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

Date: October 1, 2026
Program Name: River Valley Place of Fort Madison
Address: 5025 River Valley Road Fort Madison, IA 52627
Type of Action: Recertification, Investigation #131802-C, 131766-C, 131641-C, 131617-C, 131565-C
Date(s) of Action: 7/15/26 - 8/11/26
Citation #11263

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 adequate care and treatment to 2 of 7 current tenants reviewed (Tenant #2 and Tenant #5) and 3 of 4 discharged tenants reviewed (Tenant C1, Tenant C2 and Tenant C3) and potentially all tenants. Findings follow: 1. Record review on 8/5/26 revealedTenant C1 was a 76-year-old male who visited the wound clinic on 1/30/26 for an evaluation of a nonhealing ulcer on his buttock. He had additional wounds present to the left lower leg and right third toe. His wife believed the wounds were present for about one week. He had mild relief with the topical ointments. He also changed positions often. Tenant C1 sat on an eggcrate cushion. Record review on 8/5/26 revealed Tenant C1's Service plan dated 1/9/26 revealed he was totally dependent on staff to administer and order his medication. Tenant C1 received moderate nursing services as the Health and Wellness Director (HWD) ordered supplies, scheduled appointments and coordinated with his physician and outside providers such as his wound provider. He required skin care provided by licensed and unlicensed staff who were delegated by the nurse. Staff should refer to the Medication Administration Record (MAR) for specifics. He could wash his left foot daily with soapy water and use lotion for dry skin. He had a mild orientation issue that did not interfere with functioning in familiar surroundings. Tenant C1 could have some short-term memory issues.	**$8000.00**

	Record review of wound clinic notes revealed treatment ordered at the 1/30/26 wound clinic visit for the Stage II ulcer on his buttock changed from mupirocin and mometason creams to Medihoney. He did not need to cover with a Band-Aid but a piece of gauze could be placed over the wound to keep it from sticking to undergarments. It should be applied daily and as needed after bowel movements. Staff should clean the area with soap, water and pat dry. There was a nonhealing ulcer on his left lower leg which should be covered with gauze to protect the skin. He could wear Tubigrips to his bilateral lower legs each day, but should consider switching to compression stockings. Wash daily with soap and water and pat dry. Apply Prisma to the open area on the right third medial toe and buddy tape to the next toe. Change on bath days. Change positions at least every hour. Consider a ROHO cushion for the wheelchair instead of an egg carton cushion. A review of Tenant C1's February 2026 MAR was conducted on 7/16/26 at 11:16 AM with the Corporate Director of Operations (CDO), due to the Program switched to a new electronic record system and being unable to print out the MAR. The Program continued to treat a wound to his right heel (though it was not identified at the wound clinic). The Program failed to administer a band aid to his heel on: 2/12, 2/13, 2/14, 2/20, 2/23, 2/24, 2/25, 2/26, 2/27 and 2/28. He did not receive Diclofenac gel to his right shin on 2/14, 2/15 and 2/21. He did not receive the ordered treatment to his left lower leg on 2/12 to 2/28. Tenant C1 had a wound to his left buttock and did not receive the treatment from 2/12 to 2/28. Staff were to apply Tubigrips to Tenant C1's legs daily but they were not applied from 2/11 to 2/28. Treatment to Tenant C1's wound to his right third toe was not completed from 2/15 to 2/28. Tenant C1 returned to the Wound clinic on 2/27/26. He sat on a donut cushion to offload his buttocks and wore Tubigrips for compression. He did not have a dressing on his right third toe. The Stage II pressure ulcer to his buttock was healing nicely with only a very small open wound noted. The skin ulcer to the third toe of the right foot was limited to breakdown of skin with no open wounds. There were no open wounds to his left lower extremity but he still had 2+ edema. Treatment orders changed to use Medihoney to the left buttock wound, cover with gauze and tape, war compression stockings or Tubigrip daily and remove at night, and no dressing was needed to the left lower leg or right third toe.	

	Requests were made to the Executive Director for Tenant C1's March MAR on 7/16/26, 7/21/26 and 8/7/26 but a copy was not received in a format the surveyor could open. Review of a Progress Note on 8/5/26 indicated Tenant C1's bilateral lower extremities were red and painful on 3/15/26. The HWD encouraged him to go to the Emergency Room (ER). His wife took him. A review of hospital records revealed Tenant C1 went to the ER on 3/15/26 due to concerns for cellulitis of his lower extremity. He reported for the prior two to three days he experienced erythema and swelling of the left lower extremity and was starting to notice some redness in the right lower extremity as well. It was very tender to the touch. He had a history of Type II diabetes, peripheral neuropathy, obstructive sleep apnea, atrial fibrillation, hyperlipidemia and hypertension and amputation of the right fifth toe. He was predominantly wheelchair bound with a history of uncontrolled diabetes and recurrent lower extremity infection. During his hospitalization Tenant C1 experienced severe anxiety and agitation, Methicillin-resistant Staphylococcus aureus (MRSA) positive lower extremity cellulitis and sepsis with leukocytosis. Tenant C1 developed Acute hypoxic respiratory failure secondary to daptomycin toxicity. His family noted he displayed some signs of dementia. He was provided IV steroids and would taper off Prednisone upon his return to the Program. Tenant C1 was on high-dose short acting insulin along with Lantus. The Prednisone could induce hyperglycemia (high blood sugar) but this would improve with the Prednisone taper. He did not adhere to the recommended low carbohydrate diet as his family brought in high carbohydrate snacks and drinks. Tenant C1 was discharged with orders to check his blood sugar four times daily (before meals and at bedtime). His insulin should be held if his blood sugar was less than 120 or if he did not eat a meal. Tenant C1's needs were not reassessed by the HWD following this hospitalization. Record review on 7/16/26 of the April MAR revealed instructions for staff to inject 50 units of Humulin (insulin) 3 times daily before meals. There were no instructions about holding the insulin if his blood sugar was low or if he did not eat a meal. In a wound clinic note dated 4/6/26, the clinician noted his 2/27/26 visit his wounds were minimal. However, when he entered the hospital on 3/15/26 he had multiple wounds to include the left buttock, right buttock and right heel. The wife shared she may have caused a wound to his scrotum by using tape	

	there. He was using a doughnut cushion for offloading. He had been incontinent of bowel recently which was causing pain to his buttocks and scrotum. Since returning home his arms and legs were swollen and he didn't feel well. Treatment orders included: apply a thin layer of TheraHoney to buttock wounds daily and as needed. Apply Prisma to the right lower leg wound and cover with Mepilex border. Change dressing every two to three days. Continue wearing Tubigrip to bilateral lower legs. Reposition frequently throughout the day to relieve pressure. Sitting on the donut pillow was not recommended and he should switch to a ROHO cushion. Tenant C1 was edematous and his oxygen level was 94. He agreed to go to the ER. Tenant C1 presented at the ER on 4/6/26. He was assessed and his symptoms were determined to be related to his chronic medical conditions. He should follow up with his primary care provider (PCP) if his symptoms continued. The Program had no notes about the wound clinic visit or ER visit. The new wound orders were not added to the April MAR. There was no documentation Tenant C1's PCP was notified of his change of condition. Further review of progress notes revealed Tenant C1 received insulin the night of 4/7/26. Staff documented he refused the 8:00 AM dose of insulin (and all his morning medications) at 1:34 PM on 4/8/26. The HWD documented in the progress notes on 4/8/26 at 11:03 AM the Med Technician reported to her Tenant C1 missed his morning medication as he was sleeping in his apartment. The Med Technician said she raised her voice to try and wake him up but he wouldn't wake up. The HWD instructed the Med Technician to check his blood sugar and it was 24 (very low). The HWD administered 1 milliliter (ml) of IM Glucagon and called EMS. He was transported to the ER. The HWD called the Emergency Room (ER) and learned he would be admitted for altered mental status, hypoglycemia and urinary tract infection. The April MAR did not show documentation of staff checking Tenant C1's blood glucose four times daily as ordered when he was discharged from the hospital on 3/30/26. The Executive Director, Regional Director of Clinical Operations and Corporate Director of Operations were asked in an email to provide evidence staff completed Tenant C1's blood glucose readings on 8/7/26, but did not respond to the request. Record review on 8/7/26 revealed the Emergency Documentation indicated Tenant C1 arrived at the ER on 4/8/26 at 11:50 AM.	

	Upon arrival he was moaning with his eyes opened, but not following commands or providing meaningful communication. His wife arrived at 12:30 PM and reported they went out to eat the previous evening and she took him back to the Program. He seemed normal. Tenant C1 continued to display agitation in the ER, yelling at staff and striking his wife. He was transferred to another hospital. A further review of progress notes on 7/16/26 indicated the HWD went to the hospital on 4/20/26 to assess Tenant C1 for return to the Program. She determined he required a minimum assistance of two people.. He had a significant cognitive decline, did not respond to much and was frequently unable to take his medication. He was discharged from the Program. Hospital records reviewed on 8/7/26 revealed Tenant C1 discharged on 5/1/26 to a higher level of care. Diagnoses upon discharge included hypoglycemic encephalopathy, altered mental status, sepsis with leukocytosis due to urinary tract infection, cellulitis of the bilateral lower extremities and right upper extremity edema. The discharge instructions noted Tenant C1 would be discharged on a sliding scale insulin due to his hard to control blood sugars and to prevent further hypoglycemia. He had a high risk of readmission due to progressive dementia (not a noted issue prior to his 3/15/26 hospitalization). During an interview on 7/15/26 at 3:02 PM Staff C recalled working on 4/8/26. She went in to check on Tenant C1 later in the morning on 4/8/26 and he was not responsive. Staff C was not the Med Technician, she went in to provide a visual check. When she could not get him to wake up she got the HWD and then contacted 911. Tenant C1 did not return to the Program. The HWD and Staff O, who should have administered Tenant C1's 8:00 medication the morning of 4/8/26, no longer worked at the Program. She remembered Tenant C1 complained of leg pain all the time. She didn't know if he had sores on his legs as he always wore pants. When interviewed on 7/15/26 at 4:00 PM Staff N recalled some staff applied treatments to Tenant C1's legs and other staff did not. She recalled Staff O did not apply Tenant C1's wound treatments. The treatments took 20 to30 minutes to apply. Tenant C1 would refuse at times so Staff O would either mark refused or she administered them even if she did not do so. Staff N and others told the HWD about this but nothing was done.	

	When interviewed on 7/21/26 at 12:10 PM Staff K explained she heard Tenant C1 was not getting his dressings applied in the morning. These were generally applied in the morning and she worked at night. When she went to remove his Tubigrips at night they often weren't on. Some of the workers would say they didn't have time to apply them. When interviewed on 7/15/26 at 11:15 AM Staff L stated she entered Tenant C1's apartment and he asked her to apply his ointments and dressings because no one else had done so. He reported his legs were killing him. She asked Staff O to show her how to do these tasks because she did not know how to do them. Interviews and a review of MARs revealed staff did not reliably apply the treatments to Tenant C1's wounds. Tenant C1 presented to the wound clinic, ER and hospital reporting pain in his extremities lasting days or a week before seeking care. There was no evidence these symptoms were identified by Program staff who should have seen his wounds daily or addressed by the HWD. Tenant C1did not have his needs reassessed when he returned from the hospital on 3/30/26 or from the ER on 4/6/26 after experiencing cellulitis, uncontrollable blood sugar, signs of dementia and overall poor health. He ended up being hospitalized on 4/8/26 with extremely low blood sugar and upon discharge had a significant cognitive decline and required the assistance of two staff for transfers. There was no evidence staff monitored or checked his blood glucose levels as ordered, including on the morning of 4/8/26, to prevent hyperglycemia or hypoglycemia. 2. a. Record review on 7/16/26 of Tenant C3's Admission note, dated 1/6/26, indicated he was a 73 year old male with a history of Parkinson's Disease who presented to the outpatient neurosurgery clinic for replacement of the battery of his Deep Brain Stimulator (DBS). His diagnoses included arthritis, benign prostatic hyperplasia, chronic obstructive pulmonary disease, depression, diabetes mellitus, type two, history of skin ulcer of the left lower leg with fat layer exposed (5/4/23) and wound infection (6/15/18). During the procedure, completed on 1/6/26, he was taken to the operating room. The subcutaneous tissue was opened, the battery was removed and a new battery was connected. The wound was irrigated and vancomycin powder was applied. Closure was performed in a multilayer fashion with a vicryl suture. The skin was closed with Dermabond skin glue and a sterile dressing was applied. Tenant C3 was provided with instructions to keep the	

	wound covered for the first 3 days. He could run water over the wound after this time. He should not scrub the wound for two weeks following surgery. He could shower and pat the wound dry. His stitches were absorbable and did not need to be removed. The skin glue would flake off on its own. Record review on 7/21/26 revealed a Staff to Nurse Communication dated 1/13/26 at 9:30 (AM or PM not noted on the form) alerted the HWD Tenant C3 refused to shower as he did not want to get the patch wet from his surgery. The HWD responded in writing on 1/16/26 she spoke with Tenant C3's family and it was okay to get it wet. Continued record review revealed an Office Visit note dated 3/3/26 indicated since Tenant C3 had the battery on his IPG (Implantable Pulse Generator) replaced on 1/6/26. Today he still had the original band aide on his IPG site during the visit for he was told to keep the Band-Aid in place and not get it wet. The band aid looked dirty and was removed by the provider. The patient's left chest incision was a bit red but dry and intact. During an interview on 7/15/26 at 3:02 PM Staff C reported giving Tenant C3 a shower every Friday. She asked the HWD about the dressing and was told it should remain on until it fell off. When interviewed on 7/20/26 at 1:40 PM the Regional Director of Operations reported Tenant C3's bandage should have been removed after three days. The HWD should have requested the clinic records if she was unclear of the instructions from the physician. b. Tenant C3's Resident Assessment and Service Plan written on 3/5/26 noted he required verbal prompts and cues with toileting due to his tremors. Staff were to provide toileting assistance one to three times per week. He wore incontinence garments and used a urinal. It noted he struggled with making it to the toilet on time and urinated on the floor of his apartment unintentionally. Tenant C3 received routine housekeeping services and daily trash removal. His skin condition was described as normal, although his upper and lower extremities required staff to apply Aquaphor. He had scattered edema, flaky dry skin and ecchymosis. Tenant C3 did not use any wraps or hose to address his edema. He required staff assistance twice weekly with showering. He was able to express pain but had no pain. Tenant C3 made 0-2 errors on the neurocognitive evaluation indicating normal intellectual	

	functioning. There was no mention of him refusing assistance from staff. A review of observation notes on 7/16/26 revealed the following: - On 3/9/26 Tenant C3 refused a shower. Staff strongly encouraged him to take one but he said he was too tired. - On 3/20/26 his bilateral extremities were red and warm to the touch from ankle to mid-calf. The left lower extremity had a fluid filled blister. The HWD encouraged him to get evaluated but he refused. His PCP and wife were notified. A review of the MAR indicated the Program received an order for Ace bandages to his bilateral lower legs which started on 3/24/26. - On 4/7/26 at 6:50 PM Tenant C3 fell in his room and was found on the ground in front of his toilet. The HWD was called to his room. He reported pain to his lower back and bilateral lower extremities on 4/9/26. The HWD contacted Tenant C3's PCP with a request for pain management. On 4/10/26 staff reported he could not complete his activities of daily living himself and refused a shower (although staff documented on the task sheet a shower was completed). The HWD contacted the PCP's office again and left a message. On 4/13/26, Tenant C3 reported discomfort when walking to his posterior left lower extremity just above the knee which was a 5 out of 10 when walking. He had no pain when sitting. His PCP was again notified. A review of Tenant C3's April MAR revealed no over the counter or prescription pain medication administered during this time period. The PCP responded to the HWD's fax from 4/13/26 about his pain on 5/6/26 and asked her to monitor the situation. "A review of the April 2026 MAR revealed that starting on 4/10 and 4/11, after his pain started from the fall, Tenant C3 refused the Ace bandages to his lower legs. Staff documented, beginning on 4/12/26, that the bandages were "on hold per the nurse's orders," "nurses orders to hold off on wrapping legs," "discontinued," and "nurse's orders holding off on wrapping." - Tenant C3 had many dates on the April, 2026 MAR and May, 2026 MAR documented as refusing application of his Aquaphor ointment which staff were to apply to his legs twice daily as needed. On 4/12, 4/14, 4/16, 4/21, 4/25, 5/3, 5/5, 5/9, 5/10, 5/14, 5/18 it was documented as not administered as it was on hold per the doctor's orders. Other dates through the month staff did not administer the Aquaphor ointment noting Tenant C3 refused the	

	treatment. Staff applied the ointment to his legs twice between 5/9/26 and 5/30/26. There was no indication his PCP was contacted to inform him the tenant was not getting the ordered treatment. - He began taking Cephalexin twice daily on 5/21/26 as seen on the May MAR (no reason noted in the observation notes). On 5/26/26 he was seen by the Nurse Practitioner for a red, warm open area on his left lower extremity. The Cephalexin was increased to four times daily. Staff were to cleanse his lower left extremity with soap and water, apply telfa to the open lesions, wrap with kerlix and change daily. It was documented on the May MAR the wound treatment was self-administered. - Tenant C3 moved out of the building on 5/29/26. Record review on 7/20/26 and 7/21/26 of Monthly task logs, Care Tracking Sheets and Consumer-Directed Attendant Care Daily Service Records from March, 2026 - May 2026 indicated Tenant C3 received the following personal care which was identified on his assessment and service plan: March 2026: Housekeeping - completed on 3/3, 3/10, 3/15, 3/17, 3/19, 3/29 Laundry - completed on 3/3, 3/10, 317 Shower - completed on 3/6, 3/10, 3/15, 3/17, 3/20 April 2026: Weekly housekeeping - completed on 4/7, 4/14 Laundry - completed on 4/7, 4/14 Shower - completed on 4/7, 4/10, 4/17, 4/24 May 2026: Shower - completed on 5/8, 5/19, 5/26 During an interview on 7/15/26 at 8:30 AM and 8/4/26 at 11:50 AM Tenant C3's daughter reported when they took her father for his follow-up visit the neurologist said she had seen a lot over the years but nothing like that. They were paying the Program to provide her father with regular showers and could not understand why these weren't being done. After the appointment she spoke with the HWD and was told she did not receive instructions for wound care. Her father's apartment was not getting cleaned regularly. She was told they would have someone clean the bathroom daily as he urinated on the floor. This was not done. His legs were swelling and oozing at times. Due to her father's	

	functional limitations, he would not have been able to self-administer his wound care from 5/26/26 through discharge. When they gave a 30-day notice of discharge she felt like her father received worse care. Now that her father is home he is doing better and has no swelling in his legs. When interviewed on 8/4/26 at 12:10 PM Tenant C3's wife explained there were a couple of times she noticed her husband had red and swollen legs. She called the Program to alert them to the condition multiple times but did not receive a call back. The wife was aware of the seriousness of the condition as a few years ago he had edema and developed a wound which broke the skin open from his knee to the ankle. Her husband had to go to the wound clinic and it took forever to heal. She knew the symptoms to watch for to prevent this from happening. When he developed the blisters and oozing places on his skin this time she went to Walgreens and bought patches similar to what he had at the wound clinic. The staff used this material on his legs (there is no evidence of this on the MAR). Her husband could be testy at times but it would surprise her to learn he refused to let staff apply Aquaphor lotion to his legs through most of April and May. When she looked at his legs, they did look dry and this could lead to the open areas on his skin. His wife did not believe she was told he was on an antibiotic or had ordered wound treatment when she brought him home. When interviewed on 7/20/26 at 1:20 PM Staff A explained she noticed cleanliness issues with Tenant C3's apartment and person. The apartment had a strong odor. She was never directed to clean it more than once a week. When she went in to care for him, he commented it had been so long since he had help. His feet were swollen and cracked all over. It appeared as if his feet weren't getting taken care of at all. She tried to take care of all the tenants but there was only so much one person could do. When she learned he was moving it made sense to her. When interviewed on 7/21/26 at 10:30 AM Staff D recalled Tenant C3's legs looked as if they had eczema or psoriasis on them. When she was training, she never saw anyone apply lotion to his legs, they told her he didn't have any lotion. His apartment smelled of urine but not as strongly as Tenant #5's apartment. People didn't care to go into the apartment due to the odor. She didn't blame Tenant C3 for leaving as no staff wanted to go in the apartment. When interviewed on 7/15/26 at 3:02 PM Staff C described there were issues with getting people showers as scheduled until May,	

	2026 as only one person was scheduled in the front of the building. They didn't have a housekeeper at the time so the aides were responsible for doing cares, administering medications, answering pendants and cleaning apartments. Tenant C3's apartment smelled of urine and was always nasty. During an exit meeting on 7/23/26 at 10:50 AM with the Executive Director, CDO and Regional Director of Clinical Operations confirmed the findings. On 8/5/26 at 8:52 AM the Regional Director of Clinical Operations confirmed the Program failed to obtain an order to start Ace Bandages, discontinue the Ace bandages and discontinue the Aquaphor ointment. 3. Record review on 7/16/26 of Tenant #2's face sheet identified she was a 66-year-old female diagnosed with a fall with pelvic fracture, alcohol abuse, TIA, lumbar pain with sciatica and chronic pain. a. A review of Tenant #2's July MAR revealed staff administered her the following medication on a PRN or as needed basis: Butalbital-Acetaminophen-Caffeine 50-325-40, one tablet every 6 hours as needed for pain (a prescription combination used to treat tension headaches caused by muscle contractions, Butalbital is a barbiturate) and Hydrocodone/Apap tab 7.5-325, take 1 tablet four times daily as needed (a prescription painkiller, hydrocodone is an opioid). The July MAR showed Tenant #2 used both medications anywhere from 1-4 times daily for pain. The Program tracked the length of time it took for staff to respond when tenants pushed their pendants for assistance on a Device Activity Report. A review of this report on 7/21/26 revealed during the period of 6/20/26 to 7/21/26, Tenant #2 pushed her pendant 115 times. It took staff an average of 16 minutes and 44 seconds to respond to her pendant. The following instances were dates when it took staff more than 20 minutes to respond to Tenant #2's page for assistance: 6/20/26: 39 minutes 6/22/26: 24 minutes 6/23/26 at 5:56 AM: 41 minutes, 11:31 AM: 36 minutes 6/24/26: 31 minutes 6/26/26 at 2:15 AM: 39 minutes, 1:23 PM: 24 minutes, 4:26 PM: 50 minutes 6/28/26 at 5:19 AM: 34 minutes, 3:51 PM: 105 minutes	

	6/29/26 at 1:39 AM: 21 minutes, 2:34 PM: 34 minutes, 7:27 PM: 69 minutes 7/1/26 at 4:30 PM: 51 minutes 7/3/26: 22 minutes 7/7/26 at 7:42 AM: 24 minutes, 8:51 AM: 38 minutes, 5:32 PM: 30 minutes 7/8/26 at 5:17 AM: 21 minutes, 5:13 PM: 32 minutes, 10:24 PM: 45 minutes 7/12/26 at 11:57 AM, 5:29 PM: 26 minutes 7/13/26 at 12:45 AM: 33 minutes, 1:25 PM: 36 minutes 7/14/26: 25 minutes 7/15/26 at 7:36 AM: 41 minutes, 9:43 AM: 23 minutes 7/17/26: 61 minutes 7/19/26: 108 minutes During an interview on 7/15/26 at 3:02 PM Staff C reported concerns Tenant #2 was overly dependent on her pain medication. She would utilize her pendant requesting PRN medication every four hours on the dot. Sometimes she wondered if Tenant #2 really needed the medication or not so she would not rush to her room to administer the medication. When interviewed on 7/20/26 at 1:20 PM Staff A reported Tenant #2 would report her pain level as a 7/8 out of 10 to get her pain medication every four hours. Staff A would question if Tenant #2 really needed her pain medicine as it seemed like an addiction to her. She would drink beer and lay in bed all day. Tenant #2 told a co-worker she would check the medication cart as she walked by to ensure it was locked. Staff A supposed this was so she could get additional medication. Staff L was a former employee. She recalled a time when she entered Tenant #2's apartment to find her crying due to not receiving her pain medication. When Staff L asked her co-workers why Tenant #2 had not been administered her PRN medication, they said they were to put her off for an hour because she was pill-seeking. During an interview on 7/21/26 at 12:05 PM the CDO explained there was no policy on how quickly staff should respond to pendant requests but she thought it should be within 10-15 minutes. During an exit meeting on 7/23/26 at 10:50 AM the Executive Director, CDO and Regional Director of Operations confirmed	

	Tenant #2 was entitled to receive her PRN medication as ordered by her physician. The Program failed to ensure staff were properly trained in substance abuse issues to provide adequate care to Tenant #2. Her medical provider prescribed her PRN to be administered every four hours or four times a day. It was not for staff to decide if a medication should be administered in a different manner. b. A review of observation notes for Tenant #2 revealed the following: - She was observed with a harsh, productive cough with yellow mucus on 3/31/26. She was assessed and wheezing was discovered in her bilateral lung fields. An antibiotic was prescribed for seven days. - She completed her antibiotic on 4/7/26 but a harsh, productive cough continued. She continued to take an expectorant and an albuterol inhaler as needed. - The PCP ordered a new antibiotic for Tenant #2 on 5/5/26. - Tenant #2 met with her PCP on 6/8/26 and discussed her chronic cough. A new order was written for a chest x-ray. - She reported dryness and cracking skin to the bilateral bottoms of her feet on 6/22/26 as well as coughing and back pain. New orders were received for Aquaphor, Biofreeze and Tessalon Perles. A review of Tenant #2's July MAR revealed Ipratropium/Sol Albuter (Ipratropium and albuterol inhalation solution), inhale 1 vial via nebulizer every six hours was added to the MAR on 7/6/26. However, Tenant #2 did not receive the medication through at least 7/22/26. Staff documented on the MAR, "medication not available" and "does not have the machine". Observation of a medication pass for Tenant #2 on 7/21/26 at 1:50 PM. Staff D reported she was unable to administer the Ipratropium/Sol Albuter as the tenant did not have a nebulizer. Staff D reported Tenant #2 did have a cough. During the medication pass Tenant #2 stated she did not know why the nebulizer hadn't been delivered. She was told there was an issue with the pharmacy but hadn't been provided with any additional information. Tenant #2 experienced a coughing episode during the conversation.	

	The Program failed to take steps to get a nebulizer when it was prescribed for Tenant #2 who had been experiencing a harsh cough for over three months. 4. Record review on 7/22/26 for Tenant #5 noted she had a service plan dated 1/5/26. She was independent with toileting but had a history of urinary tract infections and used a urinary pad. Tenant #5 received routine housekeeping and laundry services. When interviewed on 7/20/26 at 1:20 PM Staff A described the condition of Tenant #5's room as a biohazard. She was known to urinate on her clothing and then hang the soiled clothing up. Her carpet needed deep cleaning. Tenant #5 was very independent so staff were only in her apartment to take out her trash and collect laundry. During an interview on 7/21/26 at 8:05 AM Staff J reported when she entered Tenant #5's apartment it was very dirty and had a strong odor. The clothing on her floor was soiled with urine. When interviewed on 7/21/26 at 12:10 PM Staff K explained she was able to smell urine coming from Tenant #5's apartment when walking down the hall. She was not sure if the tenant needed more assistance with cares as the tenant was very reserved. Staff K could not visibly see signs of Tenant #5's incontinence but could smell the odor when she was in her presence. During an interview on 7/21/26 at 10:30 AM Staff D stated Tenant #5's apartment was stinky. The tenant would leave her soiled clothing sitting in her bathroom. Staff D would encourage her co-workers to wash Tenant #5's clothing twice to try and rid them of the smell of urine. When Tenant #5 came to meals she would smell of urine. When walking through the building on 7/15/26, 7/16/26, 7/21/26 and 7/23/26 a smell of urine was present in the vicinity of Tenant #5's apartment. During a tour of the building on 7/21/26 at 9:05 AM the Executive Director confirmed she was aware of the odor on that date. There was no evidence of interventions being put in place to address Tenant #5's incontinence and the manner in which it was likely becoming a dignity issue.	

	During an interview on 7/23/25 at 10:05 AM the Regional Director of Clinical Operations reported she was not aware of these issues but would address them when she returned to the community. 5. Record review on 7/16/26 of a preadmission Comprehensive Assessment for Tenant C2 dated 2/9/26 revealed he was admitted from another assisted living program with a planned move in date of 2/23/26. He used a walker and wheelchair for mobility. Tenant C2 required standby assistance when transferring. He had experienced 3 or more falls within the previous 90 days. Tenant C2 was diagnosed with Lewy Body Dementia with tremors. The HWD took Tenant C2's vitals but did not obtain his height or weight. A Care Plan was developed on 2/23/26, his move-in date, which noted Tenant C2 required the assistance of 2 staff for transfers. They should use a gait belt and grab bar. Review on 7/16/26 of the Nurse Practitioner ' s Progress note dated 3/2/26 identified he was experiencing ongoing, worsening evening delusions and hallucinations related to Lewy body dementia. He was recently hospitalized for dehydration. Staff reported he experienced more than 4 falls since admission. He required 2-3 staff for assistance with transfers. Tenant C2 discharged from the Program on 4/15/26. During an interview on 7/15/26 at 8:10 AM Staff M recalled Tenant C2 was a large man, perhaps 400 pounds, who had frequent falls. There were often only two caregivers working in the building, but even 2-3 staff could not get him up. When he was on the floor, they had to call the fire department to get him up. When interviewed on 7/15/26 at 4:00 PM Staff N explained it would routinely take 4 staff to lift Tenant C2 from the time he moved to the Program. He would slip from his chair to the floor. The Program admitted a tenant who required the assistance of two staff for transfers. Program staff were unable to provide adequate services to Tenant C2 and had to call the fire department to lift him from the floor. They were unable to meet his needs on a routine basis. When interviewed on 7/16/26 at 11:16 AM the Regional Director of Clinical Operations confirmed Tenant C2 should not have been admitted to the Program if he was a two-person transfer, however she was not working at the Program at the time he resided there.	

	6. During an observation on the dementia-specific unit on 7/15/26 at 11:45 AM there were 6 tenants sitting in the dining room. Five tenants received the regular meal and one tenant had an alternative meal. There were two additional tenants who needed the main dish, cottage pie, but no food was available. There was a sufficient amount of dessert. Staff requested food at 11:45 AM and again at 11:52 AM. Extra food was brought at 11:54 AM. When interviewed on 7/15/26 at 11:12 AM Staff L reported the kitchen frequently did not send enough food to the dementia specific unit to meet the needs of the tenants. There were men who would ask for additional food and the kitchen would not send it back. When interviewed on 7/16/26 at 8:55 AM Staff P explained she believed there used to be issues with the former cook not sending enough food to the dementia specific unit but she thought for the most part things had improved. When interviewed on 7/15/26 at 8:10 AM Staff M reported in the past there were times the kitchen wouldn't send back enough food for the tenants living on the dementia specific unit. The kitchen staff would get upset when they asked for more food. They expected the tenants to eat half meals and that didn't work. Observations on 7/16/26 at 11:40 AM there was a sufficient amount of food sent to the dementia specific unit for lunch. A plate of food sat on the table when Tenant #8 arrived and sat down in that spot. She reported her food was cold. Tenant #9 also indicated her food was cold. A review of the Daily Temp log indicated the Chicken Alfredo was 105 degrees when the employee checked the temperature. The biscuit was 48.3 degrees and the watermelon and cucumber were 57 degrees. The food was on a warming cart that was not plugged in. A further review of selected Daily Temp Logs from 6/1/26 - 7/20/26 revealed the following temperatures in degrees Fahrenheit: 6/1/26: bacon - 88.5, tomato soup - 105.2, grilled cheese - 104 6/9/26: pork tenderloin sandwich - 97.8, tater tot - 101.2, cold sandwich - 71.9 6/21/26: sausage patty - 123.8, bacon - 113.9, diced pork - 101.3, broccoli and carrot mix - 99.1, potato wedges - 109.2, ravioli - 122.4, fruit cocktail - 69.9	

	7/15/26: cottage cheese - 42, butterscotch pudding - 60, cheese - 69.4, tomatoes - 53.2, eggs - 64.7, carrots - 55.7, lettuce - 46.7, onions - 61.9 7/17/26: salad bar - eggs 42, grapes - 49.1, watermelon salad - 45.9, cottage cheese - 46.8, shredded cheese - 57.8, peppers - 50.3, carrots - 51.2, lettuce - 50 7/18/26: yogurt - 57.9, mandarin oranges - 51.8 During a meeting with the Culinary Director and Executive Director on 7/16/26 at 12:10 PM, the Culinary Director reported there was no cord to plug in the warming cart but one was on order. They would put a plan in place to ensure food was not taken to the dementia specific unit until all tenants are seated. Record review on 7/21/26 of the Program's Food Safety and Sanitation Policy (undated) noted cold foods would be maintained at 41 degrees or below and hot foods would be maintained at 135 degrees or above. During an interview on 7/21/26 at 8:25 AM the Executive Director reported a new plug arrived for the warming cart and was installed. She did not know how long the food temperatures were at an unacceptable level but they were talking as a team about ways to solve the problem.	