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

Date: October 7, 2025
Program Name: Emery Place
Address: 901 South Mentzer Road Robins, IA 52328
Type of Action: Investigation # 129285-I
Date(s) of Action: 8/18/25 – 8/20/25
Citation #: 10920

State Rule #	State Rule	Amount of Civil Penalty
IAC 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.** Based on interview and record review the Program failed to provide care, treatment and services that were adequate and appropriate. This pertained to 1 of 1 tenant reviewed (Tenant #1). Findings follow: 1. Record review revealed an incident report dated 6/4/25 at 5:30 p.m. indicated Tenant #1 requested to use a wheelchair, staff tried to move the wheelchair for him to sit and he lost his balance and fell. A mechanical lift and the assistance of two staff were used to get him up and into the wheelchair. Tenant #1 denied hitting his head or needing to go the emergency department (ED). Vitals were recorded and there was no injury noted. Continued review on 8/18/25 of the Program's Internal Investigation document indicated the date of incident was 6/5/25 (this was noted to be an error based on other documentation) at 5:30 p.m. The location of the incident was the hallway by Tenant #1's apartment. An initial report was made to the Healthcare Coordinator at 5:30 p.m. The description of the incident indicated Staff A was walking with Tenant #1 from the dining room to his apartment. Tenant #1 told Staff A that he wanted to brush his teeth and Staff A asked if he wanted to sit in the wheelchair and Tenant #1 said yes. Staff A went to get the wheelchair and when she grabbed the wheelchair, Tenant #1 lost his balance and fell. He landed on the ground on his left side. Staff A called for assistance and he was able to move this arms and legs and had no complaints of pain. Staff A spoke with the Healthcare Coordinator and he was assisted up with a mechanical lift and put into the wheelchair. On 6/4/25 at about 8:43 p.m. staff	**$3,000.00**

	called the triage nurse and reported Tenant #1 had complaints of pain to his left hip and he had difficulty walking. Tenant #1 was taken to the ED. It was determined he had a pelvic fracture and he was admitted to the hospital. The investigation document noted Staff A, Staff B and Staff C were interviewed related to the investigation. It was noted during the investigation the Program determined Staff A did not use a gait belt for Tenant #1. His service plan and task record both reflected the use of the gait belt. The investigation conclusion indicated Tenant #1 required the assistance of one person with a gait belt for all ambulation. Staff A did not use the gait belt when she ambulated him as it was indicated in Tenant #1's service plan. It was noted if Staff A had used the gait belt at the time of Tenant #1's fall, she "should have been able to lower resident to the floor, potentially preventing the hard fall and causing the pelvic fracture." It was determined Staff A would receive counseling on not following Tenant #1's service plan and re-education was provided related to the Safe Resident Handling Policy. The investigation document indicated a report was made to the Department on 6/7/25 at 8:30 a.m. It was an electronic report and was completed by the Regional Nurse Specialist with the management company. Further record review revealed a Counseling Documentation Form for Staff A indicated on 6/3/25 (this was noted to be an error based on other documentation) Staff A ambulated Tenant #1 without a gait belt. Tenant #1's service plan indicated he was not supposed to ambulate without the assistance of one person and a gait belt. It was policy and procedure that staff followed the service plans. Staff A signed the document dated 6/10/25. She also received re-education on the Safe Resident Handling policy and procedure. The Safe Resident Handling Procedures document indicated all tenant tasks would be carried out in accordance with the service plans for each tenant. 2. Staff A was not employed by the Program at the time of investigation. An attempt was made to contact Staff A for an interview; however, it was not successful. Staff A's statement to the Program indicated on 6/4/25 Staff A assisted Tenant #1 from the dining room to his apartment. Staff A indicated "Before ambulating with him, I had forgotten to put his gait belt on." When they were walking, Tenant #1 said that he wanted to brush his teeth and asked if Staff A could use the wheelchair to take him to the bathroom to brush his teeth. When they arrived at his apartment, Tenant #1 stopped at the doorway and she moved from behind him to in front of him.	

	That was to try and get the wheelchair and position it for him to sit down when he came into the apartment. Staff A indicated when her back was turned she heard a loud noise, turned around and observed Tenant #1 laying on the floor on this left side with his walker on top of him. Staff A called for help and received assistance immediately from the Former Director and Healthcare Coordinator. When interviewed on 8/20/25 at approximately 2:10 p.m. Staff C said she split a shift with Staff A (worked 2 to 10 p.m.) and she worked 6:00 p.m. to 10:00 p.m. Staff A told her Tenant #1 had fallen and he had no pain and was fine. Staff A told her that she did use a gait belt with him (regarding the fall). At about 8:30 p.m. or 9:00 p.m. Tenant #1 pushed his pendant. He wanted to go to the bathroom and he had complained of pain when attempting to stand up. He had complaints of pain in his hips and he could not get onto the toilet. He was also confused and could not remember his family member's name. She called triage and called emergency medical services (EMS). They came and took him to the hospital. Triage called back as they were not able to reach Tenant #1's family member. Staff tried from Tenant #1's phone to call the family member and were able to reach the family member. Tenant #1's family met him at the hospital. She said Tenant #1 always required the assistance of one person and a gait belt. He used a wheelchair to brush his teeth and at times to come out for meals. At that time he used his walker to come out for meals. When interviewed on 8/19/25 at 2:46 p.m. Staff B said he could vaguely remember as it was two to three months ago. He was on break and was coming back and heard Tenant #1 had fallen. He was sitting on the ground at that time. He said Staff A told him that she did not have a gait belt on Tenant #1 when she was taking him to or from the bathroom and he fell. He said an ambulance came later and he was not involved with the calling EMS. He said a gait belt was to be used every time for transfers with Tenant #1. Staff B said Tenant #1 required the assistance of one person with a gait belt and walker and sometimes a wheelchair. When interviewed on 8/19/25 at 2:06 p.m. the Assistant Director said the incident happened shortly after she had left for the day. She was told about it the next morning. She was told Tenant #1 had fallen going out to the dining room with Staff A. She said the Former Director completed the investigation process and spoke with staff. The Assistant Director and Healthcare Coordinator completed the counseling with Staff A. It was regarding the use of the gait	

	belt and Safe Resident Handling policy and procedure. Staff A admitted she did not use the gait belt (regarding the incident with Tenant #1). She was tearful and was remorseful. The Assistant Director said Staff A was aware of the requirement with Tenant #1 to use the gait belt and it was on his service plan. She said Tenant #1 had a fractured hip bone or pelvis, regarding his injury. She said it was hopeful he would return to the Program this week. She confirmed Staff A had training on the gait belt, transfers and ambulation before the incident. When interviewed on 8/20/25 at 8:36 a.m. the Healthcare Coordinator said a kitchen staff told her and the Former Director that Tenant #1 had fallen. They were both still in the building at the time of the incident. When she responded he was laying right outside of his apartment door on his left side. His walker was right in front of him. Tenant #1 had no complaints of pain, confirmed he did not hit his head and wanted to get up. He was assisted up using a mechanical lift and was assisted to his recliner in his apartment. He had gotten up to use the bathroom and was fine. Staff A said she lost control of him, he lost his balance and fell. The Healthcare Coordinator asked Staff A if she used the gait belt and she confirmed the gait belt was not used and she did not do it. Staff A had her hand on him, went to grab the wheelchair and let her hand off of him. About three to four hours later Tenant #1 got up to use the bathroom again, complained of pain and requested to go to the hospital. She was in contact with his family that night and it was reported there was no injury to the hip. She received a text message from family that he had a fractured pelvis. At that point she was in contact with the hospital. She thought he was admitted to the hospital and then went to skilled care. He was non-weight bearing for two to three weeks and no surgery was required. Tenant #1's service plan (at the time of the incident) indicated he required the assistance of one person with a gait belt for all transfers and ambulation. She said the gait belt was available to use. She had never seen staff not use a gait belt with Tenant #1. The Healthcare Coordinator said Staff A was aware of the requirement to use the gait belt. She was written up for it and had other issues with attendance. Staff A was also re-educated on the Safe Resident Handling policy and procedure. She said the Former Director completed the investigation and she was not involved with reporting to the Department. Tenant #1 was currently at the nursing facility, he was an assist of one person at the nursing facility and at times required the assistance of two people.	

	When interviewed on 8/19/25 at 11:56 a.m. the Former Director said it happened close to 5:30 p.m. and supper time. She was in her office and the beautician from the onsite salon/beauty shop alerted her that Tenant #1 had fallen. She and the Healthcare Coordinator went to his apartment and he was laying on his buttocks on the ground. He was in the hallway right outside the apartment. They were walking back from dinner. Tenant #1 had said he wanted to brush his teeth, staff was going to put him into the wheelchair, he lost his balance and fell. The Healthcare Coordinator assessed him and he was able to move his legs. Tenant #1 was assisted up with a mechanical lift. He was able to walk a little bit. Later that night he had pain and he was sent out to the hospital. He had a fracture (pelvic). The Former Director and Healthcare Coordinator asked the aide (staff) if she had used a gait belt with Tenant #1 and she had not. She grabbed the chair for a second and he fell. The Former Director said the staff was upset and tearful about it. The staff was written up regarding the incident. The Former Director said she believed Tenant #1 was supposed to have the assistance of one staff and a gait belt. 3. Record review of Tenant #1's file revealed he was staged at two on the Global Deterioration Scale (GDS), which indicated very mild cognitive decline. His service plan dated 3/16/25 indicated staff escorted him to and from meals and activities. He required the assistance of one person and a gait belt. For transfers, the service plan indicated that he required the assistance of one person with a gait belt for all transfers. It reflected he used a gait belt and grab bars. For mobility/ambulation the service plan reflected Tenant #1 might require prompts/cues for safety but did not need hands on assistance. He required the assistance of one person with a walker and gait belt for all ambulation and mobility needs. It was noted Tenant #1 had a history of not calling for help, and he had falls. Review of incident reports indicated Tenant #1 had falls on 3/11/25 (three falls), 4/24/25 and 6/4/25. Continued record review revealed Progress Notes indicated the following: -On 6/4/25 at 8:43 p.m. staff called the triage nurse (on-call) and reported Tenant #1 fell around dinner time and he was now complaining of pain in the left hip and he had trouble walking. He fell earlier and declined to go to the ED. Tenant #1 was sent to the ED. -On 6/5/25 it was noted a call was received from Tenant #1's family and the Healthcare Coordinator spoke to hospital staff	

	and Tenant #1 had a fracture to his pelvis. He was non-weight bearing, would not require surgery and was admitted. -On 6/10/25 it was noted Tenant #1's family called and said he would be going to skilled care. -On 7/22/25 it was noted the Healthcare Coordinator spoke with staff at the nursing facility where Tenant #1 was at and the staff reported he was fully weight bearing and would be working with therapy five times per week. There were no plans for immediate discharge. -On 8/13/25 it was noted the Healthcare Coordinator spoke with staff at the nursing facility where Tenant #1 was at and the staff reported he required the assistance of one person and they were working on his posture. It was planned to assess next week and discharge could be the following week. In summary, Tenant #1 sustained a fall on 6/4/25 at 5:30 p.m. Tenant #1 had prior falls and his service plan indicated he required the assistance of one person and a gait belt. Per staff interviews a gait belt was available to use. Staff A did not use the gait belt as indicated on his service plan at the time of the fall. He was assessed and initially declined to go to the ED but later on 6/4/25 he had complaints of pain, difficulty walking and requested to go to the ED. It was determined he sustained a fractured pelvis, was admitted and surgery was not required. Tenant #1 was discharged from the hospital and went to skilled care. Tenant #1 had not returned at the time of the investigation but was not discharged from the Program. At the time of the fall Tenant #1 required the assistance of one person with a gait belt for transfers and all ambulation; however, those services were not provided at the time of the fall. Tenant #1 did not receive services, care and treatment that were adequate and appropriate related to the incident on 6/4/25.	