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

Date: February 11, 2025
Program Name: Maple Memory Lane
Address: 100 Bulger Drive Fayette, Iowa 52142
Type of Action: Incident 122379-I
Date(s) of Action: 11/26/24 – 12/5/24
Citation #: 10735

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 observations, interviews, and record reviews, the Program failed to follow established policies and procedures including those for the Delayed Exit Code Alarm System, and Electrical Outage. This directly affected 1 of 1 tenants reviewed (Tenants #1) and potentially affected all 10 tenants living in the Program. Findings include: 1). On 12/2/24 a review of Tenant #2's record revealed a diagnosis of dementia with a GDS score of 5 which indicated moderately severe cognitive decline. A review of Tenant #2's incident reports revealed on 7/15/24 the tenant eloped from a locked and alarmed door of the Program during a power outage which released the door's locking mechanism and main alarm at approximately 5:45 pm. She was found in the parking lot looking for her car by staff from the adjoining nursing home. The tenant was wearing a shirt, pants, and shoes. Tenant #2 received no injuries from the incident. On 11/26/24 at 2:23 pm, Staff A stated she worked when Tenant #2 eloped from the Program on 7/15/24. Staff A stated around dinner time, the electricity went out due to a thunderstorm. On 7/15/24, the tenants were all sitting in the dining room area. Staff A and Staff B assisted Tenant #6 to his apartment to use the restroom. Tenant #6's apartment door was adjacent to the dining area. Staff A stated Tenant #2 was sitting at the table when they left. While in Tenant #6's apartment, the back-up alarm sounded on the unit door. Staff A looked out into the dining area but saw nothing and assumed someone entered the unit. Staff A stated she continued helping Tenant #6. When Staff A and Staff B brought Tenant #6 back out to the dining area they noticed Tenant #2 was not in her seat. Both she and Staff B began to search the unit. Within a short time, a nurse from the nursing home side of the building brought Tenant #2 back into the unit. The nurse discovered Tenant #2 approximately 20 feet away from the outside door of the Program. Tenant #2 was missing 10 minutes or less. Staff A stated it was her belief the door lock did not work only during the brief period between the electricity going out and the generator coming on. It was only after this incident that	**$2000.00**

	she learned the doors stayed unlocked during a power outage and the generator did not cover the locks, only the lights. On 12/3/24 at 8:35 am, Staff B stated she worked when Tenant #2 eloped from the Program on 7/15/24. Staff B stated at around dinner time, the electricity went out due to a thunderstorm. She assisted Staff A to take Tenant #6 to the restroom at approximately 5:30 pm. Tenant #2 was sitting in the dining room when they entered Tenant #6's apartment. Staff B stated they were only in Tenant #6's apartment for a few minutes. Tenant #2 was not in the dining room when they came out. They began to search immediately but a nurse brought Tenant #2 back from outside. On 11/26/24, a review of historical temperatures on Wunderground.com revealed at 5:54 pm on 7/15/24 it was 73 degrees, fair, with 3 mph winds. When interviewed on 12/2/24 at 2:20 pm, the Maintenance Director stated the Program door unlocked anytime the electricity went out. The locks were not covered by the generator. The Maintenance Director stated the main alarm also did not work but the back-up alarm, which did not run on electricity, would sound. On 12/3/24 at 11:20 am, the Director stated Staff A should have gone to the actual door and checked when the back-up alarm sounded instead of just looking out Tenant #6's apartment door. The Director stated both staff who worked were disciplined and all staff were retrained on policies. On 12/3/24, the Program's policy titled Delayed Exit Code Alarm System was reviewed. The policy stated when a tenant attempted to open an exit door, an alarm would sound and the door would not open for 15 seconds. Staff were to promptly go to the exit door if they heard the alarm sound in order to safely move the tenant away from the area. On 12/4/24, a review of personnel records revealed Staff A was trained on all policies on 2/8/21 and Staff B was trained on all policies on 5/11/22. On 12/2/24 at 9:44 am, the surveyor entered the Program. When the surveyor entered, the door alarm sounded. No staff came to check the exit door to see who set off the alarm until 9:48 am. On 12/3/24 at 10:16 am, the surveyor entered the Program. The door alarm sounded upon entry. No staff arrived to check to see who set off the alarm system. The Director came back into the Program from the nursing home side of the building at 10:22 am and discovered the surveyor had arrived. On 12/3/24 at 12:45 pm, the Director and the DON confirmed staff had not followed the Program's policy titled Delayed Exit Code Alarm System on 7/15/24 and had continued to not follow the policy during the onsite surveyor visit.	

	2). On 11/26/24 at 2:23 pm, Staff A stated she worked when Tenant #2 eloped from the Program on 7/15/24. Staff A stated the electricity went out shortly before dinner. After Tenant #2 eloped and was returned to the Program, staff kept a very close eye on her the rest of the night but had not documented hourly checks on all tenants in the Program after the electricity went out. Staff A could not recall how long the electricity was out. On 12/3/24 at 8:35 am, Staff B stated she worked when Tenant #2 eloped from the Program on 7/15/24. Staff B stated at around dinner time, the electricity went out due to a thunderstorm. After Tenant #2 eloped and was returned to the Program, staff kept a very close eye on all of the tenants the rest of the night but had not documented hourly checks on everyone. Staff B stated she was not sure how long the electricity was out, but that it went out right before dinner at 5:30 pm and was still off when she ended her shift at 8:00 pm. On 12/3/24, a review of the Program's Electrical Outage policy was reviewed. The policy directed staff were to complete a door to door wellness check on all tenants at the time of the electrical outage and every hour thereafter. The checks would be documented on the Visual Check sheet. On 12/3/24 at 11:20 am, the Director stated Staff A and Staff B were disciplined for not conducting/documenting hourly checks on all tenants in the Program. On 12/3/24 at 12:45 pm, the Director and the DON confirmed staff failed to document the initial and hourly checks on all tenants during the power outage on 7/15/24.	