IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER

Complaint Intake #: 50916-C

December 29, 2014

Ms. Cindy Egdorf, Director
Bickford Cottage Fort Dodge
1536 20th Avenue North
Fort Dodge, IA 50501

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL RECERTIFICATION & COMPLAINT/INCIDENT INVESTIGATION REPORT - BICKFORD COTTAGE FORT DODGE
II. Reduction of Civil Penalty
III. Informal Conference
IV. Standard Certification
V. Conclusion

Dear Ms. Egdorf:

I. Final Recertification & Complaint/Incident Investigation Report – Bickford Cottage Fort Dodge, Fort Dodge, IA

Enclosed is the **Final Recertification & Complaint/Incident Investigation Report ("Report")** issued by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following an investigation by DIA on **December 3, 4 and 8, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Program Policies and Procedures and Program Notification to Department.

Bickford Cottage Fort Dodge ("Program") is being assessed a **$3,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

Pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC rule 67.17(1)(a), a program's noncompliance that results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference;** however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

The factors to be considered in determining the amount of a civil penalty are contained within rule 481 IAC 67.17(3) and include:

(1) the frequency and length of time the regulatory insufficiency occurred;
(2) the past history of the program as it relates to the nature of the regulatory insufficiency;
(3) the culpability of the program as it relates to the reasons the regulatory insufficiency occurred;
(4) the extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;
(5) the relationship of the regulatory insufficiency to any other types of regulatory insufficiencies;
(6) the actions of the programs after the occurrence of the regulatory insufficiency;
(7) the accuracy and extent of records kept by the program which relate to the regulatory insufficiency and the availability of such records to DIA;
(8) the rights of tenants to make informed decisions; and
(9) whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

The determination of a **$3,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, staff failed to follow program policy two times after door alarm went off. As a result, the tenant was found outside with hypothermia.

II. Reduction of Civil Penalty

If, within 30 days of the notice or service of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481–67.17(5). If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send

a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the **State of Iowa** in the amount of **one thousand nine hundred fifty dollars ($1,950)** within 30 days after the notice or service of this demand letter.

III. Informal Conference

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report.

IV. Standard Certification

Enclosed you will find the Assisted Living Program Certificate **S0008** with effective dates of **June 1, 2014** through **May 31, 2016**.

V. Conclusion

The Program is being assessed a **$3,000 civil penalty** pursuant to Iowa Code section 231C.14(1)(a) and 481 IAC 67.17(1)(a).

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so as provided in IAC rule 481-67.14.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

Jim Friberg

Jim Friberg, Acting Bureau Chief
Adult Services Bureau

Enclosure

cc: Jean Herrity, Legal Assistant
Disability Rights Iowa

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0008	A. BUILDING: _____ B. WING _____	C 12/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE FORT DODGE	1536 20TH AVENUE N FORT DODGE, IA 50501

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A 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 36 Number of tenants with cognitive disorder: 6 Total Population of Program at time of on-site: 42 TOTAL census of Assisted Living Program: 42	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on observation of a medication pass, policy reviews, review of Tenant #7's file, incident report review and staff interviews, staff did not follow the policies and procedures extablished by the Program. During a medication pass Staff C administered medications to 6 of 6 tenants without consistently washing her hands prior to and after administration of medications. In regards to an incident involving Tenant #7, (Complaint #50916-C) Staff D and E did not	A 003		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 003	Continued From page 1 follow the policy for an Unwitnessed Door Alarm when the alarm sounded between 3:00 a.m. and 3:30 a.m. and at 5:00 a.m. (A Recertification visit and Complaint Investigation #50916, related to a tenant eloping, were conducted.) On 12-3-14 at 3:40 p.m. a medication pass was observed by the monitor. Staff C washed her hands prior to preparing the medications needed for the medication pass. She retrieved bubble packs from the medication cart for three tenants, placed them in a basket, locked the medication room and carried a laptop and scanner to Tenant #1's room. Medications were administered to Tenant #1 followed by Staff C washing her hands. Staff C proceeded to Tenant #2's room. Staff C washed her hands prior to administering Tenant #2's medications. Staff C proceeded to Tenant #3's room and administered medications. Staff C returned to the medication room. Tenant #4 came to the medication room and was given his/her medications. Staff C retrieved the medications for two more tenants. Staff C administered medications to Tenant #5 and then proceeded to Tenant #6's room. Staff C washed her hands and gloved for the administration of eye drops. Staff C washed her hands after removing the gloves. Staff C had left the scanner in Tenant #3's room, so she went to retrieve the scanner and returned to Tenant #6's room. She administered the oral medications to Tenant #6 and finished documentation. Staff C returned to the medication room. On 12-4-14 at 10:38 a.m. the Director was interviewed and stated basically the policies say you must wash your hands before and after all cares, including medication administration. Review of the Handwashing policy indicated	A 003		

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A 003	Continued From page 2 thorough handwashing was the most important factor in controlling the spread of communicable disease. Thorogh handwashing should be done by all staff: a. prior to giving direct care to a tenant, b. after giving direct care to a tenant. The policy was signed by Staff C and the Nurse on 12-19-13. Tenant #7, a 96 year old, with a GDS of 3, was admitted on 4-23-10 and diagnoses included: Alzheimer's disease, dementia, gradual decline in cognitive function and coronary artery disease. According to a service plan dated 11-7-14, Tenant #7 ambulated independently with use of a walker or cane, using the walker most of the time. Tenant #7 required rest periods when ambulating long distances. If needed to rest, would sit on the seat of the wheeled walker and rest until ready to ambulate. Tenant #7 was discharged from the Program on 12-6-14. According to an incident report dated 11-23-14 at 7:40 a.m., Tenant #3 called for assistance, stating Tenant #7 was sitting outside in the grass. Vital signs taken at 7:45 a.m indicated blood pressure of 126/92, temperature of 95.5, pulse 72 and respirations 20. Tenant #7 was brought inside and walked with assistance of a staff member and walker. Tenant #7 was given coffee and a donut. Range of motion (ROM) was completed and Tenant #7 performed without difficulty. Tenant #7 was taken to the hospital by family. Vitals taken before leaving were: Temperature 95.5 degrees, pulse 84, respirations 24, blood pressure 119/74. Tenant #7's physician was notified of the incident via fax. Tenant #7's family was notified at 7:50 a.m. Notation by the Nurse dated 11-23-14 at 10:45 a.m. indicated Tenant #7 appeared to be stable at that time. Vital signs	A 003		

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A 003	Continued From page 3 and neuro status was intact, ROM within normal limits. Tenant #7 complained of some discomfort to left hip and knee. Tenant #7 was able to ambulate and bear weight at the time. Tenant #7 did not appear confused. Tenant #7's family taking Tenant #7 for evaluation due to confusion that comes and goes quickly. Will continue to monitor. On 12-4-14 at 9:37 a.m. Staff A was interviewed and stated on 11-23-14 she came to work at 6:00 a.m. and started getting tenants up. About 7:30 a.m. Tenant #3 called and said come fast, Tenant #7 is outside without a coat. Staff A took the call and was in the dining room at the time. She ran down the hall to Tenant #3's room and looked out the window and saw Tenant #7 laying flat on back. Tenant #7's walker was outside on the northeast corner of the building facing the building. Tenant #7 was laying in the grass on the east side of the sidewalk. As Staff A was running outside she called Staff C for help. They both picked up Tenant #7 who was covered in mud, leaves and grass as if had been crawling in order to get up. Staff A knew it was 50 degrees at 5:00 a.m. that morning per the bank sign she saw downtown on her way to work. Tenant #7 was wearing a knit shirt, long pants, shoes and nylon ankle socks. Staff A cleaned the shoes and was going to wash the clothes, was soaking them to avoid stains. Tenant #7's family asked for the clothes and took them. Staff A stated Tenant #7's temperature was 92 degrees or 91 degrees. Tenant #7 was very confused that morning. Staff A took off the clothes and washed Tenant #7, wrapped hands and feet in blankets, turned up the heat and covered Tenant #7 with two blankets. Staff C called the Nurse and the Director. Tenant #7's family arrived after 10:00	A 003		

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A 003	Continued From page 4 a.m. Tenant #7 complained of left hip hurting but could bear weight. Staff A said Tenant #7 would normally go to bed around 9:00 p.m. Staff A stated Tenant #7 had exited the same door about a week earlier during the day and walked around the corner of the building with walker. On 12-4-14 at 9:08 a.m. Staff B was interviewed and stated she was working the day shift on 11-23-14, arriving for work a few minutes before 6:00 a.m. She stated all exit doors needed a code to get in or get out or an alarm went off. Staff have to go to the door to set or shut off the alarm. At about 6:30 a.m. or 7:00 a.m. she brought the newspaper into Tenant #7's room and set it on the bed. The bed was made so she figured Tenant #7 had gone to breakfast as Tenant #7 was not in the room. Later she heard the door alarm go off and when she responded other staff were bringing Tenant #7 into the building. Staff A stayed with Tenant #7 until Tenant #7's family arrived. She stated Tenant #3 saw Tenant #7 outside the window and called for help. Tenant #7 was wearing pants, shirt, sweater, shoes and socks. There was mud on shoes, hands and under fingernails. There was also mud on Tenant #7's walker. Staff B stated there was one other time when it was still warm outside, maybe in September, she heard a door alarm and found Tenant #7 had gone out, hadn't gotten too far when Staff B brought Tenant #7 back into the building. Tenant #7 was confused at the time, was a little confused sometimes. On 12-8-14 at 3:50 p.m. Staff C was interviewed and stated she was working the day shift on 11-23-14 as a medication aide. The phone rang and Staff A answered it. Tenant #3 had called and said Tenant #7 was outside. Staff A went out and found Tenant #7 was cold, muddy, had mud	A 003		

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A 003	Continued From page 5 under fingernails and dried leaves in hair. Tenant #7's walker was about 20 feet away. Staff C helped Staff A get Tenant #7 into room and changed clothes. Staff C called the Nurse and reported Tenant #7's temperature was 92.3 degrees. The Nurse said to put Tenant #7 in the whirlpool and warm up. The temperature got up to 93 degrees. The Director was notified. Staff C completed her medication pass and then called Tenant #7's daughter and told her Tenant #7 was found outside and was brought back in. When Tenant #7's family arrived the temperature was up to 95,5 degrees; the family took Tenant #7 to a hospital. Tenant #7 was wearing a blue jogging top and pants and shoes. Tenant #7's bed was made when they brought Tenant #7 into the room. Tenant #7 made own bed. Staff C said it was 50 degrees outside that morning. On 12-8-14 at 1:35 p.m. Staff D was interviewed and stated she had worked from 6:00 p.m. on 11-22-14 to 6:00 a.m. on 11-23-14. At 3:00 a.m. she took a 30 minute lunch break. She wears a headset to listen to music during her break but sometime between 3:00 a.m. and 3:30 a.m. a door alarm went off. She figured Staff E turned it off as the alarm was not on very long. At about 4:00 a.m. Staff E said they should do a room check which she did and all of her tenants were in their rooms. She went to each and every room and made sure it was the right tenant in the right room or bed and turned on the lights. She told Staff E all her tenants were in bed as she pulled back the covers to make sure it was the right tenant. Tenant #7 was not one of the tenants she was providing care. Tenant #1 was asleep sitting in a chair by the door that alarmed around 4:00 a.m., thus Tenant #1 could have set off the alarm. Staff D saw Tenant #7 at 7:45 p.m. in Tenant #7's room watching television, dressed and sitting in a	A 003		

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A 003	Continued From page 6 chair. She stated she was trained to turn off alarms and then immediately do checks; one staff checks the rooms and another checks the outside perimeter of the building. On 12-8-14 at 2:18 p.m. Staff E was interviewed and stated she worked from 6:00 p.m. on 11-22-14 to 6:00 a.m. on 11-23-14. She stated Tenant #3 got a medication at 4:00 a.m. and again at 5:00 a.m. After she administered the 5:00 a.m. medication she returned to the med room and heard the alarm go off. She stated Staff D was at the nurses station and didn't hear anything so she told Staff D to recheck the tenants. Tenant #1 was by the door where the alarm went off as well as Tenant #1's monitoring watch was alarming. About 5:30 a.m. to 5:40 a.m. she checked on Tenant #7. The bed was messed up and she thinks she saw Tenant #7's hair as the covers were pulled way up. Staff E stated she couldn't swear she saw Tenant #7 but the bedding was not flat. She stated that earlier at 2:00 a.m. she saw Tenant #7 wearing snowman pajamas. She left work at 6:20 a.m. and noted the themometer in her car showed 50 degrees. She stated she received a text message from the Director to call her which she did around noon. The Director called back and asked what time she had last seen Tenant #7. She told the Director Tenant #7 was in the living room after supper and she saw her in bed at midnight and 2:00 a.m. On 12-8-14 at 3:08 p.m. the Nurse was interviewed and stated Staff C notified her about 7:30 a.m. to 7:45 a.m. that Tenant #3 looked out the window and saw Tenant #7 sitting on the ground. Staff brought Tenant #7 in the building and covered in blankets and took vital signs. The temperature was low so she told staff to recheck	A 003		

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A 003	Continued From page 7 the temperature auxillary and to warm up Tenant #7. She instructed them to put her in clean clothes and then in the whirlpool or shower and give warm fluids. She also instructed staff to call Tenant #7's family right away as they were not allowed to do anything with Tenant #7 until the family was notified. There were no visible injuries, was just cold. She told staff she would come in right away. The Director had already checked on Tenant #7 before the Nurse arrived and said Tenant #7 was alert. The Nurse saw Tenant #7 around 10:20 a.m. to 10:30 a.m. and Tenant #7 was normal self. Staff told the Nurse Tenant #7's clothes were dirty. The family took Tenant #7 somewhere, she didn't know where, and they didn't find anything wrong. There had been no elopements since and Tenant #7 had not been confused since the incident. Tenant #7 would get confused when Tenant #7 had a urinary tract infection (UTI) but did not have a UTI. Tenant #7 had bursitis in a knee and was on an antibiotic for that. On 12-4-14 at 12:20 p.m. the Director was interviewed and stated only the monitoring system worn by tenants was able to provide a print out of times that tenants set off door alarms. A copy of the monitoring system report for 11-22-14 to 11-24-14 was provided. Tenant #7 did not wear a monitoring device thus, no alarm report was available to indicate when Tenant #7 left the building. The exit doors alarm but the alarm system does not record a report of when alarms go off and no report is possible. The Program completed an incident report in regards to Tenant #7's incident of 11-23-14. The Director asked Staff E what occurred and Staff E stated the exit door alarm went off at 5:00 a.m., she looked outside, both ways and did not see anyone outside. She asked Staff D what	A 003		

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A 003	Continued From page 8 occurred and she said the alarm went off but everyone was in bed. The Director arrived at 9:00 a.m. and Tenant #7 was fine. The tips of fingers were red as staff had scrubbed the fingers which were dirty. She stated Tenant #7's temperature was 95.5 degrees and it was a warm morning, between 40 to 45 degrees. Tenant #7's family took Tenant #7 to be seen between 10:30 a.m. and 11:00 a.m. and returned at 9:30 p.m. Tenant #7 did not have any new physician orders. On 12-8-14 at 4:00 p.m. Tenant #3 was interviewed and stated one morning, Tenant #3 woke up, opened the blinds and saw Tenant #7 sitting with legs out in front on the ground. Tenant #3 called and Staff A responded. Tenant #7 was moving arms and legs, with no walker seen. Tenant #3 had never seen Tenant #7 without a walker. According to the Unwitnessed Door Alarm policy, if a door alarm occurs and a staff member does not witness the events surrounding the alarm, staff must immediately check their pagers for the type of alarm that occurreed, i.e., whether it was a general door alarm or whether a tenant with a monitoring device caused the alarm. The inside and outside area surrounding the door that caused the alarm must be visually searched immediately after an unwitnessed door alarm occurred. If no tenant is found during the visual search around the door that caused the unwitnessed door alarm, immediately summon the assistance of the other employees on duty. If the door alarm was caused by a tenant wearing a watch, make sure all employees know they are searching for this specific tenant. If the door alarm was caused by a general door alarm, make sure all employees know they must account for all tenants. The Program staff did not comply with	A 003		

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A 003	Continued From page 9 the policies and procedures as outlined in the Unwitnessed Door Alarm policy.	A 003		
A 025	481-67.4(4) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(4) When a tenant elopes from a program. This REQUIREMENT is not met as evidenced by: Based on review of Tenant #7's file, review of incident report, policy review and staff interviews, the Program failed to report an elopement to the Department. Tenant #7 was found outside at 7:40 a.m., staff reported a door alarm sounding at 3:00 a.m. and 5:00 a.m. Staff did not physically do a tenant check or a visual and physical check of the area when the alarm sounded. The Program did not notify the Department when Tenant #7 eloped. Tenant #7, a 96 year old, with a GDS of 3, was admitted on 4-23-10 and diagnoses included: Alzheimer's disease, dementia, gradual decline in cognitive function and coronary artery disease. According to a service plan dated 11-7-14, Tenant #7 ambulated independently with use of a walker or cane, using the walker most of the time. Tenant #7 required rest periods when ambulating long distances. If needed to rest, would sit on the seat of the wheeled walker and rest until ready to ambulate. Tenant #7 was discharged from the Program on 12-6-14.	A 025		

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	S0008	A. BUILDING. _____ B. WING _____	C 12/08/2014

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A 025	Continued From page 10 According to an incident report dated 11-23-14 at 7:40 a.m., Tenant #3 called for assistance, stating Tenant #7 was sitting outside in the grass. Vital signs taken at 7:45 a.m indicated blood pressure of 126/92, temperature of 95.5, pulse 72 and respirations 20. Tenant #7 was brought inside and walked with assistance of a staff member and walker. Tenant #7 was given coffee and a donut. Range of motion (ROM) was completed and Tenant #7 performed without difficulty. Tenant #7 was taken to the hospital by family. Vitals taken before leaving were: Temperature 95.5 degrees, pulse 84, respirations 24, blood pressure 119/74. Tenant #7's physician was notified of the incident via fax. Tenant #7's family was notified at 7:50 a.m. Notation by the Nurse dated 11-23-14 at 10:45 a.m. indicated Tenant #7 appeared to be stable at that time. Vital signs and neuro status was intact, ROM within normal limits. Tenant #7 complained of some discomfort to left hip and knee. Tenant #7 was able to ambulate and bear weight at the time. Tenant #7 did not appear confused. Tenant #7's family taking Tenant #7 for evaluation due to confusion that comes and goes quickly. Will continue to monitor. On 12-4-14 at 9:37 a.m. Staff A was interviewed and stated on 11-23-14 she came to work at 6:00 a.m. and started getting tenants up. About 7:30 a.m. Tenant #3 called and said come fast, Tenant #7 is outside without a coat. Staff A took the call and was in the dining room at the time. She ran down the hall to Tenant #3's room and looked out the window and saw Tenant #7 laying flat on back. Tenant #7's walker was outside on the northeast corner of the building facing the building. Tenant #7 was laying in the grass on the	A 025		

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A 025	Continued From page 11	A 025		

east side of the sidewalk. As Staff A was running outside she called Staff C for help. They both picked up Tenant #7 who was covered in mud, leaves and grass as if had been crawling in order to get up. Staff A knew it was 50 degrees at 5:00 a.m. that morning per the bank sign she saw downtown on her way to work. Tenant #7 was wearing a knit shirt, long pants, shoes and nylon ankle socks. Staff A cleaned the shoes and was going to wash the clothes, was soaking them to avoid stains. Tenant #7's family asked for the clothes and took them. Staff A stated Tenant #7's temperature was 92 degrees or 91 degrees. Tenant #7 was very confused that morning. Staff A took off the clothes and washed Tenant #7, wrapped hands and feet in blankets, turned up the heat and covered Tenant #7 with two blankets. Staff C called the Nurse and the Director. Tenant #7's family arrived after 10:00 a.m. Tenant #7 complained of left hip hurting but could bear weight. Staff A said Tenant #7 would normally go to bed around 9:00 p.m. Staff A stated Tenant #7 had exited the same door about a week earlier during the day and walked around the corner of the building with walker.

On 12-4-14 at 9:08 a.m. Staff B was interviewed and stated she was working the day shift on 11-23-14, arriving for work a few minutes before 6:00 a.m. She stated all exit doors needed a code to get in or get out or an alarm went off. Staff have to go to the door to set or shut off the alarm. At about 6:30 a.m. or 7:00 a.m. she brought the newspaper into Tenant #7's room and set it on the bed. The bed was made so she figured Tenant #7 had gone to breakfast as Tenant #7 was not in the room. Later she heard the door alarm go off and when she responded other staff were bringing Tenant #7 into the building. Staff A stayed with Tenant #7 until

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A 025	Continued From page 12 Tenant #7's family arrived. She stated Tenant #3 saw Tenant #7 outside the window and called for help. Tenant #7 was wearing pants, shirt, sweater, shoes and socks. There was mud on shoes, hands and under fingernails. There was also mud on Tenant #7's walker. Staff B stated there was one other time when it was still warm outside, maybe in September, she heard a door alarm and found Tenant #7 had gone out, hadn't gotten too far when Staff B brought Tenant #7 back into the building. Tenant #7 was confused at the time, was a little confused sometimes. On 12-8-14 at 3:50 p.m. Staff C was interviewed and stated she was working the day shift on 11-23-14 as a medication aide. The phone rang and Staff A answered it. Tenant #3 had called and said Tenant #7 was outside. Staff A went out and found Tenant #7 was cold, muddy, had mud under fingernails and dried leaves in hair. Tenant #7's walker was about 20 feet away. Staff C helped Staff A get Tenant #7 into room and changed clothes. Staff C called the Nurse and reported Tenant #7's temperature was 92.3 degrees. The Nurse said to put Tenant #7 in the whirlpool and warm up. The temperature got up to 93 degrees. The Director was notified. Staff C completed her medication pass and then called Tenant #7's daughter and told her Tenant #7 was found outside and was brought back in. When Tenant #7's family arrived the temperature was up to 95.5 degrees; the family took Tenant #7 to a hospital. Tenant #7 was wearing a blue jogging top and pants and shoes. Tenant #7's bed was made when they brought Tenant #7 into the room. Tenant #7 made own bed. Staff C said it was 50 degrees outside that morning. On 12-8-14 at 1:35 p.m. Staff D was interviewed and stated she had worked from 6:00 p.m. on	A 025		

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A 025	Continued From page 13 11-22-14 to 6:00 a.m. on 11-23-14. At 3:00 a.m. she took a 30 minute lunch break. She wears a headset to listen to music during her break but sometime between 3:00 a.m. and 3:30 a.m. a door alarm went off. She figured Staff E turned it off as the alarm was not on very long. At about 4:00 a.m. Staff E said they should do a room check which she did and all of her tenants were in their rooms. She went to each and every room and made sure it was the right tenant in the right room or bed and turned on the lights. She told Staff E all her tenants were in bed as she pulled back the covers to make sure it was the right tenant. Tenant #7 was not one of the tenants she was providing care. Tenant #1 was asleep sitting in a chair by the door that alarmed around 4:00 a.m., thus Tenant #1 could have set off the alarm. Staff D saw Tenant #7 at 7:45 p.m. in Tenant #7's room watching television, dressed and sitting in a chair. She stated she was trained to turn off alarms and then immediately do checks; one staff checks the rooms and another checks the outside perimeter of the building. On 12-8-14 at 2:18 p.m. Staff E was interviewed and stated she worked from 6:00 p.m. on 11-22-14 to 6:00 a.m. on 11-23-14. She stated Tenant #3 got a medication at 4:00 a.m. and again at 5:00 a.m. After she administered the 5:00 a.m. medication she returned to the med room and heard the alarm go off. She stated Staff D was at the nurses station and didn't hear anything so she told Staff D to recheck the tenants. Tenant #1 was by the door where the alarm went off as well as Tenant #1's monitoring watch was alarming. About 5:30 a.m. to 5:40 a.m. she checked on Tenant #7. The bed was messed up and she thinks she saw Tenant #7's hair as the covers were pulled way up. Staff E stated she couldn't swear she saw Tenant #7 but	A 025		

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A 025	Continued From page 14 the bedding was not flat. She stated that earlier at 2:00 a.m. she saw Tenant #7 wearing snowman pajamas. She left work at 6:20 a.m. and noted the themometer in her car showed 50 degrees. She stated she received a text message from the Director to call her which she did around noon. The Director called back and asked what time she had last seen Tenant #7. She told the Director Tenant #7 was in the living room after supper and she saw her in bed at midnight and 2:00 a.m. On 12-8-14 at 3:08 p.m. the Nurse was interviewed and stated Staff C notified her about 7:30 a.m. to 7:45 a.m. that Tenant #3 looked out the window and saw Tenant #7 sitting on the ground. Staff brought Tenant #7 in the building and covered in blankets and took vital signs. The temperature was low so she told staff to recheck the temperature auxillary and to warm up Tenant #7. She instructed them to put her in clean clothes and then in the whirlpool or shower and give warm fluids. She also instructed staff to call Tenant #7's family right away as they were not allowed to do anything with Tenant #7 until the family was notified. There were no visible injuries, was just cold. She told staff she would come in right away. The Director had already checked on Tenant #7 before the Nurse arrived and said Tenant #7 was alert. The Nurse saw Tenant #7 around 10:20 a.m. to 10:30 a.m. and Tenant #7 was normal self. Staff told the Nurse Tenant #7's clothes were dirty. The family took Tenant #7 somewhere, she didn't know where, and they didn't find anything wrong. There had been no elopements since and Tenant #7 had not been confused since the incident. Tenant #7 would get confused when Tenant #7 had a urinary tract infection (UTI) but did not have a UTI. Tenant #7 had bursitis in a knee and was on an	A 025		

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A 025	Continued From page 15 antibiotic for that. On 12-4-14 at 12:20 p.m. the Director was interviewed and stated only the monitoring system worn by tenants was able to provide a print out of times that tenants set off door alarms. A copy of the monitoring system report for 11-22-14 to 11-24-14 was provided. Tenant #7 did not wear a monitoring device thus, no alarm report was available to indicate when Tenant #7 left the building. The exit doors alarm but the alarm system does not record a report of when alarms go off and no report is possible. The Program completed an incident report in regards to Tenant #7's incident of 11-23-14. The Director asked Staff E what occurred and Staff E stated the exit door alarm went off at 5:00 a.m., she looked outside, both ways and did not see anyone outside. She asked Staff D what occurred and she said the alarm went off but everyone was in bed. The Director arrived at 9:00 a.m. and Tenant #7 was fine. The tips of fingers were red as staff had scrubbed the fingers which were dirty. She stated Tenant #7's temperature was 95.5 degrees and it was a warm morning, between 40 to 45 degrees. Tenant #7's family took Tenant #7 to be seen between 10:30 a.m. and 11:00 a.m. and returned at 9:30 p.m. Tenant #7 did not have any new physician orders. On 12-8-14 at 4:00 p.m. Tenant #3 was interviewed and stated one morning, Tenant #3 woke up, opened the blinds and saw Tenant #7 sitting with legs out in front on the ground. Tenant #3 called and Staff A responded. Tenant #7 was moving arms and legs, with no walker seen. Tenant #3 had never seen Tenant #7 without a walker. According to the Unwitnessed Door Alarm policy,	A 025		

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A 025	Continued From page 16 if a door alarm occurs and a staff member does not witness the events surrounding the alarm, staff must immediately check their pagers for the type of alarm that occurreed, i.e., whether it was a general door alarm or whether a tenant with a monitoring device caused the alarm. The inside and outside area surrounding the door that caused the alarm must be visually searched immediately after an unwitnessed door alarm occurred. If no tenant is found during the visual search around the door that caused the unwitnessed door alarm, immediately summon the assistance of the other employees on duty. If the door alarm was caused by a tenant wearing a watch, make sure all employees know they are searching for this specific tenant. If the door alarm was caused by a general door alarm, make sure all employees know they must account for all tenants. A copy of the floor plan was provided. Staff A walked with the monitor on the potential route that Tenant #7 took, exiting from the northwest exit door by rooms 109/110, walked approximately 30 feet along the west side of the building, headed north, rounded the corner of the building, walked approximately 219 feet along the north side of the building, rounded the corner heading south, leaving the walker on the northeast corner of the building. Tenant #7 would have walked another 30 feet and was found on the east side of the sidewalk, approximately 21 feet from the building. The Program provided alarm report print outs of all tenants who wore monitoring devices. Tenant #1 wore a monitoring device and the report showed the alarm sounded at 2:58 a.m. by room 110 near the northwest exit door. Tenant #7 did not wear a monitoring device, thus no records exist for Tenant #7.	A 025		

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A 025	Continued From page 17 The monitor contacted the exit door alarm company. The alarm company stated the system didn't record the monitoring of the doors and there were no records of when exit doors opened or closed. According to the State Climatologist on 11-23-14 at the Fort Dodge airport at 4:00 a.m. it was 52 degrees, winds from the south at 10 miles per hour, cloudy skies, no precipitation and the snow cover from earlier in the month was gone. The Program completed an incident report but did not notify the Department.	A 025		

Plan of Correction
Ft. Dodge Bickford

A. Program policies and procedures

Regulatory Insufficiency: Staff did not follow the policies and procedures established by the Program.

Plan of Correction
The insufficiency will be corrected as follows:

- BFMs will wash their hands between contact with different residents, when providing direct care to residents, including any hands-on tasks, and at other times as delineated in the handwashing policy, including medication administration.
- Bickford staff will respond to all Unwitnessed Door Alarms per Unwitnessed Door Alarm policy as outlined in the Emergency Handbook.

The following measures will be taken to ensure the problem does not recur:

- All staff were re-educated, per delegation by the RNC on hand washing and all medication aides were re-educated on medication administration per delegation by the RNC, on or before December 18, 2014.
- An In-Service meeting will be held on January 13, 2015. Re-Education will be completed with all Bickford Staff re: the Unwitnessed Door Alarm Policy.

The program will monitor performance to ensure permanent solutions in the following manner:

- The Divisional Director of Resident Services will audit medication administration to ensure proper hand washing is being completed, at least twice a year.
- The Divisional Director of Operations will audit documentation to ensure that the Unwitnessed Door Alarm policy, has been reviewed at least annually, or more often as needed.

Date deficiencies corrected by: January 13, 2015

B. Program Notification to Department

Regulatory Insufficiency: Program failed to reports an elopement to the Department.

Plan of Correction:
The insufficiency will be corrected as follows:

- Bickford staff will notify the Department within 24 hours or next business day, by the most expeditious means available as required per regulations, including when a resident elopes from the Program.

The following measures will be taken to ensure the problem does not reoccur:

- The Branch Director was re-educated on the criteria for notification to the Department and when an Investigation is to be completed, including when a resident elopes from the Program, by the Vice President of Resident Services and the Divisional Director of Operations on January 8, 2015.

The Program will monitor performance to ensure compliance as follows:

- The Divisional Director of Resident Services will audit at least twice a year, the resident Incident Reports to determine if they were handled appropriately, including notification to the Department.

Date deficiencies corrected by: January 8, 2015