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

Date: July 10, 2024
Program Name: Homestead of Estherville
Address: 2015 3rd Ave North Estherville, IA 51334
Type of Action: Recertification Visit and Investigations #116645-C, 116802-I, 116906-C & 119613-I
Date(s) of Action: 3/10/24 – 6/10/24
Citation #: 10464

State Rule #	State Rule	Amount of Civil Penalty
Iowa Administrative Code 481-67.2(3)	**67.2(3) The program shall follow the policies and procedures established by the program.** Based on interview and record review the Program failed to consistently follow policies and procedures regarding incident reporting/fall management. This pertained to 1 of 1 tenant identified in Incident 116802-I (Tenant C2). Finding follows: 1. Record review on 3/18/24 revealed three incident reports (IR) for Tenant C2 dated 10/23/24 (4:36 p.m.), 10/23/24 (5:24 p.m.) and 10/29/24 (12:59 p.m.) noted the following: a. The IR for 10/23/24 4:36 p.m. described Tenant C2 wanted to leave the memory care unit, broke a lamp, television, hit windows and kicked a mirror. The tenant asked for police and thought someone was trying to hurt her. The IR included documentation from the nurse notified the tenant's family of their aggressive behavior. b. The IR for 10/23/24 at 5:24 p.m. documented staff heard a thud inside C2's room followed by a painful groan. Staff entered Tenant C2's room and found her laying on the floor between her chair and bed. Staff noted a bump on her left side back of her head. c. The IR for 10/29/24 at 12:59 p.m. documented Tenant C2 walk out of their room when staff noticed bruising on the side of her neck. Further review of the IRs for 10/23/23 at 5:24 p.m. and 10/29/23 at 12:59 p.m. did not include any notifications of	**$3000.00**

	POA/responsible party/family. The Program documented notification of the physician on 10/23/23 at 4:36 p.m. and 5:24 p.m. but not for 10/29/23. Record review on 3/19/24 revealed the Program's Fall Management policy, undated. The policy directed the Program to complete and document the notification of the physician, the responsible party, and/or the family. A daily follow up note should be completed in the electronic medical record for 72 hours. The policy further directed staff to follow the head injury policy if head injury present or was suspected. Record review revealed the Head Injury policy, undated, directed tenants who had a fall that may have included striking the head on a solid surface would be evaluated for possible head trauma in the emergency room. The policy indicated the nurse would direct the tenant be transported to the Emergency Room (ER) to be evaluated for possible head trauma. If the tenant refused, the nurse would educate the tenant on importance of being evaluated. The policy directed the Program to notify tenant's physician and Power of Attorney (POA)/responsible party. Further review of the Fall Management on 3/19/24 revealed the policy directed a daily follow up for falls be documented in the electronic medical record for 72 hours. Circumstances be recorded in the electronic record and review and/or revise the plan of care with new intervention following each fall. Review of Tenant C2's Progress Notes revealed no entries in the electronic record regarding C2's fall or review/revision of the care plan. Record review revealed Progress Notes for Tenant C2 included the following: a. On 10/24/23 at 2:30 p.m. the RN documented she was called back to assist with Tenant C2. The tenant was very irritable and agitated. Resident actively tried to exit the unit upon her arrival. The RN asked the tenant to walk with her and she yelled, "You are all liars. You keep me in here like a slave." Tenant continued to yell profanities and tried to push	

	staff out of the way to leave. The RN was able to b. A note from the RN on 10/30/23 at 9:32 a.m. documented she contacted the hospital or a status update on Tenant C2. Family told ER staff the tenant had 2-3 falls the last couple weeks and hit her head twice, once on the floor and once on the corner of the wall. Family stated she had increased confusion and behaviors over the past weeks. CT scan completed and showed a 1-2 millimeter (mm) acute subdural hematoma. Another CT scan was scheduled for 10/31/23. c. A note from the RN on 10/30/23 at 10:28 a.m. documented she was informed Tenant C2's family took her to the hospital on 10/29/23 after noticing a bruise. The nurse was unable to assess the resident, as she was at the hospital and did not return to the Program. The nurse did call the hospital and was told the resident was there and would have a CT done after complaints of two falls and hitting her head. d. On 10/31/23 at 4:02 p.m. the RN documented upon contacting the hospital for an update on Tenant C2 she was informed family asked them not to give the Program any information regarding the patient as she was no longer a resident there. When interviewed on 3/14/24 at 11:40 a.m. the POA confirmed the Program failed to contact her or any other family member regarding the Tenant C2's agitation/aggression on 10/23/23 at 4:36 p.m. and the fall on 10/23/23 at 5:24 p.m. Additionally, the Program failed to ask the tenant and/or POA if Tenant C2 should be sent to the Emergency Room (ER). The POA reported Tenant C2 had bruising around her head and neck after experiencing two falls from her bed. The family took her to the emergency room where she was diagnosed with a brain bleed of the frontal lobe. When interviewed on 3/19/24 at 5:00 p.m. the Director confirmed the Program failed to follow policy regarding fall	

	management and head injury for Tenant C2. The Director explained the nurse documented notification, but failed to notify the family. The Director confirmed the Program failed to notify Tenant C2's family and determine if Tenant C2 should be sent to the ER for evaluation.	
IAC 481-69.32(2)	**69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.** Based on observations, record review and interview the Program failed to ensure an operating alarm system connected to all exit doors. This potentially pertained to 1 of 1 tenant identified in Incident 119613-I and potentially 10 of 10 tenants with cognitive impairment. Findings follow: 1. Record review on 3/18/24 revealed a progress note, dated 3/12/24, documented the delegating nurse documented she saw Tenant #1 outside in the parking lot at 1:35 p.m. The nurse brought Tenant #1 inside and completed assessments with no injuries noted. Tenant #1 returned to the memory care unit. Further record review revealed an Incident Report (IR) dated 3/12/24 documented the nurse observed Tenant #1 outside in the front parking lot attempting to leave the property. No injuries noted by the nurse. On 6/6/24 at 2:23 p.m. the State Climatologist confirmed weather conditions on 3/12/24 at 1:35 p.m. as the following Temperature: 67 degrees F, Relative Humidity: 15%, winds out of the North at 3 miles per hour and no precipitation detected with clear conditions Record review revealed Tenant #1's diagnoses included Alzheimer's Disease and unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance and anxiety. Her Global Deterioration Scale score, dated 3/12/24, measured 5 which indicated moderate cognitive decline. The Program admitted Tenant #1 on 11/17/23. Review on Tenant #1's service plan dated 12/18/23 revealed no documentation regarding elopement or wandering.	**$3000.00**

	When interviewed on 3/19/24 at 2:00 p.m. the delegating nurse stated she found Tenant #1 in the parking lot approximately 30 yards from the front door. Tenant #1 wore clothes appropriate for the weather conditions. She noted no injuries. 2. When interviewed on 3/14/24 at 4:00 p.m. the Director said door alarms on outside doors of the assisted living area of the building had been disengaged from 6:00 a.m. - 9:00 p.m. daily. The Director did not understand Assisted Living Programs for People with Dementia (ALPD) required functioning door alarms on all outside doors.	
IAC 481-69.32(4)(a)	**69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have:** **a. Written procedures regarding alarm systems, if an alarm system is in place.** Based on observations, interview and record review the Program failed to implement policies and procedures to address operating door alarms and staff response to the alarms. This pertained to 1 of 1 tenant identified in Incident 119613-I and potentially 10 of 10 tenants with cognitive impairment. Findings follow: 1. Record review on 3/18/24 revealed a progress note, dated 3/12/24, documented the delegating nurse documented she saw Tenant #1 outside in the parking lot at 1:35 p.m. The nurse brought Tenant #1 inside and completed assessments with no injuries noted. Tenant #1 returned to the memory care unit. Further record review revealed an Incident Report (IR) dated 3/12/24 documented the nurse observed Tenant #1 outside in the front parking lot attempting to leave the property. No injuries noted by the nurse. On 6/6/24 at 2:23 p.m. the State Climatologist confirmed weather conditions on 3/12/24 at 1:35 p.m. as the following Temperature: 67 degrees F, Relative Humidity: 15%, winds out of the North at 3 miles per hour and no precipitation detected with clear conditions Record review revealed Tenant #1's diagnoses included Alzheimer's Disease and unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance and anxiety. Her Global Deterioration Scale score, dated 3/12/24,	

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		$500.00

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IAC 481-67.19(3)		

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