

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

Date: June 2, 2026
Program Name: Apple Valley
Address: 300 Lyndale Street, Osage, IA 50461
Type of Action: Investigation #131670-C
Date(s) of Action: 4/23/26 – 4/28/26
Citation #11140

State Rule #		Amount of Civil Penalty
Iowa Administrative Code 481 Chapter 67.2(2)	67.2(2) The program shall follow the policies and procedures established by the program. Based on interview and record review, the Program failed to follow policies related to medication management and on-call nurse communication for 1 out of 6 tenants reviewed (Tenant C2). Findings follow: 1. Record review revealed Tenant C2 had diagnoses including hypertensive urgency, acute cystitis, nausea with vomiting, diabetes mellitus type 2, mild cognitive impairment, chronic kidney disease, Aicardi-Goutieres syndrome, presbycusis, major depressive disorder, and edema. Tenant C2's service plan, dated 11/26/25, noted Tenant C2 had a Global Deterioration Scale (GDS) score of 2 and required assistance with medication ordering, storage, and administration. The service plan further noted Tenant C2 required staff assistance with injectable medication and communication with primary care physician. 2. Record review on 4/27/26, revealed Tenant C2 had a physician's order dated 11/6/25 for the following medication: torsemide 20 (milligram) mg daily to address fluid retention. Tenant C2's November 2025 medication administration record (MAR) lacked documentation the medication was given 11/06/25 through 11/10/25. The Health and Wellness Coordinator documented an administration of the medication on 11/11/25 although Tenant C2 was hospitalized on this day. A hospital discharge report obtained from the hospital on 4/29/26, revealed Tenant C2 was initially admitted to the hospital due to acute congestive heart failure with preserved ejection fraction exacerbation 11/10/25. On 11/14/25, Tenant C2 was transitioned to skilled care to address ongoing issues with	\$5000.00

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	fluctuations in blood sugars, kidney function, and blood pressure until 11/26/25. Tenant C2's nurse's notes revealed the following documentation: a. 11/06/25 - The Health and Wellness Director confirmed Tenant C2 had a doctor appointment on 11/06/25 and returned with the following orders: Stop humalog insulin 75/25 twice daily and start tresiba insulin 25 units nightly, start novalog insulin 6 units three times a day before meals, check blood sugars before meals and at night, check basic metabolic panel in one week. Check weight every three days in the morning. Send blood pressure, blood sugars and blood pressure to the physician in one week. The Health and Wellness Director's documentation failed to include the order for the torsemide 20 mg daily. b. 11/10/25 - The Health and Wellness Director noted Tenant C2 had edema in her face and lower extremities with increased blood pressure. Tenant C2's daughter was called and Tenant C2 was taken to the emergency room to get evaluated. c. 11/10/25 - The Health and Wellness Director received a call Tenant C2 was admitted to the hospital due to fluid retention. d. 11/10/25 through 11/26/25 Tenant C2 was hospitalized. Continued record review on 4/27/26, revealed the Program's Medication Management policy, dated 9/25/25, indicated each administration of medication must be documented in the resident's medication administration record (MAR), including the date, time, dosage, and the name of the staff member administering the medication. When interviewed on 4/28/26 at 9:01 a.m., the Health and Wellness Director indicated she believed the order for torsemide 20 mg was for three days a week at that time and that was why it had not been given between 11/06/25 through 11/10/25 as well as the fact Tenant C2 refused to take the medication for staff which was documented in nurse's notes on 10/30/25. 3. Record review on 4/27/26, revealed a physician's order and nurse's note dated 10/22/25, to increase Tenant C2's metoprolol succinate to 150 (milligram) mg daily and increase 70/30 insulin to 30 units in the a.m. and 28 units in the p.m.	
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	Tenant C2's October 2025 medication administration record revealed Tenant C2's blood sugar reading was 56 on the morning of 10/23/25 and no reading was completed on 10/26/25 in the p.m. A fax document to Tenant C2's physician from the Health and Wellness Director, dated 10/27/25 revealed the following: Tenant C2's blood sugar dropped to 49 on 10/24/25 and to 54 on 10/23/25 (which was likely the reading of 56 on 10/23/25). Nurse's notes reflected no documentation by on-call nurse that staff reported unusually low blood sugar levels at any time between 10/22/25 through 10/26/25. Nurse's notes dated 10/27/25 revealed a new order for Tenant C2's 70/30 insulin to increase to 32 units in the a.m. and 25 units in the p.m. Record review on 4/28/26, revealed the Program's policy titled: Call the on-call Nurse for, revised 9/21/25, directed staff to call the on-call nurse for elevated or low blood sugars. When interviewed on 4/28/26 at 10:30 a.m., the Health and Wellness Director reported she was on vacation the week staff indicated Tenant C2 had low blood sugar levels. She was not sure why staff reported different numbers than what was documented. The Health and Wellness Director confirmed she was told about the low blood sugar levels on 10/27/25 when she returned from vacation. The Health and Wellness Director indicated she immediately notified the physician and received a new order. She confirmed staff should have called the on-call nurse at the time the low blood sugars were observed. 4. When interviewed on 4/28/26 at 1:30 p.m., the Regional Director of Operations, the Health and Wellness Director, and the Corporate Director of Operations confirmed the above findings.	
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