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

Date: May 1, 2023
Program Name: Courtyard Estates at Hawthorne Crossing
Address: 601 Hawthorne Crossing Drive SE Bondurant, IA 50035
Type of Action: Complaints #111387-C
Date(s) of Action: 3/6/23 – 3/7/23
Citation #: 6092

State Rule #	State Rule	Amount of Civil Penalty
IAC 481-69.27(1)(c)	**69.27(1) If a tenant does not receive personal or health-related care, but an observed significant change in the tenant's condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse:** **c. To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status;** Based on interview and record review the Program failed to complete nurse reviews for 1 of 1 discharged tenants reviewed that exhibited a change in condition (Tenant C1). Findings follow: 1. Record review on 3/6/23 and 3/7/23 of Tenant C1's file revealed diagnoses included: personal history of transient ischemic attack and cerebral infarction without residual deficits, hypertension (HTN), hyperlipidemia, aortic valve stenosis and paroxysmal atrial fibrillation. Tenant C1 was staged at a four on the Global Deterioration Scale (GDS) on 1/18/23, which indicated moderate cognitive decline. He was staged at seven on the GDS on 3/1/23, which indicated very severe cognitive decline. Tenant C1 passed away on 3/4/23. Record review of Tenant C1's file on 3/6/23 and 3/7/23 revealed Tenant C1's Progress Notes indicated the following: a. On 1/11/23 Tenant C1's Primary Care Provider (PCP) prescribed antibiotics for treatment of a urinary tract infection. On 1/18/23 Tenant C1 completed the treatment and no complaints of pain or blood in his urine were reported. b. On 2/6/23 Tenant C1 complained of bloody, painful urinations in the morning. A urinalysis (UA) was obtained and no pathogens were noted. On 2/13/23 Tenant C1's UA results were sent to the PCP. c. On 2/17/23 an attempt to contact the family to discuss the service plan and service agreement and difficulty obtaining results from the PCP. On 2/20/23 the UA results were sent again to the PCP. On	**$5000.00**

	2/21/23 Tenant C1 requested to go to an urgent care clinic due to blood in his urine. Tenant C1 had an appointment with the PCP that afternoon. Tenant C1's family did not show up to take Tenant C1 to his appointment. Calls to Tenant C1's family went unanswered. e. On 2/28/23 Tenant C1 had an appointment at 11:00 a.m. with his PCP and received an order for antibiotics. Tenant C1 returned from his appointment with slurred speech and an unsteady gait. At 2:20 p.m. voicemail messages were left for Tenant C1's family members regarding his condition. The PCP was contacted and directed to monitor Tenant C1 since his vitals were within normal limits (WNL) and he received antibiotic treatment earlier in the day. The PCP office further reported Tenant C1's family did attend his appointment and the family did not know Tenant C1's baseline. At 2:31 p.m. Tenant C1's family was informed of Tenant C1's slurred speech and unsteady gait. Tenant C1's family did not want him sent out to the emergency department (ED) and wanted to wait 24 hours for the antibiotics. At 4:57 p.m. it was noted Tenant C1 continued to have slurred speech, he ate some of his evening meal and his vitals were stable. At 6:10 p.m. staff found Tenant C1 on the floor. He had two small abrasions on his bilateral elbows. Tenant C1 continued to have nonsensical speech. A call was placed to the PCP; however, there was no answer and no on-call services available. An attempt to contact Tenant C1's family was made without success. f. On 3/1/23 at 9:12 a.m. Tenant C1 did not want to get up and staff called the nurse to Tenant C1's apartment. Tenant C1 did not respond to verbal stimuli but opened his eyes with physical stimuli. Tenant C1's family was called and a message was left. At 9:17 a.m. emergency medical services (EMS) was notified. At 9:25 a.m. EMS arrived and transported Tenant C1 to the hospital. Due to Tenant C1's condition the hospital and family opted for hospice services. A change of condition was completed by the Healthcare Coordinator on 3/1/23. At 6:00 p.m Tenant C1 returned to the Program with hospice services and received comfort cares only. Tenant C1 passed away on 3/4/23. Continued record review revealed the ambulance run report indicated on 3/1/23 at 9:25 a.m. a call for service was received, they were dispatched at 9:26 a.m. and arrived at the building at 9:32 a.m. The clinical impression was a stroke, the duration was 22 hours and the onset time was 2/28/23 at 1:00 p.m. When EMTs arrived Tenant C1 was unconscious and did not respond to verbal stimuli. It was noted on 3/1/23 staff found him on the couch, wearing clothes from the day prior, they moved him from the bed to the couch and he became unresponsive. When moved from the couch to the cot he opened his eyes, moved an arm and made moaning noises. Vital signs were as follows: blood pressure was 194/97, pulse was 67, oxygen saturation was 97% on room air. EMTs noted Tenant C1 had right sided facial droop and did not respond to pain on his right side. Tenant C1 was transported to a hospital via ambulance and arrived at 10: 10 a.m.	

	Continued record review of Tenant C1's file revealed Comprehensive Assessments were dated 1/18/23 and 3/1/23. A nurse review, completed by a RN, was not documented with the changes noted in Tenant C1's health status on 2/28/23 and 3/1/23, including changes in his speech, with slurred and nonsensical speech, changes with his ability to eat and use utensils, changes in his gait and ability to ambulate, changes with his ability to take medications and significant altered mental status changes that were noted on 2/28/23. Additionally when staff discovered Tenant C1 was minimally responsive on 3/1/23, in his clothes from the prior day and sleeping on the couch, all of which was a change for Tenant C1, a nurse review was not completed as needed. The EMS run reported noted right sided facial drooping and Tenant C1 had no response to pain on his right side. Tenant C1 was transported to the hospital and had "massive" cerebral hemorrhage. Tenant C1 was placed on comfort cares, hospice services were initiated and died on 3/4/23. Nurse reviews were not completed as needed for Tenant C1 on 2/28/23 and 3/1/23 with significant and acute changes noted in his health status. When interviewed on 3/7/23 at 9:32 a.m. Staff E stated when she took Tenant C1 to his appointment on 2/28/23 and he acted like he did not want to go. Tenant C1 acted confused like he did not remember where doors were and he bumped into doors. While sitting at the doctors office he looked around like he was looking for chairs. After Tenant C1's appointment the nurse at the doctor's office said they wanted a urine sample sent back to them. Staff E brought Tenant C1 back to the building at about 1:00 p.m. and Tenant C1 continued to run into doors. She reported Tenant C1 was different with the way he acted and he did not know what was going on. When interviewed on 3/7/23 at 10:01 a.m. Staff A stated she worked in Tenant C1's hall on the first shift on 2/28/23. She reported there was nothing unusual with Tenant C1 until Tenant C1 returned at approximately 12:30 p.m. Tenant C1 was very confused and was not acting normal. Tenant C1 talked about going to fairs and had an unsteady gait. Two staff walked him back to his apartment and about 1:00 p.m. the licensed practical nurse (LPN) obtained his vital signs. At shift change she told the second shift to keep an eye on him as he was not very stable. The LPN and Director were in his apartment, took vitals again and spoke with the primary care provider (PCP). The PCP would not let them send Tenant C1 out to the hospital. The next morning on 3/1/23, at approximately 6:10 a.m. when checked Tenant C1 was asleep on his couch wearing the same clothes from the previous day. At 7:00 a.m. when she checked on him he opened up his eyes but did make any verbalizations. At 7:30 a.m. or 8:00 a.m. she returned and shook Tenant C1 to wake him. Tenant C1's spouse also tried to wake him to no avail. Staff A notified the LPN who was in the building. They attempted to help him stand up as Tenant C1 was incontinent of urine. When they stood him up he laid on Staff A and they sat him back on the couch. The LPN said to get a set of vitals and the LPN called the doctor. The doctor said to keep monitoring. Tenant C1's	

	blood pressure was a little high. She stated she was not okay with what the doctor said as Tenant C1 was not himself. Tenant C1 was sent out to the hospital before lunch. She said Tenant C1's family said he had a stroke, was septic and was not going to make it. She spoke with second shift staff, who worked the prior evening, who said he was unstable, had a fall and did not really eat the evening meal (on 2/28/23). Staff knew something was very wrong. When interviewed on 3/6/23 at 4:39 p.m. Staff B said she worked second shift on 2/28/23 and first shift staff reported Tenant C1 was acting unusual. She checked on Tenant C1 at approximately 3:00 p.m. and it seemed like he was looking for something and his words did not make sense. At about 3:00 p.m. she called the Healthcare Coordinator, and reported how Tenant C1 was acting and expressed concern. The Healthcare Coordinator said Tenant C1 jad been to the doctor and had a urinary tract infection (UTI) and told her the medications would be coming in. She told Staff C about how Tenant C1 was acting and Staff D overheard her talking about it. Staff B, Staff C and Staff D went to see him. Staff D told Staff B to call the LPN. The LPN told Staff B Tenant C1 received an antibiotic shot from the doctor. Staff B reported Tenant C1 was wobbly and staff needed to assist him when he came out to the meal. During the meal he did not know how to eat, he ate with his fingers, and a lot of the food did not go into his mouth. On the way back from the meal Tenant C1 attempted to get up and almost fell. Staff B obtained a wheelchair to assist him. She explained Tenant C1 had a hard time understanding what was going on and he could not bend his legs. Staff B and Staff C assisted him back to the couch. Staff B came back in about ten minutes later and Tenant C1 was on the floor by the coffee table. Staff C came back to help. Staff B called the LPN and she told her to take his vitals, complete an incident report and to get him up. Staff B and Staff C assisted him back to the couch. Tenant C1 was sliding off of the couch, spoke "gibberish" and was incoherent. At about 7:30 p.m. she administered Tenant C1's antibiotic. Tenant C1 had a blank stare, was not responding and did not understand. He was not swallowing water and came out his mouth. She explained it was very difficult to administer the medication and she put it in his mouth. She explained she administered medications to Tenant C1 during the evening meal and it was easier then. When she checked back on Tenant C1 he slept on the couch. She told the third shift about the fall, what was going on with Tenant C1 and to keep an eye on him. When interviewed on 3/6/23 at 4:12 p.m. Staff C said she worked second shift on 2/28/23. When she came on shift, Tenant C1's words were slurred. Staff B, Staff C and Staff D went to see Tenant C1. Staff B called the LPN and was told to check his vitals. She said Staff B asked her to help get Tenant C1 and his spouse out to the meal. She said staff helped him get his walker and he walked out to the dining room. She said Tenant C1 acted very odd, he talked but it did not make sense. Tenant C1 displayed slurred speech. At the table, Tenant C1 could not use utensils and used his hands. After the meal he attempted to get up and staff assisted him back to his apartment. Tenant C1 acted confused about where he	

	was going. Tenant C1 walked but he was unsteady. He pushed his walker away. Staff C returned to her assigned hallway and was called back to help by Staff B. Tenant C1 was on the floor and Staff B contacted LPN. When interviewed on 3/7/23 at 9:09 a.m. Staff D said on 2/28/23 at 4:50 p.m. Staff C said Tenant C1 and his spouse were not out to dinner and it was unusual. She went to their apartment and Tenant C1 sat on the couch. Tenant C1's speech was very slurred and he needed assistance to stand up. Once up, he walked to another room when Staff D attempted to get him to go out for the meal. When she saw his condition she told Staff B to call the LPN and let her know. When interviewed on 3/7/23 at 10:47 a.m. the LPN said Tenant C1 had an appointment and returned without any paperwork. When Tenant C1 got back to his apartment, she obtained his vitals and they were WNL. Tenant C1 talked "gibberish" and had nonsensical speech. The Director came to the apartment and took his vitals and verified the blood pressure. She called the doctor's office and reported Tenant C1 was not able to follow commands and reported how he was acting. She was told the doctor had seen him and there were not any concerns. The LPN explained it was not Tenant C1's baseline. The nurse from the office said Tenant C1 received a Rocephin (antibiotic) injection and an antibiotic was ordered for a UTI. The LPN asked if he needed to be sent out and she was told to monitor him. The urinalysis (UA) previously completed was negative for pathogens. She called Tenant C1's family and family did not want Tenant C1 sent out for evaluation. At about 4:30 p.m. Staff B reported Tenant C1 was acting odd and speaking "gibberish." Staff B was told he had an appointment earlier and the family and doctor did not want him sent out. At 6:10 p.m. she received a telephone call that Tenant C1 was sitting on the floor. After a check of range of motion and vitals she told staff to get him up with the lift and staff assisted him to the couch. She called the doctor's office after hours and received no response. She attempted to contact Tenant C1's family without success. The LPN did not hear anything from staff after the call about Tenant C1's fall. The next morning Staff A said she could not wake Tenant C1. The LPN responded and Tenant C1 responded to physical stimuli. She activated emergency medical services (EMS) to have him sent out. She called the doctor's office and family multiple times. The ambulance arrived and Tenant C1 was taken to the emergency department (ED). Family reported he had a stroke and was not expected to make it. Tenant C1 returned to the building on hospice services. When interviewed on 3/7/23 at 11:20 a.m. the Healthcare Coordinator said he was out of the building in the afternoon on 2/28/23. He was aware Tenant C1 was going out for an appointment in the morning but did not see him prior to the appointment. The LPN was in the building and on-call on 2/28/23. He denied staff contacted him on 2/28/23, including second shift staff. He was not contacted by the LPN on 2/28/23. He returned to the building at 12:00 p.m. on 3/1/23 and was informed about Tenant	

	C1. At 12:30 p.m. or 1:00 p.m. the LPN received a telephone call and Tenant C1 had a significant brain bleed, had a stroke, was not going to make it and they wanted him to return to the building. It was explained that all medications needed to be discontinued, hospice medications needed to be in house and he needed to complete an assessment. He said he would have liked to have been notified on 2/28/23; however, the LPN was his surrogate when he was not in the building. When interviewed on 3/7/23 at 12:30 p.m. the Director said Staff E called and said it was hard to get Tenant C1's on the bus (related to his appointment). Staff met Staff E when she returned with him after the appointment to assist in getting him off of the bus. The LPN said Tenant C1 had slurred speech, was unstable and his vitals were WNL. She asked the Director to take his vitals. The LPN attempted to call Tenant C1's family and called the doctor's office. The doctor's office said family did not show up to the appointment and they did not know his baseline. The LPN told the office it was a change for him. Tenant C1 was administered Rocephin and was prescribed an antibiotic for a UTI at the appointment and were told to monitor him. Tenant C1's family declined to have him sent out for evaluation. The next morning staff reported Tenant C1 was unresponsive. Tenant C1's family was contacted after multiple attempts regarding sending Tenant C1 out for evaluation. When a visitor arrived to see Tenant C1's spouse the Director contacted Tenant C1's family and she was told Tenant C1 was not going to make it. It was requested that Tenant C1 return to the building on hospice services. When interviewed on 3/7/23 at 2:30 p.m. the Healthcare Coordinator confirmed the LPN did not complete a full assessment. The assessment was completed on 3/1/23 at the hospital.	

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