

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

Date: April 14, 2021
Program Name: Prairie Hills Senior Living
Address: 2903 F. Avenue NW Cedar Rapids, IA 52405
Type of Action: Complaint 93272, recertification visit
Date(s) of Action: 2/3/21 to 2/16/21

THIS FORM HAS BEEN AMENDED TO REFLECT THE REVISED EXIT DATE

State Rule #	State Rule	Amount of Civil Penalty
67.3(2)	<p>481-67.3 Tenant rights. All tenants have the following rights: <u>67.3(2) To receive care, treatment and services which are adequate and appropriate.</u></p> <p>Based on interview and record review the Program failed to provide care, treatment and services that were adequate and appropriate to 2 of 2 former tenants reviewed (Tenant #1 and Tenant #2). Findings follow:</p> <p>1. On 2/8/21 a review of Tenant #1's file revealed an electronic Incident Report dated 9-5-20 at 7:30 p.m. indicating Tenant #1 was found unresponsive by staff when they entered his apartment. Staff called emergency medical services (EMS) and the nurse on-call (Nurse 1). Tenant #1's family was notified. Nurse 1 completed the incident report.</p> <p>Tenant #1's diagnoses included Parkinson's disease, hypertension, long term and current use of anticoagulants and non-rheumatic aortic valve disorder. The service plan indicated Tenant #1 ambulated independently with a wheeled walker. Review of Tenant #1's oxygen saturation readings from 8-24-20 to 8-31-20 indicated they ranged from 95% to 99%.</p> <p>Review of a handwritten IR dated 9-5-20 at 7:30 p.m. indicated Tenant #1 returned to the Program at approximately 3:00 p.m. after an outing with family. Tenant #1 and his family both reported he was dizzy. Staff took Tenant #1 to his apartment in a wheelchair. Once he was in his chair staff asked if he had eaten and both Tenant #1 and his family member confirmed he had. Staff advised him to drink water and rest. His vitals were taken and his oxygen saturation was 83%. Staff asked him if he had trouble breathing and he said it was a little harder than normal but it might have been the mask. Staff placed him on one hour vital checks and went in at 4:30 p.m., 5:30 p.m. and 6:30 p.m. At 5:30 p.m. his oxygen saturation was 88% and temperature was 97.6. Staff called the on-call nurse (Nurse #1) who advised to have him lay down and continue to drink more water. After dinner Tenant #1 laid down in bed and at 6:30 p.m. his oxygen saturation was 89% and temperature was 97.3. Since he "was improving" staff advised him to keep laying down. At 7:30 p.m. Tenant #1 was found sitting in chair and was unresponsive. He was cold to the touch and no pulse or oxygen saturation could be measured. Staff called the Assistant Healthcare Coordinator (at the</p>	\$5000.00

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time) and EMS. One staff stayed with Tenant #1 and attempted cardiopulmonary resuscitation (CPR) and the other staff went to wait for EMS. The incident report was completed by Staff F.

When interviewed on 2-16-21 at 2:18 p.m. the former AHC (Assistant Healthcare Coordinator) said she was told Tenant #1 had been out with family and was light headed and not feeling well. Staff called the nurse on-call at that time, took vitals and checked on him. She got a call from Staff G that Tenant #1 was not breathing and they could not get a pulse. Tenant #1 had recently changed his resuscitation status to a full code. She instructed staff to put him on the floor and start CPR. Staff F called 911. When she arrived to the building EMS was there. She contacted Tenant #1's family and the Director. Per protocol the ambulance called the police and the police called the medical examiner. The former AHC was not contacted about Tenant #1, prior to the call about his being found unresponsive.

According to a typed statement completed by the former AHC on 9-5-20 the incident report indicated Nurse #1 (the on-call nurse) was notified by Staff F that Tenant #1 was not feeling well after a visit with his family. At 7:35 p.m. she received a call from Staff G that Staff F had checked on Tenant #1 and he was not breathing and was without a pulse. Tenant #1 had recently signed a full code I-POST. Staff was instructed to lower Tenant #1 to the floor, begin CPR and call 911. Staff F went to the front door to direct EMS and Staff G administered CPR. EMS took over when they arrived and she arrived just after EMS. At 7:48 p.m. Tenant #1's family was called and called back at 7:56 p.m. Resuscitation efforts were unsuccessful and the time of death for Tenant #1 was called at 8:05 p.m. The medical examiner arrived per protocol at 8:48 p.m.

On 2-9-21 at 3:36 p.m. the Director said she was told Tenant #1 was not feeling well when he was out with family. Staff said Tenant #1 laid down and did not feel well. She was notified by the former AHC that she was on her way into the building and staff was administering CPR on Tenant #1. The Director was not the on-call nurse and was not notified by staff regarding Tenant #1.

Review of Tenant #1's Certificate of Death revealed he passed away on 9-5-20 at 8:05 p.m. of arteriosclerotic cardiovascular disease. The manner of death was indicated as natural.

The Program's Nurse Delegation for Measuring Vital Signs indicated to notify the nurse if a tenant's oxygen saturation was less than 90%.

In summary, Tenant #1 returned to the building and was not feeling well. Staff used a wheelchair to assist him to his apartment. Tenant #1 typically ambulated independently with a wheeled walker. The incident report indicated staff took his vitals and his documented oxygen saturation level was 83%. Hourly vitals checks were started. The incident report documented the on-call nurse was contacted at the 5:30 p.m. check when Tenant #1's oxygen saturation was at 88%. This was the first documentation of the on-call nurse (Tenant

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#1 returned at 3:00 p.m.). Instruction provided included for Tenant #1 to lay down and continue to drink more water. At 6:30 p.m. his oxygen saturation level was at 89%. Oxygen saturations for a two week period prior to the incident ranged from 95% to 99%. There was no documentation of any recommendations for Tenant#1 to be evaluated in the emergency room for dizziness, SOB, not feeling well or low oxygen saturation levels. Tenant #1's oxygen saturation did not exceed 90% in the hours prior to being found unresponsive by staff at 7:30 p.m. There was only one time the on-call nurse was documented as contacted (5:30 p.m.) until staff found Tenant #1 unresponsive. Staff then contacted the former AHC who was not the nurse on-call.

2. Review of Tenant #2's file revealed an electronic Incident Report dated 8-3-20 at 12:30 p.m. indicating staff responded to Tenant #2's emergency pendant and found her sitting on the bathroom floor without her oxygen. Tenant #2 said she had come from lunch to use the bathroom before an activity. She had taken her portable oxygen off and left it on her walker in the living room while she used the restroom. Tenant #2 had complaints of pain in the left hip near the buttock. Per the nurse, Tenant #2 was assisted to a wheelchair with instructions to not bear weight on the left leg. Tenant #2 was taken to the hospital where it was determined she sustained a left hip fracture. The incident report was completed by the former AHC.

Tenant #2's diagnoses included pulmonary hypertension, peripheral vascular disease, emphysema, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia and pneumonia. The service plan reflected she ambulated independently with a walker and had continuous oxygen at 2L per NC.

According to a handwritten Incident Report dated 8-3-20 at 12:30 p.m. Tenant #2's pendant went off and a fall was detected. When staff responded Tenant #2 was observed seated on the bathroom floor without her oxygen. She did not know how it happened. There were injuries noted to her left hip and left leg/knee. The incident report was signed by Staff D.

When interviewed on 2-10-21 at 10:30 a.m. Staff D said she responded to a pendant that indicated a fall for Tenant #2. She found Tenant #2 on the bathroom floor and asked if she was hurt. Tenant #2 said her leg hurt pretty badly. Staff D called Staff E and the former AHC. When the former AHC arrived she asked Tenant #2 if she was hurt and Tenant #2 said her leg hurt. Tenant #2 was between the toilet and the sink and was sitting up. The former AHC wanted to walk her to the bed and put her arms around her in a "bear hug." Tenant #2 could not walk and Staff D got her a stool to sit on. Staff E went and got a wheelchair and all three staff helped the tenant into the wheelchair. When Tenant #2 was assisted from the floor to standing she had tears in her eyes and said she could not move her leg. Tenant #2 did not complain of pain when transferred from stool to the wheelchair. Tenant #2 was not moved prior to the arrival the former AHC.

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A handwritten statement signed by Staff D indicated on 8-3-20 at 12:30 p.m. the pendant went off for Tenant #2 that a fall was detected. She found Tenant #2 seated on the bathroom floor and asked her if she was hurt. Tenant #2 said her leg hurt. Staff D called for Staff E and the former AHC to assist. The former AHC asked Tenant #2 if she was hurt and Tenant #2 said her leg hurt. The former AHC said to get Tenant #2 up off the floor and staff did. The former AHC told Tenant #2 they were going to walk to the bed and put her arms around the tenant like a "bear hug." Staff D stood behind Tenant #2 and Staff E was to her left. Tenant #2 voiced that she could not move her leg and the former AHC told her she would help her get to the bed. Staff D grabbed a stool that was in front of Tenant #2's vanity and put it behind Tenant #2 so she could sit down on it. Staff E brought a wheelchair and the three staff transferred her into it. An ambulance was called. Staff D and Staff E did not move Tenant #2 until they directed to by the former AHC to move her.

A handwritten statement signed by Staff E indicated Tenant #2's pendant went off as a fall, Staff D responded and then called Staff E for assistance and to bring the vitals kit. When Staff E responded she observed Tenant #2 on the floor in her bathroom without her oxygen and walker. She applied her oxygen and Staff D told the former AHC to come upstairs. Staff took her vitals and when the former AHC arrived, the three staff assisted Tenant #2 up. She was unsteady on her feet and staff put her on the chair that she had in her bathroom. The former AHC directed staff to get a wheelchair. Staff E got a wheelchair and they put her in the wheelchair. The former AHC left and Staff E pushed the tenant to the living room. Staff E then left as her shift was over.

On 2-16-21 at 2:18 p.m. the former AHC said she was in the building when she received a call from Staff D to help right way in Tenant #2's apartment. Tenant #2 had gone to her apartment after lunch to use the restroom prior to Bingo. She did not have her walker or portable oxygen in the bathroom. She stated when she arrived Tenant #2 was standing with a staff on each side of her and bearing weight on the right leg but was unsteady. She took a hold of her in a "bear hug" while staff got a wheelchair. One staff stayed with her. She put her foot under Tenant #2's foot and she did not put any weight on it. She realized how much pain Tenant #2 was in. The tenant was assisted into the wheelchair. Tenant #2's family was contacted and agreed to have her sent to the hospital. The former AHC believed staff lifted her up as Tenant #2 would not have been able to get up herself. Staff were not supposed to move tenants until they called a nurse. She responded very quickly when called to Tenant #2's apartment. Tenant #2 was standing when she arrived at the apartment.

When interviewed on 2-19-21 at 3:36 p.m. the Director said she was notified Tenant #2 had fallen, was in a lot of pain and EMS was called. She talked to couple of staff who were upset. The former AHC made a comment along the lines of knowing something was broken based on how Tenant #2 yelled. Staff said they were told by the former AHC to move Tenant #2. The former AHC denied she

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	<p>told staff to move Tenant #2. Staff was re-educated on the training for falls and to not move a tenant but to call 911.</p> <p>The Program's policy for Fall Procedure and Head Injury indicated staff were to not move the tenant but to call the nurse. If the tenant denied pain and the nurse instructed to do so, the tenant could be assisted up. This policy was reviewed and signed by Staff D on 8-6-20, Staff E on 8-26-20 and the former AHC on 9-9-20</p> <p>Further record review revealed a Certificate of Death for Tenant #2. The certificate indicated Tenant #2 died on 8-8-20 at 2:20 p.m. The cause of death was indicated as physical deconditioning due to the displaced fracture of neck of the left femur due to a fall. The manner of death was listed as an accident.</p> <p>In summary, Tenant #2 activated her pendant and was found sitting on the floor in her bathroom. Tenant #2 verbalized severe pain in her left leg. Staff D and Staff E's staff statements and Staff D's interview indicated Tenant #2 was not moved until the former AHC arrived. The former AHC said Tenant #2 was standing with staff on one side of her when she arrived to the apartment and Tenant #2 would not have been able to get up herself. Staff D reported she was sat on a stool and then transferred to a wheelchair. Staff E also indicated she was placed on a chair that was in her bathroom and then transferred to a wheelchair. Tenant #2 had an unwitnessed fall, was moved from the floor to a stool/chair and then to a wheelchair, despite verbalization of severe pain. Tenant #2 was transferred to the hospital with a hip fracture and died on 8-8-20.</p>	
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