

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0371</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/26/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MORNINGSTAR AT JORDAN CREEK ALP/D</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>525 SOUTH 60TH STREET WEST DES MOINES, IA 50266</b>
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A 000	<p><b>Initial Comments</b></p> <p>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.</p> <p>Tenants without cognitive impairment: 6 Tenants with cognitive impairment: 18 Total census: 24</p> <p>The regulatory insufficiencies were cited during the investigation of Complaint #131511-C.</p>	A 000	see attached poc 4/30/26	
A 150	<p><b>481-67.2(3) Program Policies and Procedures</b></p> <p>67.2(3) The program shall follow the policies and procedures established by the program.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to follow established policies on Incident Reporting and Investigation, along with additional policies on Fall/Injury Response, and Medical Emergency Response for 1 of 3 tenants reviewed (Tenant #C1). Findings follow:</p> <p>1. Record review on 2/23/26 of Tenant #C1's file revealed the following documents:</p> <p>a. A progress nurse's note, dated 6/01/25, indicated at 8:40 p.m. Staff A called the Wellness Director and reported the incident as a fall. Staff A indicated Tenant #C1 was found on the floor. Staff A left to get help from another staff and when they returned Tenant #C1 got up on his own. She reported he had no pain and vitals were good.</p>	A 150	This Plan of Correction is submitted in response to the findings of the Iowa Department of Inspections, Appeals, and Licensing. Submission of this Plan of Correction does not constitute an admission by the community, its leadership, or its team members of any wrongdoing, fault, or liability.	

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

*Phyllis Spadit* Executive Director

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A 150	<p>Continued From page 1</p> <p>b. A progress nurse's note, dated 6/04/25, indicated at 3:28 p.m. Tenant #C1 communicated pain in his right shoulder blade and back. It took two staff to get the tenant to stand, and he experienced stiffness and pain in his back. He received PRN (as needed) Tylenol for the pain and the nurse was notified. The nurse completed an assessment.</p> <p>c. A progress nurse's note, dated 6/4/25, indicated at 3:31 p.m., the Wellness Director assessed Tenant #C1 due to complaints of pain in the left shoulder. Tenant #C1 demonstrated good range of motion. The tenant's Advanced Registered Nurse Practitioner (ARNP) was notified and would follow up the next day when onsite. PRN Tylenol was given and noted to be effective.</p> <p>d. A progress nurse's note, dated 6/5/25 at 1:23 p.m. documented the Wellness Director was alerted by staff the tenant was increasingly stiff and required two staff to assist standing and one staff to assist with ambulation. Tenant #C1's ARNP assessed and recommended he be seen at the emergency room for evaluation. Tenant #C1 was transferred via ambulance.</p> <p>e. An incident report was created by the Wellness Director on 6/05/25, four days after the incident. The report indicated on 6/01/25 at 7:45 p.m. the incident type was a fall. The Wellness Director noted based on information gathered from the post incident investigation the incident was misrepresented as reported as the tenant was found on the floor. Information gathered post-incident revealed the tenant was startled and became aggressive when Staff A approached to give another tenant mediation. Review of video</p>	A 150	<p><b>1. Corrective Actions to Address Each Regulatory Insufficiency (Including System-Level Corrections)</b></p> <p><b>A. Failure to Follow Fall Policy and Protocols</b></p> <ul style="list-style-type: none"> <li>• Immediately upon identification of the deficiency, all team members involved were removed from direct resident care pending review.</li> <li>• The Wellness Director completed a full re-evaluation of the resident involved, including updated vitals, pain assessment, mobility assessment, and care plan review.</li> <li>• The incident was reclassified accurately based on video evidence and staff interviews.</li> <li>• The community reissued and re-educated staff on the Fall Management Policy, including:             <ul style="list-style-type: none"> <li>o Immediate assessment requirements</li> <li>o Mandatory reporting timelines</li> <li>o Required documentation elements</li> <li>o Prohibition of resident lifting without proper assessment and assistance</li> </ul> </li> <li>• All staff to complete mandatory in service training by 4/30/2026.</li> </ul>	

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A 150	<p>Continued From page 2</p> <p>revealed it appeared Staff A pushed Tenant #C1 to the ground. When Staff A left to get another staff to assist, Tenant #C1 got himself up from the floor. There were no signs or symptoms of pain or limited range of motion observed. The tenant went to the emergency room for left shoulder pain on 6/05/26. The investigation follow up indicated possible suspected abuse.</p> <p>f. No incident report was created by Staff A was found in Tenant #C1's file.</p> <p>2. Record review on 2/23/26 revealed the Program's policy, Incident Reporting and Investigation, dated July/2021, directed to fill out an incident report related to falls. The policy indicated the incident report needed accurate information which included but not limited to: date, time, what the individual stated happened, document witnesses include statements, what contributed to the incident, who was notified of the incident, and the response to the incident (vitals, injuries, any first aid). The policy further directed staff to fill out a progress note and the tenant was placed on short term observations.</p> <p>Continued review of the policy indicated an investigation and conclusion of the incident needed to be completed within three business days by the Wellness Director (WD) or designee. The policy directed the WD determined and documented the cause of the incident and prevention measures for future incidents. The WD completed a progress note with the summary of the findings, reviewed the incident report and short term observations documentation and updated the resident ' s service plan with prevention measures.</p>	A 150	<p><b>B. Failure to Complete Incident Report Timely</b></p> <ul style="list-style-type: none"> <li>The delayed incident report was corrected.</li> <li>The Wellness Director and Executive Director review all incident reports for accuracy, timeliness, and completeness before final submission.</li> <li>A 24 hour reporting expectation was communicated to all staff.</li> </ul> <p><b>C. Failure to Conduct a Thorough and Timely Investigation</b></p> <ul style="list-style-type: none"> <li>A full retrospective investigation was completed, including video review, staff interviews, and resident assessment.</li> <li>Care Leaders received targeted training on conducting thorough investigations, including root cause analysis, documentation standards, and interview procedures.</li> </ul> <p><b>D. Failure to Report the Incident Timely</b></p> <ul style="list-style-type: none"> <li>The community submitted the required report to the state immediately upon discovery of the misrepresented event.</li> <li>An inservice was completed to review protocol was requiring: <ul style="list-style-type: none"> <li>o Immediate notification to the Executive Director and Wellness Director for any fall, injury, or suspected abuse</li> </ul> </li> </ul>	

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A 150	<p>Continued From page 3</p> <p>Per the Program's policy Staff A failed to complete an incident report after the incident occurred, and failed to complete all steps related to the incident report. After receiving a verbal report of the incident on 6/01/25, Program leadership failed to initiate/complete the incident investigation within three business days of the incident, and failed to complete all steps related to the investigation of the incident.</p> <p>During an interview on 2/24/26 at 9:00 a.m. the Wellness Director confirmed Staff A called her on 6/01/25 to report the incident and reported the incident as a fall. The Wellness Director indicated Staff A left the room to go get assistance and upon return, Tenant #C1 had already gotten himself back up with no apparent injuries. The Wellness Director confirmed Staff A failed to initiate or complete an incident report at the time of the incident but should have completed one on 6/01/25 following the incident.</p> <p>During a follow-up interview on 2/24/26 at 10:49 a.m., the Wellness Director indicated the Program held clinical meetings on Mondays, but didn't review incident reports as part of the clinical meeting at the time the incident occurred as they trusted staff to complete the reports.</p> <p>3. Record review revealed the Program's policy, Fall/Injury Response, dated July/2020, indicated after a fall there was a five step process which included evaluation, intervention, notification, documentation and investigation. The policy directed for an incident with no apparent injury to complete the incident report, initiate short term observations, and the nurse completes the event investigation report. The policy further directed to notify the Wellness Director of any changes in condition or short term observations and notify</p>	A 150	<ul style="list-style-type: none"> <li>o Same day review of all incidents for potential reportability</li> <li>o Documentation of decision making regarding reportability</li> <li><b>2. Measures to Ensure the Problem Does Not Recur</b></li> <li><b>A. Staff Education &amp; Competency</b> <ul style="list-style-type: none"> <li>• All staff completed in service training on:                             <ul style="list-style-type: none"> <li>o Fall policy and protocols</li> <li>o Timeliness of reporting</li> <li>o Incident report completion</li> <li>o Abuse prevention and mandatory reporting</li> <li>o Interventions and short term monitoring requirements</li> </ul> </li> <li>• All Care Leaders completed additional training on:                             <ul style="list-style-type: none"> <li>o Conducting thorough investigations</li> <li>o Documentation accuracy</li> <li>o Identifying discrepancies in progress notes</li> </ul> </li> <li>• New hires will receive this training during onboarding.</li> </ul> </li> </ul>	

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A 150	<p>Continued From page 4</p> <p>the family or legal representative. The investigation process identified what happened, how did it happen, and possible contributing factors. After identifying the information the policy directed to take appropriate steps based on the information. The policy indicated the information went to a committee for quality review.</p> <p>Per the Program's policy Staff A failed to complete an incident report after the incident was reported a fall. The Program leadership failed to complete an investigation report, to initiate Short-Term Observation, and to notify the tenant's legal/family representative following the incident on 6/01/25.</p> <p>4. Record review revealed the Program's policy Fall Management, dated July/2021, directed staff to follow the emergency response protocol for a fall with no injury.</p> <p>Per the Program's policy Staff A failed to implement the procedures in the emergency response policy.</p> <p>5. Record review revealed the Program's policy, Medical Emergency Response, dated July/2021, directed staff who witnessed the incident to complete an incident report for minor/non-medical emergencies. Staff were to document all observed details of the incident. The policy directed staff to contact the Executive Director, Wellness Director and the tenant 's family.</p> <p>Per the Program's policy Staff A failed to complete an incident report and failed to document details of the incident. The staff failed to contact Tenant #C1's family on 6/01/25 about the incident per the policy.</p>	A 150	<p><b>D. Failure to Report the Incident Timley</b></p> <ul style="list-style-type: none"> <li>o Same day review of all incidents for potential reportability</li> <li>o Documentation of decision making regarding reportability</li> </ul> <p><b>2. Measures to Ensure the Problem Does Not Recur</b></p> <p><b>A. Staff Education &amp; Competency</b></p> <ul style="list-style-type: none"> <li>• All staff completed in service training on: <ul style="list-style-type: none"> <li>o Fall policy and protocols</li> <li>o Timeliness of reporting</li> <li>o Incident report completion</li> <li>o Abuse prevention and mandatory reporting</li> <li>o Interventions and short term monitoring requirements</li> </ul> </li> <li>• All Care Leaders completed additional training on: <ul style="list-style-type: none"> <li>o Conducting thorough investigations</li> <li>o Documentation accuracy</li> <li>o Identifying discrepancies in progress notes</li> </ul> </li> <li>• New hires will receive this training during onboarding.</li> </ul> <p><b>B. Process &amp; System Improvements</b></p> <ul style="list-style-type: none"> <li>• The Wellness Director will: <ul style="list-style-type: none"> <li>o Review and sign off on all incident reports</li> <li>o Ensure short term observation sheets and interventions are initiated and completed</li> </ul> </li> </ul>	

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A 150	<p>Continued From page 5</p> <p>During an interview on 2/24/26 at 2:45 p.m. the Wellness Director acknowledged procedural steps of the above policies were not completed.</p> <p>During exit on 2/26/26 at 9:20 a.m. the Executive Director and Wellness Director confirmed the above findings.</p>	A 150	<p>o Update care plans with prevention measures within 72 hours</p> <ul style="list-style-type: none"> <li>• All falls will be reviewed <b>during the daily morning clinical meeting.</b></li> <li>• All falls and investigations will be reviewed during the <b>monthly QAPI meeting</b> to identify trends and prevention opportunities</li> </ul> <p><b>3. Monitoring Performance and Ensuring Ongoing Compliance</b></p> <p><b>A. Daily Monitoring</b></p> <ul style="list-style-type: none"> <li>• Wellness Director or designee will review all incident reports daily.</li> <li>• Daily clinical huddles will include:               <ul style="list-style-type: none"> <li>o Review of any new falls</li> <li>o Verification that assessments and documentation were completed</li> <li>o Confirmation that interventions and monitoring are in place</li> </ul> </li> </ul> <p><b>B. Weekly Monitoring</b></p> <ul style="list-style-type: none"> <li>• The Executive Director and Wellness Director will conduct a weekly audit of:               <ul style="list-style-type: none"> <li>o Incident report timeliness</li> <li>o Investigation completeness</li> <li>o Documentation accuracy</li> <li>o Care plan updates</li> </ul> </li> <li>• Any discrepancies will result in immediate coaching and retraining.</li> </ul> <p><b>C. Monthly Monitoring (QAPI)</b></p> <ul style="list-style-type: none"> <li>• All falls, incident reports, and investigations will be reviewed monthly in QAPI.</li> <li>• QAPI will track:               <ul style="list-style-type: none"> <li>o Time from incident to report creation</li> <li>o Time from incident to investigation completion</li> <li>o Staff compliance with fall protocols</li> <li>o Trends in pain reporting, mobility changes, and repeat falls</li> </ul> </li> <li>• QAPI will implement corrective actions for any identified trends.</li> </ul>	