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

Date: August 7, 2026
Program Name: Addington Place of Clinton
Address: 1701 13th Ave North Clinton, IA 52732
Type of Action: Recertification Visit & Investigations #130808-I, 130919-C, 131752-C, 131951-A, 131976-M
Date(s) of Action: 4/8/26 – 5/21/26
Citation #11209

State Rule #		Amount of Civil Penalty
Iowa Administrative Code 481 Chapter 67.3(2)	**481-67.3(231B,231C,231D) Tenant rights. All tenants have the following rights:** **67.3(2) To receive care, treatment and services that are adequate and appropriate.** Based on interview and record review the Program failed to provide adequate services to 2 of 8 discharged tenants reviewed (Tenant C3 and Tenant C7), and 2 of 10 current tenants reviewed (Tenant #7 and Tenant #3). Findings follow: 1) Record review on 4/13/26 revealed an Internal Occurrence Report form for Tenant C3 dated 1/1/26 at 7:05 AM. Staff entered Tenant C3's apartment and found him face down on the floor with his head toward the bathroom. He had blood around his head and no pulse; his skin was cold and his body was stiff. Record review revealed Tenant C3's death certificate noted the cause of death as cardiopulmonary arrest. On 12/30/25, the Nurse Practitioner noted Tenant C3 was a 96-year-old male with dementia, agitation, and anxiety. A daily task sheet from 12/31/25, 10:00 PM - 1/1/26, 6:00 AM, required 8 hourly safety checks. Staff C worked in the secured memory care unit and documented hourly checks from 2200 (10:00 PM) through 4:44 AM. When interviewed on 4/23/26 at 10:06 AM Staff C stated she worked alone in the memory care unit on 12/31/25 - 1/1/26. She could not recall the last time she checked on Tenant C3 before leaving on 1/1/26. She documented her tasks at 4:44 AM, but stated this reflected the time she completed documentation, not the time of the check. Staff C reported she hesitated to enter	**$8,000.00**

	apartments where tenants slept because of high needs, including wandering. She reported she had to break up fights and keep others from tearing up items in their rooms such as the air conditioning unit. Almost all of the tenants were at risk of falling. She begged the Executive Director to staff two employees in the memory care unit at night. When two staff were present, they were able to provide safety checks to tenants as required. During an interview with Staff J on 4/27/26 at 2:00 PM he reported he arrived for his shift at 6:00 AM on 1/1/26, and entered Tenant C3's apartment between 6:30 AM and 7:00 AM. He confirmed staff must fully visualize tenants during safety checks. When interviewed on 4/15/26 at 10:10 AM Staff F confirmed she entered rooms to ensure tenants breathed. Staff F explained Tenant C3 was often confused when she checked on him at night. He always thanked her for checking on him if she happened to wake him up. When completing his safety checks she would go all the way into his room and get close enough to ensure he was breathing. Record review revealed Program Staff received training on how to perform Visual Checks on tenants. They were to enter a tenant's apartment and make visual contact whether the individual was awake or sleeping. They should document the visual check in the electronic system according to the time the check was required. The key was for the tenant to be viewed throughout the entire shift and ensure safety. At the end of the shift, ensure proper documentation was completed. Visual checks were meant to be completed as close to the scheduled time as possible. Falsification of documentation could lead to counseling and/or termination. When interviewed on 4/27/26 at 3:40 PM the Assistant Director of Health and Wellness (ADHW) confirmed on 4/27/26 that staff should complete checks once every hour to confirm tenant location and status. The Program failed to ensure Tenant C3 and other memory care tenants received appropriate supervision when only one staff member worked. The ADHW confirmed during the time period when Tenant #3 died, Tenant C4 was into everything, Tenant #12 was tearing down blinds and Tenant #2 would stay up all night. The scheduling of staff was not done properly. She worked a couple of overnight shifts and experienced how Tenant C4 and Tenant #2 would be in everything. She knew working alone in the secured memory care unit was a challenge.	

	The Program failed to ensure Tenant C3, and other tenants living in the secured memory care unit, received appropriate supervision when only one staff was working. 2. Record review revealed the Program completed a 90-day assessment for Tenant C3 on 11/14/25, which noted diagnoses including atherosclerotic heart disease, non-rheumatic mitral and aortic valve insufficiency, tachycardia, insomnia, neuropathy, lung nodule and lung pain. He required assistance with showering, medication administration, reminders to brush his dentures and reminders to attend meals. Tenant C3 wore TED hose with which he required assistance in putting on and removing each day. No behaviors were noted. When interviewed on 5/6/26 at 9:15 AM a family member of Tenant C3, who was a medical professional, explained the family put a motion-activated camera in his apartment in November, 2025 after having concerns about whether he was receiving adequate care. Tenant C3 went to the emergency room (ER) and she visited 4-5 days later. The staff told her he wouldn't come out of his room and refused to eat. When she put her hands on his skin they were like dough with 4+ edema. She also found electrodes from the ER visit still attached to him. He was not wearing his TED hose and it took her 30 minutes to get them on. It made sense to her he was not leaving his apartment, as he would not have been able to walk with such swelling. She asked the staff to come to his apartment. Staff reported to her they did not know he was supposed to wear TED hose. When she watched video she saw staff were not entering his room every hour. She reported on 1/1/26, she saw video of Tenant C3 coming out of his bathroom at 2:38 AM. He then sat in a chair, let out a yelp and fell face down on the floor. He had intermittent movement from his feet for a short time before it stopped and he died. No one entered the apartment again until 7:00 AM. During an interview with Tenant C3's daughter on 4/17/26 at 9:38 AM she expressed frustration with the care her father received at the Program. She had a camera in the apartment which allowed her to monitor the services he received. The daughter stated her father's legs were very swollen as he did not receive assistance with getting his TED hose put on daily. She sent multiple pairs of TED hose to the Program but the RN did not have the staff put them on him despite frequent requests for them to do so. Tenant C3 ' s daughter further noted he might go a week without a shower. It took her calling to complain to get things done. When	

	she visited she might see staff sitting in the dining room talking or watching videos. His room was often filthy. She sent her father a lift chair for his birthday, but no one helped him to use it. One aide yelled at her father for sitting in the lift chair and turned it toward the wall so he was unable to use it. Another time he tried to stand up from his recliner and fell. He yelled for help. An aide came to his apartment and scolded him for yelling. She told him to be quiet because another tenant was dying. 3) Record review on 4/21/25 of ER records dated 6/2/25 identified Tenant C7 was a 90-year-old female with a history of atrial fibrillation with a cardiac pacemaker in place, chronic kidney disease, diabetes and lower extremity edema. A review of a 90-day assessment dated 7/11/25 identified staff assisted Tenant C7 with bathing twice weekly. She required stand-by assistance with dressing. Staff were required to help her put on and take off her TED hose each day. She required wound care for weeping bilateral lower extremities, including twice-daily dressing changes. A request for records was presented to local medical providers. Tenant C7 received the following care: - On 7/17/25 she was referred to the ED by her cardiologist due to concerns including bilateral pedal edema with weeping and open areas. She had scattered superficial ulcerations to the distal tibia. Tenant C7 received IV Lasix and was discharged home. - Tenant C7 returned to the ED on 7/28/25 due to concerns with weeping leg wounds and swelling. Tenant C7 was noted to have chronic peripheral edema on her bilateral legs. An examination of her skin showed skin with no significant erythema and no breakdown other than a superficial layer of maceration from wet wound dressings. Her wounds were cleansed and appropriately redressed. She was strongly encouraged to follow-up with her cardiologist and given the number for the wound clinic. Tenant C7 received outpatient treatment at the Wound Care Clinic on 8/5/25 and 8/11/25. On 8/5/25, the Wound Care Clinic provided treatment orders to the Program as noted below: -Wound #1 (Right and Left Lower leg wounds): clean with Skintegrity, cover with a single layer of Xeroform and gauze, use Soform wrap, tape and then mildly compress with Spandagrip. Ensure there are no wrinkles or rolling near the ends of the Spandigrip to avoid additional tissue injury. Change dressing every other day.	

	- Wound #2 to the right posterior thigh: Cut Xeroform to the size of the wound, fold gauze and use Medipore tape. Change dressing every other day. - Wound #3 to the left and right heels: Apply Betadine to the blistered areas of the heels, then dry gauze. Keep feet elevated off bed. Keep pressure off the heels at all times. Change dressing daily. - Wound #4 to the left 2nd toe: Betadine to cover the open area and weave dry gauze between the toes. When interviewed on 4/17/26 at 2:05 PM Staff G explained she told a former nurse about Tenant C7's extreme weeping from the legs. There would be puddles on the floor from the fluid coming out of her legs. Tenant C7 would yell at Staff G and ask why she wouldn't wrap her legs. Staff trained in administering medication and treatments were the only ones who were supposed to apply the wrappings to Tenant C7's legs. Staff G did not have this training, but sometimes there wasn't anyone around to do this, so she would do it. She also reported the Program would run out of gloves, bandages or chux pads to complete Tenant C7's wound care. When interviewed on 4/17/26 at 5:45 PM Staff B reported Tenant C7's legs would weep, clear up and then break open again. She had puddles of liquid in her room as a result of the pooling. This caused Tenant C7 pain. Staff B never received training on how to apply the bandages to her wounds. She discussed her concerns about the lack of training with the former nurse and Executive Director. She also told them about the lack of supplies such as gloves, gauze pads and gauze wraps, as they were out for about a month. On 4/20/26 at 3:00 PM Staff H stated Tenant C7 was vocal about directing her on what treatment to apply to her legs. A co-worker, not a nurse, directed her on providing wound care to the tenant. Staff I was interviewed on 4/27/26 at 2:45 PM and recalled Tenant C7's legs became red and moist. Her legs wept and she would leave a trail of fluid when she moved in her wheelchair. A co-worker trained her on how to apply the dressings to the tenant's legs. At times her legs were to be wrapped and other times they were to be left open. There was no evidence the Program nurse sought care for Tenant C7 from her Primary Care Provider to address her swollen, weeping legs from 7/17/25 - 8/5/25. Staff were not adequately	

	trained to address Tenant C7's needs. The program lacked the appropriate supplies to address Tenant C7's wounds according to staff interviews and there was no evidence the Program nurse reached out to others to obtain these supplies. 4) Record review on 4/22/26 revealed a Resident Information form identified Tenant #7 as a 92-year old woman with diagnoses of Alzheimer's disease, atherosclerotic heart disease of the native coronary artery with unspecified angina pectoris, occlusion and stenosis of the left carotid artery, aphasia following cerebral infarction, personal history of pulmonary embolism and essential hypertension. A December Medication Administration Record (MAR) for Tenant #7 revealed she was administered Nitroglycerin SL 0.4 mg on 12/26/25 at 8:43 PM. She received significant relief from the medication. When interviewed on 4/15/26 at 1:50 PM Staff J recalled on 12/26/25 he entered the secured memory care unit around 9:00 PM and heard Tenant #7 yelling out. As he got closer, he saw she was sweating and pale. Tenant #7 said she had chest pains and was dizzy. She was sitting about 25 feet from Staff O and he was able to hear the tenant when he entered the unit from a distance of 300 feet. Tenant #7 was within eyesight of Staff O, although the employee was watching television on an electronic device. Staff J immediately assisted Tenant #7. He believed her blood pressure was 192/87, although this was not documented anywhere. He called the Assistant Director of Health and Wellness who directed him to administer Nitroglycerin SL 0.4 mg. Staff J gave Tenant #7 two to three tablets of Nitroglycerin SL. Staff O did not explain why she did not assist Tenant #7 or call for assistance. When interviewed on 4/15/26 at 2:30 PM the ADHW reported hearing concerns from staff about Staff O coming to work and spending time on her tablet. Staff J called her to report the tenant's chest pain. She could not remember the tenant's vitals. When she came to the Program to follow up on this concern Staff O acted timid. The ADHW could not believe an employee would be on her tablet when a tenant was in distress. 5) Record review on 4/9/26 revealed Care History notes for Tenant #3 included the following entries: - Tenant #3 had a small nose bleed on 1/20/26 at 1:20 PM but the bleeding continued through the afternoon so the tenant's daughter asked to transport her to Urgent Care for treatment; the ADHW called the Power of Attorney (POA), the tenant ' s other	

	daughter, to see if this was acceptable and she agreed. The daughter called the Program at 5:45 PM and asked to take her mom home for the night. Program staff called the POA to ask for approval. The POA gave permission for the daughter to keep Tenant #3 at her home for the night. - On 2/12/26, Tenant #3 ' s daughter took her mom out of the building without permission of the POA. The ADHW called the POA to make her aware. - Tenant #3's POA requested the daughter no longer be allowed to visit her mother. It was noted on the tenant's notification page. During an interview with Tenant #3 on 4/8/25 at 11:53 AM she reported her daughter (not the POA) used to visit, but no longer did so. She stated she would like her daughter to visit again. On 4/9/26 at 9:10 AM Staff D was interviewed and recalled Tenant #3's daughters did not get along. Tenant #3's daughter used to visit all the time. She recalled hearing Tenant #3 stating the POA could not make all decisions for her and her other daughter was important to her as well. Staff B was interviewed on 4/9/26 at 10:08 AM and believed Tenant #3 was depressed when her daughter was banned from the building. She knew there were times the daughter was disruptive in the building. Tenant #3 and the Executive Director signed the Occupancy Agreement, Addendum D - Resident Bill of Rights on 9/26/24. The Bill of Rights included the right to associate and communicate privately and without restriction with persons of the resident's choice on the resident's initiative or on the initiative of the person at any reasonable hour. The State Long-Term Care Ombudsman developed a memo on 8/1/24 to address Visitation and Substitute Decision Makers. A Durable Power of Attorney was designated to make health care decisions. Visitation and access to a tenant was not a health care decision. Therefore, that right remained with the tenant. During a meeting with the ADHW on 4/8/25 at 1:15 PM she reported Tenant #3's daughter would come to the Program to see her mother. The daughter would yell while in the building and caused problems with the Hospice worker. The POA banned her sister from the building.	

	6. During an exit meeting with the Executive Director and ADHW on 4/28/26 at 11:30 AM they confirmed the Program failed to provide adequate and appropriate services to tenants as addressed above. The Executive Director and ADHW met with Tenant #3's daughter on 4/27/26 and made arrangements for her to begin meeting with her mother at the Program again.	