community member of Tenant C1 out walking. The nurse called the program and asked if they knew his whereabouts. The Findings of the Investigation were that staff responded to the door alarm in 38 seconds. She went through the memory care door and down to the general population door and did not see anyone. Staff A asked Staff B if she saw anyone and she said no. A head count was not done. Visual checks were signed off for Tenant C1 at 10:40 a.m. and 10:44 a.m. by Staff K when Tenant C1 was not in the building from 10:30 a.m. until 11:17 a.m. The Investigative Conclusion included staff interview revealed the memory care door did not always latch and staff had to ensure it latched (maintenance was made aware). It was protocol to start a head count when the alarm alerted, which was not followed. Tenant C1 exited at 10:30 a.m. and returned at 11:17 a.m. per video footage. He did not sustain any injuries. The statement provided to staff at the program from the local community member (former staff member) indicated she called the Healthcare Coordinator at 11:14 a.m. when Tenant C1 was seen walking down the street. The community member witnessed him walking near Bethel Church, pulled over and got out of the car to walk with him. The community member walked back to the building with Tenant C1. Tenant C1 was determined to walk home. Spoke with staff and asked if they knew he was out and Staff J said they had heard the alarm but were so busy. Employee Investigation Questions were completed for the three staff working at the time of the elopement and indicated the following: a. Staff A's document indicated Tenant C1 was last seen at 10:30 a.m. in another tenant's apartment. When asked how she was notified about Tenant C1 leaving, she said she received a call from the Healthcare Coordinator who asked if Tenant C1 was in the building because she had just received a call from a local community member who was walking him back. Staff A said she went and looked and ran to the front lobby but did not go out of the door. She asked Staff B if she had seen any other tenants and she said no. A head count was not completed. She said a staff member did not show up at 10:00 a.m. and they were busy. b. Staff B's document indicated Tenant C1 was last seen in another tenant's apartment. She learned of Tenant C1 missing when another staff reported a community member was bringing Tenant C1 back. She was not aware of any alarm notifications but as on the other side of the general population.	

	c. Staff J's document indicated Tenant C1 was last seen about 10:30 a.m. in another tenant's apartment. She was notified Tenant C1 had exited when the Healthcare Coordinator called about 11:00 a.m. and staff checked his apartment and he was not there. She indicated the alarm sound was questioned between Staff A and Staff J. Further record review revealed Counseling Documentation Forms were completed for Staff A and Staff B for not following the policy regarding door response/visual checks which resulted in an elopement on 7/1/23. Staff J also received a Counseling Documentation Form for not following the policy regarding door response/visual checks which resulted in an elopement on 7/1/23 and Staff J signed off visual checks at 10:40 a.m. and 10:44 a.m. when Tenant C1 was not in the building. When interviewed on 3/28/24 at 9:15 a.m. Staff A said she and Staff J were getting a tenant dressed when she heard a scream and found Tenant C1 in another tenant's apartment. Staff separated them and he went down the hall. She heard M1 (memory care) door alarm sound and received a page. She came out the general population, looked around. Staff B was out there and Staff A asked her if she had seen Tenant C1 and she said no. She figured if he had gone out the door she would have seen him. Staff A did not look out of the front door or exterior doors. She looked in entryway of the building but not outside of the building. Staff J started a head count and they received a telephone call that someone had seen him walking around. She was then told was told a prior staff member had him and she brought him back in approximately 15 minutes. He had no injuries and was dressed appropriately for the weather. She said she should have gone out of the front door when the elopement occurred. When interviewed on 4/2/24 at 2:27 p.m. the Healthcare Coordinator said she received a telephone call from someone in the community. The person called and had picked up Tenant C1 and brought him back. When the Healthcare Coordinator arrived he had already been brought back to the building. He had no injuries. She said she did not know how he was able to leave the building but the alarms did function. She was not the on-call nurse that weekend. He was dressed appropriately for the weather and did not use an assistive device. After the elopement his visual checks were increased to every 30 minutes and an electronic wandering monitoring device was placed. When interviewed on 4/4/214 at 11:22 a.m. the Community Director said she was not in her current position until 7/5/23 and she was previously a resident assistant. She did not have much to do with the paperwork. She said when a door alarm went off, staff should respond immediately and check outside of the door. They need to check visually and then follow up with head count. Review of Tenant C1's file on 4/1/24 revealed he was staged at a five on the GDS, which indicated moderately severe cognitive decline. The service plan in place at the time of elopement reflected Tenant	

	C1 was independent with ambulation. He required safety checks and resided in the memory care unit. The Documentation Survey Report from July 2023 reflected visual checks eight times per shift. On 7/1/23 the 10:00 a.m. check was documented at 10:40 a.m. by Staff J. The 11:00 a.m. check was documented at 10:44 a.m. by Staff J. Both checks were documented when Tenant C1 was not in the building and staff were unaware he had eloped. The walking directions per Google Directions from the Program to Bethel Lutheran Church reflected it was 0.3 of a mile and estimated it would take six minutes. When observed on 3/28/24 at approximately 2:20 to 2:50 p.m. the possible route Tenant C1 traveled when he eloped was observed. The highway 57/14 in front of the building had a posted speed limit of 35 mph. It was a west/east road, two lane road. Driving west on highway 57/14, a right turn (north) on 2nd street/Church Street/Miller Avenue and then a right turn on to 3rd Avenue. That street was a two way north/south street with post speed limit of 25 mph. The State Climatologist provided the following weather conditions at the time of Tenant C1's elopement: temperature was 80 degrees, relative humidity was 58%, winds were from the east, southeast, at 3 mph and there was no heat index. There were low clouds and no precipitation. 3. Review of the Program's Door Alarm Response protocol indicated if a notification had been received regarding a breach or opened door, staff was to immediately respond to the door. Staff would look inside and outside of the door to know who last used the door. After it was determined who came in or out, staff reset the door. If they did not know who went in or out of the door, they would immediately do a head count of all tenants. If a tenant was not accounted for staff would immediately call the emergency contact, the director and nurse on-call and the local police department. The Program's Missing Resident Elopement policy indicated in the event a tenant was missing, the staff who noticed the tenant was missing would notify the director or designee, who then assumed the lead role and would take the following steps: notify all staff within the building that the tenant was missing, do a thorough search inside the building, call the people on the emergency contact list to see if they have taken the person out, if not found notify the director and/or nurse, assign staff to search outside the building. If the tenant was not found call 911. The Program's Visual Check protocol indicated staff made visual contact of the tenant and documented the visual according the scheduled time. The key was for the tenant to be viewed throughout the entire shift and ensure safety. If a tenant was not in their apartment they should check the memory care unit and building. If the tenant was not found to notify staff in the building and to refer to policies and procedures for a missing tenant or elopement.	