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

Date: January 20, 2022
Program Name: Stirlingshire of Coralville MC
Address: 1140 Kennedy Parkway Coralville, IA 52241
Type of Action: Incident #100149-I
Date(s) of Action: 10/27/21 to 11/1/21
Citation # 5534

State Rule #	State Rule	Amount of Civil Penalty
67.3(2)	**481-67.3 Tenant rights. All tenants have the following rights:** **67.3(2) To receive care, treatment and services which are adequate and appropriate.** Based on observations, interviews, and record review, the Program failed to provide adequate and appropriate services for 1 of 2 tenants reviewed (Tenant #1). Findings include: A review of Tenant #1's record on 10/27/21 revealed an admission date of 9/30/21. Tenant #1 had a diagnosis of unspecified dementia with behavioral disturbance. He scored a 5 on his most recent Global Deterioration Scale (GDS) dated 9/22/21 which indicated moderately severe cognitive decline. Tenant #1's service plan implemented on 9/30/21 indicated a history of wandering and elopement from previous homes. He received scheduled safety checks daily which were generally spaced 2 hours apart. An incident report dated 10/22/21 revealed at approximately 5:45 PM, staff could not locate Tenant #1 in the Program. The building and grounds were searched with no results. Staff called 911 for assistance. Staff also contacted the Executive Director and Clinical Registered Nurse (RN) upon discovery of the missing tenant. Staff said they did not think they heard the alarm while sitting in the nurses' station. The staff noted the door alarm light located in the nurses' station was set to off when it previously been on. The tenant was located by the police department and returned to the building at 5:58 PM. The incident report documented the tenant had received no injuries. The form had an area for vital signs which was not completed. In addition the report was not signed or dated by the person who completed it. On 10/27/21 at 10:48 AM the Executive Director stated the police returned Tenant #1 to the facility. The police stated the tenant was picked up by someone driving from the ALP/Independent Living complex area and driven to the front of the high school two miles away where he was dropped off. The video showed he walked out the door of the memory care unit at 5:29 PM. The police picked the tenant up in front of the high school and returned him to then facility at 5:58 PM. The police indicated he was driven to where he was picked up.	**$3000.00**

	Information provided by the Program revealed the temperature at the time the tenant left was 46 degrees. He wore sweatpants, a sweatshirt, tennis shoes and a stocking cap when he left. On 10/27/21 at 11:15 AM, the Clinical RN stated she was contacted by Staff B on 10/22/21 that Tenant #1 was missing. The Executive Director was also contacted and was going to the Program. The Clinical RN stated she did not go in as she lived 45 minutes away and knew others were headed there. After the tenant was returned by police, Staff E told the Clinical RN she assessed him when she got him ready for bed and had not seen any injuries. On 10/28/21 at 3:00 PM, the Clinical RN confirmed she had not come in and completed an assessment of the tenant. In addition, evaluations for the significant change of elopement from the Program were not completed until 4 days later. The Clinical RN said since the tenant's 30 day evaluations were due on 10/26/21, she decided to wait to do the significant change evaluations until that time. On 10/27/21 at 10:30 AM, Staff A stated he was the person working on the night of 10/22/21 and was in charge of Tenant #1's safety. This was his first time working with the tenant. Staff A recalled Tenant #1 was pacing that night. After supper was completed, he went into the staff office to do computer work. The office contained a glass window to view the common areas and an automated closed door. Staff A noticed that around 5:30 PM, he couldn't see Tenant #1 in the common areas. Staff A looked in Tenant #1's apartment but he wasn't there. Staff A searched other areas of the Program but could not find him. Staff A asked Staff B, Staff I, and Staff J who were all in the connected assisted living program if they had heard an alarm or saw Tenant #1, but they had not. He then searched outside and around the neighborhood. Staff B contacted the Executive Director and 911. Staff A stated at first that he had not heard the alarm go off at all. He later said while in the staff office, he might have heard a noise but was not sure what it was and thought it could have been a doorbell. Staff A added he noted the door alarm light was green when he went to ask the assisted living staff if they had seen Tenant #1. Staff A stated it hadn't registered with him at the time the green light meant the door was unlocked or had been released. On 10/28/21 at 1:10 PM, Staff B stated she was training Staff I on 10/22/21. At some point between 5:00 PM and 5:30 PM on 10/22/21, Staff A came over to the assisted living program and asked if they had seen Tenant #1. Staff B stated they had not. They had been assisting with the dinner service and had not seen him or heard an alarm. Staff B stated she had seen Tenant #1 touch the door push bar before and make the alarm beep but he had never opened the door before that she was aware of. On 10/28/21 at 2:00 PM, Staff I stated he was in training and worked back and forth between the memory care program and the assisted living program on 10/22/21. Staff I stated he last observed Tenant #1 in the memory care program at around 4:30 PM or 4:45 PM when he served him dinner. Staff I stated he helped in the assisted living program and served dinner there until approximately 5:30 PM. At 5:30	

	PM, Staff I stated he went to the memory care to use the restroom and noted Tenant #1 not pacing around as usual. Staff I questioned Staff A about this. He then left the memory care and went back to the assisted living. Several minutes later, Staff A came to the assisted living and asked Staff I and Staff B if they had seen Tenant #1. They stated they had not. Staff B contacted 911 and Staff I assisted in searching inside and outside of both programs. On 10/27/21 at 1:15 PM, Staff J stated she was washing dishes at around 5:30 PM on 10/22/21 when Staff A popped in and asked if she had seen Tenant #1 or if she had heard the alarm go off. Staff J stated she had not. On 10/27/21 at 11:01 AM, the Maintenance Director stated he came in to the Program on 10/22/21 as he was called by the Executive Director. He immediately checked the memory care exit door and the door alarm worked properly. This meant the alarm had to have gone off when Tenant #1 exited the Program. The Maintenance Director stated after reading up on the alarm, he realized the alarm would have gone off on 10/22/21 for exactly 2 minutes after the tenant exited and then would have shut off and reset. He changed the alarm the next day to stay on permanently if triggered until staff turned it off using a key. The Maintenance Director also reviewed the hallway camera footage which showed Tenant #1 leaving the memory care program at 5:29 PM. On 10/27/21 at 3:15 PM, the Executive Director stated she implemented 15 minute checks on Tenant #1 immediately upon his return and for staff to only do paperwork in areas where Tenant #1 was and not the office. All staff were notified of this change the next day. The Executive Director also indicated staff were no longer to allow Tenant #1 out of their sight in common areas unless another staff was available to take over supervision until a second safety measure/alert could be added to all of the Program's exit doors. On 10/27/21, the Alarm Response policy for the Program was reviewed. The policy revealed the following: 1.) Check to determine the location of the alarm that is sounding. This will indicate the door that has been opened. (the memory care Program has 2 exit doors) 2.) Staff must immediately respond to all door alarms. On 10/28/21 at 9:50 AM, the surveyor sat in the staff office and had the Clinical RN trigger the door alarm. The surveyor could hear the muffled door alarm. On 11/1/21 at 4:00 PM, the Executive Director confirmed the above findings.	