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

Date: June 11, 2026
Program Name: Country Manor Memory Care
Address: 900 W 46th Street Davenport, IA 52806
Type of Action: Investigations
Date(s) of Action: 5/11/26 – 5/18/26
Citation #11155

State Rule #		Amount of Civil Penalty
Iowa Administrative Code 481 Chapter 67.5(2)e(3)	**481-67.5(231B,231C,231D) Medications.** **67.5(2) Each program shall follow its own written medication policy, including the following:** **e. When medications are administered traditionally by the program:** **(3) Medications and treatments will be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or PA.** Based on interview and record review the Program failed to ensure medication and treatments were administered as prescribed to 1 of 2 current tenants reviewed (Tenant #1). Findings follow: Record review on 5/11/26 of a Service Plan for Tenant #1 dated 2/5/26 revealed he required assistance with medication administration, the ordering of medication, communication with the pharmacy and completing lab orders. This would be completed by the Certified Medical Assistants (CMAs), Nurse Manager, Director of Wellness and Wellness Coordinator. The task was initiated on 2/5/25. He also required wound treatment which would be completed by trained staff (CMAs, Director of Wellness) three times a week. The wound clinic would monitor and change dressings at appointments as well. 1) A review of Tenant #1's MARs from October, 2025 - March, 2026 revealed he received wound care throughout these months. The Program provided physician's orders from the Wound Care	**$5000.00**

	Clinic (WCC) dated 12/9/25, 1/16/26, 1/13/26, 3/3/26 and 3/10/26. He discharged from the wound care clinic on 3/24/26. The Program requested additional records from the WCC on 5/12/26. Upon receipt of these records it was discovered Tenant #1 also received treatment and potential order changes on: 10/14/25, 10/21/25, 11/4/25, 11/11/25, 11/25/25, 12/16/25, 12/23/25 and 2/24/26. The Program failed to complete wound care as ordered for Tenant #1 as follows: Tenant #1 was seen at the WCC on 10/14/25 and received orders for treatment of Wound #20, to his Lateral Fifth toe. The Program provided him with the correct dressing, but the orders on the MAR directed staff to change the dressing daily while the physician ordered the dressing to be changed three times per week. The Program did not add an order to the MAR for Wound #21 to the Left, Distal Second Toe: band aid as needed to keep from rubbing. There were also no orders for Wound #22 to the Proximal, Lateral Fifth Toe: Primary dressing: Silver Alginate, Secondary dressing: roll gauze, change dressing three times per week (it was healed on 11/4/25). The WCC continued to provide the same orders for Tenant #1 to receive wound care to Wound #21 (Left, Distal Second Toe) on 10/21/25, 11/4/25, 11/11/25, 11/25/25 and 12/9/25 and 12/16/25. On 12/9/25, Tenant #1 developed a wound on his Right Foot, Wound #23 which staff were to treat with a Primary dressing of Puracol and a Secondary dressing of 4 x 4 gauze. The Program failed to provide treatment to Tenant #1's Left, Distal Second Toe or Right Foot until 12/24/25. A note from the WCC dated 12/16/25 identified Tenant #1 was sent to the Emergency Room (ER) due to elevated blood sugar readings of 343, weakness, shortness of breath and an elevated pulse rate. The hospital Discharge Summary dated 12/19/25 identified while at the ER Tenant #1 was diagnosed by podiatry with osteomyelitis of the left foot and offered amputation but he refused. He grew Staph epidermin in 1 of 2 bottles and infectious disease was consulted. They did not think the osteomyelitis needed any long-term antibiotic. Upon discharge he was diagnosed with Acute osteomyelitis of the left foot and at-risk for sepsis. He was instructed to apply a single layer of Xeroform and Silicone Foam or a bandaid daily to the Right Foot (#23), Left 2nd toe (#21) and Left 5th toe (#20).	

	A review of the December, 2025 MAR identified the Program did not implement the hospital wound orders at the time of discharge. The Program did institute the orders from the WCC dated 12/16/25 for Wound #21 and Wound #23 on 12/24/25. Tenant #1 returned to the WCC on 1/6/26. The WCC updated the orders for Wound #21 to: Primary dressing: Silver Alginate, Secondary dressing: Optifoam or other Hydrophilic foam in between great toe and 2nd toe, roll gauze and tape, change dressing three times per week. The Program failed to include the Secondary dressing on the MAR. The WCC had orders for Tenant #1's Right Foot (Wound #23) for a Primary dressing: Silver Alginate and a Secondary dressing: roll gauze, gauze 4 x 4, change dressing three times per week. The Program did not update the wound care orders. Tenant #1 also received orders to Wound #24 on his Left Dorsal Great Toe. The Program did not add these to the MAR. Tenant #1 presented at the ER on 1/18/26 with his left, lower extremity hot and red from the lower to upper lateral shin which was consistent with strep cellulitis. Given his history of MRSA colonization, empiric Vancomycin and Zosyn were initiated (two powerful, broad-spectrum antibiotics often given together to acutely ill hospitalized patients). He was initially switched to Bactrim, but developed an acute kidney injury so was switched to Doxycyline. A plan was made for suppressive Doxycyline 100 mg. by mouth once daily after discharge. An x-ray was ordered and an area of concern was noted which correlated with dry gangrene of the Left 2nd toe, there was osteomyelitis of the Left 5th Toe. On 1/30/26 Tenant #1 underwent a Left 2nd toe amputation. Upon discharge, the Program was ordered to provide wound care to the Right Foot, Left 2nd toe and Left 5th toe of a single layer of Xeroform and Silicone foam or a bandaid. Tenant #1 received this treatment to his Left 2nd toe. The Program did not follow these orders when treating his Right Foot or Left 5th toe, although they did treat the wounds with an alternate dressing. His home Lasix and Lisinopril were held while inpatient due to infection and surgery without issue so they were discontinued upon discharge. His Potassium Chloride was also discontinued. A review of the February, 2026 MAR revealed the Program failed to discontinue Tenant #1's Lasix, Lisinopril or Potassium Chloride when he returned. Tenant #1 was prescribed Doxycycline upon discharge but the Program did not administer the medication. During interviews with the Director of Wellness (DOW) on 5/12/26 at 11:50 AM and 5/13/26 at 11:25 AM she reported she often did not receive orders from the WCC. She might receive a baggie with	

	dressings when he returned from the WCC but did not know how to apply them. The DOW told Tenant #1's daughter she needed orders from the WCC or she had to stick with the treatment she was providing. When she did receive the orders she made the changes to the MAR. The DOW believed the delay in putting in the 12/9/25 order was related to not having the dressings, but she did not have documentation of this. She did not receive the Xeroform when Tenant #1 discharged from the hospital on 12/20/25 which was why she did not put this order into the MAR. On 5/18/26 at 2:30 PM the DOW stated she did not catch the medication changes when Tenant #1 discharged from the hospital on 2/4/26 as the orders were sent directly to the pharmacy. Tenant #1's daughter was interviewed on 5/13/26 at 7:45 AM and stated each time she took her father to an appointment at the WCC she would receive a copy of the physician's orders and provide a copy to the DOW. She put the orders under the DOW's door as well as dressings he received from the clinic. On 5/13/26 at 8:10 AM a nurse from the WCC reported the physician's orders were sent to the Program following each appointment Tenant #1 attended. If the DOW had questions she could have called as there was a nurse's line and all calls were responded to daily. During an exit meeting conducted with the Executive Director and DOW on 5/13/26 at 11:45 AM they confirmed the Program failed to ensure Tenant #1 received his medication and treatments as ordered by his medical providers.	