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

Date: February 12, 2025
Program Name: Grand Living at Tower Place MC
Address: 540 South 51st Street West Des Moines, Iowa 50265
Type of Action: Incident 121624-I
Date(s) of Action: 8/19/24 – 12/3/24
Citation #: 10738

State Rule #	State Rule	Amount of Civil Penalty
67.2(3)	**67.2(3) The program shall follow the policies and procedures established by the program.** Based on observations, interview and record review the Program failed to follow the established policy regarding door alarms. This pertained to 1 of 1 tenants reviewed who had eloped (Tenant #1). Findings follow: Record review on 8/20/24 revealed an Incident Report (IR) dated 6/5/24 at 2:42 pm documenting a gentleman and his son brought Tenant #1 back to the building from a daycare located next door. Further review revealed a Progress Note (PN) dated 6/7/24 (identified as a late entry for 6/5/24 at 4:00 p.m.). The note said the front desk notified the Director of Health and Wellness (DOHC) a young man and his son found Tenant #1 at the daycare and walked her back. No injuries were noted. Observations on 8/21/24 revealed the adjacent daycare was located approximately 40 to 50 yards through the Program's parking lot. According to wunderground.com at the time the tenant was outside it was 84 degrees with no precipitation. When interviewed on 8/21/24 at 2:25 the Director of Facets (DOF) explained he had been an activity assistant when the incident occurred. He said he assisted with tenant care and supervision on 6/5/24. He described the environment as unsettled as tenants were having personal conflicts. While attempting to calm the tenants he noticed Tenant #1 wandering up and down the hallway. He admitted he heard the door alarm go off and went to the door and listened, but did not check to see if anyone went thru the door. After a few minutes he told Staff A he did not see Tenant #1. Staff A initiated a search. He checked rooms in the Lavender unit and notified the Illuminations Director by text. He said he was notified that someone had brought Tenant #1 back to the front desk of the Program. The DOF said he had not yet received training regarding elopement or how the door alarm operated at the time the incident occurred. When interviewed on 8/21/24 at 1:30 p.m. Staff A said she worked on the Lavender unit on the day of the incident. She usually worked on the Monarch wing but they needed someone to help cover on	**$2000.00**

	Lavender as two ladies had a conflict that escalated and had affected many of the tenants. Staff A said Tenant #1 had a history of wandering in the afternoon. She said the Director of Facets told her he had heard the alarm but didn't see Tenant #1. Staff A started a search for Tenant #1 but did not locate her. Record review on 8/22/24 revealed the DOF's written statement dated 6/10/24. He noted he entered the Lavender unit on 6/5/24 at 2:23 p.m. He believed Tenant #1 attempted to open the stairway door unwitnessed. He looked down the hall and went to the door and listened at 2:31 p.m. but did not open the door to search for Tenant #1. He communicated to Staff A he didn't see Tenant #1. Staff A started a search for Tenant #1 but did not locate her. He texted his supervisor at 2:44 p.m. Record review on 8/22/24 revealed Tenant #1's service plan in effect at the time of the incident was dated 8/28/23 and identified Tenant #1's wandering behavior (effective date of 8/1/23). The plan said staff should redirect Tenant #1 away from exit doors daily and as needed to manage wandering and prevent elopement. Tenant #1's diagnosis included Alzheimer's disease, unspecified. Her cognitive evaluation dated 10/6/23 revealed her Global Deterioration Scale (GDS) scored four signifying moderate cognitive decline (mild dementia). She resided in the secured memory care unit. Further review revealed the Program's policy entitled Dementia Specific Exit Doors dated 11/1/20. The Policy directed staff to promptly check the door when the alarm sounds. They were to check thoroughly inside and outside and account for all tenants. During the exit on 12/3/24 at 11:15 a.m. the administrative staff confirmed staff failed to follow the Program's policy.	