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 04/01/2025

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	Initial Comments 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. Number of tenants without cognitive impairment: 29 Number of tenants with cognitive impairment: 16 Total census: 45 There were no regulatory insufficiencies identified related to the investigation of Incident #125272-I. The following regulatory insufficiencies were cited related to the investigation of Complaint #124843-C:	A 000		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow the established policy and procedure related to the administration of as needed (PRN) medications. This pertained to 1 of 2 current tenants reviewed who received staff assistance with medication administration (Tenant #1). Findings follow: 1. When interviewed on 3/31/25 at 4:39 p.m. Tenant #1 reported that morning she called at about 3:00 a.m. for cough syrup and a new staff responded. The staff told her she could not get	A 150	The Plan of Correction is attached	

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 04/01/2025

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 150	Continued From page 1 into her medications. She paged later but again did not receive her medication. She said it was a new staff and thought that maybe that particular staff could not administer medications. The tenant received cough syrup at approximately 8:00 a.m. When interviewed on 4/1/25 at approximately 10:25 a.m. Staff A said when she got to work on first shift on 3/31/25, a staff from third shift mentioned that Tenant #1 was complaining of a cough. Staff A was not sure why third shift staff did not administer the cough syrup. Staff A talked to Tenant #1, who said she had been up early and requested the cough syrup but it was not given. At that time Tenant #1 still wanted the cough syrup, so Staff A administered it. When interviewed on 4/1/25 at 3:34 p.m. the Community Director said Tenant #1 told her on Monday (3/31/25) that she did not get her cough syrup that night. There was something mentioned about the staff not being able to administer medications. She followed up with the Healthcare Coordinator and told her that Tenant #1 had reported she did not get her medication as requested. The Healthcare Coordinator said she did get the medication. She looked at the medication administration record (MAR) and talked to Tenant #1. 2. On 4/1/25 review of Tenant #1's March 2025 MAR reflected an order for guaifenesin chest congestion 100 milligram (mg)/5 milliliters (ml), 10 ml by mouth every 8 hours as needed (PRN). It was documented as administered on 3/31/25 at 8:09 a.m. and 5:39 p.m., both times documented as effective. There were no documented doses administered prior to 8:09 a.m. on 3/31/25. It was last administered on 3/30/25 at 6:44 p.m.	A 150		

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 04/01/2025

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 150	Continued From page 2 Further record review revealed Tenant #1's pendant history for 3/31/25 revealed Tenant #1 pushed her pendant at 3:04 a.m. and received a response in 5 minutes and 6 seconds. Tenant #1 pushed her pendant again at 5:51 a.m. and received a response in 2 minutes and 50 seconds. She pushed her pendant at 7:44 a.m. and received a response in 14 minutes and 58 seconds. Tenant #1's service plan dated 2/12/25 indicated staff administered her medications. The Global Deterioration Scale completed on 2/12/25 indicated Tenant #1 was staged at a two, which indicated very mild cognitive decline. 3. On 4/1/25 review of the Program's policy and procedure related to medications and medication administration indicated if a tenant received medication management and received PRN medications, the medications would be stored per Program process and labeled with the other medications. PRN medications would be administered per tenant request. The administration of PRN medications and their effectiveness would be documented on the MAR. A review of staff working on third shift in the morning of 3/31/25, indicated there were three staff, including one staff who could administer medications. 4. When interviewed on 4/1/25 at 3:34 p.m. the Community Director confirmed there was always a staff member on duty who could administer medications. In summary, Tenant #1, who received medications administered by the staff, requested	A 150		

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 04/01/2025

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 150	Continued From page 3 PRN cough syrup twice on third shift on 3/31/25. The MAR reflected no doses were administered until first shift at 8:09 a.m. Review of a list of staff working on 3/31/25 indicated there was a medication passer on duty to administer medications. The PRN medication was not administered when requested by Tenant #1 as indicated in the policy and procedure.	A 150		
A 145	481-69.22(3) Evaluation of Tenant 69.22(3) Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed This pertained to 1 of 5 current tenants reviewed (Tenants #1). Findings follow: 1. Review of Tenant #1's file on 3/31/25 and 4/1/25 revealed Progress Notes indicating the following:	A 145		

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 04/01/2025

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 145	Continued From page 4 - On 11/13/24 at 4:00 p.m. requested the nurse come to her apartment to check her blood pressure. She had a headache, had started a new medication and was concerned it was a side effect. Her blood pressure was 210/94 and her pulse was 77. She was advised to call her doctor and report her symptoms. - On 11/13/24 at 5:00 p.m. Tenant #1's phone was brought to the nurse. The tenant's provider was on the phone and said the tenant had tightness in her chest and arm pain and suggested she be sent to the hospital. A call was made to 911 and Tenant #1 was sent to the hospital. - On 11/14/24 returned from the hospital following an overnight stay and an After Visit Summary (AVS) was received. - On 11/22/24 a change of condition was completed related to chest pain. A review of the AVS from the emergency department (ED) dated 11/13/24 indicated she was seen for chest pain. The AVS indicated labs were completed including topronin 5th generation (twice). She was diagnosed with chest pain and was to follow up with cardiology in two days. Further record review revealed evaluations were completed on 11/22/24 related to the chest pain; however, were not completed when the tenant returned from the hospital on 11/14/25 with a diagnosis of chest pain and a recommendation for a follow up appointment with a cardiologist. 2. When interviewed on 3/31/25 at 4:11 p.m. the Healthcare Coordinator confirmed all evaluations were provided for the tenants reviewed.	A 145		

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 04/01/2025

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 350	Continued From page 5	A 350		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed. This pertained to 1 of 5 current tenants reviewed (Tenant #1). Findings follow: 1. Review of Tenant #1's file on 3/31/25 and 4/1/25 revealed the tenant was sent to the hospital on the evening of 11/13/25 due to having tightness in her chest and arm. She returned the next day with an After Visit Summary indicating a diagnosis of chest pain and a recommendation to follow up with cardiology in two days. Review of the tenant's service plan revealed it was updated on 11/22/24 to reflect the history of chest pain and the hospital visit; however, it was not updated when the tenant returned from the hospital on 11/14/25 with a diagnosis of chest pain and need for a follow up appointment with a cardiologist. 2. When interviewed on 3/31/25 at 4:11 p.m. the Healthcare Coordinator confirmed all service	A 350		

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 04/01/2025

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 350	Continued From page 6 plans were provided for the tenants reviewed.	A 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER/SUPPLIER/CLIA INDENTIFICATION NUMBER: S02351	DATE SURVEY COMPLETED: 4/1/2025

Tag #	SUMMARY STATEMENT OF DEFICIENTCIES (EACH DEFICIENCY SHOULD BE PRECEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY	Identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute(s). Include information about how the provider will maintain compliance in the future.	COMPLETION DATE
Tag #1	**Regulation and Reg Number** **481-67.2(3) Program Policies and Procedures 67.2(3)** The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to follow the established policy and procedure related to the administration of as needed (PRN) medications. This pertained to 1 of 2 current tenants reviewed who received staff assistance with medication administration (Tenant #1).	**Tag #** A 150	All care staff will receive re-education on use/timeliness of PRN medications and communication to the med passer when a resident is requesting PRN meds by 6/6/25. All care staff will receive re-education on pendant response expectations and use of pendant exception report by 6/6/25.	All new hires will receive education on pendant response expectations and use or pendant exception report within 30 days of hire. All staff will receive education on notification to the med passer when a resident is requesting PRN medications within 30 days of hire. Director and/or designee will complete audits weekly, monthly, as needed, as determined by the Director or designee, of pendant responses to ensure compliance. Director and/or designee will complete weekly, monthly, as needed, as determined by the Director or designee, audits of PRN medication use and will touch base with the appropriate resident to ensure meds were received timely.	**Implementation Date: 04/25/25** **Completion Date:** Ongoing **Responsible Party: Director and or designee**

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Tag #2	**Regulation and Reg Number 481-69.22(3) Evaluation of Tenant 69.22(3)** Evaluation annually and with significant change. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional, a human service professional, or a licensed practical nurse via nurse delegation when the tenant has not exhibited a significant change. A licensed practical nurse shall not complete the evaluation when the tenant has exhibited a significant change. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to complete evaluations as needed This pertained to 1 of 5 current tenants reviewed (Tenants #1).	**Tag # A145**	Tenant #1 COC was completed on 11/22/2024. HCC will receive re-training on timeliness of documentation/charting by exception, timely communication to physicians and change of condition timepoints by 6/6/25.	Director and or designee will complete weekly, monthly, as needed, as determined by the Director or designee, audits of Comprehensive Assessments to include change of conditions to ensure assessments are being completed timely.	**Implementation Date: 4/25/25** **Completion Date:** Ongoing **Responsible Party: Director and or designee**

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

Tag #3	**Regulation and Reg Number** **481-69.26(1) Service Plans 69.26(1)** A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules **69.22(1) and 69.22(2)** and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to update service plans as needed. This pertained to 1 of 5 current tenants reviewed (Tenant #1).	**Tag #** A 350	Tenant #1's ISP was updated to reflect new dx of chest pain on 11/22/24. HCC will receive re-education regarding ISP expectations and the process of updating ISP's timely by 6/6/25.	Director and or designee will complete weekly, monthly, as needed, as determined by the Director or designee, audits of Comprehensive Assessments to include change of conditions to ensure assessments are being completed timely and ISP's are being updated appropriately.	**Implementation Date: 04/25/25** **Completion Date:** Ongoing **Responsible Party: Director and or designee**

Compliance Date: 06/06/2025

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of regulatory insufficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state law.

✓ 5.16.25