

**Iowa Department of Inspections, Appeals, and Licensing
Health & Safety Division
Citation**

Citation Number: 11022		Date: 1/21/26		
Facility Name: Chatham Oaks		Survey Dates: 11/24/25-11/25/25		
Facility Address/City/State/Zip 4515 Melrose Avenue Iowa City, IA 52246		CC		Actions: Investigations #129527-I
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

Iowa Administrative Code (IAC) 481-57.34(3)	The licensee of a residential care facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (I, II, III) Residents shall receive adequate supervision to ensure against hazard from themselves, others, or elements in the environment. (I, II, III) Based on interview and record review, the facility failed to ensure the safety of 1 of 3 current residents reviewed (Resident #3). Finding follows: Record review on 11/24/25 of a note from Resident #3's Advanced Registered Nurse Practitioner (ARNP), dated 11/11/25 revealed she was diagnosed with schizoaffective disorder, unspecified; essential hypertension and a learning disability. She had a mental health commitment to receive treatment at the facility. An Internal Resident Incident Report Form revealed staff could not find Resident #3 during the 9:00 p.m. rounds on 11/19/25. An internal investigation of Resident #3's elopement noted earlier in the day she started crying and told Staff A she was worried about her belongings which	I	\$2500.00	UPON RECEIPT
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Facility Administrator

Date

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty-five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

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	were in a storage unit in Cedar Rapids. Resident #3 wanted to call the police so they could transport her from the facility to the hospital in Cedar Rapids. A facility activity was planned for a group to go to the library to watch a movie and Resident #3 agreed to attend. She told Staff A she was excited to go to the library because there would be a lot of cops outside and she would be able to get them to take her to Cedar Rapids. Staff A told Resident #3 she would not be able to go to the library if her intentions were only to find an officer to take her to Cedar Rapids. Resident #3 agreed she would not seek out an officer, but would watch the movie. Staff A transported Resident #3 and six other residents to the library. When they arrived, Resident #3 wanted to remain in the car but Staff A told her she needed to go to the library. Once inside, she said she forgot things in the car. Staff A walked with her to the car to get them. While at the car Resident #3 stated she was a free person and could do what she wanted and asked Staff A to stop following her. Staff A stated he understood, but needed to go to the car to help her get her stuff and provide support. The group then went to the movie. Staff A decided to stand outside the entrance to the room in which the movie was			
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	showing to ensure Resident #3 did not leave. When Staff A was speaking with someone, Resident #3 was able to walk outside. Staff A went into the movie room and Resident #3 was not there. Staff A went outside to look for Resident #3 and she was down the street from the library. He walked to get her and Resident #3 seemed frustrated. She said she was trying to find a police officer to take her to Cedar Rapids. She initially refused to return to the library but agreed to do so when Staff A said he would take her to Cedar Rapids the following day. The group left the library around 7:40 p.m. Staff A watched Resident #3 walk into the facility with another resident. This was the last time he saw her that night. During an interview with Staff D on 11/24/25 at 4:55 p.m. she reported someone asked her around 9:00 p.m. if she saw Resident #3 and she had not. She knew Staff A left the building to go back to the library to pick up an item he left there so they called to see if he might have the resident with him. He did not. It was at this time Staff A informed them Resident #3 eloped from the library and talked about wanting to go to Cedar Rapids. The staff did not increase Resident #3's level of supervision upon her return			
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	from the library because Staff A did not inform her there was a problem until the 9:00 p.m. phone call. When interviewed on 11/24/25 at 6:52 p.m., Staff B indicated he saw Resident #3 prior to the library trip and did not notice any signs of distress. When he looked for her around 9:00 p.m., he was unable to find her in or around the building. Staff B was not aware Resident #3 eloped from the library or had any difficulty while on the outing. After he spoke with Staff A, he searched the building, grounds and contacted the on-call supervisor. When interviewed on 11/24/25 at 5:10 p.m., Staff A reported Resident #3 came to him the afternoon of 11/19/25 crying because there was no service on her phone. She wanted to go home and leave the facility. He offered to take her to the library activity with him where there was Wifi and she agreed. On the way there, Resident #3 made comments such as, if I see the police, I will stop them to see if they will give me a ride to Cedar Rapids to do my business and he attempted to provide redirection. When they arrived at the library Resident #3 did not want to watch the movie. She indicated she did not want to stay there			
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	and wanted to go to Cedar Rapids. Staff A went to speak with one individual and when he returned he could not see Resident #3. He looked around outside and did not see her. Staff A then looked down the street and was able to locate her. Resident #3 said she was trying to get to Cedar Rapids and would not return. She began insulting Staff A until he agreed to take her to Cedar Rapids the following day. When he got her back to the library the group returned to the facility. Resident #3 was yelling, crying and shouting. Resident #3 did not want to go inside the facility because she wanted to go to Cedar Rapids. The facility policy, Elopement (Missing Resident) noted team members would report as soon as possible to management on duty, or on-call, any resident leaving the premises without authorization or any resident that was missing. When a resident returned to the facility, they would be assessed by a team member to determine if medical care was needed. If medical treatment was not needed, the resident would have 15 minute welfare checks for a period of two hours after return.			

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	During an interview on 11/25/25 at 8:45 a.m. the Administrator indicated Resident #3 should not have gone to the library when she made comments about wanting to leave and go to Cedar Rapids. Staff A should have notified the on-call manager and his co-workers about Resident #3's elopement at the library. Upon her return to the facility, she should have been put on heightened checks.			

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