IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
58218-C

May 2, 2016

Ms. Debbie Crosser, Manager
Emery Place
901 S. Mentzer Road
Robins, IA 52328

RE: Final Complaint/Incident Investigation Report, Emery Place, Robins, Iowa

Dear Ms. Crosser:

Enclosed is the **Final Complaint/Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69, following an investigation by DIA on **April 12 & 13, 2016.** There were no regulatory insufficiencies identified related to Complaint #58218-C. There was a regulatory insufficiency cited during the course of the investigation of Complaint #58218-C which is indicated on the enclosed report.

The following allegations were investigated in regards to Complaint #58218-C:

1. Allegation: Staffing
   Findings: Unsubstantiated
   Comments: Review of tenant files, staff interviews and review of Program documents did not reveal a regulatory insufficiency related to staffing.

2. Allegation: Level of care
   Findings: Unsubstantiated
   Comments: Review of tenant files, staff interviews and review of Program documents did not reveal a regulatory insufficiency related to level of care.

The Report notes a Regulatory Insufficiency in the area(s) of: Service Plans.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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
	S0351	A. BUILDING: _____ B. WING _____	C 04/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERY PLACE	901 SOUTH MENTZER ROAD ROBINS, IA 52328

(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	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 15 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 16 Dementia-Specific Program by Dedication: Unit #1 Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 6 Total Population of Program at time of on-site: 8 Dementia-Specific Program by Dedication: Unit #2 Number of tenants without cognitive disorder: 7 Number of tenants with cognitive disorder: 5 Total Population of Program at time of on-site: 12 TOTAL census of Assisted Living Program: 36 An investigation of Complaint #58218-C was completed. There were no regulatory insufficiencies identified related to Complaint #58218-C. A regulatory insufficiency was identified during the course of the investigation of Complaint #58218-C.	A 000		

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

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
	S0351	A. BUILDING: _____ B. WING _____	C 04/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERY PLACE	901 SOUTH MENTZER ROAD ROBINS, IA 52328

(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 089	Continued From page 1	A 089		
A 089	481-69.26(4)a Service Plans 481-69.26(231C) Service plans. 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant ' s identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on review of tenant files and review of Program documents the Program failed to develop service plans that were individualized and indicated at a minimum the tenants' identified needs and preferences for assistance for two of four tenant files reviewed (Tenants #1 and #3). Two tenants did not have service plans that reflected the identified needs of the tenants. 1. Tenant #1, a 90 year old, was admitted on 7-8-15 and diagnoses included: vascular dementia, Alzheimer's disease, glaucoma and macular degeneration. Tenant #1 was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Tenant #1 resided in a dementia unit. According to Progress Notes dated 3-11-16, Tenant #1 had a new order for Nitrostat 0.4 milligram (mg) sublingual, place tablet under tongue every five minutes for chest pain and may repeat up to three times. The service plan reflected the Program administered Tenant #1's medications. The service plan did not reflect Tenant #1 had an order for Nitrostat, including the storage and administration of the medication. According to Progress Notes dated 3-30-16,	A 089		

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
	S0351	A. BUILDING: _____ B. WING _____	C 04/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERY PLACE	901 SOUTH MENTZER ROAD ROBINS, IA 52328

(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 089	Continued From page 2 therapy called to discuss the addition of occupational therapy (OT) services for Tenant #1. Staff had been having difficulty with showering Tenant #1 and concerns were brought to physical therapy (PT). The first day of OT would be the next day at 7:00 a.m. The service plan reflected PT services; however, did not reflect the addition of OT services and the difficulty with showering Tenant #1. The service plan did not reflect the identified needs of Tenant #1. 2. Tenant #3, an 84 year old, was admitted on 5-1-15 and diagnoses included: history of urinary tract infection, cataract surgery, dementia, keratocanthoma and anxiety. Tenant #3 was staged at a five on the GDS, which indicated moderately severe cognitive decline. Tenant #3 resided in a dementia unit. According to Progress Notes dated 3-22-16, the advanced registered nurse practitioner (ARNP) was at the Program to visit with Tenant #3 and enroll Tenant #3 in palliative care. Staff discussed Tenant #3's constant movement on the unit and combativeness with cares. New medication orders were received and family was to be notified by palliative care. According to Progress Notes dated 3-29-16 (late entry), the ARNP was at the Program to re-evaluate Tenant #3. Since the start of the psychotropic regimen Tenant #3 had been easier to redirect and staff reported resistance to cares had decreased. There were no new orders at that time and palliative care was to follow up in one month. The service plan did not reflect palliative care. The service plan did not reflect the identified needs of Tenant #3.	A 089		

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
	S0351	A. BUILDING: _____ B. WING _____	C 04/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERY PLACE	901 SOUTH MENTZER ROAD ROBINS, IA 52328

(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 089	Continued From page 3 3. According to the Program's policy regarding service plans, the service plan would identify all services needed and/or requested by the tenant, who would provide the service, outcomes related to the service and the service provider, if other than the Program.	A 089		