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

Date: December 1, 2025
Program Name: Homestead of Estherville
Address: 2015 3rd Avenue North, Estherville, Iowa 51334
Type of Action: Investigations #127785-I, 128522-C, 128679-I
Date(s) of Action: 8/27/25 – 8/28/25
Citation #10979

State Rule #	State Rule	Amount of Civil Penalty
Iowa Administrative Code 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 interview and record review, the program failed to ensure an operating alarm system was connected to each exit door in the dementia-specific program. This affected 1 of 4 memory care tenants reviewed (Tenant C1), and potentially affected all cognitively-impaired tenants residing in the program. Finding follows: Record review on 8/27/25 revealed Tenant C1's elopement incident report, dated 3/30/25, indicated at 9:50 a.m., Tenant C1 eloped from the memory care unit and was located outside the front entrance of the building. The report indicated Tenant C1 exit seeked and wandered. Staff reported increased confusion and exit seeking behaviors over the past few days. Tenant C1's chart indicated on 4/08/24, Tenant C1 admitted to the Program and his diagnoses included Alzheimer's Disease, depression, and anxiety disorder. The Service Plan, dated 4/01/25, noted Tenant C1's Global Deterioration Score (GDS) of 5, which indicated moderately severe cognitive decline and included "resides in memory care where the doors are secure and alarmed" with an initiation/identified date of 3/05/25. Tenant C1's hourly checks revealed the last recorded observation at 9:07 a.m. Tenant C1's nursing progress note dated 3/30/25, indicated at 10:05 a.m. following the incident Tenant C1's vitals were within normal limits and no apparent injuries. The nursing progress note further noted the tenant had increased confusion over the past few days and exit seeking behaviors. Following the incident, Tenant C1's service plan was reviewed/updated on 4/01/25. Additions to the service plan identified Tenant C1 as a risk for elopement/wandering and included interventions to help prevent	**$5000.00**

	further exit-seeking behaviors/attempts. Tenant C1 discharged from the Program on 5/19/25. Staff A's written statement obtained by the Program at the time of the incident revealed Staff A arrived at the building at 9:55 a.m. on 3/30/25 and observed Tenant C1 standing at the front door alone. When Staff A pulled up in her vehicle, Tenant C1 opened her passenger door and got into the vehicle. Staff A assisted the tenant back into the building to the memory care unit and alerted Program staff. Once Tenant C1 was safely in the unit, Staff A checked the secondary fire exit door. Staff A discovered the door wasn't alarmed, she instructed the staff member on duty in the unit on the proper setting and reset methods for the alarms on the door. Staff B's written statement obtained by the Program at the time of the incident revealed Staff B worked in the memory care unit of the Program and was only made aware Tenant C1 exited the unit when he was escorted back to the unit by other staff. Staff B recorded the next hourly check at 10:01 a.m. when the tenant returned to the unit. Staff B indicated no alarms alerted her Tenant C1 exited and she assisted another tenant in a room at the back of the unit. Staff B's written statement noted staff determined the alarm/s did not go off on the emergency exit door by the staff bathroom and Tenant C1 exited. The statement further noted the alarm on the door hadn't been properly reset and Staff B didn't know the alarm needed reset. Staff C's written statement obtained by the Program at the time of the incident revealed Staff C observed Tenant C1 walking inside with Staff A. Staff A indicated Tenant C1 had been outside. She noted it was "sprinkling' outside, a little chilly, and he did not have a coat on." During an interview on 8/27/25 at 1:55 p.m., Staff B confirmed she was the staff member on duty in the memory care unit at the time of the elopement and confirmed the information within her written statement. She didn't know Tenant C1 left and the alarm was not on. She explained there was an audible alarm on the door and the alarm was not hooked up to the system, which the alarm company called the Program when the alarm went off. She recalled Tenant C1 had been dressed in a short sleeve shirt, jeans, and slip on shoes. She recalled it being a chilly day. On 8/28/25, the State Climatologist provided the weather conditions for the date and suspected time of the elopement	

	incident. The temperature between 9:00 a.m. to 10:00 a.m. was 35 to 36 degrees Fahrenheit, with winds out of the north to northwest between 8 to 12 miles per hour (mph), but wind chill temperatures ranged from 28 to 29 degrees Fahrenheit. The conditions were a wintry mix. A review of the program policy, Electronic Surveillance Systems, indicated each exit door in the dementia-specific program connected to an operating alarm system. The policy indicated the alarms were tested daily. During an interview on 8/27/25 at 3:00 p.m., the Executive Director explained the secondary door (located by the memory care public bathroom) was not originally wired into the Viking alarm system and the door contained a built-in alarm which originally was audible, but did not alert phones. There was also a secondary, louder audible alarm which was mounted to the door as well. The Executive Director indicated it was her understanding both systems did not alarm on the day of the incident, the loud one was stuck in between the on/off setting, and then speculated staff might have thought the other quieter alarm was reset but actually wasn't, as the alarm required a key to reset, so therefore was disarmed. It was ultimately unknown when the alarms may have last been attempted to be reset, and unknown how long both alarms had not been operational. The Executive Director was uncertain if the door alarms were tested routinely, but the maintenance director would check the alarms following an elopement or exit-seeking incident. Following the elopement incident with Tenant C1, the program initiated a form where staff were to check the memory care door alarms and sign off. On 8/28/25 at 9:20 a.m., the Executive Director and interim Health Care Coordinator confirmed the above findings.	