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

Date: March 6, 2025
Program Name: Primrose Retirement Community
Address: 1801 East Kanesville Blvd Council Bluffs, IA 51503
Type of Action: 121513-I
Date(s) of Action: 11/12/24 – 11/14/24
Citation #: 10763

State Rule #	State Rule	Amount of Civil Penalty
67.26(1)	**<u>69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.</u>** Based on interview and record review the program failed to ensure service plans were based on evaluations, included specific service needs, and were updated as needed for 1 of 1 former tenants reviewed (Tenant C1). Findings follow: Record review on 11/12/24 revealed Tenant C1, age 97, was admitted to the program on 6/26/20 with a Global Deterioration Scale (GDS) score of 5 indicating moderately severe cognitive decline. Review of an Incident Report dated 6/9/24 at 11:15 am revealed Tenant C1 eloped from the program and was stopped about a block down the street. Staff became aware after receiving phone calls from the community-at-large as well as a visitor entering the program who reported Tenant C1 was observed walking on E. Kanesville Rd. The incident report failed to indicate whether the door alarms were activated at the time of the elopement. The tenant's vital signs were taken at 11:35 am upon her return and were within normal limits. No injuries were noted. When interviewed on 11/12/24 at 1:45 pm, the Executive Director stated the doors were not alarmed during the hours of 7:00 am to 7:00 pm and staff would not have been alerted if someone had exited the building on the date/time of the elopement. A summary of the program's internal investigation and review of camera footage by program staff revealed Tenant C1 exited through the front door of the program at approximately 10:30 am on 6/9/24. On 11/19/24 at 10:00 am the State Climatologist stated the temperature at the time of the elopement was 78-80 degrees Fahrenheit with fair conditions and no precipitation. Winds were out of the NW to WNW at 7-12 miles per hour (mph), with gusts up to 21 mph. Iowa Traffic Data from the Iowa Department of Transportation	**$4500.00**

	revealed a total average annual daily traffic on E. Kanesville Rd as 10,000 vehicles. When interviewed on 11/14/24 at 8:33 am, the responding officer from the Council Bluffs police department stated he was in the area and had been stopped at a light on 6/9/24 when community members verbally reported to him an elderly woman was in the middle of E. Kanesville Rd. The officer stated he immediately made a U-turn and began to head in the direction of the reported incident when an additional call came through his dispatch. When he arrived on scene, he observed Tenant C1 in the middle of the road. Vehicles were stopped and people were attempting to offer aide to the tenant. He stated Tenant C1 was unharmed but he could tell she was confused and stated two program staff were running towards the area. When interviewed on 11/12/24 at 11:50 am, Staff A stated she worked on the day of the elopement. She had received a phone call from someone in the general public who reported there was a lady out on the highway. Progress notes from Staff A revealed the call came in to the program at approximately 11:15 am. Staff A further stated during the interview she immediately thought of Tenant C1 and went to her apartment but could not locate her. Staff A then received a verbal report from the daughter of another tenant who was entering the building and believed she observed Tenant C1 out on the highway. Staff A paged staff for assistance as she headed towards the front entrance along with another staff member who joined them. By the time she reached the front part of the campus grounds and looked down the highway, traffic had been stopped and a police officer was in the process of transporting Tenant C1 back to the building. Staff A stated Tenant C1 normally had confusion and had exhibited wandering behavior before, but usually exited out a side door. Tenant C1 had just exited from the program out the side door a few days prior. On 11/13/24 at 3:45 pm, Staff C stated she had just received the nurses page for assistance on 6/9/24 when she also received a phone call from someone in the community-at-large who reported a woman out on the highway. Staff C made her way downstairs to 1st floor and then met other responding staff members who then all went out the front door. She saw activity down the street more than a block away and saw the police. Review of an incident report dated 6/7/24 revealed Tenant C1 was observed outside of an exit door area by room 126. She stated she didn't know where/why she was there but was redirected back inside without difficulty. Staff C stated during her interview on 11/13/24 she had been instructed to complete 15-minute checks after the incident on 6/7/24, but was unaware of any additional interventions or hourly checks prior to the elopement on 6/9/24. Staff C stated she felt Tenant C1 had started to wander a little bit more. She indicated other staff mentioned Tenant C1 previously sat outside and then came back in the building, but she noticed as time went on Tenant C1 started to wander farther	

	away from the doors. She recalled one time (no date specified) Tenant C1 wandered all the way to the trash area and she had to go get her and bring her back in. Staff C stated she knew of no interventions put into place to help address the increased wandering behavior. When interviewed on 11/12/24 at 12:10 pm Staff D stated when she started employment earlier in the year she had observed Tenant C1 outside on occasion. She questioned if the tenant was safe to be outside on her own, and was told she was. She had noticed Tenant C1 had increased confusion leading up to the elopement incident on 6/9/24. Review of a 6 month evaluation dated 2/26/24 revealed Tenant C1 had poor recent mental health status and required regular prompting due to confusion and disorientation. The elopement risk section of the evaluation indicated Tenant C1 hallucinated and/or looked for individuals that were not present, had disorientation and intermittent confusion, purposelessly wandered, and had a history of elopement. Tenant C1's service plan, last updated 2/26/24, had a need area regarding Orientation/Prompting in which staff where to orient and prompt her as necessary. Under the Safety/Risk category, the tenant had need areas for Fall Risk Assistance and Evacuation Assistance if needed. The service plan did not address the tenant's wandering behaviors and interventions or her history of elopement as noted in the 6 month evaluation completed on 2/26/24. In addition, the program failed to revise the service plan to include interventions after repeated episodes of wandering outside of the building as noted by staff. On 11/14/24 at 1:00 pm the Nursing Director and Executive Director confirmed the above findings.	