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 09/09/2025

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 visit. Tenants without cognitive impairment: 1 Tenants with cognitive impairment: 37 Total census: 38 No regulatory insufficiencies were cited during the investigation of Incident #130146-C. The following regulatory insufficiencies were cited during the investigation of Incidents #129966-I and #130210-I.	A 000	See attached POC 12/19/25	
A 160	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 by: Based on observation, record review and interview, the program failed to ensure provide adequate care and services to ensure tenant safety for 2 of 2 tenants with recent elopements (Tenant #1 and Tenant #2.) Finding follows: 1. Record review on 9/03/35 revealed an incident	A 160		

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report (IR) for Tenant #1 dated 8/20/25 indicated the tenant exited the Memory Care (MC) building without staff knowledge on the afternoon of 8/20/25. According to the IR, Tenant #1 walked out the secured front door at 1:55 p.m. after two staff entered the building through the same door. Tenant #1 sat outside on a bench near the building and then returned to the front door for re-entry at approximately 1:59 p.m. He was dressed appropriately for the weather. A nursing assessment revealed no injuries or adverse effects. A video surveillance camera reportedly showed Tenant #1 sat on the bench the entire time.

According to the state climatologist, the temperature on 8/20/25 at approximately 2:00 p.m. was 81 degrees Fahrenheit with a heat index of 85 degrees. There was no precipitation, with partly cloudy skies.

Additional record review revealed Tenant #1 was 70 years old with a diagnosis including Alzheimer's Disease with early onset. Per a Global Deterioration Scale (GDS) assessment dated 11/08/2024, Tenant #1 had a score of 5, which indicated moderately severe cognitive decline. Tenant #1's service plan, last updated 8/04/25, indicated he had displayed exit-seeking behavior and had a history of walking out the doors when open. Staff should direct Tenant #1 away from the exit doors when they saw him near the doors. The service plan also noted staff would remain conscious of the fact Tenant #1 had a history of elopement and ensure his safety at all times. The service plan indicated staff provided safety checks for Tenant #1 once per shift.

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The Elopement Risk Screening form dated 11/08/24 indicated Tenant #1 was at risk for elopement. "Potential Interventions" included frequent monitoring.

Tenant #1's nursing progress note dated 5/23/25 indicated the exit doors were "completely locked" and Wander Guards were no longer in use. All Wander Guard devices were removed from residents.

Review of previous IRs revealed Tenant #1 eloped on 9/20/24 and 11/08/24. During the incident on 9/20/24, the tenant exited the building through a delayed egress door and the alarms sounded immediately. Tenant #1 walked along the sidewalk to the parking lot. Within one minute of exit, staff were with the tenant and directed him back inside the building. On the morning of 11/08/24, staff discovered Tenant #1 in the parking lot and directed him back inside the building. Review of surveillance video revealed the tenant followed a visitor out the exit door 10 minutes prior to being found. He had a Wander Guard in place at that time, but the IR didn't indicate whether the alarm sounded.

Observation of the front exit doors on 9/03/25 revealed the inner door was locked. Staff opened the door by swiping their fob on a device on the wall near the door. Visitors pressed a door bell to alert staff to let them in. A staff person sat at a reception desk near the door and unlocked/opened the automatic inner door from her desk. The inner door stayed open approximately 12 to 13 seconds, before closing and locking.

During interview on 9/03/25 at 3:00 p.m. the

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A 160	Continued From page 3 Assistant Director/Registered Nurse (RN) stated the exit doors were locked. Staff used their fobs to unlock the doors. A front desk receptionist worked daily from 8:00 a.m. to 8 p.m. and opened the front inner exit door from the desk area. At the time of the elopement on 8/20/25, two staff used their fobs to open the inner door and enter the building. Staff didn't notice as Tenant #1 exited through the open door after the staff entered. The front desk receptionist was present and also didn't notice. Surveillance video showed Tenant #1 exit the building, sit on the bench near the front door and re-enter the building approximately 4 minutes later. (The video was not available at the time of the DIAL investigation.) The RN said the potential interventions listed on Tenant #1's Elopement Risk Screening form indicated possible interventions, but not necessarily interventions in place. She confirmed Tenant #1 had safety checks once per shift, as indicated in his service plan. The RN stated the program did hourly checks on some tenants in the past, but they no longer did hourly checks on tenants because staff didn't document it correctly. Tenant #1 wore a Wander Guard device prior to 5/23/25, when the exit doors were locked. During interview on 9/04/25 at 9:00 a.m. Staff A stated she worked at the time of the incident on 8/20/25 and was assigned to Tenant 1's group. Staff A walked across the parking lot to the assisted living program to pass medication to a MC tenant who was visiting in the other building. Staff A returned to the MC building, along with Health Services Coordinator (HSC). After they entered the building, Staff A said she didn't notice Tenant #1 was in the entry area. Someone later told her Tenant #1 went outside.	A 160		

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A 160	Continued From page 4 During interview on 9/04/25 at 3:00 p.m. the HSC stated she entered the MC building, along with Staff A around 2:00 p.m. on the day of the elopement. The HSC used her fob to open the inner exit door. She entered the building and went to the nursing office, to her immediate left. Staff A immediately turned to her right, to the room used by staff during shift change. The HSC said she noticed Tenant #1 standing by the front reception desk as she entered the building. Tenant #1 was facing the receptionist, not the front door. The HSC said she watched the surveillance video afterwards and saw Tenant #1 exited through the open inner door as it was closing, after the two staff came inside. The HSC said she and other staff were trained at the time of the incident to ensure the door shut before leaving the entry area. She said she was aware Tenant #1 had a history of elopement. 2. Record review on 9/08/25 revealed an incident report (IR) for Tenant #2 dated 7/13/25, which indicated the tenant exited the MC building without staff knowledge on the morning of 7/13/25. According to the IR, staff discovered Tenant #2 in the dining room of the assisted living program (ALP) building at approximately 11:36 a.m. ALP staff notified MC staff, who accompanied Tenant #2 back to the MC building. A nursing assessment revealed no injuries or adverse outcome. Tenant #2 was dressed appropriately for the weather. Review of surveillance video revealed the front desk receptionist opened the front exit door for Tenant #2 at approximately 11:10 a.m. and allowed her to leave the building unaccompanied. (The surveillance video was unavailable at the time of the DIAL investigation.)	A 160		

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A 160	Continued From page 5 According to the state climatologist, the temperature on 7/13/25 at approximately 11:00 a.m. was 77 degrees Fahrenheit with fair conditions. Observation on 9/08/25 revealed the distance between the front door of the MC building and front door of the ALP building was approximately 150-160 feet. A designated walkway was painted on the concrete. The area consisted of an entry drive for each building and a short walk across the parking lot, with stop signs posted for the walkway area. The area was approximately 1-2 blocks from a two-lane city street. Additional record review revealed Tenant #2 was 73 years old with a diagnosis including Alzheimer's Disease. She moved to the MC program on 5/03/25. Per a Global Deterioration Scale (GDS) assessment dated 6/03/25 Tenant #2 had a score of 4, which indicated moderate cognitive decline. Tenant #2's service plan, dated 6/03/25, indicated she resided in a locked unit and had a history of leaving her home prior to moving to the MC program. The service plan noted on 5/05/35 Tenant #2 would no longer go on outings due to elopement risk. The service plan indicated staff provided safety checks for Tenant #2 once per shift. Tenant #2's 30-day assessment dated 6/03/25 indicated she had long term and short term memory deficits. Care staff assisted with reorientation as needed. The assessment noted Tenant #2 was an elopement risk. The Elopement Risk Screening form dated 6/03/25 indicated Tenant #2 was at risk for	A 160		

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elopement. "Potential Interventions" included frequent monitoring.

The program internal investigation indicated a caregiver staff noticed Tenant #2 was missing around 11:31 a.m. and began searching and asking other staff if they had seen her. The MC program building was conducting a search for Tenant #2 when ALP staff alerted them of Tenant #2's presence at their building.

A nursing progress note dated 5/05/25 described an incident when Tenant #2 went on a group outing and became agitated. The group went out to lunch, but when it was time to board the bus to leave, Tenant #2 became agitated and ran back into the restaurant, asking people to help her and to call the police. She became aggressive when staff tried to direct her back to the bus and began walking toward a busy street. Management staff arrived to provide assistance. The police were called and transported Tenant #2 back to the MC program. The progress note indicated a Wander Guard device was placed on Tenant #2 following this incident and she would no longer go on outings "due to further elopement risks".

Tenant #2's nursing progress note dated 5/23/25 indicated the exit doors were "completely locked" and Wander Guards were no longer in use. All Wander Guard devices were removed from residents.

When interviewed on 9/09/25 at 11:15 a.m. Staff B stated she went to Tenant #2's room on 7/13/25 to prompt her to go to lunch (approximately 11:30 a.m.), but she wasn't in her room. Staff B estimated she last saw Tenant #2 in the hallway in the previous 1-2 hours. Staff B said

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she began searching for Tenant #2 and alerted other staff. A short time later, she was notified Tenant #2 was at the ALP building.

When interviewed on 9/09/25 at 10:10 a.m. Staff C stated she helped serve lunch in the ALP dining room on 7/13/25. She didn't recognize Tenant #2 when she sat at one of the dining tables, but assumed she was a new tenant. Staff C assisted Tenant #2 when she seemed confused regarding how to select items from the menu. Another staff in the dining room recognized Tenant #2 as tenant from the MC program and alerted management staff.

When interviewed on 9/09/25 at 10:00 a.m. Staff D stated she primarily worked as the front desk receptionist at the ALP building, but covered for the front desk at the MC building every other Sunday. Staff D was covering on 7/13/25 and was not familiar with Tenant #2. Staff D said it was a busy morning. A new program bus driver was talking with Staff D and asking questions. Staff D had just opened the exit door for a visiting family to leave, as she also talked with the bus driver. She then saw Tenant #2 standing near the exit door and assumed she was with the family that just left. Staff D opened the exit door for Tenant #2, who then left the building.

3. When interviewed on 9/09/25 at 11:10 a.m. the RN confirmed Tenant #1 and Tenant #2 were both identified as elopement risks and should not have been outside the locked memory care building on their own.

Plan of Correction – Senior Star at Elmore Place

Date: 12.19.25
To: Iowa Department of Inspections & Appeals (DIA)
From: Amanda Buchholz, Assistant Executive Director
RE: DIA Investigation 09/03-09/09/2025

Enclosed is the Plan of Correction (POC) in response to investigation visit by a representative of the department from September 3rd , 2025 thru September 9th , 2025, to Senior Star at Elmore Place Memory Care. Regulatory Insufficiencies in the area(s) of: tenant rights, 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 place wander guards back on those tenants identified for high risk for elopement.
2. **The following measures will be taken to ensure the problem does not recur:** The registered nurse and or designee will evaluate the need for wander guards being placed on tenants and will place on tenant based off assessment.
3. **The Program plans to monitor performance to ensure compliance by:** The registered nurses and or designee will review IR and state reports to ensure reduction in elopements.
4. **The regulatory insufficiency will be corrected by:** 12/19/25

Area: *Tenant Rights*

Regulatory Insufficiency #2: 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 re-educate staff who is high risk for elopement by placing a picture in a binder at the desk.
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 monitor compliance with any new move ins and or CIC for tenants in need of wander guards.
4. **The regulatory insufficiency will be corrected by:** 12/19/25