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
	S0011	A. BUILDING: _____ B. WING _____	C 07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE BURLINGTON	3301 STERLING DR BURLINGTON, IA 52601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site visit. Number of tenants without cognitive impairment: 17 Number of tenants with cognitive impairment: 10 Total census: 27 The following regulatory insufficiencies were cited during the investigation of Incident #128590-I.	A 000	See attached POC 9/29/25	
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 observation, interview and record review, the program failed to implement policy regarding exit door alarms for 1 of 1 tenant reviewed regarding an incident of elopement (Tenant #1). Finding follows: Record review on 7/23/35 revealed an incident report and progress notes for Tenant #1 indicated she left the Bickford Cottage building through the alarmed front exit door without staff knowledge on the afternoon of 5/10/25. A family member of another tenant observed Tenant #1 walking along the street near the program driveway and returned her to the program. Tenant #1 was absent from the building for approximately six minutes. She was uninjured.	A 150	Bickford Senior Living of Burlington Plan of Correction for complaint survey 7/22-7/23/25 A150 481-67.2(3) Program Policies and Procedures The program failed to follow the policy on unwitnessed door alarms involving 1 of 1 tenants. 1. Re-education provided to staff present on date of incident regarding policy of unwitnessed door alarms by ED. 2. All staff were re-educated by ED on proper action for unwitnessed door alarm activation, to include: If a door alarm occurred and a staff member did not witness the events surrounding the alarm, staff should immediately perform a visual check inside and outside of the alarming door area. If no tenant was found during the visual search around the door causing the alarm, staff must account for all tenants. 3. ED or designee to complete Unwitnessed door alarm drills per policy.	

			4. DDO to monitor compliance with door alarm drill policy with routine visits for 3 months. 5. Date of completion 9/29/25	

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

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A 150	Continued From page 1 Tenant #1 was 85 years old with a diagnosis including Alzheimer's dementia, anemia, anxiety, depression, hypertension and weakness. Tenant #1 moved to the program on 3/30/25. She did not reside in the memory care unit. Progress notes from 4/03/25 to 5/04/25 indicated episodes of confusion, such as entering other tenants' rooms and getting into their beds and entering common areas of the building only partially clothed. A Mini-Mental State Examination (MMSE) dated 3/31/25, indicated Tenant #1 achieved a score of 16 out of 30 points, which indicated severe cognitive impairment. A Resident Assessment dated 4/19/25, indicated Tenant #1 scored 13 out of 30 points on the MMSE. According to assessment, she needed a moderate level of assistance due to disorientation, memory loss and difficulty completing tasks. The assessment noted Tenant #1 wandered in the building and into other tenant rooms, but did not indicate a problem with exit seeking or prior elopement. Tenant #1 ambulated independently. The program completed a Global Deterioration Scale on 5/10/25 and documented a score of 5, which indicated moderately severe cognitive decline. When interviewed on 7/22/25 at 3:55 p.m. Staff A stated she walked past the front entry area on her way the memory care unit on the afternoon of 5/10/25. Staff A noticed Tenant #1 sitting in an easy chair in the living room area, taking with another tenant (approximately 30 feet from the front door). As Staff A left the memory care unit a short time later, she heard the front door alarm sounding. Staff A said she ran to the front door and saw Tenant #2 standing by the door. Staff A stepped outside and looked around, but noted	A 150		

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A 150	Continued From page 2 she didn't step out far enough to see past a wall that blocked her view to the north. Staff A returned to the building. She said she assumed Tenant #2 had opened the exit door and caused the alarm. Staff A said staff were not trained to check on all of the tenants after the door alarm sounded if they didn't live in the memory care unit. Staff A noted Tenant #1 didn't live in the memory care unit, but was not supposed to be outside on her own. Staff B informed Staff A a short time later another family member found Tenant #1 outside and brought her back. When interviewed on 7/23/25 at 11:15 a.m. the family member of another tenant recalled the incident on the afternoon of 5/10/25 when she returned Tenant #1 to the program. The family member said she was driving north out of the program parking lot and saw Tenant #1 walking along the street, not far from the end of the program driveway. The family member recognized Tenant #1 and stopped to talk with her. Tenant #1 asked the family member if she knew where she (Tenant #1) lived. The family member said she attempted to point out the Bickford Cottage building to Tenant #1, but she seemed confused, so the family member offered to give her a ride and Tenant #1 willingly got into her vehicle. Tenant #1 was uninjured and appropriately dressed, other than wearing slipper socks instead of shoes. The family member flagged down a staff person who was near the dumpster by the Bickford Cottage building. When interviewed on 7/23/25 at 10:10 a.m. Staff B stated she worked as a cook at the program. On the afternoon of 5/10/25, she took trash out to the dumpster (on north side of building). She noticed a woman in a white car waving at her, just past the driveway. The white car approached and	A 150		

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A 150	Continued From page 3 Staff B saw the family member driving and Tenant #1 in the passenger seat. Staff B and the family member walked Tenant #1 back into the building. Staff B immediately notified the caregiver staff. When interviewed on 7/23/25 at 1:05 p.m. Staff C confirmed she worked on 5/10/25, when Tenant #1 left the building. Staff C said she worked a 12 to 16 hour shift and went home for a one hour break in the afternoon. When she returned, Staff A told her the front door alarm had sounded, but she thought Tenant #2 had done it since Staff A looked around outside and didn't see anyone. A few minutes after Staff C returned to the program, Staff B told her a family member brought Tenant #1 back to the building. Staff C said staff weren't checking on tenants whereabouts when she arrived back from her break. Staff C had worked at the program for three years and didn't recall if she was trained to do an accountability check after an unwitnessed exit door alarm. She said staff hadn't done that type of check in a long time. The exit door logs revealed the front exit door was "breached" and opened at 3:06 p.m. The log showed Staff A reset the door breach and door lock at 3:06 p.m. Staff A used her bypass swab to open the door at 3:06 p.m.. The door was closed and secure again at 3:06 p.m. A side service exit door was opened with Staff B's fob at 3:10 p.m., when she left the building to take out trash and again at 3:12 p.m. when she reportedly entered the building, along with Tenant #1. The front exit door of the building had a push bar to open the door and a electronic device near the door. If someone swiped a bypass fob over the electronic device, the door could open easily. Otherwise, the alarm sounded when the bar was pushed and the door didn't open for 15 seconds	A 150		

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A 150	Continued From page 4 (delayed egress). The staff and some of the family members had fobs to swipe the electronic device so they could come and go out the front door with no alarm sounding. Observation of the outside area revealed one parking lot entrance to the north leading to a short street with no posted speed limit. The street had light traffic near the program parking lot entrance, but was more heavily traveled by the McDonalds' parking lot approximately one to two blocks north. According to the description by the family member, she saw Tenant #1 walking north on the side of the street, approximately 30 to 50 feet from the end of the program driveway. Review of the "Unwitnessed Door Alarm" policy/procedure on 7/23/25 revealed staff should immediately visually search the inside and outside area surrounding the exit door after the occurrence an unwitnessed door alarm. If no tenant was found during the visual search, staff should immediately summon the assistance of other staff on duty. The staff must account for all tenants. When interviewed on 7/23/25 at 1:45 p.m. the Executive Director verified the staff should have followed the policy and initiated an accountability check for all tenants at the time of the incident.	A 150		