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

Date: August 26, 2026
Program Name: Addington Place of Clinton
Address: 1701 13th Avenue North Clinton, IA
Type of Action: Investigation #132184-I, #132216-I, #132037-C, #132284-C, #132529-C, #132214-C, 132215-C
Date(s) of Action: 7/28/26-8/10/26
Citation #11233

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 interview and record review, the Program failed to provide care, treatment, and services that were adequate and appropriate for 2 out of 6 discharged tenants reviewed (Tenant C1, Tenant C4). Findings follow: 1. Record review on 8/04/26, revealed Tenant C1 resided at the Program from 4/03/26 through 5/29/26. Tenant C1's diagnoses were Alzheimer's disease, hypertension, osteoporosis, repeated falls, and dizziness/giddiness. Tenant C1's evaluations completed on 4/02/26 and service plan completed on 4/03/26 revealed Tenant C1 had a global deterioration score (GDS) of six which indicated severe cognitive decline. The Tenant Assessment indicated Tenant C1 was a Level 3 on the Morse Fall Screen which indicated Tenant C1 required high risk fall reduction interventions on the service plan. A review of Tenant C1's service plan dated 4/03/26 revealed no fall reduction interventions identified. Tenant C1's record revealed she was found on the floor by her recliner on 4/14/26 and 4/18/26. On 5/26/26 Tenant C1 was found sitting on the floor in her apartment on 5/22/26 by staff. Tenant C1's service plan lacked any information regarding the supervision levels staff were to provide.	**$4000.00**

	Tenant C1's service plan showed Tenant C1 required full assistance with bathing, physical assistance with dressing and grooming, assistance with oral cares, one-staff assistance with transfers, four toileting assists daily which included transferring and assistance with changing incontinence products, physical assistance with eating, and three daily prompts for activities participation. A review of care task sheets revealed the following gaps in service documentation: 4/03/26 through 5/29/26 - tenant had no showers as documented as completed. 5/08/26, 5/10/26, 5/11/26, 5/13/26, 5/14/26, 5/15/26, 5/16/26, 5/21/26, 5/24/26, 5/28/26 - No documentation of cares tasks the entire day. 5/04/26 - tenant refused toileting assist twice and no other toileting assists documented, no assist with dressing or grooming, no prompting for activities, tenant refused to be transferred once and on other transfers documented, no assistance with eating documented. 5/07/26 - no toileting documented at dinner time, no toileting documented on first shift or third shift, no dressing assist at bedtime, no oral care assist, no transfer assist at bedtime. 5/18/26 - Toileting assistance documented once for the day, 1 transfer assist documented, no oral cares documented, no assistance with eating documented. 5/19/25 - Toileting assistance documented once for the day, no transfers documented, no assistance with eating documented. 5/20/26 - Toileting assistance documented twice for the day, 1 transfer assist documented. 5/22/26 - Toileting assistance documented once for the day, 1 transfer assist documented, no oral cares documented, no assistance with eating documented.	

	5/23/26 - Toileting assistance documented twice for the day. 5/25/26 - Toileting assistance documented once for the day, 1 transfer assist documented. 5/26/26 - Toileting assistance documented once for the day and the tenant refused toileting assistance once, 1 transfer assist documented. 5/27/26 - No toileting assistance documented, no transfer assists documented, no oral cares. 5/29/26 - Tenant C1's family moved her to a new home. When interviewed on 7/30/26 at 10:46 a.m., Staff L confirmed she worked with Tenant C1. Staff L believed Tenant C1 was neglected. Staff L found many staff would not take Tenant C1 out to the dining room to eat so she missed meals. Tenant C1 fell a lot. Staff L believed staff failed to toilet Tenant C1 when they should have. Staff L reported there were staff that failed to assist her to the restroom all day. She stated because Tenant C1 was not toileted frequently enough, Tenant C1 had open sores and diaper rash on her buttocks. Staff L confirmed Tenant C1's buttocks were raw all of the time. Staff L went back in the memory care area to assist staff and she found Tenant C1 on the floor with her wet brief around her ankles. Staff L indicated the staff that were in memory care during these times no longer worked at the Program. Staff L confirmed Tenant C1's daughter was livid. Tenant C1's daughter wanted to move her mother to a new home because Tenant C1 was neglected at the Program. Staff L confirmed staff called the Corporate Office regarding their concerns on Tenant C1's care. Staff L stated the Director of Health and Wellness knew about the concerns of care. Staff L observed Tenant C1's daughter in her apartment one day crying because the Director of Health and Wellness failed to do anything about her concerns. When interviewed on 7/30/26 at 1:13 p.m., Staff E confirmed she worked with Tenant C1. Staff E noticed on one occasion Tenant C1 was left in the same outfit for three days. Staff E also marked	

	Tenant C1's brief at 2:15 p.m. on one occasion then returned later that night at 10:00 p.m. and found Tenant C1 still in the same wet brief. Staff E came in on some of her shifts and found Tenant C1 soaking wet in urine. Staff E confirmed Tenant C1 had red and sore buttocks. Staff E confirmed staff physically fed Tenant C1 and she knew many staff failed to do so. So Tenant C1 would not eat meals. Tenant C1 fell a lot because she would attempt to get up on her own. Staff were supposed to do safety checks on her to prevent this, as all tenants at least get hourly checks. Staff E shared her concerns with the Director of Health and Wellness but she never responded right away when you approached her. When interviewed on 8/06/26 at 9:27 a.m., the Director of Health and Wellness reported she had no knowledge of Tenant C1 having any open areas on her buttocks. The Director of Health and Wellness stated she received no communication or incident reports regarding any open areas. She confirmed she received some concerns via text message from Tenant C1's daughter but when she looked into the issues there were no concerns found. 2. Record review on 8/04/26, revealed Tenant C4's diagnoses were obesity, major depressive disorder, anxiety disorder, adjustment disorder, Parkinson's disease, restless legs syndrome, mild cognitive impairment, migraine, insomnia, tinnitus, hypertension, calculus of kidney and ureter, and prostatic hyperpiesia. Tenant C4 passed away on 6/15/26 at the Program. Tenant C4's evaluations dated 5/27/26 showed Tenant C4 had a GDS of three which indicated mild cognitive impairment. Tenant C4's service plan dated 5/27/26 revealed he required assistance with bathing, dressing, oral cares, 2 transfer assists daily, and incontinence cares four times daily. A review of care task sheets revealed the following gaps in service documentation during the last 2 weeks he resided at the Program: 6/01/26 through 6/11/26 - tenant had no showers documented as completed. 6/02/26 - Toileting assistance documented twice, 1 transfer assist documented, no oral cares documented. 6/03/26 - No documentation of cares tasks the entire day.	

	6/05/26 - Toileting assistance documented twice, 1 transfer assist documented. 6/9/26 - toileting assistance documented twice, 1 transfer assist documented. 6/10/26 - Toileting assistance documented once, 1 transfer assist documented, no dressing/grooming assistance documented. 6/11/26 - Toileting assistance documented twice, 1 transfer assist documented. When interviewed on 7/29/26 at 1:44 p.m., Staff H confirmed he had concerns about Tenant C4's end of life care. Staff H reported he believed Tenant C4 was not changed and checked for incontinence enough. Staff H confirmed he knew staff on all three shifts were not changing him when he was incontinent like they should have. Staff H added he knows staff did not complete the toileting cares but would document they did anyway. Staff H confirmed Tenant C4 was on hospice during this time. Further record review of Tenant C4's physician's orders in conjunction with medication administration records for June 2026 revealed the following: a. Therapeutic-M tablet - one tablet by mouth daily. The medication was not given on the following days because it was unavailable in the medication cart or no reason was given: 6/01/26, 6/02/26, 6/03/26, 6/05/26, 6/07/26. b. Azelastine spray 0.1% - one spray in each nostril twice daily. The medication was not given on the following days because it was unavailable in the medication cart or no reason was given: 6/01/26 twice, 6/02/26 twice, 6/03/26 once, 6/05/26 once, 6/07/26 once. c. Haloperidol 0.5 ml - twice daily for anxiety. The medication was not given on the following days because it was unavailable in the medication cart or no reason was given: 6/02/26 once, 6/03/26 twice, 6/04/26 twice, 6/05/26 once, 6/06/26 twice, 6/7/26 twice, 6/08/26 twice, 6/09/26 twice, 6/10/26 twice. Further record review revealed Tenant C4 ' s incident report dated 6/06/26 regarding a fall that required sutures to an abrasion on his	

	forehead above the right eye. A physician's order dated 6/06/26 revealed an order for ibuprofen 400 milligrams (mg) for pain from the fall. One tablet to be given orally twice daily as needed. Tenant C4's medication administration record for June 2026 was not updated with the new prescription for ibuprofin, therefore the tenant was not given the chance to take the medication for pain. Tenant C4's medications were stopped due to a decline in health after 6/10/26 per physician's orders. When interviewed on 7/30/26 at 10:46 a.m., Staff L reported she did not believe Tenant C4's needs were met. Staff L confirmed Tenant C4 yelled all day long in his last weeks due to anxiety. Tenant C4 wanted someone to come sit with him for 10 minutes and reassure him. Staff L confirmed she would sit with him, but believed other staff would not. When interviewed on 7/29/26 at 1:44 p.m., Staff H reported the Director of Health and Wellness had not filled empty medications in the medication cart or she would put it off until the last minute. Staff H confirmed it was mainly liquid medications as she was the person who was supposed to fill syringes for staff. Staff H noticed hospice put in orders before but the Director of Health and Wellness would fail to put the new order on the medication administration record. Staff H confirmed he had concerns regarding Tenant C4's end of life care. When interviewed on 8/05/26 at 10:27 a.m., Staff N confirmed on 8/01/26 when she passed medications for the 8:00 a.m. pass, she found she could not give many medications to tenants that day because they were not available in the medication cart. Staff N asked Staff A about this concern and Staff A told her it was always that way. When interviewed on 8/06/26 at 9:27 a.m., the Director of Health and Wellness indicated staff were pretty good about letting her know when medications had run out. The Director of Health and Wellness reported she was surprised the medication administration records had gaps due to the unavailability of medications.	

	When interviewed on 8/10/26 at 12:30 p.m., the Executive Director and Director of Health and Wellness confirmed the above finding.	