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

Date: January 10, 2023
Program Name: The Summit of Bettendorf MC
Address: 4699 53rd Ave Bettendorf, Iowa 52722
Type of Action: Incident #108695
Date(s) of Action: 10/31/22 to 11/1/22
Citation #5959

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 adequate treatment and services for 1 of 1 tenants reviewed (Tenant #1). Findings follow: Record review on 10/31/22 revealed an Incident Report for Tenant #1 dated 10/28/22. Tenant #1 was brought back to the Memory Care unit by the Concierge. She informed them Tenant #1 walked into the front door by himself. Tenant #1 had followed staff out the side door of the locked Memory Care unit when they exited the building. He had no injuries and his range of motion was within normal limits. Tenant #1 was wearing jeans and a long-sleeved shirt. A progress noted identified the weather was sunny and 57 degrees. A review of Tenant #1's file revealed a score of 5 on the Global Deterioration Scale completed on 8/30/22 indicating moderately severe cognitive decline. His service plan, dated 8/30/22, revealed Tenant #1 had previously followed a tenant's family out of the Memory Care exit door. Staff were to redirect Tenant #1 away from the door if it appeared he wanted to leave. The service plan also indicated the tenant walked independently with his walker. At other times he ambulated independently without any assistive devices. Observation of a video dated 10/28/22 at 12:01:29 PM showed the Assisted Living Registered Nurse (ALRN), Staff A and Staff B exiting from an interior office to the Memory Care side door and walking past Tenant #1, who was standing in the dining area approximately 23 feet from the side door. There was no clear indication anyone noticed or acknowledged Tenant #1. The ALRN was on the phone. Staff A used a key fob to open the door and exited first, followed by Staff B and finally the ALRN. Tenant #1 watched the women leave the unit. At 12:01:51, Tenant #1 began walking quickly toward the side door. He stuck his walker into the gap between the door and the jam at 12:01:54 before it closed. Tenant #1 left the Memory Care unit at 12:02 PM and re-entered through the front door of the building at 12:11 PM.	**$1000.00**

	A tour of the building on 10/31/22 revealed after Tenant #1 exited through the Memory Care door, he would have entered an enclosed breezeway. The breezeway had an exterior door that led to the parking lot. On 11/2/22 at 12:10 PM, the ALRN reported she and two others were walking out the side door of the Memory Care unit on 10/28/22. She was on the phone. The ALRN said she did not see Tenant #1. The three went out the door and into a car. She got a call about 10 minutes later informing her Tenant #1 was at the front door of the building. The ALRN reported Tenant #1 wasn't an exit-seeker; he just took advantage of a situation. Following the incident, the ALRN sent out a message letting staff know the only door they could exit through in the Memory Care unit was the main one unless there was an emergency. On 11/2/22 at 12:30 PM, Staff A said she walked out first with the ALRN and Staff B. They came from the ALRN's office in the Memory Care unit. She unlocked the side door and looked around for people but didn't see anyone nearby. Tenant #1 was on the other side of the room. They walked out to the car in the parking lot and left. On 11/2/22 at 12:50, Staff B said she went out the Memory Care door behind Staff A. She didn't see Tenant #1 at all before the elopement. When they exited the ALRN's office, they went right out the side door and into the parking lot. She didn't know Tenant #1 was a flight risk before the incident. She described the elopement as an issue of opportunity. On 11/2/22 at 3:30 PM, the Executive Director confirmed staff should have checked the area to ensure there were no tenants who could exit through the door behind them. On 12/28/22 at 10:48 AM, the Clinical Quality Specialist stated staff were expected to perform rounds continuously on tenants in the locked memory care area.	