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

Date: January 27, 2022
Program Name: Senior Star at Elmore Place Memory Care
Address: 4504 Elmore Ave
Type of Action: Incidents 95309-I and 100797-I
Date(s) of Action: 11/29/21 – 12/8/21
Citation # 5553

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 interview and record review, the program failed to provide appropriate care and services to 1 of 2 current (Tenant #1) and 1 of 4 former (Tenant C1) tenants reviewed. Findings follow: 1) Record review on 12/7/21 revealed an incident report for Tenant C1 dated 1/26/21 in which the Health and Wellness Program Director alerted memory care staff a tenant was outside. The Health Services Director went outside to assist with getting Tenant C1 into the building. Staff completed an assessment on the tenant who was taken to his room where an assessment of his entire body was completed. Tenant C1 denied pain and was changed into dry clothing. Tenant C1's temperature was taken upon his return to the program and it was 95.7 degrees Farenheit. Based on camera footage, the program developed a timeline of events for Tenant C1's elopement. Tenant C1 exited the program on 1/26/21 at 3:21 PM. Staff A responded to the door at 3:22 PM. No resident was around the door at the time the alarm was sounding, so she turned the alarm off. The Health and Wellness Program Director assisted Tenant C1 into the building at 3:33 PM. Tenant C1 was outdoors for 12 minutes. The outdoor temperature was 32 degrees Farenheit. On 12/8/21 at 2:10 PM, Staff A reported she was a new employee to the program on 1/26/21. She heard the door alarm go off alerting her someone had opened the door. Staff A looked around the door but did not go outside to look to see if a tenant had left the building. She reported she did not know to do so at that time. On 12/8/21 at 11:00 AM, the Health and Wellness Program Director reported she was leaving the program when she looked over and saw Tenant C1 standing in the parking lot. He was standing in one spot and seemed confused. She assisted Tenant C1 into the building. On 12/8/21 at 9:05 AM the Health Services Director reported when she saw Tenant C1 upon his return to the building, he told her he went for a walk. She recalled he appeared cold. Tenant C1 was wearing a	**$3500.00**

	heavier sweater, pants, socks and shoes while outside but no hat or coat. The Health Services Director confirmed when a door alarm went off, staff were to look around outside and to count the tenants to ensure they were all present. This did not occur when the alarm sounded on 1/26/21. 2) A review of an Incident Form for Tenant #1 revealed she was ambulating in the hallway with Staff B on 11/25/21 at 11:58 AM. As Staff B turned to talk to another tenant, Tenant #1 fell backwards and hit her head on the wall causing a laceration. Vitals were taken and neurological screenings were initiated. Tenant #1 went to the emergency room for an evaluation. Tenant #1 returned to the program with a diagnosis of fractures to her clavicle and left humerus. Her arm was placed in a sling. Tenant #1 had staples placed in the laceration to the back of her head. Tenant #1's service plan (prior to the fall) was dated 9/9/21. Staff were to provide her with assistance during mobility to prevent injury or falls due to a history of falls. Staff were to assist Tenant #1 with mobility and transfers. Tenant #1 was to use her walker and gait belt at all times when ambulating. On 12/8/21 at 1:20 PM, Staff B reported he was aware Tenant #1 required 1:1 assistance with ambulation, but was not aware prior to her fall of the need for staff to use a gait belt when walking with her. On 12/8/21 at 4:15 PM the Health Services Director and Assistant Health Services Director reported staff members were informed of the need to provide 1:1 assistance and gait belt usage with Tenant #1 when her service plan changed on 9/9/21. All staff members know they were to look at service plans to be aware of tenant's needs. Staff B should have used a gait belt with Tenant #1 and did not.	