Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation

Date: April 28, 2023
Program Name: Addington Place Ottumwa
Address: 173 East Rochester Street Ottumwa, IA 52501
Type of Action: Complaints #108559-C, #109456-C and #109480-C
Date(s) of Action: 12/13/22 – 12/30/22
Citation #: 6086

State Rule #	State Rule	Amount of Civil Penalty
IAC 481-67.9(1)	**67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.** Based on interview and record review, the program failed to ensure a sufficient number of trained staff available at all times to fully meet the identified needs of 1 of 3 discharged tenants reviewed (Tenant C1). Findings follow: 1) Record review on 12/14/22 revealed an Incident Report for Tenant C1 dated 9/30/22 at 6:01. Former Staff A wrote, the kitchen fire alarm broke/malfunctioned again, so Staff B and she went down the hall to tag doors and get everyone outside. She went to Tenant C1's room to move her out, since she had done that last time this happened and it was perfectly fine. She had the wheelchair fully locked and close to her recliner. She helped her to get up and into the wheelchair. She suddenly fell down on her left arm and hip. She rolled onto her back and was crying out in pain. When interviewed on 12/15/22 at 12:25 PM, the hospice nurse who responded to Tenant #1's fall reported the (former) Director, Staff A and another staff were present were present when she arrived. Tenant C1 screamed when the on-call nurse received the call 30 minutes prior to her arrival and at the time she arrived. The on-call nurse asked how this happened. Staff A said she was getting Tenant C1 up, went to put Tenant C1 in her in the wheelchair, and the wheelchair went zip. The on-call nurse asked how the wheelchair went "zip" and Staff A said she did not have the brakes on the wheelchair. They then got a lift and transferred Tenant C1 back into her recliner. A mobile x-ray was scheduled for the following day. During an interview on 12/15/22 at 11:50 AM, Tenant C1's regular hospice nurse reported the tenant was moved to a nursing facility a few days after her fall. She was bed bound and rapidly declining. Tenant C1 needed more pain management than staff could provided in an assisted living program.	**$6000.00**

	Tenant C1 died on 10/5/22. Her cause of death was listed as complications from a hip fracture. A description of the injury noted: fell while being transferred with help of facility staff in own room. Tenant C1 had a service plan dated 8/17/22., which identified Tenant C1 was an assist of 1 with her gait belt to stand and pivot to her bedside commode. Tenant C1 received hospice services. Her primary diagnosis was malignant neoplasm of an unspecified site of the left breast. A hospice plan of care dated 8/5/22 to 10/3/22 identified Tenant C1 required 24 hour supervision, energy conservation and safe transfers. Hospice provided Tenant C1 with a gait/transfer belt to assist with these transfers. Hospice provided an aide to Tenant C1. The aide was to assist with transfers from the chair to the commode using a gait belt and walker. The plan identified interventions for Tenant C1 such as to ambulate patient using a walker and a safety intervention of a transfer belt. On 12/14/22 at 10:55 AM, the Life Enrichment Coordinator reported prior to 9/30/22, Tenant C1 had a significant fall and got a commode in her room. After the fall, Tenant C1 mostly went from the commode to the recliner in her room and vice versa. Tenant C1 never left her room. She had all her meals in her room. Tenant C1 said her anxiety was too high and didn't want to come out. On 12/19/22 at 10:20 AM, Staff B reported she worked in the kitchen with Staff A on 9/30/22. The fire alarm went off and Staff A said she would take care of Tenant C1 because she had done it before. Staff B checked on the tenants in the 400 hall and everyone was out of their apartment. Staff B realized Staff A and Tenant C1 were not out of the apartment yet so she went in to check on them. Tenant C1 was on the floor and yelling. Staff B said Tenant C1 fell. Staff B said if she was in a tenant's room, she would not help to transfer them because she was not trained to do this. She would press the tenant's pendant to get assistant from a trained staff member. On 12/19/22 at 10:50 AM, the Assistant Director stated she hired and trained Staff A. Staff A was trained not to handle tenants because she was not trained to do so. The Assistant Director did not understand why Staff A would try and move Tenant C1 if she knew the alarm came from the dishwasher and there wasn't really a fire. Dietary staff were told not to touch tenants in an emergency situation if at all possible. Staff A got trays from tenant's apartments frequently. There was a situation with another worker who helped a tenant up and got in a lot of trouble, so the Assistant Director made sure dietary staff knew not to transfer tenants.	