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
	S0292	A. BUILDING: _____ B. WING _____	C 12/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR STAR AT ELMORE PLACE MEMORY C	4504 ELMORE AVENUE DAVENPORT, IA 52807

(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 disorder: 2 Number of tenants with cognitive disorder: 33 Total census of Assisted Living Program for People with Dementia: 35 The following regulatory insufficiencies were identified during the investigaiton of Complaint #90328-C and Incident #90331-I	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow its policy and procedure regarding the completion of incident reports and critical incidents regarding 1 of 3 tenants	A 003	Plan of Correction is attached	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 003	Continued From page 1 reviewed (Tenant #1). Findings follow: Record review on 4-1-20 of an incident report dated 3-13-20 at 4:00 p.m. indicated Tenant #1 was found on the floor in the corridor/hallway and had pain/discomfort in the left wrist, left hip and back. She was observed sitting on the floor outside of her doorway. She held her left wrist and complained of pain. There was swelling noted and range of motion (ROM) was limited. There was a bump and a bruise noted to the left side of her forehead. She was assisted from the floor with assistance of two staff and once standing she complained of left hip and back pain. Tenant #1 was unable to state how the fall occurred. Staff got a wheelchair for Tenant #1 and ice was applied to the left wrist. Tenant #1's family member decided to take her to the emergency room (ER) for evaluation. The incident report indicated Tenant #1's family and physician were notified on 3-13-20. An update on the incident report indicated staff was informed by the ER that Tenant #1 suffered a brain bleed and a fractured left arm. On 4-6-20 at 11:23 a.m. the Assistant Health Services Director said the incident report was sent to her phone and she saw it on Saturday (3-14-20). She called Tenant #1's family member to discuss the incident with her. Tenant #1 told her family member a "boy" tried to get her purse, it was assumed there was a scuffle and she lost her balance. Tenant #1's family member said Tenant #1 had a brain bleed and a fractured wrist and a fractured hip. The incident report said Tenant #1 was unable to state what happened. She visited with staff on Monday, 3-30-20. At that time, two staff stated the tenant said the "boy" pushed her. It was the first time she was aware of this allegation. Staff B and Staff C were educated	A 003		

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A 003	Continued From page 2	A 003		

they should have reported right away of Tenant #1's allegation of being pushed and to include such information on the incident report.

On 4-6-20 at 1:29 p.m. the Health Services Director said she received all incident reports and had seen Tenant #1's incident report. On 3-30-20 the Assistant Health Services Director called and said detectives requested documents and she became involved. Staff stated Tenant #1 said prior to going out with her family that a man had pushed her down. They pulled the video footage. The accused tenant was Tenant #2, who had dementia and was not able to tell what had happened. It was not witnessed. Tenant #2 had a history of being busy in the Program. They spoke with all staff involved Staff A, B, C and D. The statements were completed on the 3-30-20 when there was awareness of the allegation between tenants.

Review of witness statements from involved staff revealed the statements were obtained on 3/30/20 from Staff A, Staff B, Staff C and Staff D (although dated 3/13/20, it was confirmed Staff D's statement was written on 3/30/20.) Staff C gave a verbal statement which was typed up on 3/31/20.

The Program's Incident Report Procedure indicated a staff who witnessed or responded to an incident needed to complete an incident report form through the online reporting system. Incidents to be reported included a tenant fall (including whether or not it was witnessed or the tenant was found on the floor), any injury to tenant, staff or guest, or any emergency assistance provided by staff. The policy indicated to use and follow Investigative Guidelines for Critical Incidents for critical incidents which

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A 003	Continued From page 3 included falls resulting in fractures. Statements were to be obtained using the Witness Statement form. The policy indicated for administrative staff to review and confirm that the online report was 100% complete and to follow up with staff if needed. The Investigation Guidelines for Critical Incidents document indicated critical incidents included falls with fracture. Staff were to complete the items listed including the identification of all staff involved in care of the tenant leading up to the incident. All staff were to be interviewed and complete a witness statement. The final investigation summary from administrative staff was due to the corporate office within 72 hours of the incident. In summary, Tenant #1 was found on the floor on 3-13-20. A family member took the tenant to the ER. The Program was alerted the tenant suffered a brain bleed and fractured left arm. Per the Program's policies an investigation including witness statements was to be completed and sent to the corporate office within 72 hours of the incident. An investigation into the incident was not started until 3-30-20.	A 003		
A 013	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced	A 013		

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A 013	Continued From page 4 by: Based on interview and record review the Program failed to provide services, care and treatment that were adequate and appropriate for 1 of 3 tenants reviewed (Tenant #1). Findings follow: 1. On 4-1-20 review of an incident report dated 3-13-20 at 4:00 p.m. revealed Tenant #1 was found on the floor in the corridor/hallway and had pain/discomfort in the left wrist, left hip and back. She was observed sitting on the floor outside of her doorway. She held her left wrist and complained of pain. There was swelling noted and range of motion (ROM) was limited. There was a bump and a bruise noted to the left side of her forehead. She was assisted from the floor with assistance of two staff and once standing complained of left hip and back pain. Tenant #1 was unable to state how the fall occurred. Staff got a wheelchair for Tenant #1 and ice was applied to the left wrist. Tenant #1's family member decided to take her to the emergency room (ER) for evaluation. The incident report indicated Tenant #1's family and physician were notified on 3-13-20. An update on the incident report indicated staff was informed by the ER that Tenant #1 suffered a brain bleed and a fractured left arm. A review of hospital records indicated Tenant #1 was admitted on 3-13-20 and discharged on 3-20-20. The ER report indicated Tenant #1 had wrist pain, buttock and hip pain with movement and back pain. Family indicated the bruise on Tenant #1's forehead was new. Tenant #1 had a "comminuted intraarticular fracture of the left distal left radius with dorsal angulation of the major fracture fragments by upwards of 60 degrees with major fracture fragments displaced	A 013		

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A 013	Continued From page 5 by upwards of a centimeter with associated impaction." Tenant #1 also had a "mildly displaced ulnar neck fracture metaphyseal fracture with ulnar styloid process fracture." Hospital records indicated Tenant #1 had a "subarachnoid hemorrhage following injury with a loss of consciousness." Tenant #1 had bilateral frontal lobe subarachnoid hemorrhage. On 3-16-20 a repeated scan showed worsening of the right subarachnoid bleeding. Tenant #1 also sustained a fracture of the left anterior acetabular wall and left inferior pubic ramus. A State of Iowa Certificate of Death for Tenant #1 revealed she died on 3-28-20 at a hospice house. The immediate cause of death was "Complications of Multiple Blunt Force Injuries." The manner of death was "Undetermined." The tenant's Autopsy Report indicated the Final Autopsy Diagnosis included blunt force injuries of the head, trunk and upper extremities; hypertensive and atherosclerotic cardiovascular disease; clinical history of Alzheimer-type dementia; patchy bilateral acute pneumonia; cardiac amyloidosis and focal erythema of the sacral skin with superficial breakdown. The pneumonia had features of aspiration pneumonia and was likely a complication of the injuries. The report indicated on 3-13-20 another tenant entered Tenant #1's apartment and shortly afterwards Tenant #1 was found on the floor with injuries to the upper left extremity and head. Tenant #1 reported she was pushed down had pain in the left wrist, buttock, hip and back pain. She went to the hospital and was diagnosed with a fracture of the left distal forearm and wrist, a hip fracture, and intracranial hemorrhages. Tenant #1 transferred an intensive care unit (ICU) at another hospital and then to a hospice house. Tenant #1	A 013		

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A 013	Continued From page 6 died on 3-28-20. 2. When interviewed on 4-6-20 at 9:58 a.m. Staff A said the Registered Nurse (RN) was gone for the day so Staff B and Staff C called her as she was a Licensed Practical Nurse (LPN) and reported Tenant #1 was on the floor. Staff A responded and observed Tenant #1 on the sitting on the floor, outside her door in the hallway. She held her wrist, which was swollen and limp. Tenant #1 complained of pain with ROM. Vital signs and ROM were normal. There was a bump and bruise on the left side of her forehead. Tenant #1 did not appropriately answer questions and did not make sense. Staff A said Staff B reported Tenant #1 stated there was a boy in her room. After Tenant #1 was assisted up she complained of back and hip pain. Tenant #1's family member, who had just been to the building to drop off supplies, was called. The family member returned to the Program and took Tenant #1 to the ER. When interviewed on 4-6-20 at approximately 3:10 p.m. Staff B said one of the medication passers paged for a nurse and a vitals cart. She observed Staff C sitting by Tenant #1 and asked her what happened. Staff C said Tenant #2 was seen leaving the area. Tenant #1 was on the floor, seated upright against the closed door and her legs were in front of her in the hallway. She was holding her left arm and kept rubbing it. She asked Tenant #1 what happened and she said "that boy broke my arm." Staff B said many tenants referred to Tenant #2 as a boy. Tenant #1 also said that boy was in her apartment and there was something about the bed/window (Tenant #1 had word salad speech). Tenant #1 kept picking up her arm and looking at it. From Staff B's point of view it was fractured and she immediately got	A 013		

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A 013	Continued From page 7 the nurse, Staff A. She told Staff A that Tenant #1 was on the floor and she thought her arm was fractured. Staff A came to the hallway, looked Tenant #1 over and said to notify Tenant #1's family. Staff B said she told Staff A what had been said but was not sure if she heard her. Staff A, B and C assisted Tenant #1 to stand and walked with her as Tenant #1 limped. A wheelchair was provided for Tenant #1. No other complaints of pain were verbalized. Tenant #1 rubbed her arm. Once in the wheelchair Staff B noticed a bruise on the forehead just above her eyebrows. It was difficult to get Tenant #1 into the vehicle (when she was sent out with family). The family member asked what happened and Tenant #1 saw Tenant #2 and said that boy was in her room and pushed her. Tenant #1, Tenant #1's family member and Staff B were present. When interviewed on 4-6-20 at 2:48 p.m. Staff C said she was walking down the hallway and saw Tenant #1 sitting on the floor leaning against the door. She called for a vitals kit and a nurse. The only other person she saw was Tenant #2 walking away from the apartment in the hallway. Staff C asked Tenant #1 what happened and she reported she saw a man in her bed and she tried to get him out and he fought with her. She did not say how but the man pushed her down. Tenant #1 did not identify the man. She held up her wrist and it was in an "s" shape. She tried to stand up and put pressure on her wrist. There was a bump on her left eyebrow. A nurse assessed her and a family member picked her up and took her to the hospital. Tenant #1 could not walk or stand up well. Tenant #1 had severe word salad speech; however, it was very clear regarding the information told to Staff C. The nurse was not able to get any information from Tenant #1.	A 013		

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A 013	Continued From page 8 When interviewed on 4-6-20 Staff D said she worked at the front desk and tenants often came up to the desk for help and ask to questions. On 3-13-20 shortly before 3:30 p.m. Tenant #1 came up to the desk and said there was someone in her apartment. Tenant #1 had word salad speech but she was "perturbed." Tenant #1 said to get "him" out of the apartment. Staff walked by and assisted her to her apartment. They came out and said they were concerned about Tenant #1's wrist. When interviewed on 4-6-20 at 11:23 a.m. the Assistant Health Services Director said the incident report was sent to her phone and she saw it on Saturday (3-14-20). She called Tenant #1's family member to discuss the incident with her. Tenant #1 told her family member a "boy" tried to get her purse, it was assumed there was a scuffle and she lost her balance. The family member said Tenant #1 had a brain bleed and a fractured wrist and a fractured hip. Tenant #1 went to a hospice house in hopes she would improve. Tenant #1 could not bear weight. The incident report said Tenant #1 was unable to state what happened. She visited with staff on 3-30-20. When interviewed two staff said the "boy" pushed her. It was the first time she was aware of this allegation. Staff B and Staff C were educated they should have reported right away of Tenant #1's allegation of being pushed and to include such information on the incident report. When interviewed on 4-6-20 at 1:29 p.m. the Health Services Director said she received all incident reports and had seen Tenant #1's incident. On 3-30-20 the Assistant Health Services Director called and said detectives requested documents and she became involved. Staff stated Tenant #1 said prior to going out with	A 013		

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A 013	Continued From page 9	A 013		

her family that a man had pushed her down. They pulled the video footage. The accused tenant was Tenant #2, who had dementia and was not able to tell what had happened. It was not witnessed. Tenant #2 had a history of being busy in the Program. They spoke with all staff involved Staff A, B, C and D. The statements were completed on the 3-30-20 when there was awareness of the allegation between tenants.

When interviewed on 4-7-20 at 10:30 a.m. the Executive Director said on 3-30-20 a detective showed up and she became involved. An investigation was started and statements were collected from staff who were involved (Staff A, B, C and D). The video footage was reviewed. Staff B and Staff C said there was a boy in the apartment or a boy had pushed Tenant #1, according to the tenant. The incident report was dated 3-13-20. Staff statements for Staff B and D were written on 3-30-20 (Staff D's statement was misdated). Staff C's statement was dated 3-31-20. The incident was reported to the Department on 3-31-20. It was discussed with Staff B and Staff C to report pertinent information right away. It was discussed with Staff D to be aware and try to prevent incidents.

When interviewed on 9-2-20 at 4:55 p.m. Tenant #1's family member said she had just been at the Program at 3:00 p.m. It was the first day visitors were restricted due to Coronavirus. She received a phone call that Tenant #1 had fallen and fractured her wrist and she returned to the Program. When she arrived Tenant #1 was in a wheelchair at the front desk. Tenant #1 said she hurt all over and the family member noticed a bruise on the left temple. Staff had reported they had just noticed the bruising on her head. The family member was surprised they had not called

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A 013	Continued From page 10 an ambulance. She took her to a hospital and Tenant #1 had a fractured wrist and brain bleed. Through scans later it was determined there were small fractures in the pelvic/hip area. Tenant #1 had said "that boy pushed me." She was told by staff "the boy" was Tenant #2. She was told Tenant #2 went into others' rooms and picked up stuff while in the rooms. She believed Tenant #2 had gone into Tenant #1's room before Tenant #1 did. Later Tenant #2 came out and Tenant #1 was laying on the floor. It was thought Tenant #2 pushed Tenant #1. When she talked to the Director of Nursing, regarding Tenant #2 moving to another Program, the DON told her this incident was not the first time it had happened. 3. Review of a Davenport Police Case Report (Narrative Report) revealed the following: - when interviewed by police on 4-16-20 at 9:30 a.m. Staff B said she was not contacted or approached by Staff D to assist Tenant #1 prior to the incident. She also said she called the hospital the night of the incident to get an update on Tenant #1 and was told Tenant #1 had a brain bleed and broken arm. - when interviewed by police on 4-16-20 at 9:00 a.m. Staff C said she was not contacted to remove another tenant from Tenant #1's apartment and she said Staff D did not say anything to her prior to the incident. - when interviewed by police on 4-8-20 at 2:00 p.m. Staff D said Tenant #1 came up to the desk, seemed upset and said to get "him" out of her apartment. At the front desk she could not assist with cares. She said staff walked by and she told them Tenant #1 needed assistance. Staff D said there were two staff members (Staff B and C) and she got one of them to help Tenant #1 as there was someone in her apartment. One of the two staff went with Tenant #1 to her apartment. A few	A 013		

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A 013	Continued From page 11 minutes later Tenant #1 returned with staff and her wrist looked broken, according to Staff B. During the interview police told Staff D the video footage was reviewed and Tenant #1 walked back to her apartment alone. 4. Record review revealed a timeline of events based on video footage provided by the Program indicated the following: - 3:23 p.m. Tenant #1 was at the destinations station in the hallway - 3:25 p.m. Tenant #2 walked towards Tenant #1's apartment at the end of the hallway - 3:26 p.m. Tenant #1 walked into her apartment - 3:27 p.m. Tenant #1 was at the front desk - 3:28 p.m. Tenant #1 walked back into apartment - 3:30 p.m. Staff came to Tenant #1's apartment with a vitals cart - 3:33 p.m. The AL Nurse (Staff A) went to Tenant #1's apartment - 3:35 p.m. Tenant #2 was seen walking down the hallway - 3:51 p.m. Tenant #1 left with her family 5. Review of Tenant #1's file on 4-1-20 revealed diagnoses including Alzheimer's disease, hypertension, atherosclerosis and cardiac amyloidosis. Tenant #1 was staged at Global Deterioration Scale (GDS) of five, which indicated moderately severe cognitive decline. The service plan dated 1-8-20 reflected Tenant #1 was independent with transfers and mobility and her fall risk was low. 6. Review of Tenant #2's file on 4-1-20 revealed diagnoses including Alzheimer's disease. Tenant #2 was staged at a six on the GDS, which indicated severe cognitive decline. She moved out of the Program on 3-31-20 to another	A 013		

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(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 013	Continued From page 12 assisted living program. The service plan dated 2-18-20 reflected Tenant #2 went into other tenants' apartments and gathered belongings. Staff "traded" her items instead of taking them away from Tenant #2 to reduce agitation. Staff retrieved other tenant's items from Tenant #2's apartment when she was not present to avoid confrontation and agitation. 7. Record review revealed there were Employee Performance Communication forms completed on 4-1-20 for Staff B and Staff C. The forms indicated Staff B and Staff C should report all conversations that would be necessary for management to know when an incident occurred including statements from tenants and other staff. Incidents included falls, disagreements between tenants or staff or anything that required the completion of an incident report. The forms indicated staff needed to know "the importance of management needing to know all information that is critical to events. This is in accordance to our policy of reporting all pertinent information." There was also an Employee Performance Communication form completed on 4-1-20 for Staff D. The form indicated Staff D was to respond quickly to tenant needs and to make sure direct care staff were alerted. Safety was a top priority and a "quick response" to tenants ensured the response was "above and beyond." If Staff D was unable to get a direct care staff and it was an emergency she was to respond to the situation. 8. On 12-2-20 at the time of the exit meeting (approximately 1:55 p.m.) the Health Services Director said there was no policy regarding activation of Emergency Medical Services (EMS). The decision for transport was made by the tenant or family and if it was an emergency the	A 013		

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
	S0292	A. BUILDING: _____ B. WING _____	C 12/02/2020

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SENIOR STAR AT ELMORE PLACE MEMORY C	4504 ELMORE AVENUE DAVENPORT, IA 52807

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A 013	Continued From page 13 licensed nurse made the determination. 9. In summary, Tenant #1 requested assistance from Staff D due to another tenant being in her apartment. Staff D said she told Staff B and Staff C who walked by to respond to Tenant #1's request to assist with removing the other tenant from her apartment and one of them went with Tenant #1. Staff B and Staff C denied being informed of the request to assist Tenant #1 prior to the incident. The video revealed no staff returned with Tenant #1 to her apartment. Tenant #1 returned to her apartment without staff assistance or intervention and shortly after was found on the floor with injuries to her wrist and head. Tenant #1 reported "that boy pushed me" to staff that responded to incident and Tenant #2 was seen in the area. Tenant #1 had a limp, was assisted to a wheelchair, had complaints of pain and could not put pressure on her hips. The family was called to take Tenant #1 to the hospital. EMS was not utilized Per a staff interview it was difficult to assist Tenant #1 into the family member's vehicle.	A 013		
A 024	481-67.4(3) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(3) When there is an act that causes major injury to a tenant or when a program has knowledge of a pattern of acts committed by the same tenant on another tenant that results in any physical injury. For the purposes of this subrule, "pattern" means two or more times within a	A 024		

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
	S0292	A. BUILDING: _____ B. WING _____	C 12/02/2020

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A 024	Continued From page 14 30-day period. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure major injuries were reported to the Department as required for 1 of 3 tenants reviewed (Tenant #1). Findings follow: On 4-1-20 review of an incident report dated 3-13-20 at 4:00 p.m. revealed Tenant #1 was found on the floor in the corridor/hallway and had pain/discomfort in the left wrist, left hip and back. She was observed sitting on the floor outside of her doorway. She held her left wrist and complained of pain. There was swelling noted and range of motion (ROM) was limited. There was a bump and a bruise noted to the left side of her forehead. She was taken to the emergency room (ER) by a family member. An update on the incident report indicated staff was informed by the ER that Tenant #1 suffered a brain bleed and a fractured left arm. The incident on 3-13-20 resulting in a major injury was not reported to the Department by the Program until 3-31-20.	A 024		

Plan of Correction – Senior Star at Elmore Place

Date: 1.13.21
To: Iowa Department of Inspections & Appeals (DIA)
From: Amanda Buchholz, Assistant Executive Director
RE: DIA Investigation 4.1.20 to 12.2.20

Enclosed is the Plan of Correction (POC) in response to investigation visit by a representative of the department from April 1st, 2020 to December 2nd, 2020, to Senior Star at Elmore Place Memory Care. Regulatory Insufficiencies in the area(s) of: tenant rights, Policies and Procedures, program notification and provides specific information regarding the regulatory insufficiency and how the Program failed to comply with regulations. Each area of regulatory Insufficiency is noted in this document including a detailed POC. Submission of this Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the surveyor's agency.

PLAN OF CORRECTION

Area: *Tenant Rights*

Regulatory Insufficiency #1: 481-67.3(2) tenant rights. All tenants have the following rights: 67.3(2), to receive care, treatment and services which are adequate and appropriate.

POC:

1. **The Program will correct the regulatory insufficiency by:** Senior Star at Elmore Place will correct any service plan to reflect the resident needs to ensure services are adequate and appropriate. The electronic health record will allow the nurse to document changes and allow documentation related to resident needs. The community will ensure all staff is following individual service plans.
2. **The following measures will be taken to ensure the problem does not recur:** The registered nurse and or designee will continue ongoing training regarding policies and procedures specific to tenant rights, care, treatments, and services as deemed necessary.
3. **The Program plans to monitor performance to ensure compliance by:** The registered nurses and or designee will review service plans annually to ensure the service plans accurately reflect the care, treatment and services appropriate for the tenant. The policies and procedures related to tenant rights related to care, treatment, and services will be reviewed at least annually for any changes and make any necessary changes at the time identified.
4. **The regulatory insufficiency will be corrected by:** 1.31.21

1/27/21

1.27.21

Plan of Correction – Senior Star at Elmore Place

Area: *Program policies and procedures*

Regulatory Insufficiency #1: 481-67.2(1)e Program Policies and Procedures, including those for incident reports. A programs policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.

POC:

1. **The Program will correct the regulatory insufficiency by:** Senior Star at Elmore Place will complete the critical incidents report and send to designee at corporate according to policy as defined in our policy.
2. **The following measures will be taken to ensure the problem does not recur:** The Clinical nursing team will be re-educated on completion of the critical incident report. The Assistant Executive Director and or designee will continue ongoing training with procedures as deemed necessary.
3. **The Program plans to monitor performance to ensure compliance by:** The Assistant Executive Director and or designee will monitor incidents to ensure documentation is completed as required by policy.
4. **The regulatory insufficiency will be corrected by:** 1.31.21

Area: *Program Notification to Department*

Regulatory Insufficiency #1: 481-67.4(3) Program notification to the department. The director or the director's designee shall be notified within 24hrs, or the next business day, by the most expeditious means available. 67.4(3) When there is an act that causes major injury to a tenant or when the program has knowledge of a pattern or acts committed by the same tenant on another tenant that results in any physical injury. For the purposes of this subrule, "pattern" means two or more times within a 30 day period.

POC:

1. **The Program will correct the regulatory insufficiency by:** Senior Star at Elmore Place will notify the department according to the regulations; the clinical team will be re-educated on the rules and regulations for reporting by 1.31.21.
2. **The following measures will be taken to ensure the problem does not recur:** The Assistant Executive Director and or designee will continue ongoing training with reporting to DIA as the rule specifies.
3. **The Program plans to monitor performance to ensure compliance by:** The Assistant Executive Director and or designee will monitor incidents to ensure reporting is completed as the rule specifies.
4. **The regulatory insufficiency will be corrected by:** 1.31.21