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

Date: September 1, 2026
Program Name: Addington Place of Fairfield
Address: 3000 W. Madison Ave. Fairfield, IA 52556
Type of Action: Investigation #131442-C, #131535-C
Date(s) of Action: 6/24/26-7/8/26
Citation #11239

State Rule #		Amount of Civil Penalty
Iowa Administrative Code 481 Chapter 67.3(2)	**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.** Based on observation, interview and record review the Program failed to provide 1 of 5 current tenants reviewed (Tenant #5) and 1 of 3 discharged tenants reviewed (Tenant C3) with adequate treatment. Findings follow: 1) Record review on 6/29/26 of a physical exam for Tenant #5 dated 4/3/26 revealed she was a 77-year-old female who presented to the appointment in a wheelchair. She had a medical history of Type II diabetes, osteoarthritis, pressure ulcer, encephalopathy, severe rhabdomyolysis and hyperkalemia. A Tenant list provided by the Executive Director noted Tenant #5 moved to the program on 3/27/26. Among the prescription orders at the time of admission was: Econazole Nitrate Cream 1%, apply to sacrum every day shift for Stage III to sacrum. Cover with Mepilex. The Program Nurse Practitioner (NP) signed the orders on 3/30/26. Tenant #5 met with the NP on 4/16/26 for treatment of excoriation to the bilateral groin folds and abdominal fold. Her incontinence and extensive wheelchair use were contributing factors to the development of skin breakdown in the groin and abdominal fold areas. The presence of a stage two pressure wound to the intergluteal fold indicated tissue damage requiring specialized wound care management. A ROHO air cushion would be beneficial for pressure distribution given her wheelchair dependence and existing wound which would aid in the healing of the pressure ulcer. She encouraged frequent changing of the incontinence briefs and movement to help with offloading.	**$8000.00**

	On 4/27/26, Tenant #5 began receiving services from an agency which provided skilled nursing (wound treatment), occupational therapy (OT) and physical therapy (PT). A review of Progress notes from the Skilled Nurse (SN), Outside Agency Documentation forms, Provider Visit forms and an After Visit Summary for Tenant #5 revealed the following: 5/7/26: The SN noted a pressure ulcer to the coccyx was resolved. 5/12/26: OT identified staff should continue to position her in the recliner and out of wheelchair every couple of hours. Keep encouraging activities to decrease behaviors. 5/12/26: The SN charted she received a call from staff at the Program notifying her Tenant #5 had a weeping, open area and because they could not provide wound care they needed the SN to see the patient that day. She was sitting in a recliner with her legs minimally elevated. She had a small open area to the middle inner calf which was bumped resulting in the skin opening. Due to Tenant #5's leg swelling, the area would continue to weep until the edema decreased (pitting edema of +3 to the RLE and +2 to the LLE). The SN reported the wound to the tenant's Primary Care Provider (PCP) and she provided orders: apply foam dressing after applying skin prep to peri wound on left inner and posterior lower leg weeping areas and change at least every 3-5 days or until saturated with drainage. The PCP prescribed TED hose to reduce Tenant #5's edema. The SN documented the Program employee told her she wasn't allowed to ask Tenant #5 if she was hurting and pain medication could only be administered if a tenant requested it. A previous nurse told the employee Lortab or Tramadol could be ordered by the PCP. The SN asked if Tylenol was easing Tenant #5's pain and the employee reported she hadn't given this medication because it did not work. The SN was unsure of how the determination was made the Tylenol did not work. 5/18/26: The SN documented she was at the Program due to edema to Tenant #5's bilateral lower extremities and weeping open areas. She asked staff to watch for bunching areas on the TED hose around the top of the foot and bottom of the leg to prevent pressure. Skilled nursing visits would increase as the wounds increased from 1 to 3. Foam dressings were applied. If drainage was coming out around the dressing it should be removed. The SN provided this health information to Tenant #5's PCP who instructed the tenant to go to a walk-in clinic for medication to reduce the edema as the wounds would not heal	

	and more could develop as long as the swelling remained in her legs (pitting edema of +3 in her right leg and +4 in her left leg). 5/20/26: An After Visit Summary report from the Emergency Room noted Tenant #5 was seen in the Emergency Room due to lip swelling. She was to discontinue the medication Tramadol and start taking Clairitin and Prednisone for 5 days. She should use cool compresses for 15 minutes several times daily and have close primary care follow-up. 5/21/26: The OT directed staff to have Tenant #5 get out of her wheelchair and change positions every couple of hours. She should sit in her recliner with the air cushion throughout the day. 5/28/26: When the SN met with Tenant #5 she continued to experience pitting edema in her legs (+2 in her right leg and +4 in her leg leg but all wounds to her legs were resolved. The SN talked with the Executive Director (ED) about the need for Tenant #5 to obtain a pressure relieving cushion for her wheelchair as this is where she spent most of her time. The ED explained sometimes the patient became upset and combative if she didn't want to get out of the wheelchair. The SN explained a cushion, preferably a ROHO cushion, was the best option to prevent pressure areas from continuously occurring. The SN told the ED she educated the staff last week to stand Tenant #5 up for 30 - 60 seconds to restore blood to her tissue about every hour. The ED then told the SN Tenant #5 had another red area on her right buttock but it wasn't open. The SN said she would observe and measure it next week as the treatment would not change from what was previously applied to her buttocks. 6/4/26: Tenant #5 met with the SN and had pitting edema of +4 to her left and right leg. The SN took her to the bathroom to observe the wound and found her incontinence brief was extremely wet. There was a new pressure area over her Ischial tuberosity which staff were to cleanse with a wound cleanser and iodine two times weekly and cover with foam dressing until healed. It measured 3.7 cm x 2.4 cm x 0.1 cm. The SN discussed with staff on the unit the need to keep Tenant #5 as dry as possible and to place in seating other than her wheelchair such as bed. She reminded the ED and ARNP Tenant #5 would continue to have skin breakdown until she got a ROHO cushion for her wheelchair. The ED reported it was difficult to get in contact with Tenant #5's family but they were aware of the need to purchase the cushion.	

	6/8/26: The SN visited Tenant #5 and provided a number of directives: Wound care provided and covered with a transparent dressing which was waterproof. Staff should leave it on unless it was soiled. Tenant #5 needed to walk three times a day, preferably with shoes or slippers on but per the Physical Therapist it was not worth it if she was refusing. Please walk from her apartment to the dining area or dining room to the toilet. Her urine smelled strong. Encourage fluids. The PCP's office was contacted to write a prescription for a wheelchair cushion. 6/17/26: Tenant #5 needed to be seen by a podiatrist for a foot assessment. SN again documented the wound was worsening as there was 90% slough tissue and 10% granulation tissue. Staff reported they applied Econazole Cream twice daily and as needed to her buttocks (it was ordered once every morning). She would be discharged from skilled nursing the following week. 6/22/26: When discharged from Physical Therapy, Occupational Therapy and Skilled Nursing on 6/22/26, the SN noted she was saturated with urine and itching in the perineal area. She needed to be cleaned well in all areas that came in contact with urine. She was itching under her breasts and could use corn starch, baby powder or Nystatin to treat this. The wound on her buttocks measured 3.3 x 1.5. She was not wearing TED hose. Staff should moisturize her lower extremities but not between her toes. All staff should assist her with walking three times daily and provide toileting assistance every two hours. She should stand up for once minute every hour if she was not walking. In order to prevent the condition from worsening she needed to wear compression stockings and get a cushion for her wheelchair. A review of the Task Administration Record for Tenant #5 for the months of April, May and June, 2026 revealed a task for staff to apply TED hose or lotion to her legs was not included. The task for mobility noted employees needed to escort or push her wheelchair because of a physical limitation. She was able to pedal herself around independently. No changes were made directing staff to have her stand or walk with staff. April 1, 2026 - June 8, 2026, staff were to assist Tenant #5 with removing her clothing and/or incontinence products, onto the toilet and with personal cleaning tasks as needed at 7:00 AM, 10:00 AM, 1:00 PM, 4:00 PM, 7:00 PM, 10:00 PM and as needed. The Task Administration Record was updated in the area of toileting assistance on 6/9/26 so staff would provide toileting cares at different times: 5:00 AM, 9:00 AM, 1:00 PM, 6:00 PM, 10:00 PM and as needed. Staff were taking Tenant #5 to the toileting every three hours during waking	

	hours from 4/1/26 - 6/8/26. The task of toileting was changed to every 4-5 hours on 6/9/26. When the SN encouraged staff to take her to the toilet every 2 hours on 6/22/26, no change was made to the task sheet (as of the review on 6/28/26). Observations on 6/24/26 at 12:18 PM revealed Tenant #5 at lunch. She sat in her wheelchair without a cushion on the seat. During a tour of Tenant #5's apartment on 6/25/26 at 2:45 PM when accompanied by Staff D the medication Econazole Nitrate Cream 1% was on her sink. Staff D had witnessed other staff apply the cream to Tenant #5's buttocks after toileting but she did not do so as she wasn't a certified medication manager. The prescription medication was not locked up. The ED was interviewed on 6/29/26 and 6/30/26. She reported the Registered Nurse approved the order on the Medication Administration Record allowing staff to administer the Econazole Nitrate Cream daily without including the Mepilex dressing. Tenant #5's Power of Attorney (POA) contacted the Program while at the pharmacy on 6/19/26 and shared she would not privately pay for the ROHO cushion while it was pending insurance coverage. The Program needed to provide information to the pharmacy which they did. The POA was coordinating with the PCP for additional information. She was not aware of the need for Tenant #5 to be seen at the walk-in clinic or by the podiatrist and could not find documentation of these appointments having occurred. The ED confirmed there was no evidence on Tenant #5's task sheets of an increase in toileting checks. The task sheets did not include directives for staff to walk with Tenant #5, have her stand to increase blood flow or apply lotion to her legs. The ED would ensure Tenant #5's medication was stored in a locked drawer and applied appropriately. The ED confirmed Tenant #5 did not receive adequate care at the Program. 2) Record review on 6/24/26 of incident reports and Care History entries revealed the following for Tenant C3: 12/26/25: Staff heard Tenant C3 take a fall in her room. Staff responded quickly to the noise and found her on the floor. She said she hit her head and complained of left arm pain. Tenant C3 was assessed by the Health and Wellness Director (HWD) and hospice nurse. She reported generalized discomfort with ambulation. Planned interventions included additional toileting assistance and additional visuals for safety.	

	12/27/25: The HWD identified contributing factors to the 12/26/25 fall in a Care History note; these included poor balance/gait, medication side effects (dizziness), impaired judgement, vision changes, confusion, physical weakness and wandering, all of which were exacerbated by dementia's impact on brain function and safety awareness. 1/8/26 at 6:55 AM: Staff entered Tenant C3's room and found her on the floor next to her bed with a blanket around her feet. Tenant C3 said she was getting dressed and fell to the floor. She expressed discomfort in her left elbow. It was noted she was pleasantly confused per her baseline and remained independent with ambulation when using her wheeled walker. 1/13/26: A care history entry noted she was a little off baseline. During movement she seemed to forget what she was doing and would freeze mid-movement. Staff reported she needed assistance with taking her oral pills which was never an issue. 2/3/26: The Hospice social worker found Tenant C3 on the floor in her bathroom. She took a shower without staff assistance and slipped on the wet floor. The nurse assessed Tenant C3. She was cognitively intact and denied any pain. Interventions of fall follow-ups for three days would occur and her family would purchase Velcro shoes. Tenant C3 was educated to ask staff to help her with showering. 2/6/26: The HWD assessed Tenant C3 and noted her mood was pleasant, appetite low and she remained confused. 2/7/26 at 8:00 AM: The HWD assessed Tenant C3 and noted she was more tired in the mornings. Staffed confirmed Tenant C3 was up throughout the night. She had a decrease in appetite. 2/7/26 at 11:45 PM: Staff reported Tenant C3 slid from her recliner to the floor. She was assisted to her feet and into bed. She denied pain or discomfort. An intervention of an anti-slip pad for her chair was written on the report. 2/9/26 at 12:31 PM: Tenant C3 was found on the floor. She complained of falling and hitting her head on the floor. Tenant C3 was transferred to the hospital. An entry on a care history identified a contributing factor was Tenant C3's recent tiredness. 2/12/26: Tenant C3 was admitted to the hospital and diagnosed with an acute subdural hematoma. She received IV pain	

	management and in-patient hospice care. As on 2/12/26 Tenant C3 was non-responsive. She died in the hospital on 2/22/26. The Program was faxed a copy of Tenant C3's 1/13/26 Hospice Interdisciplinary Team Review on 1/21/26. It noted she was an 87-year-old woman with a primary terminal diagnosis of Alzheimer's Dementia who entered hospice on 11/24/25. She was oriented to self only and was unable to carry on a conversation. She used a walker for ambulation for gait instability. She needed assistance in all areas of activities of daily living with the exception of eating. Due to her impaired mobility, staff were to assist Tenant C3 to her room after meals to assure she got into her recliner or bed safely. Tenant C3 was at risk of falling so the HWD initiated an increase in rounding on 1/8/26 according to an entry on the plan. The Hospice Aide provided assistance to Tenant C3. She was directed to provide stand by assistance when assisting Tenant C3 with transfers and ambulation (as of 11/24/25). Tenant C3 had a Resident Assessment (health, cognitive and functional evaluations) completed by the HWD on 12/21/25. The HWD's assessment varied greatly from that of the Hospice nurse, indicating Tenant C3 could communicate independently and was independent with dressing, grooming and dining. Tenant C3 also scored a 6 on the Global Deterioration Scale indicating a severe cognitive decline. She was independent with mobility with the use of a walker and did not need reminders to use an assistive device. The assessment noted Tenant C3 was a level 3 on the Morse Fall Screen indicating the need to implement high risk fall interventions, although none were listed on the Resident Assessment or 12/23/25 Care Plan. A review of the Dec. 2025, Jan. 2026 and Feb. 2026 Task Administration Records revealed no increase in visual checks following Tenant C3's 12/26/25 fall, although there was an increase in toileting reminders. There was no task added for staff to provide standby assistance with transfers or walk with her to her room after meals. During an interview with Tenant C3's hospice nurse on 6/29/26 at 12:10 PM she recalled the tenant started requiring standby assistance with transfers and verbal encouragement from staff in the weeks prior to her fall on 2/9/26 due to weakness. Her energy level could vary by the day. The hospice nurses from her agency would remind the Program workers they needed to provide additional assistance with mobility and standby assistance during transfers. The employees seemed receptive to these suggestions.	

	The hospice nurse also told the HWD staff needed to check on Tenant C3 more frequently, provide standby assistance and walk with her. The HWD said she would communicate this to the staff and make sure they were doing this. The Program had a Falls policy dated 6/13/24 which noted all tenants would be evaluated for fall risk and their service plans would be developed/updated accordingly. Should a tenant experience a fall, staff will provide immediate care and follow through with service planning. The community's fall reduction program evaluation included a fall risk evaluation which would be conducted by a licensed nurse or trained designee. Each tenant's identified fall risks would be addressed with recommended interventions which would be included in their service plan. Each tenant's service plan and fall risk evaluation would be reviewed and updated whenever a tenant had a first fall with no history of falls, two or more falls within 30 days, a fall with injury requiring medical intervention or treatment or a change in condition. For 48 hours following each shift the Director of Health and Wellness or designees on each shift will monitor the tenant and make a brief narrative charting entry. If a tenant is falling frequently, the Director of Health and Wellness may need to request 1:1 care if the tenant is not responding to interventions. When interviewed on 6/30/26 at 9:45am the Executive Director confirmed the HWD should have reassessed Tenant C3 following her falls to ensure she was receiving adequate care and treatment.	