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

Date: July 30, 2025
Program Name: Allen Place
Address: 1406 East 19th Street Atlantic, IA 50022
Type of Action: 129932-I, 129930-C, 129933-C, 129934-C, 129950-C
Date(s) of Action: 7/15/25 - 7/17/25
Citation #: 10871

State Rule #	State Rule	Amount of Civil Penalty
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 ensure appropriate care, treatment, and services for 1 of 1 former tenants reviewed (Tenant C1). Findings follow: Record review on 7/15/25 revealed Tenant C1 admitted to the program on 1/7/22 with a diagnoses including dementia, Waldenstrom Macroglobulinemia (type of non-Hodgkin lymphoma), and enlarged prostrate without lower urinary tract symptoms. His medications included low dose aspirin, memantine, ferrous sulfate, abilify, Remeron and Flomax. A service plan dated 6/3/25 identified Tenant C1 required staff to use stand by assistance with weekly showers to ensure safe transfer in/out of the shower, to wash hard to reach areas, shampoo, and towel dry. The service plan further identified Tenant C1 required one-person staff assistance for dressing, and for grooming. The service plan identified the tenant was at risk for falls and staff were to escort him to and from meals and activities. The service plan identified Tenant C1 required the assistance of one staff for toileting needs. A "180-Day" evaluation dated 3/4/25 (the last evaluation/assessment on file) further confirmed the above needs and staff assistance levels. An incident report dated 7/8/25 at 6:30 pm revealed Tenant C1 was in the shower when he slipped on the wet floor. Apparent injuries at the time of the incident were abrasions on the tenant's head and right arm, and a hematoma. Vitals were obtained which included a blood pressure reading of 121/90. The tenant was assisted up from the floor, dried off, and dressed. Emergency services were notified and transported Tenant C1 to the emergency room (ER). The incident investigation revealed a non-skid bathmat was not in place at the time of the incident. Non-skid bathmats were used as a standard protocol for the tenants residing at the program. Review of the ER report dated 7/8/25 at 7:44 pm revealed abrasions were noted to the right elbow and left head. He admitted to a headache, but had no other complaints of pain. The evaluation at the ER noted discharge present of both eyes and included the following	**$10,000.00**

	comments: Pupils 2mm bilaterally, right pupil sluggish to direct light, left pupil unresponsive to direct light. The neurological exam noted no focal deficit present and Tenant C1 was alert and oriented x 3 (self, place, and situation) and mental status was at baseline per Tenant C1's dementia. Blood pressure was noted as 181/97. A CT without contrast of the head was obtained and included the following results: The brain demonstrates findings of a large mixed density subdural collection involving the right cerebral hemisphere. The subdural collection measured on axial image 25 is measuring 15mm in maximum thickness. There is localized compression of the cortical sulci throughout the left cerebral hemisphere related to the mass effect from the hemorrhage. There is hemorrhage seen to extend along the tentorium of the cerebellum on the left and slightly into the posterior falx. There is a small component of hemorrhage seen within the right frontal lobe which has the appearance of subarachnoid blood. There is midline shift by 2 mm. No associated mass. The posterior fossa is unremarkable. Progress/nursing notes from the hospital included the following: - 2037 (time): Radiologist called to report large subdural hemorrhage and subarachnoid hemorrhage. - 2055 noted a nurse reported Tenant C1 was declining and needed to be intubated and noted a discussion with the son of Tenant C1 there was no guarantee he would recover. - 2101 noted Tenant C1 would be admitted for comfort cares The hospital documentation did not note Tenant C1's time of death. Program progress/nursing notes revealed the following: - on 7/8/25 at 10:13 pm it was documented outreach was received from Case County Memorial Hospital ER. Reports that resident will be admitted for brain bleed. - on 7/10/25 it was documented outreach received from Cass County Memorial Hospital. Resident passed away 7/9/25. According to the program's internal investigation Staff C began employment on 6/6/25. Staff C was responsible for assisting Tenant C1 with his shower on the date of the incident. In Staff C's written statement dated 7/15/25 he wrote he was trained by a fellow co-worker and stated Tenant C1 required stand by assistance. He believed stand by assistance was "where the resident showers themselves while the caregiver steps out." Staff C wrote he had previously given Tenant C1 a shower with this method. On the date of the incident on 7/8/25 he thought this method was the correct assistance level to be provided to Tenant C1. Staff C included the following in his statement: "I lacked the proper training on the proper stand by procedure. Due to this lack of training, I thought the shower mat that's normally down but was up that day should remain up" ...and "once [Tenant C1's] in the bathroom, I leave the bathroom as to what I was taught before and leave the door half open while I sit in a near-by chair and feet away from the bathroom. Around a minute into the shower he falls." On 7/16/25 review of Staff C's training revealed an untitled checklist used for orientation/delegation training that included four sections of	

	training under the headings "Day One Items", "Prior to Continuing in Orientation", "Remainder of the First Week", and "First Month of Employment." The section entitled "Day One Items" and "Prior to Continuing in Orientation" which related to program policies and human resource/onboarding tasks was initialed as complete on 6/12/25. The additional sections which noted orientation topics such as demonstrating of proper technique for resident cares, including bathing and standards indicated as to occur on "Week 2" of the training were blank/incomplete. No orientation topics listed on the document addressed the definitions of assistance levels such as stand by assistance as required for Tenant C1. Further review of online orientation training via the program's Relias learning platform revealed ten courses were completed by Staff C, but none related to bathing or to the definitions of assistance levels as required by Tenant C1. During an interview on 7/16/25 at 2:45 pm, the Executive Director/Nurse (ED) stated the training process included Staff C shadowing another staff/trainer with his orientation/delegation packet. The trainer was to check off (sign/date) a care task once they felt the new employee was confident in completing it. She stated she relied on the word of the staff trainers to determine when a new employee was ready to work on the floor. Staff C had been working on the floor providing care without the supervision of a trainer. She stated she had previously asked Staff C to return his orientation/delegation packet but he did not prior to the department's investigation. If he had she would have known his orientation/delegation checklist was incomplete. The ED stated the standard program expectation for stand by assistance was for staff to be "right next to the resident with any type of cares, within a hands reach distance of that resident" and stated during the internal investigation of the incident she had questioned Staff C as to his understanding of this expectation and realized Staff C did not have an accurate understanding. The ED acknowledged Staff C's orientation/delegation checklist was incomplete and lacked proof of training related to resident care areas and levels of assistance. She acknowledged services for Tenant C1 were not provided as identified on his service plan. During an exit on 7/17/25 at 11:35 am the ED and Regional Director of Resident Care (attended by the Area Director of Operations via phone) confirmed the above findings.	
69.29(3)	**481—69.29(231C) Staffing.** **69.29(3) The owner or management corporation of the program is responsible for ensuring that all personnel employed by or contracting with the program receive training appropriate to assigned tasks and target population.**	

	Based on interview and record review, the program failed to ensure 1 of 7 staff reviewed received training appropriate to assigned tasks and target population (Staff C). Findings follow: Record review on 7/15/25 revealed Staff C was hired on 6/6/25. Review of Staff C's delegation checklist on 7/17/25 revealed training topics under a section entitled "Day One Items" were signed/dated on 6/12/25. The remaining pages (pages 2 and 3) which included training appropriate to assigned tasks and target population were blank and incomplete. During an interview on 7/16/25 at 2:45 pm, the Executive Director/Nurse (ED) stated Staff C's training process included shadowing another staff member/trainer who was to check off (sign/date) each care task on his orientation/delegation packet once the trainer felt Staff C was confident completing it. She had not received Staff C's delegation packet back yet. She stated she relied on the word of the staff trainers to determine when a new employee was ready to work on the floor. She confirmed Staff C had been working on the floor providing care without the supervision of a trainer. During a follow-up interview on 7/17/25 at 9:15 am, the ED had received Staff C's delegation packet back from him and acknowledged his delegation training had not been completed, with no signatures/dates related to pages 2 and 3 which included training appropriate to assigned tasks and target population. During an exit on 7/17/25 at 11:35 am the Executive Director and Regional Director of Resident Care (attended by the Area Director of Operations via phone) confirmed the above findings.	