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
	S0006	A. BUILDING: _____ B. WING _____	C 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE I SIOUX CITY	4020 INDIAN HILLS DR SIOUX CITY, IA 51108

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A 000	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. Number of tenants without cognitive impairment: 25 Number of tenants with cognitive impairment: 8 Total census: 33 The following regulatory insufficiencies were cited during the investigation of Incident #129800-I and Complaint #129796-C.	A 000	See attached POC 8/14/25	
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to follow established policy for door inspections regarding 1 of 1 residents who eloped (Tenant 1), potentially affecting all tenants residing in the program. Findings follow: On 7/9/25 review of an incident report dated 7/6/25 revealed Tenant 1 eloped from the program on 7/5/25. The tenant's Care Predict Tempo system revealed his last known location was by the beauty salon door at 1:50 pm. Program staff stated they did not receive an alert of the exit and didn't notice Tenant 1 was missing until approximately 4:00 pm. Tenant 1 was later located by a local landowner at approximately 9:00 pm, with local police and family responding	A 150		

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

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to the location of the tenant approximately ½ mile from the program.

A late entry elopement incident note dated 7/9/25 by the program's Executive Director (ED) noted she had received a call around 4:15 pm from a staff member on the evening shift who alerted her Tenant 1 was missing and the ED provided further instruction on the missing persons protocol. The note indicated, "The facility had issues with fire panel earlier in the day and found the salon door to not have the mag lock re-engage to locking even though local Fire Department on site and Maintenance direction over the phone" and detailed the program's search efforts and communications. The note further revealed "Police received a call of a potential matching resident description around 9:00 pm ..." and " ...told ED to let family know he was found in the terraces behind North Middle School, about half a mile from Bickford." The note further revealed " ...was told resident was awake, dehydrated and with a few cuts on his side." Tenant 1 was then transported to the emergency room for evaluation. A progress note dated 7/6/25 revealed Tenant 1 was admitted for acute kidney injury, dehydration and elevated creatine levels.

On 7/10/25, the State Climatologist provided a weather conditions report for date of the elopement incident, which suspected time of likely exit from the program shortly before 2:00 pm through the time Tenant 1 was located at approximately 9:00 pm. The temperature at 1:52 pm was 83 degrees Fahrenheit (°F), with winds out of the west at 9 miles per hour (mph). The State Climatologist indicated thunderstorms and/or light rain with thunder were in the vicinity until 3:03 pm when conditions became fair. At 4:52 pm, the temperature had climbed to 85°F

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A 150	Continued From page 2	A 150		

with winds out of the NW at 10 mph. At 8:52 pm, approximately ten minutes prior to Tenant 1 being located, the temperature was 77°F and fair conditions.

Record review revealed Tenant 1 was admitted to the program on 6/30/25 with diagnoses including dementia, depression and anxiety. Assessments identified he was exit seeking during the night and day and had a history of wandering when he lived at home.

During an interview on 7/9/25 at 1:56 pm, Staff A stated she worked on the day of Tenant 1's elopement and said he regularly wandered and attempted to exit-seek by trying to push the different doors. She stated there are secondary audible alarms on all the doors. It was discovered after Tenant 1's elopement the beauty salon door's secondary audible alarm didn't have batteries in it. She believed this was likely due to the batteries being removed from people moving in/out previously.

During an interview on 7/9/25 at 2:20 pm, Staff B stated she worked on the day of Tenant 1's elopement and said he had been exit-seeking that day. She had gone next door to the other program building to provide a walk-in tour. She stated it was between 2:00 pm and 2:36 pm while conducting the tour when she recalled the Tempo indicated an alert for Tenant 1 and believed was when he "likely exited," but upon return to the Bickford 1 building she didn't hear any audible alarms going off. She stated her work phone had shut down and signed her out and when she signed back in, the system indicated no other alerts for Tenant 1.

When interviewed on 7/9/25 at 3:25 pm Staff C

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A 150	Continued From page 3	A 150		

stated she worked the 2nd shift and arrived at work around 3:10 pm on the day of Tenant 1's elopement. Staff C was uncertain if the fire panel was appropriately reset at the time of her arrival to work, but did recall another staff member being on the phone with the maintenance man who was talking her through the process to reset the fire alarm panel, and thus the alarm system for the doors. Staff C stated she didn't know if the system did get reset. She stated Tenant 1 regularly attempted to exit-seek and pushed on the doors, and would become agitated when the doors would audibly sound, but "unfortunately that one door didn't alarm that day." Staff C stated she and another staff member took the cover off of the secondary alarm to check it and discovered it didn't have a battery in it.

During an interview and tour of the program's doors on 7/9/25 at 3:15 pm with the Health and Wellness Director (HWD), the HWD stated she became aware after the incident that staff had discovered the secondary audible alarm on the salon door didn't have batteries in it likely from people moving in/out.

A review of the program policy entitled "Door Inspections" dated 01/2025 revealed the following under Policy: All doors listed on your branch's Door Inspection Checklist shall be inspected and maintained to always ensure appropriate functioning. As part of the required weekly testing per program policy, the policy included the following instructions:

*Audible Alarm - All door alarms must be sufficiently loud to allow Bickford Family Members (program staff) to appropriately respond.

During an interview with the Maintenance Director

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A 150	Continued From page 4 on 7/10/25 at 10:00 am, he stated weekly inspections of the doors were regularly completed (provided copies of the door inspection logs) and stated the beauty salon door was included in the check of the 400 hall. The Maintenance Director stated during his testing the week of 6/30/25 he inspected the beauty salon door mag lock, crash bar latch and keypads, but would have reached up and hit the button to silence the secondary audible alarm in order to do so, rather than additionally performing an inspection of the secondary audible alarm itself. Following the elopement of a tenant from the program, the Maintenance Director then performed door inspections on 7/8/25, and the log revealed the following notation for the 400 hall "Secondary battery alarm, missing inside cover and 1 battery?" On 7/10/25 at 2:20 pm, the Executive Director and Health and Wellness Director confirmed the above findings.	A 150		
A 638	481-69.32(4)b Life Safety - Emergency Policies / Structure 69.32(4) A program serving a person(s) with cognitive disorder or dementia shall have: b. Written procedures regarding appropriate staff response when a tenant's service plan indicates a risk of elopement or when a tenant exhibits wandering behavior. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to have written procedures addressing appropriate staff response when a service plan indicates a risk of elopement or a	A 638		

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A 638	Continued From page 5	A 638		

tenant exhibits wandering behavior for 2 of 2 tenants reviewed with such behaviors (Tenant 1 and Tenant 3). Findings follow:

1. Record review on 7/9/25 revealed Tenant 1 was admitted to the program on 6/30/25 with diagnoses including dementia, depression, and anxiety. The service plan and assessment for Tenant 1 dated 7/1/25 identified he was exit-seeking during the day and night and had a history of wandering off when he lived at home. The service plan identified Tenant 1 required minimum assistance from program staff for cueing, reminders, or redirection due to cognitive decline, disorientation, memory loss if Tenant 1 displayed wandering behavior or was exit-seeking. Tenant 1 was identified as a Level 3 fall risk due to his cognitive impairment and identified the tenant required use of the program's Tempo alert system as a special care need. An assessment dated 7/1/25 identified Tenant 1 scored 13/30 on the Mini-Mental Status Examination (MMSE) indicating moderate cognitive impairment and identified Tenant 1's personal goal was "Safety."

An Elopement incident report dated 7/6/25 revealed Tenant 1 eloped from the program on 7/5/25. The tenant's Care Predict Tempo system revealed the tenant's last known location was by the Beauty Salon door at 1:50 pm. Program staff stated they did not receive an alert of the exit and didn't notice Tenant 1 was missing until approximately 4:00 pm. Tenant 1 was later located by a local landowner and police at approximately 9:00 pm, approximately ½ mile from the program.

2. Record review on 7/10/25 revealed Tenant 2 was admitted to the program on 8/23/22 with

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A 638	Continued From page 6 diagnoses including hallucinations, and a Global Deterioration Score (GDS) of 4 indicating moderate cognitive decline. The service plan and change of condition assessment for Tenant 3 dated 6/17/25 identified he was exit-seeking during the day and night. The service plan identified Tenant 3 required moderate assistance from program staff for redirection if wandering or approaching exits, and required a monitoring device due to forgetfulness, difficulty concentrating, and memory impairment. An elopement incident report dated 6/17/25 revealed Tenant 3 eloped from the program on 6/14/25. While staff did receive an alert of the exit, the tenant had made it to the parking lot of the next building by the time program staff responded and Tenant 3 eventually had to be assisted back into the building by the oncoming shift. 3. On 7/10/25 at 1:05 pm, the Executive Director stated by email no written procedures/policy could be located specific to staff response when a tenant's service plan indicates a risk of elopement or wandering behavior. On 7/10/25 at 2:20 pm, the Executive Director and Health and Wellness Director confirmed the above findings.	A 638		

ok
8/19/25

Plan of Correction
Bickford Cottage I Sioux City

A150 481-67.2 (3) Program Policies and Procedures

Regulatory Insufficiency: Program failed to follow established policy for door inspections.

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

- Secondary door alarm checks will be conducted weekly.

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

- Weekly completed door checks to be reviewed by a member of the BLT (Branch Leadership Team).
- Any system failures shall be reported on the Branch level 10 meeting.

The program will monitor performance to ensure compliance as follows:

- Battery installed 7.7.25 to current.

A638 481.-69.32 (4b) Life Safety- Emergency Policies/ Structure

Regulatory Insufficiency: Program failed to have a written procedures regarding appropriate staff response when a tenant's service plan indicates a risk of elopement or when a tenant exhibits wandering behavior. .

Plan of Correction:
The insufficiencies will be correct as follows:

- All service plans for those with cognitive disorder or dementia will include utilizing individualization of activities; planned and spontaneous, based on their abilities and personal interests. The Program does have a Service Plan policy that states in section #8 what is to be done for residents with dementia. The policy is attached for review.

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

- Any resident exhibiting exit seeking behaviors shall have a change of condition service plan to create to instruct caregivers on redirection.
- ED and or Divisional HWD to review service plans upon completion and IDS all residents with cognitive disorders or dementia on weekly HigherPath meetings.

The program will monitor performance to ensure compliance as follows:

- Service Plan updated on 7/14/25 and HigherPath meetings for clinical reviews on 7/16/25, 7/24/25,7/30/25, 8/14/25.