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

Date: August 9, 2019
Program Name: Bickford Cottage Burlington
Address: 3301 Sterling Drive Burlington, IA 52601
Type of Action: Investigation #83979-I
Date(s) of Action: 7/17/19 – 7/18/19

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 appropriate care to 1 of 1 tenants (Tenant #1) identified as a result of program self-reported incident #83979-I. Findings follow: Record review on 7/17/19 revealed Tenant #1 was admitted to the program on 5/7/19. He was diagnosed with Dementia with behavioral disturbance. He was scored a Stage 5 on the Global Deterioration Scale which indicated moderately severe cognitive decline, according to a Cognitive Assessment dated 5/17/19. According to an Unusual Occurrence Report dated 5/23/19, Tenant #1 eloped from the building at 4:50 p.m. from the courtyard attached to the Memory Care Unit. The back-up RN received a call from an employee at a nearby school informing her she had seen Tenant #1 walking down the road. The school employee also notified Tenant #1's spouse she had seen Tenant #1. Tenant #1's spouse found Tenant #1 and returned him to the program. He was found 1.1 miles away and had crossed a highway before being found. Tenant #1 had no injuries resulting from the elopement. According to Wunderground.com, the temperature at the time of the elopement was 65 degrees with no precipitation. An Event Report for 5/23/19 noted "lock egress started" at the Courtyard Gate at 4:24 p.m., which would have indicated the door was no longer locked. The door was opened and closed again at 4:34 p.m. The Registered Nurse Coordinator reported during an interview on 7/18/19 at 8:20 a.m., she believed Tenant #1 left the building at 4:34 p.m. The door was not locked again until 4:58 p.m. According to the Event Report, Tenant #1 returned to the facility with his spouse at 5:08 p.m. Record review revealed Tenant #1's service plan, dated 5/7/19. According to the service plan, Tenant #1 ambulated independently with no can or walker. Additional record review revealed the Program's unwitnessed door alarm procedure, revised 4-2014. According to the procedure, staff should check their pagers, perform a visual search inside and	**$1000.00**

	outside of door area, summon assistance, silence the alarm, initiate missing tenant procedure, and account for all residents. The procedure further directed, when a door alarm occurred, staff should visually search the inside and outside area surrounding the door that caused the alarm if it was unwitnessed. If no tenants were seen, staff should immediately summon the assistance of other staff to either look for the tenant whose watch activated the alarm or account for all tenants. Only after all staff have been made aware of the unwitnessed door alarm, should the alarm be silenced. An interview conducted with the back up RN on 7/17/19 at 11:40 a.m. revealed when she received the telephone call from the school employee she immediately left the building to look for Tenant #1. The back up RN looked around the school and enlisted others at the school to help her look for Tenant #1. She then went further down the street to look for Tenant #1. Someone drove up and notified her Tenant #1's spouse had found him. The back up RN said the weather was warm at the time of the elopement. She recalled Tenant #1's spouse was worried about him being hot as he had double layered his pants that day. When interviewed on 7/18/19 at 8:53 a.m. Staff D reported she worked on the locked memory care unit on the day of Tenant #1's elopement. Staff D recalled being outside the unit with some tenants in an attached courtyard until about 4:30 p.m. She then brought the tenants inside to assist them with toileting. Staff D watched Tenant #1 walk towards his room and did not see him again until he was returned to the building at 5:08 p.m. According to Staff D, she did not carry a pager on which a notification would have been received when a tenant left the courtyard via the egress gate. Staff D did not hear an alarm on the courtyard gate until she went outside to check it at 4:58 p.m. When interviewed on 7/17/19 at 2:45 p.m. Staff C reported she also worked on 5/23/19. She reported there had been problems with the gate door at the courtyard since a storm on either May 18th or 19th. The pager had been going off notifying staff members the courtyard gate was open but it was not open. Staff C passed medication to other tenants in the program when the page was received about the gate door being opened and did not respond. When interviewed on 7/18/19 at 12:42 p.m. Staff E reported she worked 5/23/19. She said the pager had been receiving multiple notifications that day of the courtyard gate being opened so she didn't think much about it when the pager notified her the gate was open again. Staff E completed cares with another tenant and did not respond to check and see if any tenant had left the building. When interviewed on 7/18/19 at 3:50 p.m. the Director stated a page did go off notifying staff of the egress but no one responded to check the gate as the alarm had been going off all day.	

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