

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

Date: October 25, 2017
Program Name: Bickford Cottage Iowa City
Address: 3500 Lower West Branch Road Iowa City, IA 52245
Type of Action: Investigation #69217-I
Date(s) of Action: October 5 – 9, 2017

State Rule #	State Rule	Amount of Civil Penalty
69.32(2)	<p>481-69.32(231C) Life safety-emergency policies and procedures and structural safety requirements.</p> <p style="text-align: center;">69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.</p> <p>Based on interview and record review the Program failed to consistently ensure an operational door alarm system as required for a dementia-specific program. This affected 1 of 2 tenants reviewed (Tenant #1). Findings follow:</p> <p>1. Record review revealed Tenant #1's diagnoses included: dementia and alcohol abuse. Tenant #1 was admitted on 6-5-17 and staged at a four on the Global Deterioration Scale (GDS), which indicated moderate cognitive decline, upon assessment. Tenant #1 wore a electronic wander device.</p> <p>The Program was dementia-specific and had alarmed exterior doors. The exterior doors included a delayed egress function, as well as an electronic wandering monitoring system present on the exterior doors. According to Resident Monitoring System Watch, Panic Button and Fall Detection Device policy, a tenant would use an electronic wander device if certain triggers were met. Noted triggers included: mentation score of three or more; social score of five or more; safety score of two; inappropriate behavior at mealtimes, interrupting others' mealtime, and</p> <p>Record review revealed an investigation form, dated 6/27/17, documented Tenant #1 found outside of the Program by an Iowa City police officer. The officer identified the tenant as a resident of Bickford Cottage based on his/her Wanderguard transmitter. The investigation concluded the monitoring system failed to register Tenant #1 leaving the building. A plan of action indicated Tenant #1 was assigned a new Wanderguard transmitter, which had been test to confirm it was functional.</p> <p>Further review revealed a statement from the Nurse, dated 6/27/17. The Nurse reported she received a phone call from Staff A at 1:45 p.m. on 6/27/17 notifying her Tenant #1 was absent from the Program.</p>	\$500.00

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Staff A informed the Nurse she received a phone call from an Iowa City police officer. The officer took Tenant #1 to his home. The Nurse drove to Tenant #1's home, arriving around 1:50 p.m. Upon arrival, Tenant #1 stood on the front porch, alert and talking with his/her Wanderguard wrist band monitor intact. The officer reported Tenant #1 had been found on the corner of Scott and Court. The Nurse noted this as an 11 minute walk and half a mile from the Program, according to Google maps. She noted Tenant #1 wore jeans, socks, shoes, and a short sleeved shirt. Upon arrival to the Program at 2:00 p.m., Tenant #1's transmitter did not register him/her as returning. The Nurse completed an assessment and noted no injuries. The Nurse and former Director confirmed Tenant #1's write monitor failed; the monitoring system showed no indication Tenant #1 left the building and no pagers alarmed. All internal and external doors were checked and found to working appropriately. They concluded Tenant #1's Wanderguard wrist monitor failed. The monitor was replaced at 2:45, and checked to ensure it worked appropriately.

According to the Nurse's statement dated 6-27-17, Tenant #1 was found at the corner of Scott Boulevard and Court Street. The distance was driven in a car and was approximately 0.5 mile from the parking lot of the Program to the location provided in the Nurse's statement. The elopement was not witnessed; however, possible terrain Tenant #1 covered included: sidewalk, grass and city streets. Scott Boulevard was a two lane city street with a posted speed limit of 35 miles per hour (mph). There were sidewalks observed on each the street. In the area Tenant #1 was located; Court Street was a two lane city street with a posted speed limit of 25 mph.

The State Climatologist provided the following information: at the Iowa City Airport on 6-27-17 at 12:52 p.m. the temperature was 74 degrees, winds were light and variable, there were clear skies and humidity was 38%. On 6-27-17 at 1:52 p.m. the temperature was 75 degrees, winds were from the southeast at 12 mph, there were clear skies and humidity was 34%.

Record review revealed Tenant #1's service plan, dated 5/31/17, noted he/she ambulated independently. Tenant #1 had a walker, but elected to not use it consistently. The service plan noted staff would provide Tenant #1 with escorts to and from meals and activities he/she chose to participate in. The service plan also documented Tenant #1 moved to Bickford Cottage from his/her home after being found wandering to a neighbor's house multiple times complaining of being cold. The tenant recently incurred a mechanical fall with compression fractures of the spine. Tenant #1 moved to Bickford Cottage due to increasing confusion, alcohol intake, and requiring more assistance with activities of daily living.

When interviewed on 10-5-17 at 11:25 a.m. the Nurse revealed police located Tenant #1 outside and picked him/her up. The officer noticed Tenant #1's Wanderguard transmitter and identified the tenant as a resident of Bickford Cottage. The tenant gave the officer his/her home address and the police took him/her there. The Nurse went to Tenant #1's house and found Tenant #1 on the front porch with the officer.

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Tenant #1 returned to the Program with the Nurse without issue. When Tenant #1 returned to the building, no alarm sounded, nor was there any record of Tenant #1 leaving. It was determined his/her Wanderguard wrist monitor did not work, and the device was replaced. An assessment was completed when Tenant #1 returned to the Program, and no concerns were noted. The Nurse reported it was a nice day and Tenant #1 dressed appropriately for the weather. According to the nurse, Tenant #1 ambulated independently and required no assistive devices. The Nurse reported staff saw Tenant #1 at lunch, served around noon, and also after lunch about 30-40 minutes later. Tenant #1 frequently wandered throughout the common areas and his/her apartment, but had no exit seeking behavior. The Nurse confirmed the door alarms failed, resulting in Tenant #1's elopement. According to the Nurse the delayed egress failed and did not alarm, nor did the Wanderguard system.

Staff A was unavailable for interview; however, record review revealed Staff A's statement from the incident, dated 6-27-17. Staff A documented she received a phone call from a police officer at 1:43 p.m. and was asked if Tenant #1 was a current tenant at the Program. The officer explained to Staff A she was familiar with the tenant. The officer noticed the tenant wore a Wanderguard transmitter and immediately began contacting surrounding facilities. After receiving the call, Staff A immediately notified the Nurse at 1:45 p.m. She then notified the Director. They checked the alarm history and noted no indication of a breach at any door other than the front door and kitchen door. The daily event log indicated Tenant #1 present at 11:45 a.m. Another staff noted Tenant #1 present at lunch service until 12:45 p.m. Staff A noted at no point did the pagers alarm staff Tenant #1 exited the building.

An interview with the Maintenance Director (MD) on 10-9-17 at 9:03 a.m. revealed Staff A reported to him earlier in the day that the front door acted up; a wire that went into the magnet was loose. The MD repaired the door when Staff A received a call from police regarding Tenant #1. Staff A notified both the Nurse and the Former Director Tenant #1 was with police. The Nurse picked Tenant #1 up and brought him/her back to the building. They concluded Tenant #1 left the program while the main door alarm did not work, but the tenant's Wanderguard transmitter also failed to work. The MD reported he repaired the front door within 30 minutes of awareness it did not work appropriately.

An interview with Staff B on 10-9-17 at 10:10 a.m. revealed Tenant #1 was present for lunch on the day of the elopement and was there at 12:45 p.m. Staff B confirmed staff pagers did not alert when Tenant #1 left and returned to the building.

Tenant #1 left the building without staff knowledge on 6-27-17 after 12:45 p.m. and returned to the building at 2:00 p.m. The electronic wander device did not function as Tenant #1 left the building or when Tenant #1 was returned to the building. The front door, which was a delayed egress door, also failed to function appropriately for a time period on 6-27-17, the date Tenant #1 eloped. As a result, staff were

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	not alerted when Tenant #1 left the building.	
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