Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation

Date: August 23, 2024
Program Name: Addington Place of Clinton
Address: 1701 13th Ave North Clinton, IA 52732
Type of Action: 122196-M
Date(s) of Action: 7/22/24 – 7/24/24
Citation #: 10551

State Rule #	State Rule	Amount of Civil Penalty
67.9(4)	67.9(4) Nurse delegation procedures. The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following: f. Services shall be provided to tenants in accordance with the training provided. Based on interview and record review, Program staff failed to provide services in accordance to the nurse delegated training they received which affected 1 of 1 tenants reviewed (Tenant #1). Findings include: 1. On 7/22/24, a review of Tenant #1's record revealed an admission date of 11/14/22. Tenant #1 had a diagnosis of dementia and a score of 6 on the Global Deterioration Scale (GDS) which was completed on 5/22/24. A score of 6 identified severe cognitive decline. Tenant #1's service plan dated 5/22/24 revealed the following need areas: dressed in excessive layers of clothing, experienced hallucinations or delusions, demonstrated anxious/paranoid or suspicious behaviors, unable to follow directions, and required 8 safety checks per shift (once per hour, daily). Tenant #1's record revealed an incident report dated 7/17/24. The incident report revealed that on 7/17/24 at 4:15 pm, the Executive Director (ED) and the Healthcare Coordinator (HCC) learned a person was observed standing in the drainage ditch of the property. Staff ran to the area to find Tenant #1 lying in the drainage ditch. The tenant was assessed for injuries and sent to the emergency room for further assessment. Tenant #1 was returned later with no findings/injuries. An internal investigation was completed by the ED after the incident. 2. On 7/22/24, a search on https://www.wunderground.com revealed on 7/17/24 at 3:52 pm, it was 81 degrees with 13 mph winds. 3. When interviewed on 7/22/24 at 11:51 am, the ED stated at around 4:15 pm on 7/17/24, she and the HCC walked down the 400 hall of the Program and observed a lawn care worker enter the building to report he believed he saw a man in the ditch on the property. The ED, the HCC and Staff C ran outside. Staff C observed Tenant #1 lying in the drainage ditch. The ED climbed into the ditch and assessed Tenant #1. They helped Tenant #1 out of the ditch. Staff called 911 to	**$3500.00**

	have her assessed at the hospital. Tenant #1s family and physician were contacted. - She and the HCC questioned Staff A. Staff A stated she fed Tenant #1 two meals and last observed her around 1:30 pm. Staff A was able to tell the ED exactly what Tenant #1 wore that day. - They questioned Staff B, who worked in the memory care unit at the time Tenant #1 eloped. Staff B stated she completed 2:00 pm safety checks but she could not confirm the last time she laid eyes on Tenant #1. - The ED stated that on the 2 pm to 10 pm shift, Staff E worked the front assisted living area of the program as a care manager and Staff C was the float staff to assist all areas. The Executive Director stated Staff E was not in training that day but worked as an independent staff that day. - The ED stated all staff were trained to lock and alarm doors, including the door to the courtyard, after an activity is over, and staff were all trained to complete a full door lock/alarm and window check at the beginning of each shift. - The ED added that all staff were trained to call for a floater for assistance if help was needed by a second staff member. 4. On 7/22/24 at 1:50 pm, the HCC stated she worked during Tenant #1's elopement. The HCC and the ED went to the memory care unit to do incontinence checks around 3:30 pm on 7/17/24. They found people incontinent. The HCC asked Staff B when her last safety check was and Staff B stated it was at 2:00 pm. They asked what happened to Staff B's 3:00 pm check. Staff B stated to the administrative staff that she had been busy consoling a tenant who was upset and assisting with a tenant that had been incontinent. Staff B stated she failed to complete the 3:00 pm checks. At approximately 4:15 pm, she and the ED were in the hallway and the lawn service worker entered the building and stated he observed a man in the ditch by the Program garage. She, the ED and Staff C went outside. They discovered it was Tenant #1 in the drainage ditch lying down. The ED assessed Tenant #1. Tenant #1 had on a pink sweater, long pants, shoes, socks, a shirt under her sweater, and carried a winter coat. - The HCC called Staff B inside the Program and asked when the last time she observed Tenant #1 was. Staff B stated she didn't know. She asked Staff B what Tenant #1 wore that day and Staff B stated said she just saw her in her bed and she was wearing her big winter coat at the 2:00 pm safety check. Staff B could not describe any of her other clothing. - She next called Staff A who worked in the memory care unit during the 6:00 am to 2:00 pm shift. Staff A stated she last observed Tenant #1 near the end of first shift. Staff A described what Tenant #1 wore during her shift. - The HCC stated during a later interview, Staff B stated the courtyard door was unlocked when she arrived to her shift at 2:00 pm. She and the ED asked Staff B if she had thought about locking it when she came in but Staff B shrugged her shoulders. - The HCC stated the ED found the wood gate leaving the courtyard was locked but not latched. The ED confirmed the lawn service had mowed the courtyard during the 2:00 pm to 10:00 pm shift and had not completely shut the gate door when they finished.	

	- The HCC stated staff were trained when they arrived to the beginning of each shift they were to make sure the doors and alarms were secured and on. 5. On 7/23/24 at 11:56 am, Staff C stated she was the 2nd shift float staff on the day Tenant #1 eloped. Staff C observed Tenant #1 around 2 pm. Staff C stated as a float staff, the memory care staff could call her at any time for assistance. Staff B had not called her back at all that day for assistance or help with safety checks or with incontinence clean ups. Staff C stated staff had all been trained to go around and check doors and alarms when they arrived on their shift. 6. On 7/22/24 at 1:15 pm, Staff D stated staff always went around and checked all of the doors and windows to make sure they were alarmed and locked at the beginning of their shifts. Staff D stated all of the tenants in the memory care unit, which included Tenant #1, received one hour safety checks. 7. On 7/22/24 at 1:37 pm, Staff A stated she worked first shift on 7/17/24. She reported observing Tenant #1 her entire shift. Her last check was at 1:50 pm and she observed Tenant #1 lying down in her bed. Staff A stated during first shift, the Director of Celebrations had taken several tenants outside to the courtyard before lunch and then brought them back in. Staff A stated she had turned the alarm off for the Director of Celebrations so she could take them outside with no alarm sounding. This was normal as the Director did not have a key to the courtyard. Staff B arrived at 2:00 pm to work 2nd shift and they counted narcotics together. Staff A stated she told Staff B the door was unlocked to the outside courtyard and gave her door key. She gave the key to Staff B knowing she had to do the initial door lock/alarm checks at the beginning of her shift. Staff A stated she had no excuse as to why she had not re-locked the courtyard door before the end of her shift. She passed on the door key to the next shift and told them it was unlocked. 8. On 7/22/24 at 11:05 am, the Director of Celebrations confirmed Staff A unlocked the door for her to take tenants outside into the courtyard during the 6:00 am to 2:00 pm shift. The Director of Celebrations stated she had not asked Staff A to relock the door when she was finished because a family member was outside with a tenant when she finished with her activity. 9. On 7/24/24 at 10:00 am, Staff B stated she worked 2:00 pm to 10:00 pm on 7/17/24. Staff B stated she completed the narcotic count with Staff A. Staff B stated Staff A had not told her anything about the door to the courtyard being unlocked. She noticed the door to the courtyard was open right away so she closed it but did not alarm it. She checked to make sure no one was outside. Staff B stated it was normal to leave the door unlocked if an activity was going on. She did not lock the door as she stated she was within eye view of the door. Staff B stated it was not normal procedure for staff to do a safety check of all doors to ensure they were locked and alarmed at the beginning of each shift. Staff B stated Staff A from first shift did tell her that a tenant was being very emotional during first shift, so she immediately went and worked	

	with the tenant to keep her calm. Shortly after she had to assist a tenant who had fecal matter on her and assisted her to get cleaned up in her room. This left the common area of the memory care unit with no staff present. Staff B stated she then completed safety checks on the tenants who were not within eyesight, one of them being Tenant #1. She looked in Tenant #1's room and believed her to be lying on her bed face down, which was normal. Staff B stated Tenant #1 always covered herself with her winter coat and all of her blankets so you could not see her. Looking back, she was not sure if she actually observed her body under the blankets. She was not sure if the check was right at 3:00 pm, but the check was for the 3:00 pm hour. Staff B stated the ED and the HCC came back to do incontinence checks on rooms at around 3:30 pm. They advised her there were two tenants incontinent. The two administrative staff assisted Staff B in getting the tenants changed. Staff B stated the two administrative staff never asked her about, or mentioned, the 3:00 pm safety checks. They then left the memory care unit. Staff B stated she went into another tenant's room after they left and cleaned her up as she was incontinent. This took awhile and she also had to start the tenant's laundry which took more time. This left the common area of the memory care unit with no staff present. She said she had not requested the assistance of the float staff at any time that day as she had been instructed not to as the float staff was training a new staff, Staff E. She recalled she received a call from the HCC around 4:20 pm about finding Tenant #1 outside of the courtyard. Staff B stated Tenant #1 had to have gone out the unlocked courtyard door sometime while she was in tenant apartments assisting with incontinence. 10. On 7/22/24, a review of Staff A's personnel record revealed a hire date of 8/11/21. She was delegated on the Door Alarm Response procedure on 1/3/23. Staff A was trained after a door had been unlocked or un-alarmed, staff would check the area to ensure no tenants were outside and then the door and alarm would be secured and re-activated. 11. On 7/22/24, a review of Staff B's personnel record revealed a hire date of 3/1/22. Staff B was delegated on the Door Alarm Response procedure on 8/9/23. Staff B was trained after a door had been unlocked or un-alarmed, staff would check the area to ensure no tenants were outside and then the door and alarm would be secured and re-activated. Staff B was delegated on completing spot checks per the registered nurse discretion on 8/9/23. On 7/22/24 at 1:50 pm, the Healthcare Coordinator confirmed the spot checks delegation instructed staff to do a check of all memory care doors and windows to ensure the doors were locked and alarms were on. Staff B was delegated on completing visual checks on 8/9/23. The visual checks delegation revealed staff were to make visual contact of residents whether awake or asleep.	

	12. On 7/23/24 at 3:00 pm, the Executive Director confirmed Staff A had not followed through and completed door alarm responses by not re-locking doors that had been unlocked. The Executive Director confirmed Staff B had not followed through and completed door alarm responses by not re-locking doors that had been unlocked. Staff B further failed to complete spot checks on all doors and windows at the beginning of her shift. Finally, Staff B failed to make visual contact of all tenants whether awake or asleep during safety head checks.	