

PRINTED: 07/15/2025
FORM APPROVED

[illegible]

(X6) DATE

If continuation sheet 1 of 3

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
STATE FORM

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: S0009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/24/2025
NAME OF PROVIDER OR SUPPLIER PEARL CITY PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2807 CEDAR ST MUSCATINE, IA 52761			
(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 145	Continued From page 2 regarding an allegation of dependent adult abuse. On 6/24/25 at 10:45 a.m. the ED confirmed the program failed to have policies/procedures specific to dependent adult abuse. She verified there was no policy or procedure to separate an alleged victim and abuser.		A 145		