IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
Complaint Intake #: 54461-I

August 25, 2015

Ms. Debbie Crosser, Manager
Emery Place
901 South Mentzer Road
Robins, IA 52328

RE: I. NOTICE OF IMPOSITION OF CIVIL PENALTY – FINAL INITIAL MONITORING EVALUATION AND COMPLAINT/INCIDENT INVESTIGATION REPORT - EMERY PLACE
II. Reduction of Civil Penalty
III. Informal Conference
IV. Conclusion

Dear Ms. Crosser:

I. Final Initial Monitoring Evaluation and Complaint/Incident Investigation Report – Emery Place, Robins, IA

Enclosed is the **Final Initial Monitoring Evaluation and 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 **August 5 & 6, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Record Checks and Structural Requirements.

Emery Place ("Program") is being assessed a **$1,000 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 **$1,000 civil penalty** is based upon noncompliance resulting in imminent danger or substantial probability of resultant death or physical harm. As the enclosed Report details, a Tenant eloped from a locked dementia unit and an unlocked courtyard gate.

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 **six hundred and fifty dollars ($650)** 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. Conclusion

The Program is being assessed a **$1,000 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
	S0351	A. BUILDING: _____ B. WING _____	C 08/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERY PLACE	901 SOUTH MENTZER ROAD ROBINS, IA 52328

(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	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: 12 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 13 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 0 Number of tenants with cognitive disorder: 10 Total Population of Program at time of on-site: 10 TOTAL census of Assisted Living Program: 23 The following regulatory insufficiencies were cited during the Initial Certification to determine compliance with certification of an Assisted Living Program and investigation of Incident #54461-I.	A 000		
A 121	481-67.19(3)c Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3)c If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person ' s employment in the program.	A 121		

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

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A 121	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of staff files, criminal history, dependent adult abuse and child abuse record checks were not completed appropriately prior to hiring Staff B. 1. A criminal history, dependent adult abuse and child abuse record check was completed on 7-6-15 for Staff B. The criminal history background check indicated further research was required. The Program did not complete the additional paperwork indicated and hired Staff B to begin work on 7-10-15. Staff B was hired as a housekeeper. The Program did not perform an evaluation to determine whether the crime warranted prohibition of Staff B's employment in the Program. 2. On 8-5-15, the Manager stated the evaluation was not completed as required prior to hiring Staff B.	A 121		
A 122	481-67.19(3)d Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3)d If a person considered for employment has a record of founded child abuse or dependent adult abuse. If a department of human services child or dependent adult abuse record check shows that a person being considered for employment in a program has a record of founded child or dependent adult abuse, the department of human services shall notify the program that upon the request of the	A 122		

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A 122	Continued From page 2 program the department of human services will perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the program. This REQUIREMENT is not met as evidenced by: Based on review of staff files, criminal history, dependent adult abuse and child abuse record checks were not completed appropriately prior to hiring A. 1. A criminal history, dependent adult abuse and child abuse record check was completed on 5-8-15 for Staff A. The child abuse check indicated to initiate a record check evaluation. The Program did not complete the evaluation required and hired Staff A to begin work on 5-11-15. Staff A was hired as a cook. The Program did not perform an evaluation to determine whether the founded child abuse warranted prohibition of employment in the Program. 2. On 8-5-15, the Manager stated the evaluation was not completed as required prior to hiring Staff A.	A 122		
A 154	481-69.35(1)b Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. b. The buildings and grounds shall be well-maintained, clean, safe and sanitary. This REQUIREMENT is not met as evidenced by:	A 154		

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A 154	Continued From page 3 Based on review of a tenant file, incident report, policies and procedures and staff interviews, Tenant #1 exited the building from a dementia specific unit, went through an unlocked gate and was found walking on the property. The tenant was not kept safe by the Program. 1. Tenant #1, an 80 year old, was admitted on 7-24-15 and had diagnoses of Alzheimer's, shingles (healed) and history of a fractured right arm. Tenant #1 was staged at a four on the Global Deterioration Scale which indicated moderate cognitive decline. Tenant #1 was admitted to the general population on 7-24-15 but due to wandering was transferred to the dementia unit on 7-31-15. According to Tenant #1's Nurse's Notes dated 7-31-15 at 6:00 p.m., Tenant #1 moved to the dementia unit. Family was keeping 24 hour help hired until 10:00 p.m. to help Tenant #1 acclimate to new surroundings. According to an Incident Report dated 8-1-15 at 6:55 p.m., Staff C was notified by an AL tenant that the tenant's family was going to take Tenant #1 home. The family reported Tenant #1 was outside on the sidewalk asking for a ride home. Staff C informed the family Tenant #1 resided at the Program. According to the Incident Report, Tenant #1 was confused and later had no memory of what had just happened. The Nurse and Manager were notified. According to Nurse's Notes dated 8-2-15 at 9:00 a.m., on 8-1-15 Tenant #1 had gotten out of the building and was brought back in by a visitor who was outside. Tenant #1 appeared unharmed and "was just trying to get out of here." Tenant #1 was taken back to the dementia unit, family was called and updated. Checks every 15 minutes were initiated and staff educated to keep Tenant #1 occupied so less likely to wander. The service plan was updated with activities Tenant #1	A 154		

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A 154	Continued From page 4 enjoyed. Staff to check monitoring device worn by Tenant #1 every shift. 2. On 8-5-15 Staff D was interviewed and stated she worked the 2:00 p.m. to 10:00 p.m. shift on 8-1-15 in the dementia unit. She was helping a tenant with a shower, all other tenants were at the dining room table or in the living room. She started a second shower and all tenants were still in the same place. She was paged by Staff C being told Tenant #1 had gotten out. Staff D stated she did not hear the alarm message on her pager. Staff C brought Tenant #1 back to the dementia unit. Staff D had never seen anyone go through the courtyard gate, tenants or staff. She stated the gate had only been used when families moved in tenant furniture. She stated she had never checked the lock on the gate before but now it was checked at every shift change and in between. She stated Tenant #1 was wearing pants, shirt, socks and tennis shoes at the time Tenant #1 left the courtyard. She stated it was a nice night, warm and not too hot without any precipitation. 3. On 8-6-15 the Nurse was interviewed and stated on 8-1-15 between 7:00 p.m. and 7:30 p.m., Staff C called and reported Tenant #1 had gotten out of the building and was brought in by a visitor. It was believed Tenant #1 went out the building into the courtyard and walked through the gate. The Nurse instructed her to make sure the gate was locked and hold off on any personal cares. She then called the Manager who said she'd call Corporate and go to the Program. 4. On 8-6-15 the Manager was interviewed and stated on 8-1-15 about 7:00 p.m. she received a text message from the Nurse asking her to call. When they spoke the Nurse said Tenant #1 had	A 154		

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A 154	Continued From page 5	A 154		

eloped. The Manager arrived at the Program at 8:00 p.m. and checked on Tenant #1, spoke to staff and locked the courtyard gate. She watched the recording of video footage in the dementia unit and could see Tenant #1 standing in the living room and then Tenant #1 was gone. The camera was motion activated and would freeze for 12 seconds once the moving object quit moving. Apparently Tenant #1 left the building during that 12 second period. The Manager notified Tenant #1's family of the elopement.

5. On 8-5-15 the Maintenance Coordinator was interviewed and stated the gate should be locked at all times. The gate had only been used when the Program first opened for families to move in furniture. He didn't normally check the lock but when ever he was in that area he would check it. He had never found it unlocked. Sometime on the afternoon of 7-31-15 he was pulling weeds behind the courtyard, checked the gate at that time and it was locked. He stated there was no reason any staff should go out the gate as they can use a service exit if needed to go outside. Video cameras are recording all exits but only record seven seconds before and after motion. He reviewed the recording and saw Tenant #1 go out to the patio but the camera didn't capture the gate area.

6. According to an All Alarm and Event Records report the courtyard door alarm sounded on 8-1-15 at 6:35 p.m., 6:41 p.m., 6:42 p.m., 6:43 p.m., 6:45 p.m. and 6:53 p.m. indicating the garden patio door was breached and someone had exited or entered the dementia unit to or from the courtyard.

7. According to a written statement dated 8-1-15 by the Manager, a process had been

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A 154	Continued From page 6 implemented for the gate to be checked at every shift change and a few times during the shift. It was mandatory that the gate remained locked at all times. 8. The monitor walked the possible route taken by Tenant #1. From the gate area Tenant #1 would have walked approximately 45 yards, onto a side walk on the south side of the building walking another 75 yards, walking across the grass to the parking lot, approximately 50 yards to the front door. 9. According to the State Climatologist, on 8-1-15 at the Cedar Rapids airport at 6:52 p.m. it was 80 degrees, winds from the south at five miles per hour, clear skies, 75% humidity with a heat index of 85 degrees.	A 154		

Emery Place
901 S. Mentzer Rd.
Robins, Iowa 52328
Ph: 319-536-0045
Fx: 319-536-0047

Date: September 1, 2015

Complaint/Investigation Intake # 54461-I

Plan of Correction (POC) Submitted For Emery Place:

- Investigation Date: August 5th – 6th, 2015
- Monitor: Margaret Kaltefleiter

POC:

A. Discrepancy: Structural Requirements

a. Regulatory Insufficiency: 481-69.35(1)b (231C) Structural Requirements
General requirements. The buildings and grounds shall be well-maintained, clean, safe and sanitary.

Program POC:

1. **Elements detailing how the program will correct the insufficiency as it relates To the tenant:**

   A. All staff will follow policy and procedures for the Elopement Policy and Procedure for all exit door alarm notifications.
   B. All staff received re-education on redirection strategies on the Elopement Policy and Procedure on August 1st, 3rd and August 14th from the Program Manager and the Health Care Coordinator.
   C. The Manager and Program Nurse will ensure that all new employees receive and complete training on Elopement Policies and Procedures and that all staff receive ongoing education/in-service training per the community In-service Training schedule.
   D. Training will be maintained on file and annual training will be completed with all staff on-going.

2. **Actions program is taking to protect tenants in similar situations:**

   A. The Manager and Program Nurse will ensure staff is doing routine checks to ensure the Memory Care gate remains locked at all times.
   B. All staff will ensure each resident is issued and is wearing their pendent.
   C. The Manager will ensure all door alarms are responded to in a timely manner.

3. **Measures taken to ensure problem does not recur:**

   A. The RN and Manager will conduct elopement drills with the staff as it relates to our policies and procedures manual.
   B. Manager and RN will continue reviewing our policies and procedures for elopement during staff in-service meetings.

4. **Date by which the regulatory insufficiency will be corrected:**

   A. The Regulatory insufficiency will be corrected and in place immediately.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

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901 S. Mentzer Rd.
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Ph: 319-536-0045
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Date: September 1, 2015

Complaint/Investigation Intake # 54461-I

Plan of Correction (POC) Submitted For Emery Place:

- Investigation Date: August 5th – 6th
- Monitor: Margaret Kaltefleiter

POC:

A. Discrepancy: Record Checks

a. Regulatory Insufficiency: 481-67.19(3)c Record Checks
Criminal, dependent adult abuse, and child abuse record checks. If a person being considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program.
b. Based on review of staff files, criminal history, dependent adult abuse and child abuse record checks were not completed appropriately prior to hiring staff A and B.

Program POC:

1. **Elements detailing how the program will correct the insufficiency**

   A. Staff A and B were suspended with pay from work the day the program was aware of the insufficiency and was not to return back to work until the background check cleared.
   B. The manager completed the necessary documentation and submitted it to finish the process of the background check to clear.
   C. Once the background checks were cleared, Staff A and B were called to return to work.

2. **Actions program is taking to protect tenants in similar situations:**

   A. The manager will conduct background checks prior to offering employment and in the event of criminal history.
   B. The extended background check will be completed and sent to DHS for confirmation.
   C. The community manager will not offer employment until receipt of letter from DHS confirming they "may work"

3. **Measures taken to ensure problem does not recur:**

   A. All extended background files will be reviewed and audited by a second member of management for accuracy.

4. **Date by which the regulatory insufficiency will be corrected:**

   A. The Regulatory insufficiency will be corrected and in place immediately.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.