STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0023	A. BUILDING: _____ B. WING _____	C 07/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BICKFORD COTTAGE IOWA CITY	3500 LOWER W BRANCH RD IOWA CITY, IA 52245

(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. Number of tenants without cognitive impairment: 18 Number of tenants with cognitive impairment: 12 Total census: 30 The following regulatory insufficiencies were cited during the investigation of Incident #129102-I.	A 000	see attached POC 8/1/25	
A 115	481-67.2(1)b Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: b. An incident report shall be in detail and shall be provided on an incident report form. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to produce a detailed incident report regarding the elopement of 1 of 1 tenants reviewed (Tenant #1). Findings follow: Record review on 7/1/25 revealed an incident report dated 6/2/25 completed by the Divisional Director. She wrote during 15 minute checks, it	A 115	A 115 481-67.2(1)b Program Policies and Procedures The program failed to produce a detailed incident report regarding the elopement of 1 of 1 tenants reviewed (Tenant #1). 1. Re-education provided to staff present at time of incident regarding documentation and incident reports by DDHW. 2. Re-education provided to staff regarding documentation and incident reports by DDHW or designee. 3. ED/HWD or designee to monitor progress notes for presence of incident reports for incidents that require them no less than weekly. 4. DDHW to monitor for presence of incident reports for incidents that require them on routine branch visits for 3 months. 5. Date of Completion 8/1/25.	

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A 115	Continued From page 1 was noted by staff Tenant #1 was not in her apartment. Staff searched the building and surrounding outdoor area. Tenant #1 was found by staff talking to a member of the community down the street. The community member contacted law enforcement. Upon their arrival, they released the tenant to staff. The tenant had no injuries. An Elopement Investigation Follow-up for Tenant #1 dated 6/2/25 revealed Staff A and Staff B were working the evening of 6/1/25 when they heard a door alarm. Staff A wrote on the facility form she heard a door alarm sound close to apartment 122 between 7:30 PM - 7:45 PM while she was administering medication to tenants. Staff B's written statement indicated he heard an alarm sound near apartment #122 between 7:30 PM - 8:00 PM. He was finishing cares with another tenant. When he finished with this task he investigated near the door and in the area outside of the building without seeing anyone. He deemed the area clear. When they later realized Tenant #1 was missing, he notified the Executive Director immediately. Multiple interviews were conducted with Staff B on 7/1/25. He reported he was providing nighttime cares to another tenant when he received a notification through the phone system the exit door by apartment #122 was open. Staff B felt it was unsafe to leave the tenant alone and remained with her for approximately 20-25 minutes before he was able to check the door. When he arrived at the exit door, he looked around inside and outside and saw no one in the vicinity. He then went to the door at the front of the building where he encountered Staff A. Staff B was under the impression Staff A had not checked the exit doors until this time either.	A 115		

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A 115	Continued From page 2 Since they hadn't seen anyone outside they believed no tenants left the building. On 7/23/25 at 12:55 PM Staff A recalled during an interview she was in the middle of administering medication to other tenants when she was alerted on her phone the door by apartment #122 was open. Staff A couldn't recall how long it took her to respond to the door but she believed she got to the door quickly. The exit door was open when she and her co-worker arrived and after looking around they saw no sign of any tenants in the vicinity and went back to work. A door alarm detail report for the exit door by apartment #122 identified the alarm sounded at 8:00:48 PM and ended at 8:09:11 PM. Someone responded to the door in about 8 minutes. On 7/1/25 at 3:45 PM Staff C was interviewed and reported he was off work and driving home from dinner with a friend on 6/1/25 when he went past a woman who resembled Tenant #1. He noticed this woman walked with an altered gait similar to the tenant and her wig was at an angle. At that point, Tenant #1 was about 0.9 miles from the building. When he got home he immediately drove back to the program to see if Tenant #1 was at the building but the staff could not locate her. Staff C and Staff A drove around the location where he last saw Tenant #1. By that time the tenant was sitting in an unmarked ambulance 1.3 miles from the building. Staff A and Staff C checked on the tenant. When he was sure the tenant was fine, he returned to the building to provide any needed assistance with the tenants while Staff A was gone. Staff C thought Tenant #1 appeared anxious but not scared. Staff A stated during her interview when she	A 115		

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A 115	Continued From page 3 arrived at Tenant #1's location she was confused but seemed okay. It was starting to get dark. Staff A explained to the man Tenant #1 had gotten out of the building. While they were talking the police and an ambulance arrived. The report into Tenant #1's elopement was not detailed or factual. Staff A and Staff B did not determine Tenant #1 was missing from the building until alerted of this by Staff C. Tenant #1 was found 1.3 miles down the street, although the incident report implied she was in the neighborhood. She was returned to the building via an ambulance and law enforcement, not released by the community member. During an exit meeting with the Executive Director and Divisional Director on 7/2/25 at 1:20 PM they confirmed the incident report failed to include pertinent information.	A 115		
A 120	481-67.2(1)c Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: c. The person in charge at the time of the incident shall prepare and sign the report. This REQUIREMENT is not met as evidenced by: Based on interview and record review the program staff in charge at the time of an elopement involving 1 of 1 tenants reviewed	A 120	A 120 481-67.2(1)c Program Policies and Procedures The program staff in charge at the time of an elopement involving 1 of 1 tenants reviewed (Tenant #1) did not complete the incident report. 1. Re-education provided to staff present at time of incident regarding documentation and incident reports by DDHW. 2. Re-education provided to staff regarding documentation and incident reports by DDHW or designee. 3. ED/HWD or designee to monitor progress notes for presence of incident reports for incidents that require them no less than weekly. 4. DDHW to monitor for presence of incident reports for incidents that require them on routine branch visits for 3 months. 5. Date of Completion 8/1/25.	

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A 120	Continued From page 4 (Tenant #1) did not complete the incident report. Findings follow: Record review on 7/1/25 revealed an incident report dated 6/2/25 completed by the Divisional Director. She wrote during 15 minute checks, it was noted by staff Tenant #1 was not in her apartment. Staff searched the building and surrounding outdoor area. Tenant #1 was found by staff talking to a member of the community down the street. The community member contacted law enforcement. Upon their arrival, they released the tenant to staff. The tenant had no injuries. On 7/2/25 at 11:20 AM the Divisional Director confirmed she wrote the incident report on 6/2/25 based on information she gathered from the Executive Director when she discovered one wasn't written on 6/1/25 by staff. The Divisional Director was not present for the incident.	A 120		
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 the policy on unwitnessed door alarms involving 1 of 1 tenants reviewed who eloped (Tenant #1). Findings follow: Record review on 7/1/25 revealed a service plan for Tenant #1 dated 3/22/25. Tenant #1 scored a 5 on the Global Deterioration Scale, indicating	A 150	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 8/1/25	

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A 150	Continued From page 5 moderate dementia. She required occasional help due to forgetfulness and difficulty concentrating. Tenant #1 had memory impairment, repeated information, displayed poor judgement and had a difficult time recalling information or events. She was noted to often stand by exit doors and attempt to follow others out when the door was open. She was easily redirected from the door. An Elopement Investigation Follow-up for Tenant #1 dated 6/2/25 revealed Staff A and Staff B were working the evening of 6/1/25 when they heard a door alarm. Staff A wrote on the facility form she heard a door alarm sound close to apartment 122 between 7:30 PM - 7:45 PM while she was administering medication to tenants. Staff B's written statement indicated he heard an alarm sound near apartment #122 between 7:30 PM - 8:00 PM. He was finishing cares with another tenant. When he finished with this task he investigated near the door and in the area outside of the building without seeing anyone. He deemed the area clear. When they later realized Tenant #1 was missing, he notified the Executive Director immediately. Multiple interviews were conducted with Staff B on 7/1/25. He reported he was providing nighttime cares to another tenant when he received a notification through the phone system the exit door by apartment #122 was open. Staff B felt it was unsafe to leave the tenant alone and remained with her for approximately 20-25 minutes before he was able to check the door. When he arrived at the exit door, he looked around inside and outside and saw no one in the vicinity. He then went to the door at the front of the building where he encountered Staff A. Staff B was under the impression Staff A had not checked the exit doors until this time either. Since	A 150		

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A 150	Continued From page 6 they hadn't seen anyone outside they believed no tenants left the building. On 7/23/25 at 12:55 PM Staff A recalled during an interview she was in the middle of administering medication to other tenants when she was alerted on her phone the door by apartment #122 was open. Staff A couldn't recall how long it took her to respond to the door but she believed she got to the door quickly. The exit door was open when she and her co-worker arrived and after looking around they saw no sign of any tenants in the vicinity and went back to work. A door alarm detail report for the exit door by apartment #122 identified the alarm sounded at 8:00:48 PM and ended at 8:09:11 PM. Someone responded to the door in about 8 minutes. On 7/1/25 at 3:45 PM Staff C was interviewed and reported he was off work and driving home from dinner with a friend on 6/1/25 when he went past a woman who resembled Tenant #1. He noticed this woman walked with an altered gait similar to the tenant and her wig was at an angle. At that point, Tenant #1 was about 0.9 miles from the building. When he got home he immediately drove back to the program to see if Tenant #1 was at the building but the staff could not locate her. Staff C and Staff A drove around the location where he last saw Tenant #1. By that time the tenant was sitting in an unmarked ambulance 1.3 miles from the building. Staff A and Staff C checked on the tenant. When he was sure the tenant was fine, he returned to the building to provide any needed assistance with the tenants while Staff A was gone. Staff C thought Tenant #1 appeared anxious but not scared. Staff A stated during her interview when she	A 150		

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A 150	Continued From page 7 arrived at Tenant #1's location she was confused but seemed okay. It was starting to get dark. Staff A explained to the man Tenant #1 had gotten out of the building. While they were talking the police and an ambulance arrived. Staff B reported on 7/1/25 when Staff C arrived at the building he looked for Tenant #1 and could not find her. He immediately called the Executive Director and reported the tenant was missing. Staff B recalled Tenant #1 later returned to the building in an ambulance. Two police officers also came to the building. Upon her return she seemed normal. On 7/1/25 at 11:50 AM, Tenant #1 reported during a conversation she had no memory of the incident. A Johnson County Sheriff's Office Dispatch Entry dated 6/1/25 noted an off-duty paramedic found a confused, elderly female wandering at 8:52 PM. The female did not know her name. She was sitting in his pickup on the shoulder of the road waiting for a deputy to respond. The off-duty paramedic called back to dispatch at 9:01 PM to report Bickford staff stopped by to advise they were looking for the female. The off-duty paramedic still requested a deputy respond to the scene. The female was escorted back to Bickford at 9:30 PM. Sunset on 6/1/25 was at 8:35 PM. The temperature at 8:52 PM was 67 degrees with no precipitation. The walk from the building to the area where Tenant #1 encountered the off-duty paramedic was residential and she likely traveled via sidewalks. The speed limit varied from 25 MPH to 35 MPH.	A 150		

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A 150	Continued From page 8 The program had an Unwitnessed Door Alarm policy. 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 resident was found during the visual search around the door causing the alarm, staff must account for all tenants. Staff did not account for all tenants until Staff C arrived at the building to report he saw an individual who resembled Tenant #1. On 7/2/25 at 11:20 AM the Divisional Director reported both Staff A and Staff B received training on the unwitnessed door alarm policy and the proper way to respond to a door alarm. She reported Staff A or Staff B should have promptly responded to the exit door by apartment #122, not after 8 minutes. Staff B should have let Staff A know he was unable to respond to the door alarm. Staff failed to ensure all tenants were accounted for when the door alarm sounded.	A 150		