

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

Date: November 1, 2023
Program Name: Stoney Point Meadows
Address: 1900 Stoney Point Road SW Cedar Rapids, IA 52404
Type of Action: Incident #113467
Date(s) of Action: 9/11/23 to 9/28/23
Citation # 10093

State Rule #	State Rule	Amount of Civil Penalty
67.2(3)	<u>67.2(3) The program shall follow the policies and procedures established by the program.</u> Based on interview and record review the Program failed to follow established policies and procedures regarding motion sensor alarms for 1 of 1 tenants reviewed during the investigation of Incident #113467-I (Tenant #1). Findings follow: Record review on 9/11/23 revealed the following: Review of a Resident Incident Report dated 6/3/23 at 3:07 a.m. documented staff walked into Tenant #1's apartment to check on her and found her on the floor. Staff asked her if she was okay, tried to sit her up, and noticed blood on the floor that was from her head. Staff notified the nurse and then called 911. Review of medical records on 9/28/23 revealed Tenant #1 arrived at the emergency room at 3:47 a.m. and was diagnosed with a subdural hemorrhage and a midline shift of the brain due to hematoma and required 12 staples to the laceration on her head. The on-call neurosurgeon agreed due to her advanced dementia he would not recommend surgery. The physician recommended hospice care and Tenant #1 was admitted for comfort measures. The Motion Sensor Log revealed motion detected at 2:42 a.m. and again at 3:03 a.m. The Resident Care policy for Motion Sensors described motion sensors were devices intended to monitor a resident's movement and alert staff that a resident may be getting out of bed or moving around in their apartment. Motion sensors were most often used at night in the memory care units to alert staff of resident movement who may need assistance with safe mobility to their destination. Memory Care units may have motion sensors in place and staff were trained in the use of these devices. Each time the motion sensors alerts, staff were	\$6000.00

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	to go to the resident's room and visually see that the resident was ok, up and needing assistance. A Comprehensive Assessment completed 2/28/23 revealed Tenant #1 fell 6 times since 12/30/22 and the most recent resulted in a pelvic fracture. The Plan of Care updated on 2/28/23 indicated she used a walker and required the assistance of one staff for ambulation and transfers as needed. The Plan of Care noted she would abandon her walker at times and required reminders to use it. When interviewed on 9/11/23 at 3:38 p.m. about the fall on 6/3/23 the on-call Registered Nurse stated the motion sensor activated at 2:42 a.m. Review of the Program's camera in the community area revealed Staff A continued to stay seated and used the restroom before walking to Tenant #1's room to check on her approximately 20 minutes after the sensor went off. She confirmed staff were expected to respond immediately upon activation. Staff A was not available for an interview as she was no longer employed at the Program. When interviewed on 9/12/23 the Director of Health Services reported Tenant #1 required admission to hospice care for a brain bleed and did not return to the Program. She stated all staff were educated on the motion sensors during their orientation period and they were only used in the memory care unit for tenants that were a fall risk.	
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