

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

| |
|---|
| Date: November 18, 2019 |
| Program Name: Bickford Cottage Urbandale |
| Address: 5915 Sutton Place Urbandale, IA 50322 |
| Type of Action: Investigation #86202-C & 86210-I |
| Date(s) of Action: 10/1/19 – 10/8/19 |

| State Rule # | State Rule | Amount of Civil Penalty |
|--------------|--|-------------------------|
| 67.3(2) | <p>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.</p> <p>Based on interviews and record review the Program failed to provide care, treatment and adequate/appropriate services as directed by service plans. This affected 1 of 4 tenants (Tenant #1) reviewed as a result of investigations #86210-I and #86202-C. Findings follow:</p> <p>Tenant #1 resided in a dedicated dementia assisted living program and was a four (4) on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline. Tenant #1's Service Plan, dated 6-5-19, indicated he had disabled the security system at his last assisted living facility. He required temporary 10 minute checks due to recent elopement and staff interventions of activities for exit seeking behavior and agitation. The tenant's service plan also indicated a high risk of elopement and safety alarms to be installed on all windows in the dementia unit as a result.</p> <p>Record review revealed a facility incident report dated 9-1-19 at 11:45 a.m. documented, "CMA (certified medication aide) noticed resident not in main area around 11:45 a.m. and started looking for him and noticed the kitchen window wide open. All staff were notified to search in all areas. Tenant returned with no pain or discomfort and vitals were WNL (within normal limits).</p> <p>According to the state climatologist the nearest weather report available was from the Des Moines International Airport at 11:45 a.m. At that time the temperature was 76 degrees, skies were cloudy with 10 mile visibility and the wind was from the southwest at 7 mph. The humidity was 65% with no heat index computed for that time.</p> <p>Observations revealed the Program was located on Sutton Place in a 25 mile per hour speed zone with two lanes of traffic and approximately one half mile south of Interstate 80/35. The tenant opened a window in the kitchenette area and removed the screen to exit the building. He most likely walked around the building to the public sidewalk and continued west approximately .2 miles in a residential neighborhood and wooded area.</p> | \$2000.00 |

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

Staff A stated on 10-2-19 at 11:06 a.m. she observed Tenant #1 in the dining room around 11:45 a.m. She stated a tenant approached her and required medical attention for a cut and Staff H was toileting another tenant. Staff A stated she attended to the wound and after a few minutes noticed Tenant #1's absence from the dining area. She stated she completed a room to room search and called for assistance. She stated another staff called on the walkie to say Tenant #1 had been found and then as she walked by the kitchen, she noticed the open window and screen removed from it. She confirmed the window did not have an alarm installed on it but the windows in the tenants' apartments had window alarms. Staff A stated she called the on call RN (Registered Nurse) and was instructed to notify maintenance of the incident. She stated he did not show up before the end of her shift at 2:00 p.m., so she locked the kitchen door.

Staff H stated on 10-2-19 at 2:00 p.m. she took a tenant to her room and Staff A communicated via walkie that Tenant #1 was missing. She stated she noticed the kitchen window was open, screen had been removed, and no alarm was installed on this window. She stated he was found approximately 15 minutes later with no apparent injuries. She stated she communicated to the oncoming staff he required 10-15 minutes checks due to elopement and to redirect with activities as needed.

Staff B stated on 10-7-19 at 10:23 a.m. she worked in the assisted living area of the Program on 9-1-19. She stated the front doorbell rang and a neighbor was at the door asking if the Program was missing someone. She asked him what the person looked like and he described Tenant #1. She stated she left with the man to where Tenant #1 was located. She stated he stood on the sidewalk and said he was "looking for the train." Staff B told him his wife was on her way to pick him up for lunch and he proceeded to walk with her back to the Program. She stated it was a nice day, was dressed appropriately for the weather, and had no apparent injuries.

When interviewed on 10-2-19 at 3:16 p.m. Staff C reported after Tenant #1 eloped in June 2019, the Program decided to alarm the windows in the memory care unit. He installed window alarms on all windows in the memory care unit apartments and stated it did not occur to him to alarm the window in the kitchen area since it was visible to staff.

The RN (Registered Nurse) Coordinator stated on 10-7-19 at 12:47 p.m. Staff C received a written counseling for failing to alarm all windows in the memory care unit as documented in Tenant #1's service plan.

2. Continued review revealed a facility incident report dated 9-1-19 at 6:45 p.m. documented, "CMA checked residents apartment and noticed he was not there and called for help when he could not be found. Resident was found in parking lot and stated he was looking

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

for his wife. No apparent injuries noted and one to one supervision was implemented."

According to the state climatologist the nearest weather report available was from the Des Moines International Airport at 6:45 p.m. At that time the temperature was 73 degrees, skies were cloudy with 10 mile visibility and the wind was from the south at 3 mph. The humidity was 73% with no heat index computed for that time.

Observations revealed the Program was located on Sutton Place in a 25 mile per hour speed zone with two lanes of traffic and approximately one half mile south of Interstate 80/35. Tenant #1 most likely exited through the courtyard doors, dismantled the security system for the lock, and exited the gated area. The tenant was found in the parking lot approximately 50 feet from the courtyard.

Staff E stated on 10-3-19 at 1:37 p.m. she observed Tenant #1 in the immediate area around the medication room in the memory care unit. She stated she noticed another tenant go into an apartment and told Tenant #1 she would be right back and left him unsupervised as the other staff was doing the dishes. She stated the other tenant made a mess in the apartment and stayed to clean it up. When she returned she could not find Tenant #1. She stated she called for assistance and looked for him inside and outside the building. She stated Staff D came over from the assisted living and noticed him outside the courtyard in the parking lot. She stated she went outside and noticed the gate was opened and the keypad box was disassembled. She stated she noticed Tenant #1's hands were dirty and assumed he had disassembled the box himself to open the gate. Staff E stated she completed 15 minute checks during the shift and the documentation could not be located. She stated 2 staff worked the memory care unit and it was typical for one staff to leave to do the dishes in the evening.

When interviewed on 10-2-19 at 2:42 p.m. Staff F stated she worked the memory care unit and the previous shift informed her Tenant #1 eloped earlier that day and required enhanced checks. She could not recall how often they were to be done or if they were to be documented. She stated she observed Tenant #1 in the dining area after supper and left to do the dishes in the main kitchen. She stated Staff E remained in the memory care unit and later she called on the walkie that Tenant #1 was gone. She stated she looked in the apartments and he was not there. She stated she went into the courtyard and observed Staff D standing next to him in the parking lot. She stated the gate was open and the code box was broken with exposed wires. She stated Tenant #1's hands had black dirt on them and assumed he took the box apart.

When interviewed on 10-2-19 at 10:52 a.m. Staff D stated Tenant #1 returned from a visit with family approximately 6:30 p.m. She stated she worked the assisted living area and Staff E called for assistance to locate Tenant #1. She stated she they looked room to room then went outside and she observed him in the parking lot. She noticed

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

the box to enter the code to open the gate was open with exposed wires. She stated she went to Tenant #1 and he willingly returned to the Program. She noted dirt on his hands and appeared he had dismantled the box and messed with the wires.

When interviewed on 10-2-19 at 10:41 a.m. the Assistant Director stated the memory care unit required two staff present at all times. Staff were to call the assisted living staff for assistance if they needed to leave the unit. She stated Staff E and Staff F received written counseling for not providing appropriate supervision to tenants in the memory care unit. She confirmed Tenant #1 had one previous elopement prior to 9-1-19 and eloped from an assisted living prior to moving here. She stated his service plan included interventions of alarmed windows and redirection from staff when needed.

The RN Coordinator confirmed on 10-7-19 at 12:47 p.m. the memory care unit required two staff present at all times. She stated one staff should be present in the common area while other staff passed meds or completed cares. She stated this was the expectation communicated to staff during the initial training.

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