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

Date: February 12, 2019
Program Name: Bickford Cottage Marion
Address: 1100 Linden Drive Marion ,IA 52302
Type of Action: Investigations #79520-C, 80141-I, 80586-I
Date(s) of Action: 11/14/18 – 1/22/19

State Rule #	State Rule	Amount of Civil Penalty
67.9(1)	**481-67.9(231B,231C,231D) Staffing.** **67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.** Based on observation, interview and record review the Program failed to provide a sufficient number of trained staff to fully meet a tenant's identified needs. This pertained to 1 of 1 tenant (Tenant #5) reviewed as a result of program self-reported incident #80586-I. Findings follow: Record review on 1-17-19 of Tenant #5's file revealed diagnoses included traumatic brain injury (TBI), mild cognitive impairment and post-traumatic stress disorder. Tenant #5 scored a 28/30 on the Mini Mental Status Examination, dated 10-26-18. The service assessment, dated 10-26-18, reflected Tenant #5 had a large appetite and the majority of the time he would exit seek because he would be offered a snack if he stop attempting to leave. Tenant #5 also displayed exit seeking behavior because he was looking for his truck or when he thought he had guard duty. If Tenant #5 left the building staff would walk beside him and ask what he was looking for. The service assessment indicated Tenant #5 wore an electronic wandering monitoring watch due to exit seeking behaviors. Continued record review of an incident report, dated 12-9-18, revealed Tenant #5 was asked to go to bed at approximately 11:30 p.m. Two staff started to complete night checks when the pager sounded at 11:35 p.m. Staff responded to the front door and the front door alarm sounded. Tenant #5 had walked out of the front door. Two staff responded and asked Tenant #5 to come inside. He refused and said he had guard duty. Staff in the memory care unit was alerted to check the side doors and Tenant #5 was not within sight. One staff came inside to call 911, the police responded and began a search. Tenant #5 was found approximately one hour later and was returned safely. Tenant #5 was assessed upon return and vital signs were as follows: blood pressure 136/80, temperature was 97.4 degrees Fahrenheit (F), pulse 86 and respirations 20. When interviewed on 1-17-19 at 2:23 p.m. Staff B reported it was a normal night. Staff completed rounds when they heard the pager. The pager indicated Tenant #5 exited the front door. Staff responded and found Tenant #5 on the side of the building. Staff B went inside to call 911 and Staff C stayed with him outside. Staff C	**$3500.00**

	returned inside and said he would not stop. Staff called back to the memory care unit and staff there could not see him. The police showed up and started looking for Tenant #5. The Director arrived and started to search for Tenant #5. The Registered Nurse Coordinator (RNC) was also notified. The search lasted about an hour and police returned with Tenant #5. He was found seven blocks from the Program. Tenant #5 did not sustain any injuries and wore shoes, pants and a jacket. The weather was cold and there was no snow on the ground. Tenant #5 wore an electronic wandering monitoring watch and he ambulated independently. The alarms functioned appropriately and staff responded in approximately one minute. When interviewed on 1-17-19 at 3:00 p.m. Staff C reported Tenant #5 was focused on going to do guard duty the night of the incident and Staff B thought he was going to leave. Staff was completing rounds, the door alarm and pager sounded and staff responded. Staff found Tenant #5 had exited the front door and was on the southwest side of the building. Staff tried to redirect him without success. Tenant #5 reported he had guard duty and was not returning inside. Staff B went inside to call the police. Staff C stayed outside after Staff B went inside but when Staff C knew Tenant #5 was not coming inside she went inside to call staff in the memory care unit to open up the side doors (staff had their phones). Staff in the memory care unit went to the opposite door. Staff went outside and could not find him. Police arrived and searched for Tenant #5. The Director and RNC were contacted. The Director arrived at the building and searched for Tenant #5. He was found approximately six blocks from the Program. Tenant #5 was returned to the building in approximately one hour and did not have any injuries. When interviewed on 1-17-19 at 12:02 p.m. the RNC revealed she was called and told Tenant #5 eloped and staff was not able to find him. Police and the Director searched for him. She did not have any other direct involvement with the incident. The Director sent a text message to her later to let her know they had found Tenant #5 in a residential area. Tenant #5 had a TBI and at times thought he was on guard duty. Staff tried to redirect him with snacks and soda when he displayed exit seeking behavior. When interviewed on 1-22-19 at 10:13 a.m. the Director said staff called her to report Tenant #5 left the building and police were looking for him. Staff reported the front door alarm sounded (staff responded) and Tenant #5 would not come back inside. Staff went inside and called 911. The Director arrived at the building, took a flashlight and began looking for him. Tenant #5 was found by police and returned to the building. Tenant #5's hands and ears were warm to the touch and he seemed to be at his baseline. Tenant #5 did not sustain any injuries. Tenant #5 wore a heavy sweatshirt with pockets, long pants, shoes and socks. Tenant #5 was found approximately four blocks from the Program. The door alarm and electronic wandering monitoring watch functioned when Tenant #5 exited the building. When the Director questioned why Staff C came	

	into the building she said she wanted to check on the status. Staff C reported to the Director that she had her portable phone. Redirection was provided individually to the staff involved in the incident regarding not leaving a tenant unattended after exiting the building and to carry portable phones. A staff in-service was also held to re-educate staff. Staff did not follow the policy and procedure related to the incident with Tenant #5. Record review revealed Counseling Forms for Staff B and Staff C re-education was provided related to the incident with Tenant #5. It identified in a recent elopement a tenant was left unattended after exiting the building. It was expected that staff stay with the tenant and communicate to other staff via portable phones. The forms also indicated further education would be provided at an in-service. In-service documentation was provided including a list of attendees. Continued record review of the electronic wandering monitoring system records and door alarm records revealed on 12-9-18 at 11:35 p.m. the front door was opened and reflected an alert for Tenant #5's electronic wandering monitoring watch at the front door. It also reflected the front door closed. Records reflected on 12-10-18 at 12:41 a.m. the front door alarm was reset and it reflected Tenant #5's electronic wandering device alerted. Based on records Tenant #5 was gone from the building for one hour and five minutes. Weather conditions at the Monticello Regional Airport on 12-9-18 at 11:30 p.m. included the following: temperature was 16 degrees, the wind was calm, relative humidity was 92%, and there was no wind chill and no precipitation. The exact location Tenant #5 was found could not be provided as police found the tenant. Staff interviews estimated four to seven blocks. The general path described in the Director's interview was driven by car and distance traveled was 0.4 of a mile. The exact path Tenant #5 traveled could not be determined; however, possible terrain Tenant #5 encountered included: parking lots, grass areas, sidewalks, residential properties and city streets. In summary, Tenant #5 had a history of exit seeking behavior, wore an electronic wandering monitoring watch and staff was instructed to walk with him if he exited the building. Tenant #5 left the building on third shift and staff was alerted he exited through the front door. Staff responded and were unable to redirect Tenant #5 back into the building. One staff went inside the building to call 911 and then the other staff returned inside, leaving Tenant #5 unattended after he exited the building. Tenant #5 was gone for approximately one hour and returned after a search that involved police assistance.	

69.35(1)b	**481-69.35(231C) Structural requirements.** **69.35(1) General requirements.** **b. The buildings and grounds shall be well-maintained, clean, safe and sanitary.** Based on observation, interview and record review the Program failed to ensure a well-maintained building, as evidence by the failure of a secondary alarm system to monitor wandering activity. This affected 1 of 1 tenant identified as a result of program self-reported incident #80141-I (Tenant #6). Finding follows: Record review on 1-17-19 of Tenant #6's file revealed diagnoses included dementia with psychosis, major neurocognitive disorder and late onset Alzheimer's disease without behavioral disturbance. Tenant #6 was admitted to the Program 11-11-18. Tenant #6 scored a 5/30 on the Mini Mental Status Examination, dated 11-6-18. On 1-4-19 Tenant #6 was staged at a four on the Global Deterioration Scale, which indicated moderate cognitive decline. The service plan dated 11-6-18 indicated Tenant #6 wore an electronic wandering monitoring watch due to her cognition and exit seeking behavior. Continued record review revealed an incident report dated 11-15-18 at 8:30 p.m., documented the fire alarm went off at 8:30 p.m. Staff began evacuating tenants to a safe area. The Director and Registered Nurse Coordinator (RNC) were notified. Staff completed a head count and discovered Tenant #6 unaccounted for. A search began inside and outside the building. Tenant #6 was found near the entrance at a neighboring grocery store. Tenant #6 had her walker with her and did not wear a coat. Tenant #6 said, "I pulled that thing so I could get out!" An ambulance arrived and Tenant #6 was taken to the hospital. Weather conditions at the Eastern Iowa Airport on 11-15-18 at 8:30 p.m. included the following: temperature was 34 degrees, winds were from the south-southwest at 14 miles per hour, the wind chill was 23 degrees, relative humidity was 64% and skies were mostly cloudy with no precipitation. Observation on 1-17-19 and 1-22-19 revealed the approximate distance Tenant #6 traveled was 0.1 of a mile. The exact path Tenant #6 traveled could not be determined; however, the possible terrain Tenant #6 encountered included: parking lots, grass areas, sidewalks, and city streets. When interviewed on 1-17-19 at 11:09 a.m. Staff A revealed the incident occurred on second shift; everyone was in their apartments and the fire alarm went off. Staff evacuated tenants from their apartments, but Tenant #6 was not in her apartment. The Director and RNC were notified and the RNC arrived to the building quickly.	

	The fire department arrived and noted a side exit door was cracked. The RNC and firefighters found Tenant #6 outside of a neighboring grocery store. Tenant #6 did not have a coat or hat, but wore pants, shoes, shirt and a sweater. Tenant #6 told emergency medical services (EMS) she pulled the fire alarm. Tenant #6 wore an electronic wandering monitoring watch; however, nothing sounded on the pager and no door alarms were heard. Tenant #6 did not have any injuries, but went to the emergency room (ER) for evaluation. Staff A estimated Tenant #6 was gone approximately 10 to 15 minutes. When interviewed on 1-17-19 at 3:39 p.m. Staff D reported the fire alarms went off at 8:30 p.m. Staff evacuated the tenants from their apartments. The fire department was there and the RNC arrived. A head count was started and determined Tenant #6 was missing. The fire department noticed a door propped open. Staff stayed at the Program and the fire department searched and found her at a neighboring grocery store. Tenant #6 did not have any injuries that Staff D was aware of and she was taken to the hospital. Staff D estimated Tenant #6 was gone less than 10 to 15 minutes. When interviewed on 1-17-19 at 3:22 p.m. Staff E said she administered medications when the fire alarm sounded. The RNC was notified. Tenants were checked and Tenant #6 could not be found. The fire department arrived and realized a door was open. The RNC was there and they searched for her. They found Tenant #6 outside, but Staff E did not know exactly where she was located. Tenant #6 was taken to the hospital and had no injuries. Prior to that incident Staff E administered Tenant #6's bedtime medications. Staff E reported nothing came across the pager regarding door alarms or the electronic wandering monitoring system. When interviewed on 1-17-19 at 12:02 p.m. the RNC recalled staff called to report the fire alarm went off and staff began evacuating tenants. The fire department responded immediately and determined the pull station by a side door had been pulled. Staff was instructed to complete a head count and determined Tenant #6 was unaccounted for. The fire department reported a door near the pulled fire alarm station was opened. The RNC went outside to search for Tenant #6. A neighbor reported they saw a woman with a walker. Tenant #6 was found at the exit door of a neighboring grocery store (the store was open). The weather was cold and there was no snow. Tenant #6 wore a long sleeved shirt, pants, shoes and socks, but did not wear a coat. Tenant #6 did not have any injuries and she was taken into the grocery store to warm up. Tenant #6 said she pulled the fire alarm. EMS arrived and took her vital signs, which were within normal limits. Tenant #6 was taken to the ER for evaluation. Tenant #6 refused to leave the hospital and they kept her over the weekend. The time between when the fire alarm sounded and when Tenant #6 was found was approximately seven to eight minutes. Staff was not made aware the door was opened and were not alerted by electronic wandering monitoring system.	

	When interviewed on 1-22-19 at 9:43 a.m. the Maintenance Staff revealed when the fire alarm was activated all exterior doors were unlocked. After Tenant #6's elopement, he was made aware a tenant pulled the fire alarm and the electronic wandering monitoring system did not alert staff. It was determined one of the wall units of the electronic wandering monitoring system was bad and it was replaced the next day. Maintenance staff reported the electronic wandering monitoring system was checked monthly and there was no prior indication it was not working. Record review of the electronic wandering monitoring system records and door alarm records revealed on 11-15-18 at 8:28 p.m. a side door was opened and at 8:29 p.m. it was closed. There were no records of an alert for Tenant #6's electronic wandering monitoring watch at the time the door was opened and closed. Continued record review revealed the Program's policy and procedure regarding tenant monitoring system use and maintenance indicated the system would be inspected and maintained to ensure appropriate functioning at all times. The monitoring system would be inspected monthly to ensure it was functioning appropriately. The Resident Monitoring System Testing Procedure Checklist would be used to complete the inspection. The completed checklists would be kept for two years. Each building would maintain spare equipment including a spare watch. Monthly checks of the electronic wandering monitoring system were requested; however, checks were not documented or available for review. A test of the system was completed on 1-22-19, but a spare watch was not available to check the system. When interviewed on 1-22-19 at 10:11 a.m. the Director confirmed the monthly checks for the electronic wandering monitoring system were not documented. When interviewed on 1-22-19 at 10:13 a.m. the Director reported staff either did not receive a page for the electronic wandering monitoring system or received the page in a delayed manner when Tenant #6 eloped. There was a defect in the electronic wandering monitoring system and it was repaired the next day. After Tenant #6's incident, covers were placed on the fire pull stations that were audible.	

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