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

Date: September 6, 2024
Program Name: Keystone Place at Forevergreen ALP/D
Address: 1275 W. Forevergreen Road North Liberty, IA 52317
Type of Action: Recertification Visit & Investigation #121790-I
Date(s) of Action: 7/1/24 – 7/2/24
Citation #10577

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 follow the Life Safety policy on staff response to memory care door alarms for 1 of 1 tenant who eloped over the prior month (Tenant #1). Findings follow: Record review of an incident investigation dated 6/24/24 revealed Tenant #1 woke up around 4:45 AM asking to walk across the street. Staff A reported he could not go out any of the doors as they were emergency exits. Staff A assisted Tenant #1 to sit down in the commons area and left to check on other tenants. Staff A heard a door alarm sound and came back to the dining room area. Staff B shut off the alarm and assisted Tenant #1 back to his room. Staff A continued her checks on other tenants when Tenant #1 came out of his room and began wandering the halls. Staff A continued to check other tenants when she heard the door alarm go off again. Staff A returned to the commons area and noted the garden door alarm was going off. Staff A went to the garden door, turned off the alarm, looked outside but did not see Tenant #1. She returned to the unit, looked down the hall and then walked back to the medication cart. Staff A did not search for Tenant #1 or ensure the location of all tenants. Staff A heard knocking on the garden door and saw Tenant #1 trying to get back in from the courtyard. Staff A let Tenant #1 in the building and provided 1:1 supervision until the next shift arrived. Staff A notified the nurse on-call at 6:16 AM of the incident. The program developed a Resident Assessment on 12/5/23 for Tenant #1. Tenant #1 scored a 5 on the Global Deterioration Scale indicating moderately severe cognitive decline. The assessment identified Tenant #1 may exit-seek by following others when they leave the unit. Staff were to provide Tenant #1 with verbal and	**$1000.00**

	physical redirection as needed, offer a diversional activity, provide 1:1 supervision, offer a snack or turn the television onto a sports channel. Tenant #1 received safety checks every two hours to ensure his safety. He required redirection and supervision due to his elopement and wandering risk. Tenant #1 was impendent with ambulation and transfers. On 7/2/24 at 8:00 AM, Staff A reported when Tenant #1 woke up on 6/24/24, he was walking to all of the doors on the memory care unit and shaking them. He was pretty upset when she attempted to redirect him. Staff B assisted Tenant #1 the first time the door alarm sounded. The second time Staff A heard the door alarm, she responded. Staff A looked outside the garden door but it was dark outside and she did not see any tenants. She thought Tenant #1 must have pushed the door to cause the alarm but she believed he then went back inside. Staff A looked in the hallway, but it was also dark and she did not see Tenant #1. About 1-2 minutes later, Tenant #1 approached the garden door wanting to get back in. Tenant #1 was upset because he could not get off the unit. Staff A said she was trained to stay with tenants who were exit-seeking. On 7/2/24 at 8:20 AM, Staff B recalled Tenant #1 was awake much of the night. She would escort Tenant #1 to his room, he would get up and go to the living room and try to open the doors. Staff B responded to the door alarm once when Tenant #1 opened the door. After this occurred, Staff B took Tenant #1 to his room. She then went to do her last round of checking on other tenants for the day. Staff B was in another tenant's apartment when the second alarm went off. She assumed he was still in his apartment. The Life Safety policy on staff response when a door alarm was sounding indicated staff should IMMEDIATELY respond to the door alarming. Attempt to determine what set off the alarm. OPEN THE DOOR AND LOOK TO SEE IF A TENANT IS IN SIGHT. WALK OUTSIDE AND QUICKLY SCAN THE GROUNDS. ALWAYS ASSUME IT IS A TENANT WHO ACTIVATED THE ALARM (capitals per policy). On 7/2/24 at 8:35 AM the Director of Health and Wellness reported a video of the incident was no longer available, however she took notes about the incident. The alarm sounded at 5:07 AM. Staff A arrived at the door at 5:08 AM, shut off the alarm and looked outside. At 5:09 AM, Staff A turned away from the door and walked to the commons area, looking down the hallway. Staff	

	A then returned to the medication cart, she did not look for Tenant #1 in the building. Staff A returned to the garden door at 5:10 AM and let Tenant #1 in after hearing him knock. The Director of Health and Wellness confirmed Staff A and Staff B did not follow the Life and Safety policy when she did not search for Tenant #1 after the alarm sounded. **67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:** **f. Services shall be provided to tenants in accordance with the training provided.** Based on interview and record review, staff failed to supervise 1 of 1 tenant reviewed who were admitted in the past four months according to the training they received (Tenant #1). Findings include: Record review of observation notes for Tenant #1 revealed he had an increase in exit-seeking behaviors on 4/16/24. Tenant #1 was noticed to almost stumble and fall when attempting to jog to an exit door which was opened by a visitor or employee. Staff were instructed to keep one member in the day room at all times to monitor exit doors and one staff member in the hallway to monitor the back exit door. - A 90-day nurse review was completed for Tenant #1 on 5/13/24 noting he continued to have issues related to cognitive status, requiring 1:1 supervision from staff at times. Due to his intermittent 1:1 needs and repeated behaviors, the program recommended a private duty caregiver or family provide assistance at times. - Staff documented providing 1:1 supervision of Tenant #1 during episodes of wandering or exit-seeking on the following dates: 4/22/24, 5/5/24, 5/8/24, 6/12/24 and 6/13/24. An incident investigation dated 6/24/24 revealed Tenant #1 woke up around 4:45 AM asking to walk across the street. Staff A reported he could not go out any of the doors as they were emergency exits. Staff A assisted Tenant #1 to sit down in the	

	commons area and left to check on other tenants. Staff A heard a door alarm sound and came back to the dining room area. Staff B shut off the alarm and assisted Tenant #1 back to his room. Staff A continued her checks on other tenants when Tenant #1 came out of his room and began wandering the halls. Staff A continued to check other tenants when she heard the door alarm go off again. Staff A returned to the commons area and noted the garden door alarm was going off. Staff A went to the garden door, turned off the alarm, looked outside but did not see Tenant #1. She returned to the unit, looked down the hall and then walked back to the medication cart. Staff A did not search for Tenant #1 or ensure the location of all tenants. Staff A heard knocking on the garden door and saw Tenant #1 trying to get back in from the courtyard. Staff A let Tenant #1 in the building and provided 1:1 supervision until the next shift arrived. Staff A notified the nurse on-call at 6:16 AM of the incident. The program developed a Resident Assessment on 12/5/23 for Tenant #1. The assessment identified Tenant #1 may exit-seek by following others when they leave the unit. Staff were to provide Tenant #1 with verbal and physical redirection as needed, offer a diversional activity, provide 1:1 supervision, offer a snack or turn the television onto a sports channel. On 7/2/24 at 8:00 AM, Staff A reported when Tenant #1 woke up on 6/24/24, he was walking to all of the doors on the memory care unit and shaking them. He was pretty upset when she attempted to redirect him. Staff B assisted Tenant #1 the first time the door alarm sounded. The second time Staff A heard the door alarm, she responded. Staff A looked outside the garden door but it was dark outside and she did not see any tenants. She thought Tenant #1 must have pushed the door to cause the alarm but she believed he then went back inside. Staff A looked in the hallway, but it was also dark and she did not see Tenant #1. About 1-2 minutes later, Tenant #1 approached the garden door wanting to get back in. Tenant #1 was upset because he could not get off the unit. Staff A said she was trained to stay with tenants who were exit-seeking. On 7/2/24 at 8:20 AM, Staff B recalled Tenant #1 was awake much of the night. She would escort Tenant #1 to his room, he would get up and go to the living room and try to open the doors. Staff B responded to the door alarm once when Tenant #1 opened the door. After this occurred, Staff B took Tenant #1 to his room. She then went to do her last round of checking on other tenants for	

	the day. Staff B was in another tenant's apartment when the second alarm went off. She assumed he was still in his apartment. On 7/2/24 at 8:35 AM the Director of Health and Wellness reported she trained staff to provide tenants with 1:1 supervision when they displayed exit-seeking behaviors. She confirmed Staff A and Staff B did not supervise Tenant #1 in accordance with their training on 6/24/24.	