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 08/20/2025

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: 32 Number of tenants with cognitive impairment: 19 Total census: 51 The following regulatory insufficiencies were cited related to Complaint #128415-C and Incident #129285-I:	A 000	See attached POC 10/31/25	
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 observation, interview, and record review the Program failed to follow established policy and procedure related to food safety and sanitation. This potentially affected all tenants (census of 51). Findings follow: 1. Observation on 8/20/25 at approximately 9:55 a.m. revealed foods that were opened and not labeled in the walk in cooler, including a container of hot sauce and salad dressing. Both containers were opened and neither were labeled or dated. There was also a metal container with a plastic lid labeled chocolate syrup. It was dated 6/7/25 and had not been discarded. In the dry storage area there was an opened (tied off) plastic bag of	A 150		

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elbow noodles. It was also was not labeled or dated.

When observed on 8/19/25 both memory care units also had a refrigerator/freezer in the kitchenette areas. The documentation of the refrigerator/freezer temperatures for both memory care units was requested.

2. Record review on 8/20/25 of the Refrigerator Temperature Records for both memory care units from May to August 2025 was completed. Documentation indicated omissions of daily temperature checks of the refrigerators/freezers in May 2025 and July 2025.

Continued record review on 8/19/25 of the Emery Place Temperature Log for the main kitchen was completed. The documentation indicated omissions of daily temperature checks of the walk in cooler (bulk storage) and line refrigerator (reach in refrigerator) for May, June and July 2025. Additionally, there were recorded entries for the line refrigerator/freezer that were above the recommended temperatures. For example, on 5/1/25 (for the line refrigerator/freezer) it was documented as 42 and 38 degrees. On 5/13/25 (for the line refrigerator/freezer) it was documented as 40 and 42 degrees.

Further record review on 8/19/25 of food temperature logs indicated the May, June and July 2025 logs reflected omissions of food temperatures taken for each meal during the timeframe reviewed. For example on 7/11/25 and 7/13/25 there were no documented food temperatures for the three meals provided.

3. Record review of the Program's policy and procedure for Food Safety and Sanitation

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A 150	Continued From page 2 indicated food storage would be in sealed containers with dates and labels. Refrigerator and freezer temperature logs would be maintained daily. Food temperatures would be recorded on the temperature logs for each meal. 4. When interviewed on 8/20/25 at 9:45 a.m. the Culinary Coordinator indicated the resident assistants (RAs) were responsible to document the refrigerator and freezer temperatures in the memory care units daily. In the main kitchen he or one of the cooks checked the temperatures. He said he was going to change it and have the dietary staff check the refrigerators and freezers in the memory care units. He said it would probably change next month. When interviewed on 8/20/25 at 2:53 p.m. the Assistant Director confirmed all logs for temperatures had been provided. In summary, the Program failed to follow policy and procedure related to food safety and sanitation regarding foods not being labeled, refrigerator/freezer temperatures not being maintained daily and food temperatures not being documented for each meal.	A 150		
A 160	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.	A 160		

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A 160	Continued From page 3 This REQUIREMENT is not met as evidenced by: 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	A 160		

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with a mechanical lift and put into the wheelchair. On 6/4/25 at about 8:43 p.m. staff 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

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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

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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

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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

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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

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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

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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

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A 160	Continued From page 11 #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.	A 160		
A 200	481-67.4(1)a(2) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(1) Of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury. a. "Major injury" shall be defined as any injury which: (2) Requires admission to a higher level of care for treatment, other than for observation This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to notify the Department within 24 hours or the next business day of any accident that caused major injury. This pertained to 1 of 1 tenant reviewed (Tenant #1). Findings follow: 1. Record 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.	A 200		

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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 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 emergency department (ED). It was determined he had a pelvic fracture and he was admitted to the hospital. 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

See 67.3 (2) for more information related to the incident with Tenant #1.

Continued record review revealed the incident was reported to the Department on 6/7/25 at 8:30 a.m.

When interviewed on 8/20/25 at 9:30 a.m. the Regional Nurse Specialist with the management company said regarding the timeliness of reporting the incident with Tenant #1, it was related to the Former Director's departure from

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 08/20/2025

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 200	Continued From page 13 her employment and no one realized it had not been submitted. The Regional Nurse Specialist realized it had not been reported and then submitted the report on Saturday morning. The Regional Nurse Specialist said she was not aware it had not reported.	A 200		
A 465	481-69.28(5) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the Program failed to provide an orientation on sanitation and safe food handling prior to handling food and an annual in-service on food protection. This pertained to 4 of 7 dietary staff reviewed (Staff D, E, F and G). Findings follow: 1. Record review on 8/19/25 of Staff D's (culinary assistant) training documents indicated a hire date of 12/29/23. The most recent food safety and sanitation training provided was dated 1/26/24. Staff D did not have an annual training on food protection. 2. Record review on 8/19/25 of Staff E's (cook) training documents indicated a hire date of 5/20/24. The most recent food safety and sanitation training provided was dated 7/10/24. Staff E did not have an annual training on food	A 465		

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 08/20/2025

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 465	Continued From page 14 protection. 3. Record review on 8/19/25 of Staff F's (culinary assistant) training documents indicated a hire date of 8/1/25. Staff F did not have an orientation on sanitization and safe food handling, prior to serving food or at the time of the review. When observed on 8/19/25 at approximately 4:30 p.m. to 4:56 p.m. Staff F assisted with serving food in the main dining room at the evening meal. 4. Record review on 8/19/25 of Staff G's (culinary assistant) training documents indicated a hire date of 7/11/25. Staff G did not have an orientation on sanitization and safe food handling, prior to handling food or at the time of the review. 5. When interviewed on 8/20/25 at 9:45 a.m. the Culinary Coordinator said he had completed training verbally and worked with Staff F and Staff G; however, he did not have training sheets or procedures. He said there were videos staff completed and Staff F and Staff G were still completing the videos. He confirmed Staff F and Staff G had served food. Regarding the annual training for Staff D and Staff E, he said staff completed the videos annually prior to their review. The Culinary Coordinator said Staff E prepared food and at times helped serve. He said Staff D helped prepare food for the salad bar. 6. When interviewed on 8/19/25 at 2:06 p.m. the Assistant Director confirmed Staff F and Staff G were serving food on their own and training had not yet been completed. She also confirmed the most recent food safety training was provided for Staff D and Staff E.	A 465		

PLAN OF CORRECTION

Community Name: Emery Place

Plan of Correction Date: 10/20/2025 Sara Ellis, Executive Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	PROVIDER INDENTIFICATION NUMBER/LICENSE NUMBER: S0351	DATE SURVEY COMPLETED/TYPE OF SURVEY: C 08/20/2025

ID PREFIX 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
A150	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 observation, interview, and record review, the Program failed to follow established policies and procedures related to food safety and sanitation. This potentially affected all tenants	A150	Binders put in place for daily meal temperature logs to be completed at each meal. Temperature logs are put in place on all refrigerators and freezers in AL and MC. *Food not labeled or dated* *Food labeled and dated but expired and not discarded* *Refrigerator/freezer daily temp records (MC)* *Food temperature logs incomplete*	New Management company transitioned on 09/01/2025. New Program Executive Director was hired on 09/01/2025 and received training on policies and procedures. Culinary staff education provided by Executive Director on All-staff meeting to be conducted on 10/31/25. Culinary Director/Executive Director to audit temp logs daily.	Implementation Date: 09/01/2025 Completion Date: Ongoing Responsible Party: Executive Director or designee
A160	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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to provide care, treatment	A160	All staff will be delegated on proper resident transfers and gait belt usage upon hire and as needed. Staff A is no longer employed by the Program as of 06/17/2025____	New Management company transitioned on 09/01/2025. New Program Executive Director was hired on 09/01/2025 and received training on policies and procedures. All new staff will be delegated by the program nurse or designee and will have successfully completed training prior to working independently.	Implementation Date: 09/01/2025 Completion Date: Ongoing Responsible Party:

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.

	and services that were adequate and appropriate.				Health & Wellness Director or designee
A200	481-67.4(1)a(2) Program Notification to Department 481-67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available: 67.4(1) Of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury. a. "Major injury" shall be defined as any injury which: (2) Requires admission to a higher level of care This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to notify the Department within 24 hours or the next business day of any accident that caused major injury.	A200	All incidents will be reported to the nurse on-call. Major incidents will be reported to the Executive Director or designee. Major incidents will be reported to the department within 24 hours.	New Management company transitioned on 09/01/2025. New Program Executive Director was hired on 09/01/2025 and received training on policies and procedures and Assisted Living regulations. Executive Director received access to the online reporting portal and has access to report all incidents electronically.	Implementation Date: 09/01/2025 Completion Date: ongoing Responsible Party: Executive Director or designee and Health and Wellness Director or designee
A465	481-69.28(5) Food Service 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the Program failed to provide an orientation on sanitation and safe food handling prior to handling food and an annual in-service on food protection	A465	New employee orientation schedule implemented. All staff enrolled in new employee training platform.	New Management company transitioned on 09/01/2025. New Program Executive Director was hired on 09/01/2025 and received training on policies and procedures. All-staff meeting to be conducted on 10/31/25. Program director or designee will audit employee training upon hire and annually.	Implementation Date: 09/01/2025 Completion Date: ongoing Responsible Party: Executive Director or designee

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