

Iowa Department of Inspections, Appeals & Licensing
Health & Safety Division
Adult & Special Services Unit
Civil Penalty Citation

Date: May 23, 2024
Program Name: Bickford Cottage Urbandale
Address: 5915 Sutton Place Urbandale, IA 50322
Type of Action: Investigations 115146-C, 115562-I, 113317-M
Date(s) of Action: 1/29/24 – 2/19/24
Citation #: 10383

State Rule #	State Rule	Amount of Civil Penalty
IAC 481-67.2(3)	67.2(3) The program shall follow the policies and procedures established by the program. Based on interviews and record review the Program failed to consistently follow procedures regarding response to door alarms. This pertained to 1 of 1 tenant (Tenant #4) identified in Incident 115562-I. Finding follows: Observations on 2/5/24 at 6:00 p.m. revealed the walkie talkie laid on a cabinet in the kitchen area of Mary B's. When questioned the three staff who worked did not have pager and/or walkie talkie with them. Record review on 2/1/24 revealed an Incident Report for Tenant #4, dated 9/8/23, and the Program's internal investigation. Staff documented they found Tenant #4 outside in the parking lot. The internal investigation included a statement from a former staff who asked staff how Tenant #4 got out of the building. Staff F told the former staff they heard the door alarm, but didn't see anyone so they reset the alarm. Staff F admitted she did not have the pager and/or walkie talkie. There were no injuries noted. Additional record review revealed Staff L's statement, dated 9/8/23 at 5:15 p.m. noted as she left the building she saw Tenant #4 in the parking lot of the building. He wore a coat and appeared he was ready to go somewhere. She walked him back into the building to the dining room of Mary B's for dinner. She asked staff how he was able to leave and they said they heard the door going off, but didn't see anyone so they reset the alarm. She asked Staff F where her pager and walkie were and she said they were in the kitchen. Staff L reminded Staff F they needed to be on her at all times and expressed to her if a door became ajar it would send an alert to the pagers. When that happened, they needed to go immediately to	\$2000.00

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	whatever door alarmed and locate the resident after resetting the alarm. They also needed to let staff in the general population side know someone had eloped. Staff L gave Staff F a pager and told her to keep it on her. As she left, she encountered Staff M, who was also unaware Tenant #4 left. She reminded her she needed to have a pager on her, as well as walkie-talkie at all times. Tenant #4's service plan, dated 9/5/23, revealed Tenant #4's diagnoses included Alzheimer's Disease, osteoarthritis, and failure to thrive. Tenant #4 had a Global Deterioration Score of five (5) and ambulated independently. Tenant #4's service plan documented increased aggression toward his wife and increased exit seeking behavior and noted a care conference would be scheduled to discuss care and service interventions. Record review on 2/16/24 revealed Program procedures, Missing Unwitnessed Door Alarm Key Procedures, revised 4/2014. The document directed staff, if a door alarm occurred and staff member did not witness the event, to immediately check pagers for the type of alarm that occurred. Staff should also perform a visual search inside and outside the door area. The door alarm shall be silenced only "AFTER" all employees on duty were aware of the unwitnessed door alarm. Repeated requests for Staff F's training associated with the pager system went unanswered by the Program. During the exit on 2/19/24 at 12:30 p.m. the administrative staff acknowledged Staff F failed to implement procedures regarding door alarms.	
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