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

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| **Date:** March 9, 2026 |
| **Program Name**: River Valley Place of Ft. Madison |
| **Address:** 5025 River Valley Rd, Ft. Madison, IA 52627 |
| **Type of Action:** Investigations #130319-C, 130358-C, 130354-C, 130378-C, 130859-I, 131042-C, 131152-C |
| **Date(s) of Action**: 12/29/25 – 1/20/26 |
| **Citation #** 11060 |

| State Rule # | State Rule | Amount of Civil Penalty |
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| **Iowa Administrative Code 481 Chapter 67.3(2)** | **481-67.3 Tenant rights. All tenants have the following rights:**<br><br>**67.3(2) To receive care, treatment and services which are adequate and appropriate.**<br><br>Based on observation, interview and record review, the Program failed to provide services according to 6 of 12 current tenants and their families (Tenant #3, Tenant #4, Tenant #7, Tenant #9, Tenant #10, Tenant #13) and the family of 1 of 2 discharged tenants (Tenant C1). Findings follow:<br><br>1. Record review on 12/29/25 revealed Tenant C1 was an 87-year old woman diagnosed with heart failure, cardiomegaly, pulmonary hypertension, bacteremia, chronic kidney disease stage 3, dysphagia and colostomy. Tenant C1's service plan, dated 9/25/25 indicated she maintained her skin independently but was at risk for skin breakdown. She had a small healing open area to the right shin. She was to inform staff of any changes or signs of infection.<br><br>A review of progress notes revealed on 10/20/25, the Registered Nurse (RN) documented orders were received for Tenant C1 to take Cephalexin (an antibiotic) twice daily for 10 days. She also needed dressing changes to the open areas on her leg. A non-adherent pad should be applied to open areas, wrapped with gauze to assist with the weeping. Tubigrips were placed over her wrapped legs. These should be changed twice daily or as needed if soiled. Skin checks were to occur when changing the dressings to the legs. The antibiotic was sent to the Program's pharmacy. Tenant C1's daughter was going to purchase the dressing supplies. The RN noted on 10/23/25 staff used some dressing supplies from the medication room and what the tenant had in her room to dress Tenant C1's bilateral legs. There was more seeping from her left lower extremity than from the right lower extremity. Both lower legs were very edematous with pitting in the 3+ areas. She | **$6000.00** |

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| | tolerated the dressing changes well. Staff on duty watched the dressing changes. The dressing changes were added to the EMAR on 10/24/25. Staff documented providing the dressing changes twice daily from 10/24/25 to11/09/25 (with the exception of 11/09/25 in the AM when Tenant C1 refused the treatment).<br><br>On 11/03/25 Tenant C1's daughter met with the RN and expressed she was concerned the Primary Care Provider (PCP) was not doing enough to address the edema and her shortness of breath. Her mother was unable to walk to the dining area without stopping one to two times to sit and catch her breath. The RN called the PCP's office and received a return call on 11/04/25. The PCP ordered testing and a cardiology consult. The testing revealed fluid around the tenant's lungs so he increased her Lasix. If the tenant's shortness of breath increased over the weekend, she should go to the emergency room. Tenant C1 called the RN reporting increased shortness of breath. Her daughter was going to take her to the emergency room.<br><br>During interviews with Tenant C1's daughter on 12/29/25 and 1/06/26 she reported when her mother's legs started filling up with fluid, staff were supposed to wash them, apply wrappings and the tubigrips. They needed to do this because her mother was unable to bend over and complete the task herself. Staff were to do this twice daily. Sometimes staff would apply the tubigrips and sometimes they would not. They had a meeting about concerns with this and the delay in staff response time when her mother needed assistance. For instance, her mother waited 45 minutes for someone to come and get her off the toilet following an episode of diarrhea. Tenant C1 did not only go to the hospital for shortness of breath but also due to gaining 35 pounds of fluid, according to her daughter. Tenant C1's pants did not fit her and she went up two sizes. She also developed urinary incontinence during this period.<br><br>Staff C was interviewed on 12/30/25 at 1:45 p.m. and recalled Tenant C1 reported her legs felt as if they were burning prior to going to the hospital in November. Staff C told the RN about this. The RN showed about six employees how to put Tenant C1's tubigrips on and then they were to demonstrate it to the other employees. Tenant C1 told her there were two employees who cut off her circulation when they put on the tubigrips. Staff C entered the apartment and saw her legs very small, red at the ankle and quite large at the top. The bandages had a dark, mucus color on them where the sores leaked through. | |

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| | When interviewed on 12/31/25 at 10:55 a.m. Staff D reported Tenant C1 asked to have her tubigrips on all the time. When she applied new bandages she noted a lot of fluid leaking out of the tenant's legs. She assumed the nurses knew about this. Staff D reported it to the oncoming shift and those employees said they told the RN.<br><br>B. On 11/09/25, Tenant C1 presented at the Emergency Department (ED) with increased shortness of breath and bilateral lower extremity edema. She was admitted to the hospital for IV (intravenous) Lasix and fluid restriction. While hospitalized, she saw wound care for multiple pressure areas. She was found to be bacteremic with enterococcus. Tenant C1 had a chest x-ray performed which showed bilateral pleural effusions consistent with fluid overload. She then aspirated and another chest x-ray was performed showing worsening congestive heart failure. Prior to hospitalization, she was independent with activities of daily living. Due to her significant decline in the hospital and poor response to treatment, hospice was consulted. She was discharged from the hospital back to the Program. Assessment at the Program revealed the ostomy was functioning. She had a foley catheter which was in place. There was a wound to the coccyx and a skin tear to the left arm. Tubigrips were in place to her bilateral lower extremities. Her appetite was poor and she was mainly drinking protein drinks and eating ice cream. Tenant C1 needed intermittent assistance with feeding. She was on a pureed diet with thickened liquids and took her medication crushed in applesauce. Medications were reconciled with Tenant C1's PCP and would be managed by the Program. She was on bed rest.<br><br>A Hospice nursing note from 12/08/25 identified when the nurse arrived she found Tenant C1's catheter leaked. The ostomy was intact and functioning. She assisted with a bed bath as Tenant C1 was a two person assist. She removed the tubigrips from Tenant C1's legs and indents and redness were noted behind her knees. She called out in pain when the red area caused by the tubigrip was cleaned. The Hospice nurse spoke with staff after the visit and let them know the catheter leaked. She informed them to let her know if the catheter leaked again. They denied having any questions.<br><br>The Hospice nurse met with Tenant C1 on 12/10/25. The ostomy bag did not have a clamp on it. Tenant C1 said a nurse came in the previous evening and clamped it improperly. She tried to tell the Program staff how to do it the right way but the person would not | |

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| | listen. The Hospice nurse noticed Tenant C1 was saturated with urine and there was feces on her blanket and ostomy. Staff assisted with bringing in a new blanket and pad for the bed. The RN then asked how often Hospice would be providing baths to Tenant C1 as the program would not be providing this service when Hospice was doing it. The RN shared Tenant C1 was not receiving medication, other than Warfarin, as it was discontinued when she discharged from the hospital. The Hospice nurse let the RN know the medication was not discontinued and would follow up with the doctor about this. A review of Tenant C1's EMAR revealed Tenant C1 received one dose of Warfarin on 12/05/25. Her other medication did not start until 12/12/25.<br><br>The Hospice nurse and bath aide arrived on 12/11/25 to complete a bed bath and bed change. Tenant C1's catheter was leaking again. Her peri area was red with a white discharge noted. The Hospice nurse contacted the PCP for orders to address the discharge. The Hospice nurse again asked staff to let her know if the catheter was leaking.<br><br>The Hospice team had a meeting with Tenant C1's PCP on 12/11/25. They discussed concerns the program was unable to meet her needs. They increased home health visits to five per week due to concerns of the catheter leaking and a reddened peri area. The RN contacted the Hospice nurse and informed her she received the medication orders and medicine would be administered when delivered (it was not administered until 12/12/25). Hospice nursing visits were increased to daily to ensure personal cares were met and medications were being given. The Hospice nurse met with the Executive Director to discuss her concerns related to medication, the tenant being found saturated in urine from head to toe and the clamp on the colostomy bag missing with stool on the patient and bedding. The Executive Director reported it was unacceptable and would hold a meeting with staff to ensure Tenant C1 was cared for the way she deserved.<br><br>The Hospice nurse visited on 12/12/25 with no concerns. On 12/15/25 when the Hospice nurse arrived she learned from the Health and Wellness Director (HWD) Tenant C1 received a complete bath and bed change in the morning as she was saturated in urine. The ostomy bag was emptied prior to her arrival.<br><br>When the Hospice Home Health Aide (HHA) arrived on 12/16/25, she found Tenant C1 laying sideways in bed and very | |

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| | confused. Her incontinence pad was saturated with urine and/or discharge from her bottom. Program staff came to assist her with cares. The HHA asked staff how often they were checking on Tenant C1. They informed her they were unable to reposition her every two hours due to low staffing and Tenant C1 requiring a two-person assist. They discussed Tenant C1's level of confusion as this was unusual. Staff reported she was hallucinating through the night but they had not administered any medication to assist with this. Tenant C1's mouth was dry and crusted over. Staff were not feeding Tenant C1, reportedly as they were not certified to do so. She reported pain with repositioning. The HHA provided catheter, incontinence and peri-cares. Staff were unable to provide any clean linen. The HHA placed a clean bath sheet under Tenant C1 until clean sheets were provided. The coccyx wound appeared to have a greenish discharge which was new. Staff stated they were unaware of how to care for the wound and asked for information on how to do so.<br><br>Two Hospice nurses returned to visit Tenant C1 the afternoon of 12/16/25 and found her clean but gasping for air. Lunch was sitting beside her. Tenant C1 said she ate half a grilled cheese and some ice cream. They pressed the call light and waited 30 minutes for a response. The HWD arrived and they discussed concerns about medication, repositioning and the deterioration of the wound. They asked the HWD why she did not mention Tenant C1 was not receiving medication and was having issues swallowing medication when they met on 12/15/25. The HWD said she saw on 12/16/25 Tenant C1 missed some medication. The Hospice nurses reported they were initiating Morphine due to Tenant C1's shortness of breath and pain. The HWD returned with two staff who wanted education on how to give these medications. The Hospice team later spoke with Tenant C1's daughter about a transfer to the Hospice House due to concerns about the program.<br><br>Tenant C1 and her daughter decided she would move to the Hospice House on 12/17/25. She did leave the program on that date.<br><br>A Hospice nurse was interviewed on 12/29/25 at 12:22 p.m. She reported Tenant C1 was admitted to hospice on 12/04/25. A big concern of hers was the ability of staff to safely reposition and bathe Tenant C1 while she was in bed. This could be scary as she was a larger lady and the task required a two-person assist. It could be dangerous if only one person did it and she was afraid Tenant C1 would fall out of bed. The Hospice nurse provided a list of services which the program did not provide adequately: | |

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| | - the discharge medication list was not correct<br>- medication was not administered for several days<br>- Tenant C1 was not checked frequently. She would expect someone who was bed-bound to be checked every two to three hours.<br>- The ostomy bag was not closed.<br>- Staff were alerted if there were problems with the ostomy or catheter to call Hospice but this was not done.<br>- Medications were not administered from the comfort kit.<br>- Staff reported they were not certified to feed Tenant C1 so she did not receive nourishment.<br>- They put fungal cream intended for her wound on the peri area.<br>- It did not appear wound care was completed as ordered.<br><br>Tenant C1's daughter interviewed on 12/29/25 at 6:03 p.m. reported the RN evaluated her mother prior to her discharge from the hospital and was aware she was bed-bound and required two people for repositioning. The Executive Director assured the daughter they had more staff and would be able to meet her needs. The daughter called the RN when she learned her mother was not receiving her medication. She was told there was confusion with the pharmacy and no one knew the Program was to administer the medication. She recalled going to her mother's apartment and finding cups staff left everywhere. Staff would leave grilled cheese sandwiches and soup at her bedside. The daughter did not understand why this was done if her mother was choking on pills. They provided her mother with 20 ounce tumblers she could not handle and short straws which fell into the cup. The daughter bought sippy cups which the program lost. Things were bad on 12/16/25. When she talked with the new HWD she did not seem to know what medication her mother took or if her mother was swallowing her pills. The Executive Director reportedly stated she did not know there were problems related to her mother's care.<br><br>During an interview on 12/29/25 at 1:10 p.m. Staff G reported it took two staff to reposition or turn Tenant C1. They had to turn her in bed every two hours and she was unable to do this by herself. There were times she worried Tenant C1 would fall off the side of her bed as it was small and the tenant was a larger lady. They put a wedge under Tenant C1, but were unable to put her on her side. They tried to do everything they could, but there was only one staff during the nighttime shift and Tenant C1 could not be repositioned with only one employee. She did not recall seeing Tenant C1's catheter bag leaking but did know her coccyx wound was leaking a green substance. Staff G reported staff were not | |

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| | allowed to feed tenants at the program due to concerns of aspiration. She knew Tenant C1 had difficulty swallowing and would even gag if she tried to feed herself. For this reason, Staff G would bring food into Tenant C1 and leave it at her bedside.<br><br>Staff E interviewed on 1/06/26 at 10:15 a.m., recalled the first time she tried to give Tenant C1 a pill she refused it. Staff E offered to give the pill to her in applesauce but the tenant said no. The pill was not crushed. She shared with Hospice staff Tenant C1 choked on her medication.<br><br>In an interview on 12/31/25 at 10:55 a.m. Staff D reported it required two people to safely reposition Tenant C1 in bed as she was a big lady. When she worked at night, the employee covering the secured memory care unit was not able to assist with this task so she had to do it by herself.<br><br>2) Record review on 12/31/25 of a History and Physical revealed Tenant #4 carried diagnoses of Diabetes mellitus Type 2, obesity, chronic kidney disease stage III, central cord syndrome, cervical canal stenosis, neurogenic claudication, wheelchair dependent; hypertension and history of foot ulcers and wounds. The RN documented in a progress note on 11/19/25 Tenant #4 went for a podiatry appointment on 11/18/25 and received new orders for a dressing to the right heel daily, protect with gauze and tape or a band aid. Keep the area clean and dry. She faxed the order to the pharmacy and added this to the EMAR.<br><br>The HWD assessed Tenant #4's lower left extremity on 12/22/25 and noted he had redness and multiple open areas with serous drainage. He reported severe pain to the area if touched. She also assessed an open area to his inner left 5th toe.<br><br>A History and Physical dated 12/23/25 indicated Tenant #4 presented at the hospital due to a black discoloration at the tip of his left fifth toe without pain in his foot. He also had black discoloration to his right heel. An MRI of the left foot showed signs of osteomyelitis of the left fifth toe (a bone infection). He was also diagnosed with cellulitis. During the course of his hospitalization Tenant #4 chose to have an amputation of his left small toe rather than go through a prolonged course of IV antibiotics. This surgery was conducted on 12/26/25. Tenant #4 discharged from the hospital and returned to the program on 1/06/26. | |

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| | During an interview on 12/30/25 at 1:45 p.m. Staff C reported Tenant #4's leg began hurting the week before Thanksgiving after he slid off a chair. The pain increased after that time. Tenant #4 did not want to get his weight taken daily. Tenant #4 was out of his Hydrocodone and this was a medication the nurse had to refill. She reported this to the HWD and Executive Director who directed her to administer Acetaminophen. She recalled reporting to the RN on her last day in the building Tenant #4 was in so much pain he couldn't even stand.<br><br>Staff A was interviewed on 12/31/25 at 10:15 AM. She applied lotion to Tenant #4's knees and put a bandage on his heel daily when she administered his medication. Staff A did not notice issues with his heel. She did notice throughout the month of December Tenant #4 had a skin tear on his leg which seemed to be getting worse. His legs also seemed to be getting bigger and redder. She was not sure if this was related to him retaining fluid or putting on weight. Staff A said his condition did not concern her enough; she thought it needed to be reported to the nurse.<br><br>In an interview with Staff E on 1/06/26 at 10:15 a.m. and 1/13/26 at 2:20 p.m. she recalled seeing Tenant #4's legs when they were red and reporting it to the RN. Staff E applied lotion to Tenant #4's legs and also put bandages on his heel, both daily. His heel looked calloused, but not black. When she put the bandage on Tenant #4's heel he requested she not remove his sock as it was hard to put on and hurt. When she noticed the sores on Tenant #4's were leaking (on 12/22/25), she notified the HWD who immediately assessed his condition. Staff E remembered Tenant #4 asked her for his pain medication, Hydrocodone, in December, but it was not available as they ran out of the pills. She asked the nurse to request a refill but this did not occur.<br><br>The Vice President of Clinical Services reported on 1/13/26 and 1/14/26 staff received training upon hire and during the first and second weekend of December about how to reorder pain medication, such as Hydrocodone, for tenants so they don't run out.<br><br>During an interview with the HWD on 1/07/26 she reported when staff were applying a bandage to a tenant's heel they should remove his sock, assess for changes and report if there was a change or the tenant voiced a change. Staff members should have notified the RN or HWD when Tenant #4's leg was red, painful and had sores. | |

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| | 3) Record review on 1/07/26 revealed December, 2025 and January, 2026 Device Activity Reports which provided information on the length of time it took staff to respond after a tenant pushed their emergency response pendant for assistance.<br><br>a.Tenant #7 had a history of transient ischemic attack (TIA) and cerebral infarction based on her face sheet. The Device Activity Reports noted when Tenant #7 pressed her pendant for assistance in December, it took staff more than 15 minutes to respond on 41 occasions. The longest response time was 45 minutes. During the period of 1/01/26 - 1/05/26, there were five occasions it took staff more than 15 minutes to provide Tenant #7 with assistance. The longest period of time to respond was fifteen minutes.<br><br>During an interview on 1/05/26 at 11:20 a.m. Tenant #7 reported she used to be more independent. However, since she had a stroke, she couldn't get up and go to the bathroom on her own as she was unable to move her foot and had to wait for staff to walk her to the toilet. In addition, she had to use the bathroom more since having the stroke. An observation of Tenant #7 revealed she used a walker and required standby assistance from staff when ambulating due to an unsteady gait.<br><br>b. A review of the Device Activity Report indicated Tenant #13 pushed her pendant for assistance and had to wait over 15 minutes for assistance on 27 occasions in December. The longest wait time was 50 minutes. She pushed her pendant six times in January, with the longest wait being 41 minutes.<br><br>Tenant #13 reported she was 102 years old. She would push her pendant for assistance when she fell or needed assistance getting to the bathroom. There were times she had to wait for staff to help her but they did their best. She did wish staff would be better about cleaning her apartment as there were times it could be three to four weeks when there was no housekeeping.<br><br>c. A review of incident reports revealed the following:<br>- On 12/03/25 at 8:30 a.m. staff documented Tenant #4 reported a fall from his recliner after his legs became weak. The Device Activity Report indicated he pushed his pendant for help at 8:16 a.m. It took staff 23 minutes and 19 seconds to respond.<br>- On 12/23/25 at 10:00 a.m. staff noted Tenant #15 was attempting to pick up a paper from her floor and lost her balance. Information from the Device Activity Report revealed she pressed her pendant for help at 9:42 a.m. when it took 16 minutes and 38 seconds for a response. | |

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| | During an interview with the Executive Director and the HWD on 1/7/26 at 3:45 p.m., they reported concerns over pendants not being answered in a timely manner. The Executive Director reviewed the Device Activity Report on a weekly basis. She confirmed staff were having a difficult time responding to pendants in a timely manner when there were only two employees working in the building. On 12/29/25 at 9:19 a.m.the Executive Director reported the goal was for staff to respond to pendants within 10 minutes or less. Any time over 10 minutes was concerning to her.<br><br>4. Record review of progress notes for Tenant #9 revealed she moved to the Program on 11/24/25. She resided in the secured memory care unit. That evening the RN was called to the unit as Tenant #9 was yelling "Let me out of here!". She attempted to leave the building for several hours. The RN contacted Tenant #9's PCP and received a verbal order for an intramuscular (IM) injection of Lorazepam. The injection was administered and she began to calm down.<br><br>An incident reported dated 12/04/25 documented Tenant #9 fell on the floor when getting into bed. She did not require medical treatment. An incident report from 12/05/25 noted the afternoon of 12/04/25, Tenant #9 was more lethargic and sleepy. It continued through the morning of 12/05/25. PRN Haloperidol as well as Lorazepam were administered. No other abnormal behavior was noted. Tenant #9 stated she did not feel right. She was transported to the hospital for an evaluation.<br><br>Review of a Final Report from Tenant #9's hospitalization (from 12/05/25 - 12/09/25) revealed she presented with lethargy and a fall. The patient was aggressive with a behavior change. It seemed as if Tenant #9 was being overmedicated at the nursing facility. She was on Haloperidol as well as Lorazepam. Her daughter believed the patient was being given these medications as a preventative strategy even before she got excessively agitated. Upon discharge, Tenant #9's PRN IM Haldol and Lorazepam were discontinued. Her PRN medication 5 mg Haldol, 2 mg Lorazepam and 0.5 mg Lorazepam were also discontinued.<br><br>A Controlled Drug Record sheet noted Staff F administered 0.5 mg. of PRN Lorazepam to Tenant #9 on 12/10/25 at 2:00 p.m. and on 12/11/25 at 12:00 a.m., after the medication was discontinued. | |

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| | On 1/07/25 at 10:39 AM the Health and Wellness Director reported in an interview she discontinued Tenant #9's medication, including the 0.5 Lorazepam on 12/10/25 at 8:38 a.m.. Staff F should have known not to administer this medication on 12/10/25 and 12/11/25 when looking at the MAR.<br><br>During an interview with Tenant #9's daughter on 1/07/25 at 10:49 a.m. she reported her mother's first two weeks at the program were rough. Her mother was hospitalized thirty-six hours after her admission. Her mother was calling her all the time, she heard through the phone staff were putting her in an ambulance and sending her to the hospital. The daughter thought about bringing her mother home at that time. The ED doctor let her know the first month could be difficult and the family should wait it out. A week after this, there was another hospitalization. Her sister went to visit Tenant #9 and their mother was very tired. The next day her mother could not hold up a glass or even dress herself. They decided to take her to the ED. They believed she was over medicated. The ED doctor said the staff could only administer the medication which was ordered, so upon discharge most all "as needed" or PRN medication was discontinued. Her biggest concern was related to overmedication.<br><br>5. Record review of Tenant #3's face sheet on 12/31/25 revealed she had diagnoses of intervertebral disc degeneration, fracture of the left pubis with delayed healing, wedge compression fracture of the first lumbar vertebra and lumbago with sciatica. Tenant #3's December, 2025 MAR listed she was prescribed Hydrocodone/Apap tablets, 5-325 mg, as needed three to four times a day. The December MARs revealed 1-3 days gaps when Tenant #3 was not administered Hydrocodone/Apap tablets, 5-325 mg. On other dates, she received the medication 1-4 times daily. The dates are as follows: December 2 - December 3 and December 10 - December 12.<br><br>Tenant #3 interviewed on 12/30/25 at 9:55 a.m. stated she moved to the program after experiencing fractures on both sides of her pelvis. She was also having problems with her vertebrae. These issues cause her a lot of pain. Tenant #3's biggest issue at the program was when she missed her medication. She reported one weekend she went from Friday to Monday without her pain medication. Tenant #3 felt as if she went through withdrawal and was in a lot of pain. The only times she pressed her pendant was when she needed medication due to pain. Once she waited 40 minutes for staff to come and assist her. On 12/29/25 she did not | |

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| | receive her medication until 11:00 p.m. because the pharmacy did not deliver it until this time.<br><br>When interviewed on 12/30/25 at 1:45 p.m., Staff C indicated Tenant #3 had Hydrocodone/Apap which she could take "as needed" and she would request it often. When the medication needed reordered, she would inform the RN of this. Tenant #3 reported her symptoms of being sick to her stomach and having a headache when she did not have her medication.<br><br>In an interview on 12/31/25 at 10:15 a.m. Staff A reported Tenant #3 became upset when she did not receive her Hydrocodone/Apap. She asked for the medicine non-stop. When that specific medication wasn't available, it caused significant problems for Tenant #3.<br><br>Staff E was interviewed on 1/06/25 at 10:15 a.m. reported the program ran out of Hydrocodone/Apap tablets for Tenant #3 several times. They would notify the nurse when the tenant was running low on pills but they did not seem to get reordered right away.<br><br>During an interview with Staff D on 12/31/25 at 10:55 a.m. she recalled working once when Tenant #3 ran out of her Hydrocodone/Apap. The medication arrived the next day. Tenant #3 stated she really needed the medicine. Staff D administered the tenant Tylenol instead of the prescribed medication.<br><br>The Vice President of Clinical Services provided logs of calls made from the RN and her to pharmacy on 11/13, 11/14, 11/17, 12/5, 12/10, 12/11, 12/12, 12/14. These calls did not result in Tenant #3 having Hydrocodone/Apap as needed.<br><br>6. During a tour of the building with the Executive Director on 12/29/25 at 9:45 AM Tenant #10's apartment was found to have a strong urine smell throughout the rooms. Soiled clothing was found laying on the floor under the sink. The Executive Director reported the tenant kept his soiled clothes there for staff to pick up and wash. The floor in the bathroom was tacky, causing one's shoes to stick to the floor.<br><br>Upon leaving the apartment, the Executive Director reported a care conference was held to determine methods to keep the tenant's apartment clean. Prior to the meeting the smell of urine reached into the hallway. His family had a recliner in the unit professionally cleaned and the program started cleaning the floor | |

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| | with stronger products and cleaning/checking the bathroom more frequently.<br><br>A review of Tenant #10's service plan, dated 10/02/25 indicated he was to receive housekeeping and laundry services once daily. Staff were to help him with bathing twice weekly. He needed help with dressing to put on his shoes and socks. Tenant #10 was independent with toileting.<br><br>On 12/29/25 at 10:35 a.m. Tenant #10's wife reported the cleanliness of the apartment was better now than it was a few months ago. Her grandchildren did not want to visit Tenant #10 due to the smell of the apartment. She believed the program either needed to pull up the carpet or shampoo it every week or two. When Tenant #10 went to the doctor last week someone reported he smelled of urine. The family hired someone to help him shower each week.<br><br>In an interview with Tenant #10's daughter on 1/06/26 at 9:35 a.m. she stated she had concerns about the cleanliness of his apartment. She used to go in several times a week to clean it. This was no longer necessary, but it still needed to be cleaned on occasion. For instance, last weekend her mother had to clean the bathroom with several Lysol wipes due to urine being on the floor and toilet.<br><br>Tenant #10 was interviewed on 1/07/26 at 2:20 p.m. He reported there were times he thought his room needed to be cleaned up. In general, he was not overly bothered by the condition of his room.<br><br>During an interview with the Executive Director on 1/06/26 at 3:15 p.m. she reported staff shampooed Tenant #10's carpet earlier in the day but the urine smell remained. She believed they needed to replace the carpet in his apartment. | |