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

Date: October 4, 2024
Program Name: Rotary Sr Living ALPD
Address: 620 SE 5th Street Eagle Grove, IA 50533
Type of Action: 123222-I
Date(s) of Action: 9/4/24, 9/5/24, 9/9/24
Citation #: 10620

State Rule #	State Rule	Amount of Civil Penalty
69.32(2)	69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. Based on observation, record review and staff interview, the program failed to ensure the alarm system connected to each exit door in the dementia-specific program operated properly. Findings include: On 8/30/24 the department was notified Tenant #1's eloped from the secured memory care area on the morning of 8/29/24. The temperature was 82.4 degrees Fahrenheit. The tenant was dressed appropriately with shoes on. She was identified by facility staff when she was seen at 10:32 a.m. on the south side of the building standing outside the dining room area with her walker. Tenant #1 was safely returned inside the building without further incident. There were no injuries noted. Record review revealed Tenant #1 was admitted to the program on 2/14/24 with a GDS of 4. When an interview was attempted on 9/04/24 at 3:04 p.m. the tenant could not recall the event. On 9/05/24 at 1:42 p.m. interview with former Staff C revealed on the morning of 8/29/24 she reported seeing Tenant #1 inside the building between 10:15 a.m. and 10:20 a.m. On 9/05/24 at 11:11 a.m. interview with Staff B revealed when she saw Tenant #1 outside the program, she went out the southeast hallway exit door to get Tenant #1 and returned her back inside the Program. The southeast door always required a keypad to unlock the mag lock system and was primarily used for emergencies. Staff B reported the southeast exit door was ajar/not fully shut. She did not need to enter the keycode to exit the door. She pushed on the door and it opened. Staff B reported when she and Tenant #1 returned to the southeast door to enter the building, the door was locked. It had fully shut behind her when she exited the Program to get Tenant #1. A second staff let Staff B and Tenant #1 back into the building. On 9/05/24 at 1:30 p.m. review of the southeast door's magnetic locking mechanism and the pager system used to alert staff when the door was opened revealed the system was not working properly. The southeast door was held ajar for 20 minutes to test the pager's system tied to the computer. During this time, it was realized the sensor was not sensing the door was open and was not sending alerts to the	**$2000.00**

	pagers worn by staff to alert them the door was not secure. Review of the computer system revealed the door's paging alert system recognized this door as being shut when it was in fact held open and not secure. The pagers that alerted staff to the door being open showed the alarm was cleared automatically while the door remained ajar. In addition, it had been discovered the magnetic lock on the door failed the morning of 8/29/24. It could not be determined the reason it occurred but was thought to have been a combination of the hot and humid weather and the older door's frame that required adjustment for a tighter fit. On 9/05/24 at 2:31 p.m. maintenance staff reported the southeast exit door has been realigned and tightened ensuring it closed properly at all times following the incident on the morning of 8/29/24. On 9/09/24 at 4:30 p.m. the Administrator confirmed these findings.	