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

Date: December 19, 2023
Program Name: Homestead of Oskaloosa
Address: 2102 South Market Street Oskaloosa, IA 52577
Type of Action: Recertification and Investigation #112197-I
Date(s) of Action: 7/12/23 to 8/8/23
Citation #: 10133

State Rule #	State Rule	Amount of Civil Penalty
IAC 481-67.3(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 properly supervise 1 of 1 discharged tenants (Tenant C1). Finding follows: Record review on 7/13/23 of Tenant C1's service plan, dated 2/22/23, revealed he was noted to have episodes of forgetfulness. He had short-term and long-term recall issues. He scored 4 out of 10 on the Short Portable Mental Status Questionnaire (SPMSQ) indicating moderate cognitive impairment. A review of progress notes found on 3/29/23, the Resident Care Coordinator (RCC) noted Tenant C1 did not tolerate a treatment he received for an infection very well (Gentamicin flushes of his suprapubic catheter) and his confusion increased. He was placed on hourly supervision checks until his infection was over and his blood sugar values were within normal parameters. On 4/9/23 at 2:10 a.m., the RCC was contacted when Tenant C1 was found outside banging on another tenant's window. Staff went outside and found Tenant C1 without pants, socks or shoes. Tenant C1 was using his walker and informed staff he worked at the program and was locked out. A physical assessment was completed and Tenant C1 had no injuries, but was very confused. A review of hourly checks from 4/8/23 and 4/9/23 revealed one staff made four entries at 17:22 (5:22 p.m.) over four hours noting her hourly checks of Tenant C1. Another staff then noted checking on Tenant C1 over the next four hours four times at 21:57 (9:57 p.m.). Staff G made two entries at :40 (12:40 a.m.) and a third entry at 2:20 a.m.. Tenant C1 eloped at 2:10 a.m. Notes from the program investigation identified the Executive Director called Staff G on 4/9/23. Staff G stated she was in Tenant C1's room when she did her last hourly check but could not recall when it was. She stated she did not know Tenant C1 was outside until the pendant went off saying someone was beating on the window. The Executive Director reviewed camera footage of the	**$2,500.00**

	elopement on 4/10/23. The Executive Director was unable to determine what door Tenant C1 exited through or when he left the building. Staff G was seen cleaning the north hallway and then going to the cafe. She saw Tenant C1 outside without pants trying to get inside at 2:01 a.m., but the exterior door was locked. Tenant C1 wandered outside on the sidewalk, went to an outside tenant window and knocked. The Exuecitive Director then saw Staff H outside walking to Tenant C1 at 2:13 a.m. The video was not available for review at the time of the investigation. When interviewed on 7/17/23 at 11:10 a.m., Staff G reported she checked on Tenant C1 at 2:00 a.m. and then gave the worker in the memory care unit a break. She could not explain why her documentation noted she last saw Tenant C1 at 12:40 a.m. She described Tenant C1 as a little restless but did not seem to be awake. Staff G recieved a call from Staff H who informed her about the situation outside of another tenant's apartment. One of the other residents, Tenant C1's next door neighbor, said she heard a noise. By then Staff H already found Tenant C1. He was in his normal sleepwear. She was not sure if he had his walker. Tenant C1 wore a shirt. It was normal for him not to wear bottoms at night time. He did not like to wear them with his catheter. He seemed fine (no injuries) just confused. The next day Tenant C1 moved to Memory Care. The Program increased his supervision to 30 minute checks after the elopement. The nurse came in and sat with him after it occurred until a family member came. When interviewed on 7/13/23 at 1:40 p.m. Staff H stated on 4/9/23, one of the residents paged and said there was a drunk outside banging on her window. Staff H looked outside and saw Tenant C1. Staff H paged for the backup and called the nurse. Tenant C1 met her halfway to the door. He was on hourly checks at that point. He had nothing on below the waist but a gripper sock. His catheter bag was below his foot. The catheter did not come out. It was chilly. He had on a flannel, quilted t-shirt. They asked if he fell and he denied this. He had no apparent injuries. She could not say how long he was outside. She's not sure if he was checked within an hour. Staff G was covering the assisted living part of the building where Tenant C1 lived and when the elopement occurred, she was on break. She had not known Tenant C1 to exit-seek. According to Wunderground.com, the temperature in Oskaloosa, Iowa on 4/9/23 at 2:00 a.m was approximately 50 degrees with 0 precipitation. The Director, RN and RCC confirmed Tenant C1 did not receive hourly supervision on 7/19/23 at 1:30 p.m.	

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