Iowa Department of Inspections, Appeals & Licensing
Health & Safety Division
Adult & Special Services Unit
Civil Penalty Citation

Date: January 26, 2024
Program Name: Emery Place
Address: 901 South Mentzer Road Robins, IA 52411
Type of Action: Investigations #116765-C, #116105-C, #115274-C, #114895-C, #113795-C, #113773-C, #113678-C, #113845-I, #114030-I and #112318-I
Date(s) of Action: 10/11/23 – 11/15/23
Citation #: 10179

State Rule #	State Rule	Amount of Civil Penalty
Iowa Administrative Code 481-67.3(2)	**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.** Based on interview and record review the Program failed to provide services to tenants that were adequate and appropriate. This pertained 3 of 4 discharged tenants reviewed (Tenant C1, Tenant C2, and Tenant C4). Findings follow: 1. Record review on 10/30/23 and 11/2/23 of Tenant C4's file revealed Progress Notes and Staff Documentation/Communication to Nurse documents indicated on 5/27/23 Tenant C4 bled every time staff wiped him. Staff applied A & D ointment but he was in pain. It was reviewed by the nurse on 5/30/23. Progress notes indicated on 5/30/23 staff assisted Tenant C4 up from his chair with an assist of two staff. Tenant C4 was not able to ambulate and staff could not get him back in the chair. Blood was noted on his chair and through his brief. Staff called emergency medical services (EMS) and Tenant C4 was taken to the hospital due to rectal bleeding. Tenant C4 required intravenous (IV) antibiotics at the hospital for cellulitis on his buttocks. Tenant C4 required transfer to a higher level of care for therapy and wound care. Continued record review revealed hospital records indicated Tenant C4 was seen in the emergency room on 5/30/23. His weight on admission was 282 pounds. Tenant C4 had large sacral decubitus ulcer stage II, bleeding and had a "terrible smell associated with the ulcer." It was noted his "Differential diagnosis includes decubitus sacral ulcer with associated infection, UTI, electrolyte abnormality and septicemia." Tenant C4 was admitted for treatment of sacral cellulitis. The records indicated had a "significant decubitus ulcer" on his buttocks "concern for overlying cellulitis" and was started on IV antibiotics. The wound location was the buttocks, sacrum and coccyx present on admission. The etiology was a deep tissue injury. Measurements included: 11.9 x 10.9 centimeters (cm). It was "10% moist red, 40% "black adherent thinning necrotic tissue, 40% tan adherent slough, 10%	**$10,000**

	non blanchable purple discoloration to the right edge." The right upper thigh wound measurements included 4.9 x 4.6 cm, it was "20% adherent tan, 80 % moist red surrounding blanchable discoloration." Both wounds were unstageable but at least stage II. The OT notes indicated Tenant C4 required total assistance of two or more for activities of daily living (ADLs) and mobility. Final diagnoses included: cellulitis of buttock, metabolic encephalopathy, pressure ulcer of left and right buttock stage II, pressure of ulcer of sacral region stage II and pressure ulcer of other site stage II. Tenant C4 was discharged to to SNF on 6/5/23 a and had ordered to follow up with wound healing center first available appointment. When interviewed on 10/31/23 at 2:49 p.m. Staff I stated on 5/30/23 she went back to the memory care unit to check on staff and they were trying to get Tenant C4 up (on 5/30/23). Tenant C4 could not stand and his eyes were glossy. He said he hurt and had buttocks pain. There was a protective pad on his chair and dried and fresh blood could be seen on the pad. Tenant C4 was lowered to floor and there was blood on the floor. The nurse was called, 911 was called, and vitals were taken. When the emergency medical technicians (EMTs) got him up off the floor, there was blood on the floor. She recalled she wiped him once and she thought it was hemorrhoids or something and let the nurse know. She did not remember any open areas. He had a spot off of his tailbone as it was difficult to get him out of the chair. She believed it was reported to the nurse. She said staff assisted Tenant C4 with toileting assistance including changing his brief. When interviewed on 11/7/23 the Healthcare Coordinator she was made aware of Tenant C4's staff communication report dated 5/27/23 on 5/30/23 (related to the bleeding). The primary care provider (PCP) had previously noted an spot on his leg. The Healthcare Coordinator reported she received a telephone call on 5/30/23 regarding Tenant C4 bleeding. Staff reported there was blood everywhere and he was sent out for evaluation. She said she never saw Tenant C4's wound. She said Tenant C4 slept in a chair and it was hard to look. She said regarding his level of care he went back and forth. She reported she received no prior notification of a wound to Tenant C4's groin before 5/30/23. Further record review revealed Tenant C4 was staged a five on the Global Deterioration Scale, which indicated moderately severe cognitive decline and had a diagnosis of Parkinson's disease. The the service plan indicated staff assisted with bathing twice per week and to check skin with bathing and report any reddened/open areas to the nurse. The service plan also indicated staff assisted with toileting, including assistance with perineal care as needed and changing protective undergarments at times. It was noted Tenant C4 was incontinent of bladder and bowel. The service plan also reflected Tenant C4 transferred with assist of one and his walker. The service plan did not reflect Tenant C4 had history of	

	medication refusals or refusals, to get up, it also did not reflect Tenant C4 required transfer assistance of more than one person. Continued record review revealed Documentation Survey Reports for April 2023 reflected nine scheduled bathing tasks and only two documented baths/showers on 4/18/23 and 4/25/23. The remaining entries were charted as not applicable or refused. The Documentation Survey for May 2023 reflected nine scheduled bathing tasks and only three documented baths/showers on 5/13/23, 5/20/23 and 5/27/23. The remaining entries were charted as not applicable, refused or unavailable. The Documentation Survey Reports did not reflect any tasks entered for toileting assistance that Staff I, Staff J and the Healthcare Coordinator indicated was provided to Tenant C4. Further record review revealed the April and May 2023 MARs reflected orders for Baza protect cream, apply to affected area (perineal area) twice daily as needed and Calmoseptine ointment, apply topically to coccyx at bedtime as needed for redness. There were no documented doses administered in April or May 2023. In summary, Tenant C4's service plan reflected he required staff assistance with toileting, bathing and transfers. Per staff, Tenant C4 at times took two staff for transfers. Hospital records indicated he required two or more to assist with ADLs and mobility and reflected a weight of 282 pounds. Documentation reflected Tenant C4 at times refused to get up and had some discoloration noted on his buttocks in April. For April and May 2023 no documented doses of the Baza cream or Calmoseptine that were ordered as needed were documented as administered. On 5/27/23 staff noticed bleeding when wiping him. On 5/30/23 staff tried to assist him and he was lowered to the ground. There was blood (both fresh and dried) on the protective pad on his chair. Tenant C4 was lowered to the floor and there was blood on the floor from where he was sitting and he had complaints of buttocks pain. Tenant C4 was taken to hospital and upon admission it was noted he had large sacral decubitus ulcer stage II and the ulcer had a "terrible smell." Tenant C4 was admitted and received IV antibiotics. He had stage II wounds on his left and right buttock, sacral area and on the right upper thigh. He also had overlying cellulitis of the buttock. The size of the wound buttocks, sacrum and coccyx measured 11.9 x 10.9 cm. Staff were scheduled to assist with routine daily cares for Tenant C4 including with transfers, bathing and toileting as indicated in his service plan. Based on the area of the wound and the size of the wound, it should have visible with the provision of the cares indicated on his service plan (the ER also noted a terrible odor to the wound). However, his wound, which was noted as "significant" in hospital records, was not discovered until he went to the hospital on 5/30/23. There was no documentation in Tenant C4's file, with the exception of the staff report to the nurse on 5/27/23, which was three days before hospitalization, regarding Tenant C4 having blood when wiping him. Tenant C4 did not receive adequate and appropriate services	

	related to care needs and he did not receive services adequate and appropriate related to the identification, assessment and treatment of his wounds. 2. Record review on 10/16/23 and 10/17/23 of Tenant C2's file revealed the service plan reflected Tenant C2's history of falls and required safety checks every 30 minutes. It also indicated family preferred an assist with ambulation and walker inside the apartment and assistance in her wheelchair outside of the apartment. An incident report dated 3/24/23 documented staff called the nurse on-call and said Tenant C2 sat on the floor with her back to the wall. Tenant C2 was not in pain but had a bump on the back of her head. Family was notified and gave permission to call 911 to transport to the hospital. Tenant C2 was not taken to the hospital due to refusal. An Internal Investigation document indicated on 3/24/23 at 7:00 p.m. Staff D went into Tenant C2's apartment and noted her sitting on the floor with her back against the wall inside of her apartment door. Tenant C2 was an assist of one with mobility. Tenant C2 had a bump on the back on her head. Staff D called for staff assistance and the nurse on-call was notified. Staff called 911 and they arrived and Tenant C2 refused to go to the emergency room (ER) for evaluation. On 4/2/23 at 9:39 a.m. staff called the Healthcare Coordinator and told her Tenant C2 was lethargic, in pain and did not want to bear weight. Tenant C2 was taken the ER to be evaluated. The hospital staff reported Tenant C2 had a brain bleed and her brain had shifted. Tenant C2 returned to the Program on 4/2/23. The summary indicated Tenant C2 got up without calling for assistance, fell and hit her head. Visual checks were not completed as scheduled on 3/24/23 at 6:30 p.m. Continued record review revealed Progress Notes indicated the following: a. On 3/24/23 staff notified the nurse on-call that Tenant C2 fell and hit her head. She had bump and bruise on the back of her head. When family arrived to the building Tenant C2 decided she did not want to go to the ER and the refusal form was signed. b. On 4/2/23 the nurse received a call from staff Tenant C2 was really weak and had a difficult time bearing weight on her legs. Family was notified and would come in to take her to the ER for evaluation. c. On 4/2/23 Tenant C2's family called and said emergency medical services (EMS) would be transporting her to the hospital and she could not get into the car.	

	d. On 4/2/23 hospital staff reported Tenant C2 had a brain bleed from her fall last weekend. Family requested Tenant C2 return to the Program with minimal interventions. e. On 4/6/23 Tenant C2 died. Further record review revealed the ER After Visit Summary, dated 4/2/23, indicated Tenant C2 was seen for leg swelling and diagnoses include traumatic subdural hygroma and bilateral lower extremity edema. When interviewed on 11/6/23 at 3:20 p.m. Staff D reported around 7:00 p.m. and she administered medications and she went to Tenant C2's apartment where she found her on the floor behind her apartment door. Tenant C2 did not have any injuries at that time. She called the lead direct care staff working to call family to take her to the hospital. The nurse was notified too. Tenant C2 did not complain of any pain. She had her walker with her. Staff helped her stand and put her in the wheelchair. She said she could not remember how many times Tenant C2 was scheduled to be checked but she would have been checked every hour, she did not remember the last time she had seen Tenant C2 prior to her fall. Her visual check was done at 7:00 p.m. (when Tenant C2 was found). Tenant C2 said she was fine and did not want to go to the hospital. Later on it was found that Tenant C2 had a head injury and it was related to her death. When interviewed on 10/17/23 at 12:05 p.m. the Healthcare Coordinator said she was not the nurse on-call when the incident occurred. She received a text or call from the on-call nurse regarding Tenant C2's fall and that she hit her head. Family refused for her to be sent out for evaluation. On 4/2/23 she received a call from staff and she called family to have Tenant C2 sent out for evaluation. She went to the hospital and had a diagnosis of a brain bleed. Staff were re-educated on visual checks after the incident. Continued record review the Documentation Survey Report for March 2023 reflected Tenant C2 required visual checks every 30 minutes. The checks on 3/24/23 at 2:30 p.m., 3:00 p.m. and 3:30 p.m. were all documented at 3:29 p.m. by Staff D. The 4:00 and 4:30 p.m. checks were documented at 4:46 p.m. by Staff D. The 5:00 and 5:30 p.m. checks were documented at 5:29 p.m. by Staff D. The 6:00 p.m. was documented at 6:01 p.m. by Staff D The 6:30 p.m., 7:00 p.m., 7:30 p.m., 8:00 p.m. and 8:30 p.m. checks were all documented at 8:00 p.m. by Staff D. Further record review the program's Nurse Delegation for Visual Checks indicated to enter the tenant apartment, make visual contact of the tenant (sleeping or awake), document the visual check according to the scheduled time. Visual checks were to be completed as close to the scheduled time as possible.	

	In summary, Tenant C2 required safety checks every 30 minutes related to her falls and required the assistance of staff for mobility in her apartment and outside of her apartment. Staff failed to follow the policy for visual checks related to Tenant C2's fall on 3/24/23. Staff D documented a check at 6:01 p.m. and the next check was scheduled at 6:30 p.m. but was not documented as completed until 8:00 p.m. Tenant C2 was found on the floor with a bump on the back of her head at 7:00 p.m. On 4/2/23 Tenant C2 went out to hospital due weakness and non-weight bearing. Tenant C2 was diagnosed with a traumatic subdural hygroma, went on hospice services and died on 4/6/23. 3. Record review on 10/11/23 to 10/16/23 of Tenant C1's file revealed the service plan reflected Tenant C1 had history of falls and was a one assist with all mobility. Continued review of Tenant C1's file revealed the following: a. Incident reports for 6/19/23 at 12:47 a.m. noted staff observed Tenant C1 laying the floor sleeping with no clothing on and just a protective undergarment. Tenant C1 appeared to be confused, but no injuries were noted. Tenant C1 was covered with a blanket and was groaning but denied pain. The note indicated action taken was "Nurse Assessment completed", vital signs were taken and she was assisted from the floor with assist of one. Tenant C1's oxygen was noted at 92%. It indicated Tenant C1's family member was notified at 9:36 a.m. A Progress Note on 6/19/23 at 12:47 a.m. noted staff observed Tenant C1 laying the floor sleeping with no clothing on and just a protective undergarment. Tenant C1 was covered with a blanket and was groaning but denied pain. b. On 6/19/23 at 5:30 a.m. staff completed safety checks and observed Tenant C1 laying on the floor on her left side. She was groaning and reported mild pain. Injuries included a bruise on her left cheek, small lacerations on the right hand, bruises on the thighs, it was painful when touched. Her oxygen was noted at 90%. Documented "Nurse assessment," indicated she was assisted up with guided assist of one. The Healthcare Coordinator was called at 6/19/23 at 5:33 a.m. It indicated Tenant C1's family was notified at 9:36 a.m. A Progress Note On 6/19/23 at 5:30 a.m. noted staff completed safety checks and observed Tenant C1 laying on her left side. She was groaning and reported mild pain. There was bruising to the left cheek, and both legs. A small laceration was noted to the right hand. c. On 6/19/23 at 9:15 a.m. Tenant C1 observed laying the floor with no clothing on. Tenant C1 reported moderate pain and she did not have her oxygen in her nose. There was a skin tear noted on the right arm and Tenant C1 complained of pain everywhere.	

	Staff called 911 and Tenant C1 was transported to the hospital for evaluation. It indicated Tenant C1's family member was notified at 9:36 a.m. A Progress Note on 6/19/23 at 9:15 a.m. noted Tenant C1 observed laying the floor with no clothing on. Tenant C1 reported moderate pain and she did not have her oxygen in her nose. There was a skin tear noted on the right arm and Tenant C1 complained of pain everywhere. Staff called 911 and Tenant C1 was transported to the hospital for evaluation. d. A Progress Note on 6/19/23 at 4:12 p.m. documented Tenant C1 had a femur fracture and was admitted to the hospital. e. A Progress note on 6/21/23 noted Tenant C1 died. Continued record review revealed an Internal Investigation dated 6/20/23 indicated on 6/19/23 at 9:15 a.m. Staff Q completed a visual check and found Tenant C1 on the floor without her oxygen. She complained of pain all over. The Healthcare Coordinator assessed Tenant C1 and told staff to call 911. Tenant C1 was transported to the hospital for evaluation. Hospital staff called and reported Tenant C1 had a right femur fracture, was admitted and it was unsure if she was a surgical candidate. Staff B's written statement indicated around 12:40 a.m. he found Tenant C1 laying on the floor with her oxygen on covered with a blanket. Staff B tried to the call the Healthcare Coordinator and received no response. Staff B helped her up and into the seat of her recliner. He wrote the incident report. At about 5:30 p.m. he checked on Tenant C1 and he found her on the floor close to her recliner wearing only a protective undergarment. She was laying on her left side, she did not have her oxygen on and it was disconnected from the concentrator. He put on her oxygen, called the Healthcare Coordinator, took vital signs. Her oxygen was below 90% at 85%. With two staff assist they helped her to sit on her recliner and wrote an incident report. Attempts to interview Staff Q were made; however, were not successful. Staff Q's written statement indicated when completing her 10:00 a.m. visual check she found Tenant C1 on the floor, laying on her left side, face down, without her oxygen. She was not wearing any clothing with her protective undergarment ripped on the side and Staff Q indicated she must have ripped it off herself. Her walker was about three feet away. Staff Q notified the Healthcare Coordinator and she called for EMS. Tenant C1 was in a lot of pain, especially her legs. Her right wrist was also bleeding and it appeared to be a skin tear. A Counseling Documentation Report, dated 6/26/23, documented on 6/19/23 Staff B provided assisted to Tenant C1 by picking her up twice without the use of the lift. It was noted Staff B did not follow tenant fall guidelines. It was a verbal warning.	

	When interview on 10/12/23 at 3:02 p.m. Staff B stated he could not recall when he first saw Tenant C1 on his shift but he worked third shift that night. At approximately midnight he found her on the floor, close to her chair. There were no injuries and no complaints of pain. He called the on-call nurse, the Healthcare Coordinator and did not receive an answer. He assisted her back to her recliner. He wrote the incident report. He went to check on Tenant C1 around 5:00 a.m. and she laid on her side. She had bruises on her thighs and blood on her hand. She also had a scratch on her face. Her oxygen was removed and it was disconnected from her machine. She had a protective undergarment and no clothing on. She had her lower body covered with a wrap. Staff B called the Healthcare Coordinator and did not receive an answer. He requested another staff to assist in getting her up and it took two staff. She was seated on her recliner. With the second fall he took pictures on the work cell phone of her injuries for the Healthcare Coordinator as he did not talk to her when she was called. He wrote up the report and first shift arrived. He told Staff Q about the falls and showed her the pictures and gave her the work phone. He said the pictures were of her legs and hand and nothing of related to privacy. Staff B said the Healthcare Coordinator did not call back for either calls. A day or two later, corporate staff were involved and the Former Executive Director called and asked him to write a statement. Someone deleted the pictures and no one told him it was a problem. After the corporate staff called, everything was deleted. After the incident the Former Executive Director told him he should have used a mechanical lift. When interviewed on 10/16/23 at 10:04 a.m. the Healthcare Coordinator reported another nurse was on-call the weekend Tenant C1 fell. She was there on Monday when Tenant C1 fell. Tenant C1 had a skin tear from a previous fall and no visible injuries but had pain in her legs. Staff called EMS and she was taken out to the hospital. Tenant C1's family was notified. Tenant C1 went to the hospital and had a fractured femur. Tenant C1 was supposed to be an assist of one with her walker or wheelchair as needed. She did not recall if she received telephone calls on 6/19/23 and said her phone was on silent. She said did not recall missing any calls that night. She would assume staff notified nurse on-call. She said there was a calendar in the workroom with the on-call nurse schedule and phone numbers. At that time the on-call was shared every other weekend with another nurse, it started at 5:00 p.m. on Friday and she resumed call at 8:00 a.m. on Monday. She said she did not know the pictures (Tenant C1) existed for a week in the work phone. It was picture of the skin tear on the arm and a skin tear/bruise on the thigh. Staff B took the pictures and they were never shown to the Healthcare Coordinator. Staff were allowed to take pictures on the work phone or video chat.	

	Continued record review revealed the June 2023 nurse on-call schedule was provided and indicated on 6/19/23 the Healthcare Coordinator was listed as the on-call nurse. A handwritten note was added to the calendar at the time of the investigation that indicated call started at 5:00 p.m. on Friday and stopped at 8:00 a.m. on Monday. That indicated the Healthcare Coordinator's call did not start until 8:00 a.m. on Monday and another nurse was on-call on 6/16/23 at 5:00 p.m. until the Healthcare Coordinator resumed on-call on 6/19/23 at 8:00 a.m. Staff B documented he called the Healthcare Coordinator on 6/19/23 at 12:47 a.m. and 5:33 a.m. Pendant history records from 6/19/23, for the building and for Tenant C1 were requested and were not accessible at the time of the investigation. Further Record review revealed a Medication Admin Audit Report of morning medications on 6/19/23 reflected Tenant C1's medications scheduled at 7:30 a.m. and 8:00 a.m. were not administered as prescribed. The report indicated all of Tenant C1's morning medications and treatments were documented as not given due to hospitalization at 10:13 a.m., which was at least two hours after Tenant C1's medications and treatments were prescribed. Tenant C1 did not receive her medications as prescribed on 6/19/23, after sustaining three falls and prior to going out to the hospital, despite being ordered before she left for the hospital. A June 2023 Documentation Survey report (task record) indicated all of the first shift or 8:00 a.m. morning cares on 6/19/23 for Tenant C1 were documented by Staff Q at 10:02 a.m. and were charted as tenant unavailable, including dressing/undressing for first shift, TLSO brace on at all times day shift, meal reminders at 8:00 a.m.; despite Tenant C1 not going to the hospital until after the fall at 9:15 a.m. None of Tenant C1's morning cares were documented as completed prior to her going to the hospital on 6/19/23. Visual checks were scheduled four times per shift for Tenant C1. On 6/18/23 the 10:00 p.m., 12:00 a.m. and 2:00 a.m. check were all documented at 2:34 a.m. The 4:00 a.m. check was documented at 5:07 a.m. The 6:00 a.m. check was documented at 7:17 a.m. and the 8:00 a.m. and 10:00 a.m. checks were documented at 10:02 a.m. and charted as tenant unavailable, despite Tenant C1 being in the building at 8:00 a.m. In summary, Tenant C1 who had a history of falls and required assistance of one with all mobility, had three falls on 6/19/23 from 12:47 a.m. to 9:15 a.m. When the first fall occurred at 12:47 a.m. Staff B contacted the Healthcare Coordinator, who was not the on-call nurse, received no response and assisted Tenant C1 back up to her chair. It was noted she was groaning but not in pain. Her oxygen saturation was at 92%. Staff B did not report or document any additional attempts to contact the Healthcare Coordinator, other nurses or leadership staff related to Tenant C1's fall. The	

	Healthcare Coordinator did not call back per Staff B. At 5:30 a.m. Staff B found Tenant C1 on the floor for her second fall. She was without her oxygen, had visible injuries, was groaning and reported mild pain. Staff B again contacted the Healthcare Coordinator, received no response and Staff B and another staff lifted her up. Her oxygen saturation was at 90%. Staff B did not report or document any additional attempts to contact the Healthcare Coordinator, other nurses or leadership related to her fall. First shift staff, Staff Q, was informed of Tenant C1 falls from Staff B at shift report. At 9:15 a.m. Staff Q found Tenant C1 on the floor and she had complaints of pain all over and a skin tear on her right arm. Tenant C1's family was notified of all three falls on 6/19/23 after the third fall at 9:15 a.m. Tenant C1's morning medications and mornings cares were not documented as administered and completed on 6/19/23 due to her not being available; however, she did not go out to eh hospital until after the third fall which occurred at 9:15 a.m. It could not be determined when Staff Q first saw Tenant C1 on first shift as she did not return calls for an interview; however, none of Tenant C1's morning medications or cares were completed. She was found on the floor at 9:15 a.m. and first shift started at 6:00 a.m. Visual checks were also not documented at the scheduled times during the time of her three falls, by Staff B on third shift and Staff Q on first shift. Tenant C1 was sent to the hospital, was diagnosed with a femur fracture and was not a candidate for surgical repair. She died on 6/21/23. Tenant C1 did not receive services that were adequate and appropriate related to her cares, services and falls on 6/19/23.	

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