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

Date: March 9, 2026
Program Name: Addington Place of Carroll
Address: 1214 East 18th Street, Carroll, IA 51401
Type of Action: Addington Place of Carroll Recertification Visit, Investigations #130751-C and #130778-I
Date(s) of Action: 1/6/26 – 1/7/26
Citation #11059

State Rule #	State Rule	Amount of Civil Penalty
Iowa Administrative Code 481 Chapter 67.2(3)	**67.2(3) The program shall follow the policies and procedures established by the program.** Based on observation, interview, and record review, the Program failed to follow established policies affecting 2 of 5 tenants reviewed (Tenant #1 and Tenant #5). Findings follow: Record review on 1/06/26 and 1/07/26 revealed the following: 1. An incident report dated 11/01/25 revealed Tenant #1 had an unwitnessed fall which, Tenant #1 reported to staff reportedly occurred on the evening of 10/31/25 around 11:30 p.m. Per the incident report Resident Statement, Tenant #1 stated she went to go to the bathroom, then to get a drink of water and tripped over her blanket. Tenant #1 indicated she laid on the floor the rest of the night, no one checked on her, and she tried to call the Program three times and no one answered the phone so she called 911 on the morning of 11/01/25 around 9:45 a.m. The Program's internal investigation of the incident revealed the Program staff was unaware of Tenant #1's fall and the need for assistance until emergency personnel arrived in response to the 911 call. Tenant #1 was transported to the hospital for further evaluation and monitored for an elevated Troponin level. There were no other injuries noted from the fall. They were not able to determine if the elevated Troponin level was a result of the fall or a precursor which contributed to the fall. She returned back to the Program. Tenant #1 admitted to the Program 9/09/23 and diagnoses included Atherosclerotic heart disease, atrial flutter, non-ST elevation myocardial infarction, osteoarthritis, disorders of bone density and structure, chronic kidney disease, malignant neoplasm of the colon, hyperlipidemia, essential (primary) hypertension, and unspecified dementia without severity. Tenant #1 scored a three	**$3000.00**

	on the Global Deterioration Scale (GDS) which indicated only a mild cognitive impairment. During the course of the Program's internal investigation, it was determined Tenant #1 was not wearing her call pendant at the time of the fall. The Program reviewed the work phones and no calls were received in to the Program and determined Tenant #1 likely misdialed during her attempts to reach Program staff. The Program further determined an overnight staff member (Staff A) failed to conduct the overnight visual safety check for Tenant #1 per her service plan, despite having documented a visual safety check at 6:13 a.m. at the end of Staff A's shift on the morning of 11/01/25. At the conclusion of the Program's internal investigation, Staff A was terminated from employment. During an interview on 1/06/26, Tenant #1 shared she fell on the evening of 10/31/25 but didn't have her call pendant to call for assistance, didn't holler out for help, and didn't recall having her phone during the incident. She indicated she couldn't get up, and no staff came to check on her and she laid on the floor for several hours until the next morning. Review of the layout of Tenant #1's room and description of the incident of the location of the fall within her apartment from Tenant #1 revealed Tenant #1 would have been in direct line of sight from the apartment door. Review of Tenant #1's service plan dated 10/01/25, reflected Tenant #1 was independent with most Activity of Daily Living (ADL) tasks but required a visual safety check to "lay eyes on resident to ensure safety" one time per shift. The service plan noted she was capable of pressing her pendant. She occasionally was confused and had some difficulty recalling details and needed some prompting following directions or notes. Review of the ADL task documentation for the timeframe of the incident noted the 6:13 a.m. documented entry time by Staff A of a visual check. It further noted no visual safety check had been completed by Program staff during the evening shift of 10/31/25 per Tenant #1's statement of the approximate time of the fall. Further review of the October and November 2025 visual check documentation noted missing visual checks on: 2nd shift check on 10/18/25, 3rd shift check on 10/26/25, 2nd and 3rd check on 11/06/25, 3rd shift check on 11/08/25, 3rd shift on 11/12/25, 3rd shift on 11/18/25, 3rd shift check on 11/22/25, and 2nd shift on 11/27/25.	

	A review of the Program's policy entitled "Monitoring Residents" indicated tenants will be checked on in accordance with their individualized service plan. When interviewed on 1/06/26 at 4:45 p.m., the Executive Director (ED) reviewed the ADL visual task documentation from the dates of 10/31/25 and 11/01/25 and confirmed the documentation. 2. Tenant #5 was observed during a 2:00 p.m. medication pass on 1/06/26 and further reviewed. At the time of the medication pass by Staff B, it was noted Tenant #5's Furosemide medication bubble pack was labeled with a sticker which indicated the medication was to be administered at noon. Review of the physician's orders for Tenant #5 confirmed the orders were for 40 Milligram(s) (mg), one tablet of Furosemide to be administered at noon. Following the administration/medication pass Staff B further investigated and determined the medication labeling was correct, but had been entered into the electronic medication administration record (MAR) system incorrectly. A review of the Medication Administration Record (MAR) for January 2026 revealed due to the entry error, Tenant #5's Furosemide medication had been administered at 2:00 p.m. outside of the one-hour window of noon administration time on the dates of 1/01/26 through 1/06/26. A review of the Program's policy, "Receiving Medications" dated 6/13/24 included: -All medications, including over-the-counter (OTC) medications, must be verified for accuracy and labeling prior to being placed in central storage. -Verify the physician's order has been transcribed on the MAR correctly. When interviewed on 1/06/26 at 4:45 p.m., the Executive Director (ED) confirmed the medication dosage time was incorrect in the electronic medication administration record system and stated the Program corrected the order in the system on this day. On 1/07/26 at 11:00 a.m. the Executive Director and Regional nurse/current interim delegating Program nurse confirmed the above findings related to Tenant #1 and Tenant #5.	