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

Date: September 23, 2024
Program Name: Bickford Cottage Iowa City
Address: 3500 Lower Ranch Road Iowa City, IA 52245
Type of Action: 119834-M
Date(s) of Action: 8/13/24, 8/14/24
Citation #: 10600

State Rule #	State Rule	Amount of Civil Penalty
67.2(3)	67.2(3) The program shall follow the policies and procedures established by the program. Based on interview and record review, the program failed to ensure implementation of the established abuse and neglect policy regarding 1 of 1 tenants reviewed (Tenant #1). Finding follows: On 8/13/24 review of the program investigation regarding an allegation of abuse revealed a brief hand written note signed by the Executive Director (ED) as well as various staff statements about an incident that occurred on the evening of 3/27/24. Four staff witness statements, dated 3/28/24 and 3/29/24, indicated Staff A abused/mistreated Tenant #1 on the evening of 3/27/24. Staff A's written statement, dated 3/29/24, refuted the allegation. According to the ED's note dated 3/29/24, the program suspended Staff A pending investigation results. Staff statements indicated the alleged abuse occurred on the evening of 3/27/24, but did not indicate any of the four staff witnesses reported the incident on 3/27/24. On 8/13/24 at 10:20 a.m. Staff B confirmed she witnessed the incident on the evening of 3/27/24, but did not immediately report it to management. Staff B acknowledged Staff A continued to work at the program on the evening and overnight shift after the incident, through the morning of 3/28/24. On 8/14/24 at 3:00 p.m. Staff C confirmed she witnessed the incident on the evening of 3/27/24, but did not immediately report it to management. Staff C acknowledged Staff A continued to work at the program on the evening and overnight shift after the incident, through the morning of 3/28/24. On 8/14/24 at 3:25 p.m. Staff D confirmed she witnessed the incident on the evening of 3/27/24, but did not immediately report it to management. Staff D acknowledged Staff A continued to work at the program on the evening and overnight shift after the incident, through the morning of 3/28/24. Review of the program's Abuse and Neglect Policy revealed any staff who had reasonable cause to believe a resident was abused should immediately report the information to the Director or Registered Nurse	**$500.00**

	Coordinator. The policy further indicated an internal investigation would be completed and documented on an Investigation Report form. The policy noted the alleged victim and the alleged abuser would be kept separated until all investigations were completed. On 8/14/24 at 4:35 p.m. the ED stated she recalled Staff E (no longer worked at the program) reported the allegation on the morning of 3/28/24. The ED verified the four staff who witnessed the incident (Staff B, Staff C, Staff D and Staff E) failed to immediately report the allegation of abuse, per program policy. The ED said the program suspended Staff A on 3/28/24 after learning of the incident. She confirmed the program should have completed an Investigation Form related to the allegation, but she was unable to locate it. The ED provided a blank Investigation Form, which would have provided additional information had it been completed.	