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 02/18/2026

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. Tenants without cognitive impairment: 1 Tenants with cognitive impairment: 33 Total census: 34 No regulatory insufficiencies were cited during the revisit conducted to determine progress made in correcting the regulatory insufficiencies fined and cited during the investigation of Incident #129966-I, Complaint #130146-C and Incident #130210-I. The following regulatory insufficiencies were cited during the investigation of Complaint #130590-C, Incident #130806-I, Complaint #130896-C and Complaint #130981-C.	A 000	see attached POC 6/12/26	
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 staff failed to follow established policies on Medication Administration, Controlled Medication and Falls for 4 of 5 discharged tenants reviewed (Tenant C1, Tenant C3, C4 and Tenant C5) and potentially affecting all tenants utilizing controlled medication. Findings follow: 1) Record review on 2/03/26 of an internal	A 150		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

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

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 02/18/2026

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 150	Continued From page 1	A 150		

investigation into a Morphine discrepancy for Tenant C3 revealed the following timeline:

11/20/25 - Called the Former Health Services Coordinator (HSC). She stated she borrowed an unopened bottle of Morphine from Tenant C3 earlier for Tenant C5 who needed Morphine right away. The Former HSC stated she didn't think it was an issue as the Morphine came from the same hospice company and same pharmacy.

11/21/25 - The hospice nurse came in with her supervisor and audited all of their narcotics.

11/21/25 - When hospice left, the Former HSC asked the Memory Care Manager to audit the narcotics with her. They did so and there were no discrepancies at that time.

The investigation included a statement from the Former HSC. Tenant C3's hospice nurse found the unopened bottle of Tenant C5's Morphine in a box full of Tenant C3's medication. The Former HSC asked the hospice nurse to remove the label on the bottle of Tenant C5's Morphine.

A Controlled Drug Receipt/Proof of Use/Disposition Form indicated the Program received a 30 ML bottle of Morphine Sulfate SOL 20 milligrams (MG)/1 milliliters (ML) for Tenant C3 on 8/12/25. The documentation reflected the medication was not used until 11/20/25 at 10:00 a.m. when he received 0.25 ML.

A Controlled Substance Count and Usage Record reflected the Program administered 0.25 ML of Morphine Sulfate 100 MG/1 ML to Tenant C5 on 9/22/25 at 2:45 p.m. The Controlled Substance Count and Usage Record failed to indicate the date the medication was received by the

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 02/18/2026

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 150	Continued From page 2	A 150		

Program. The Former HSC administered the first dose of Morphine Sulfate to Tenant C5 from the bottle on 9/22/25.

The Former HSC was interviewed on 2/05/26 at 9:25 a.m. and reported Tenant C5 was on hospice with a standing order for Morphine but the Program did not have a bottle of the medication on hand for him, they needed to obtain it from the pharmacy. Tenant C5 was in a lot of pain on 9/22/25 and went downhill very quickly. She did not want to wait for the Morphine to get delivered from the pharmacy between 7:00 p.m. and 8:00 p.m. that evening. The Former HSC wanted to help Tenant C5 right then and there. She did not think it mattered if she used the unopened bottle of Morphine belonging to Tenant C3 so she administered Morphine from it to Tenant C5. The Former HSC then gave the new bottle of Morphine to Tenant C3 when it arrived from the pharmacy.

The Program's policy on Medication Administration indicated all medications were to have a physician's order and an indicated use. Staff were to check the Medication Administration Record (MAR) to ensure they provided the proper medication to the proper tenant. They were to compare the order on the MAR to the label on the bottle to ensure they matched. Staff took the medication to the tenant and again verified the tenant's identity. They should administer the medication to the properly identified tenant and witness the tenant swallowed the medication.

2) The Program's Narcotic Count Sheets directed two staff were supposed to initial when they counted the controlled substances at the beginning or end of each shift. A review of the count sheets for September, 2025, October, 2025

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 02/18/2026

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 150	Continued From page 3 and November, 2025 revealed the following: -September: 23 shifts no staff signed the narcotic count sheet, one staff signed the narcotic count sheet on 23 shifts -October: 24 shifts no staff signed the narcotic count sheet, one staff signed the narcotic count sheet on 28 shifts -November: 41 shifts no staff signed the narcotic count sheet, one staff signed the narcotic count sheet on 29 shifts The Program's Controlled Substance Policy directed staff should facilitate a count of all medications listed on the Controlled Medication Count Sheet by two qualified persons at shift change and when keys to the medication cart were exchanged between qualified personnel. 3) Record review of incidents reports for Tenants revealed the following: a. Tenant C1's reports noted: -On 8/08/25 at 9:44 p.m. Tenant C1 was found on the floor. He had a bruise to the back of the left thigh and was able to walk without a walker. His Power of Attorney (POA) was notified on 8/11/25 at 10:05 a.m. - On 9/17/25 at 12:19 p.m. Tenant C1 sat next to another tenant who tried to take the napkin from under his plate. Tenant C1 took the napkin back, grabbed the knife and started to cut the table. The other tenant tried to grab the knife at which time Tenant C1 started hitting the other tenant. The other tenant hit Tenant C1. No injuries were noted. Tenant C1's POA was notified of the incident on 9/18/25 at 11:13 a.m. - On 9/26/25 at 8:05 a.m. Tenant C1 was found in	A 150		

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 02/18/2026

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 150	Continued From page 4	A 150		

the front lobby bathroom on the floor laying on his back.. His pants and shoes were off. His POA was notified on 9/29/25 at 10:59 a.m.

- On 9/26/25 at 11:15 a.m. Tenant C1 was found laying in the courtyard on his back. His POA was notified on 9/29/25 at 10:59 a.m.

- On 10/05/25 at 3:10 a.m. Tenant C1 was found on the floor in the activity room. He reported lower back pain. His POA was notified on 10/06/25 at 8:38 a.m.

b. Tenant C4's reports noted:
- On 10/01/25 at 11:30 p.m. the nurse went to his room and observed him lying in a supine position. While trying to assess him he continued to scream the entire time. His POA was contacted on 10/02/25 at 10:12 a.m.

- On 10/02/25 at 2:30 a.m. Tenant C4 yelled out in pain but unable to explain where the pain was located. He was very restless. Due to his recent falls and severity of pain he was sent to the Emergency Department for further evaluation. His POA was notified on 10/02/25 at 10:12 a.m.

The Assistant Executive Director confirmed on 2/18/26 at 12:53 p.m. the normal practice was to notify family when a tenant was sent out of the community for an evaluation but the incident report for Tenant C4 reflected his POA was not notified until 10/02/25 at 10:12 a.m.

c. Tenant C5's reports noted:
- On 7/17/25 at 8:00 p.m. Tenant C5 was not responsive when staff entered his room to provide incontinence care. Staff contacted on-call, got the vitals cart and did a sternum rub. His blood pressure was 197/100. Tenant C5 was

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 02/18/2026

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 150	Continued From page 5 transported to the hospital. His wife was notified on 7/18/25 at 12:32 p.m. - On 8/19/25 at 7:30 a.m. Tenant C5 was found on the floor in another tenant's apartment. He was laying with his body at a right angle with his head between the nightstand and bed. Program staff did not inform his POA until 8/25/25 at 12:18 p.m. - On 8/26/25 at 7:00 a.m. staff found Tenant C5 on the floor next to his bed. Then he fell out of his wheelchair and got an abrasion on his right eyebrow and hand. His POA was notified on 8/27/25 at 11:53 a.m. The Program's Falls Response Protocol defined a fall as any unintentional change in position where the tenant ended up on the floor, ground or a lower level. This also included an unwitnessed fall when a tenant was found on the floor and neither the tenant or anyone else knew how he or she got there. Staff were to notify the responsible party of the fall. During an interview on 2/10/26 at 3:00 p.m. the Memory Care Manager reported Program staff were to notify the legal representative each time there was an incident unless they were instructed differently. They typically wouldn't call about a fall in the middle of the night unless there was an emergency. Tenant C1, Tenant C4 and Tenant C5's families directed Program staff to call each time there was a fall. If the Program did not call, they failed to follow the policy.	A 150		
A 155	481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the	A 155		

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 02/18/2026

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 155	Continued From page 6 following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program staff failed to treat tenants with respect in honoring the legal representative's choice for services for 1 of 5 current tenants (Tenant #4) and 1 of 5 discharged tenants reviewed (Tenant C1). Findings follow: a. Record review on 2/10/25 revealed Tenant C1's Incident Report noted he was found on the floor in the activity room. His range of motion was within normal limits. Staff assisted him off the floor. Tenant C1 reported lower back pain. Action taken by the Program included an assessment for hospice. The Program submitted a request to Tenant C1's Nurse Practitioner on 10/01/25 requesting a treatment order for hospice to evaluate and admit him to services. The Former Health Services Coordinator (HSC) noted the order on 10/07/25. There was no documentation in the progress notes of a conversation or approval from Tenant C1's Power of Attorney (POA) to begin hospice. During an interview on 2/10/26 at 11:35 a.m. Tenant C1's daughter/POA reported she did not authorize the Program to get an order for her father to be evaluated for hospice services. The Program made a referral to a hospice provider	A 155		

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 02/18/2026

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 155	Continued From page 7 without her permission. The hospice provider called her a number of times without knowing she was not ready for this service for her father. The daughter reported she made it clear to the Former HSC the family did not want hospice for Tenant C1 but the Program pushed the service. Tenant #4's POA was interviewed on 2/10/26 at 12:00 p.m. The POA reported the Former HSC really pushed hospice which made her think at one point maybe the Program wasn't the right place for Tenant #4. Hospice has not been brought up since the Former HSC left employment with the Program. An outside provider was interviewed on 2/03/26 and discussed concerns the Former HSC kept saying Tenant C1 and Tenant #4 needed hospice even though their family members were not in support of this service. When interviewed on 2/10/26 at 3:00 p.m. the Memory Care Manager indicated the Former HSC put her whole heart into taking care of the tenants but did not communicate in the best way with their families. She was not present for any conversations with tenants or their families about hospice but wished she had been. The Memory Care Manager believed the Former HSC would have and should have obtained permission prior to getting an order for hospice but confirmed there was no documentation of this and no reason to disbelieve the tenants' families.	A 155		
A 160	481-67.3(2) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights:	A 160		

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 02/18/2026

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 160	Continued From page 8 67.3(2) To receive care, treatment and services which are adequate and appropriate. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide appropriate treatment and services to 1 of 5 current tenants reviewed (Tenant #3) and 1 of 5 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 2/04/26 revealed an order from Tenant #3's psychiatrist dated 10/06/25 which read as follows: Please fulfill the following medical orders immediately, Behavioral interventions: - Patient to have blinds/curtains drawn and room lights on during the daytime hours - Sleep hours and behavioral concerns documented in EMR (Electronic Medical Record) A review of task sheets for Tenant #3 from October, 2025 to January, 2026 reflected no entries for staff to document opening his blinds/curtains or indicating if his lights were on during the daytime hours. A review of the Medication Administration Record (MAR) for Tenant #3 for October, 2025 toJanuary 2026 reflected no entries for staff to document opening his blinds/curtains or indicating if his lights were on during the daytime hours. His sleep hours and behavior concerns were not documented on the MAR.	A 160		

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 02/18/2026

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 160	Continued From page 9 During an interview on 2/10/26 at 3:00 p.m. the Memory Care Manager and the Current Health Services Director reported staff routinely opened tenant's curtains each morning so this would have been an easy task for them to document. They confirmed if a physician ordered staff to provide information on a task the Program should have provided the service. 2) Record review of Tenant C1's service plan f revealed he would receive assistance with laundering of his personal clothing and linens. During a call with Tenant C1's daughter/Power of Attorney she reported her father's items regularly went missing. She would find her father in clothing belonging to other tenants. He had items such as clothing, towels and bedding get lost. If things were lost, staff would say she should have bought a different type of clothing that didn't look like other's. When interviewed on 2/04/26 at 8:10 a.m. Staff A stated she did not believe staff were paying enough attention to putting tenant's things where they belong. If staff don't provide a seamless flow it creates an issue. Tenants pay a lot of money to live there and issues like completing the laundry should not be an issue. When interviewed on 2/03/26 at 5:00 p.m. Staff B reported a number of tenant's clothing gets mixed up in the laundry. There was a period of time when things were better and now it seems to be a problem again. On 2/4/26 at 10:40 a.m Staff D reported many family members complained about items going missing in the laundry.	A 160		

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 02/18/2026

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 160	Continued From page 10 During an interview on 2/10/26 at 3:00 p.m. the Memory Care Manager e reported there were issues with the laundry a year ago. She was working to get all shifts on a schedule of doing laundry and putting the items away in apartments. A lot of the issue were staff not pulling all items out of the washer or dryer and they don't know what item belongs to what tenant. She confirmed there has been a problem with tenants receiving their laundry as they should.	A 160		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to maintain a working alarm system at each exit door allowing 1 of 5 current tenants reviewed to elope (Tenant #1). Finding follows: Record review on 2/03/26 revealed a Final Investigation Summary Report noted Tenant #1 was observed exiting through the door on the north side of the building on 11/10/25. The mag lock on the door failed to engage after staff entered the building from the north parking lot. At 11:51 a.m., Tenant #1 exited the building wearing a sweater over a t-shirt, jeans, a hat, socks and tennis shoes. He walked to the front area of the north parking lot. An employee from the assisted living program encountered Tenant #1 and took him to the assisted living dining area. Upon	A 635		

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 02/18/2026

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 635	Continued From page 11	A 635		

arrival in the dining room, the employee asked the dining room staff if he had eaten. The Dining Room Coordinator recognized Tenant #1 and notified the Memory Care Director and former Health Services Coordinator (HSC) at 12:04 p.m. The former HSC arrived in the assisted living building at 12:07 p.m. and escorted Tenant #1 back to the Program at 12:08 p.m. They entered the Program at 12:10 p.m. Tenant #1's vitals were taken at 12:11 p.m. and they were within normal limits. Tenant #1 was outside for a maximum of 12 minutes.

Tenant #1's service plan dated 10/13/25 noted his diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris, essential hypertension and unspecified dementia. He scored a five on the Global Deterioration Scale on 10/13/25 indicating a moderately severe cognitive decline. Tenant #1's service plan noted he would not leave the building unattended if going outside or for a walk. He had not tried to exit the building unattended since being in memory care. When his plan was updated on 10/13/25 it was noted he was experiencing increased confusion and required more assistance with all tasks.

At the time Tenant #1 eloped from the building the temperature was 34 degrees Fahrenheit (F) with partly cloudy skies. The wind child temperature was 27 degrees F.

During an interview on 2/10/26 at 10:27 a.m. the assisted living employee recalled sitting in her car talking on the phone when a man came up, knocked on the car window and asked for a hit of a cigarette. She realized it was Tenant #1. The last she knew, he lived in an apartment at the assisted living program. Tenant #1 seemed

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 02/18/2026

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 635	Continued From page 12	A 635		

confused and very cold. He was mumbling under his breath and kept knocking on car windows as she helped him into the assisted living building.

When interviewed on 2/04/26 at 8:10 a.m. Staff A \reported smoking with Staff B in the north parking lot on 11/10/25. Staff A entered the Program building followed by Staff B. Staff B was to check the door was closed to the Program as she was the last to enter. This was not done. Staff A did not hear a door alarm or notice the light above the door change color.

When interviewed on 2/03/26 at 5:00 p.m. Staff B stated she was outside with Staff A. She was told Tenant #1 got out of the building when they came inside. Staff B did not hear the door alarm or notice the light above the exit door change color.

A tour of the building was provided by the Memory Care Manager and current HSC on 2/05/26 at 11:05 a.m. The Memory Care Manager explained at the time of Tenant #1's elopement the exit door was leaning and out of balance which prevented the mag lock from connecting properly. There were lights above the exit doors which were green when the door was locked and red when it was open. No one noticed the door was unlocked and the light was red when Tenant #1 was outside of the building. An alarm did not sound when Tenant #1 went through the door because an alarm was not attached to the door, although an alarm was on the door (and all exit doors) at the time of the investigation. The Memory Care Manager confirmed the Program failed to have a working alarm system at the time of Tenant #1's elopement.

Plan of Correction – Senior Star at Elmore Place

Date: 5/13/2026
To: Iowa Department of Inspections & Appeals (DIA)
From: Amanda Buchholz, Assistant Executive Director
RE: DIA Investigation 2/3/26-2/18/26

Enclosed is the Plan of Correction (POC) in response to investigation visit by a representative of the department from February 3rd through February 18th, 2026, to Senior Star at Elmore Place Memory Care. Regulatory Insufficiencies in the area(s) of: programs policies and procedures, tenant rights, and life safety 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: Program policies and procedures

Regulatory Insufficiency #1: 481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program.

POC:

1. **The Program will correct the regulatory insufficiency by:** Senior Star at Elmore Place Memory Care will follow established policies for obtaining physician orders, medication administration, controlled substances, narcotic counting, and incident reporting for all tenants.
2. **The following measures will be taken to ensure the problem does not recur:**
    - The RN and nurse designee(s) will be re-educated on Senior Star policies and procedures related to physician orders, medication administration, controlled substances, narcotic counting, and incident reporting.
    - The RN and nurse designee(s) will be re-educated on processes on obtaining medications.
    - Staff responsible for medication administration will be retrained on documentation on the MAR, narcotic counting, and incident reporting.
3. **The Program plans to monitor performance to ensure compliance by:** The registered nurses and designee will monitor areas identified in report to ensure compliance with policies and procedures written.
4. **The regulatory insufficiency will be corrected by:** 6/12/26

Area: Tenant Rights

Regulatory Insufficiency #2: 481-67.3(1) Tenant Rights 481-67.3 Tenant rights. All tenants have the following rights: 67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy.

POC:

1. **The Program will correct the regulatory insufficiency by:**
    - The Power of Attorney, when enacted, will be consulted prior to initiation of hospice services or other outside provider services.

- Staff will accurately document all services/tasks assigned.
- Staff will follow processes to ensure tenant laundry is not mixed with other tenants or lost.

2. **The following measures will be taken to ensure the problem does not recur:**
   - The RN and nurse designee(s) will be re-educated on Tenant Rights.
   - The RN and nurse designee(s) will be re-educated on involving tenant and/or Power of Attorney with implementation of outside service providers.
   - Staff will be re-educated on tenant service plan and documentation of tasks, when applicable.
   - Staff will be re-educated on processes for laundering tenant items.
   - All staff will be re-educated on regulatory requirement and Program policy for completion of incident reports
3. **The Program plans to monitor performance to ensure compliance by:** The registered nurses and or designee will review tenant files and process at least annually to confirm compliance.
4. **The regulatory insufficiency will be corrected by:** 6/12/26

Area: Life Safety

Regulatory Insufficiency #3 481-69.32(2) Life Safety - Emergency Policies /Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program.

POC:

1. **The Program will correct the regulatory insufficiency by:** Senior Star at Elmore Place will ensure doors are operating and functioning appropriately with alarm system in place as required by regulation.
2. **The following measures will be taken to ensure the problem does not recur:**
   - All staff will be re-educated on the operation of door alarms.
   - Door alarm checks will be performed monthly.
3. **The Program plans to monitor performance to ensure compliance by:** The Administrator or Designee will monitor staff compliance by reviewing door alarm checks at least every six months.
4. **The regulatory insufficiency will be corrected by:** 6/12/26