

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

Date: January 16, 2025
Program Name: Stirlingshire of Coralville MC
Address: 1140 Kennedy Parkway Coralville, IA 52241
Type of Action: 121004-C
Date(s) of Action: 10/7/24 – 10/31/24
Citation #: 10716

State Rule #	State Rule	Amount of Civil Penalty
67.3(2)	<p><u>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.</u></p> <p>Based on interview and record review the Program failed to provide care, treatment and services that were adequate and appropriate for 1 of 4 former tenants reviewed (Tenant C1). Findings follow:</p> <p>1. Review of Tenant C1's file on 10/9/24 revealed an Incident Investigation Report dated 3/29/24 indicating during lunch, staff observed Tenant C1 appear to struggle with eating and turn blue. Staff performed the Heimlich maneuver and called 911. Hospice and Tenant C1's legal representative were notified. Tenant C1 was transferred to the emergency department (ED). The staff involved were B, G, H and I.</p> <p>An internal investigation revealed staff attempted the Heimlich maneuver until she went unresponsive, then started cardiopulmonary resuscitation (CPR) per 911 directive. Tenant C1 was on hospice but staff said they were not able to find her Do Not Resuscitate (DNR) paperwork. The DNR forms were located by the Director of Nursing (DON). The internal investigation indicated corrective action was required and all tenant charts were re-organized with code status forms in a consistent location in all charts. Direct care staff were re-educated on where to locate code status paperwork. A typed statement with the report indicated on 3/29/24 at approximately 12:43 p.m. the DON was notified Tenant C1 was unresponsive during lunch. Staff reported they were overseeing the tenants during lunch and noticed Tenant C1 turn blue in the face and thought she was choking. Staff started the Heimlich maneuver, notified 911 and hospice. Per 911 dispatch, staff continued the Heimlich maneuver and were to start CPR if she went unresponsive. Staff told the 911 dispatch Tenant C1 was on DNR status and on hospice. The 911 dispatch instructed them to perform CPR nonetheless. Tenant C1 became unresponsive and two staff started CPR. Medics arrived and took over compressions. The DON arrived back as Tenant C1 was being loaded into the ambulance. The DON told the medic the tenant had a DNR status and located the DNR paperwork. Emergency medical technicians (EMTs) said she had a pulse and they were leaving to go to the hospital.</p>	\$10,000

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Staff G no longer worked at the Program and an attempt for an interview was unsuccessful. Staff G's written statement dated 3/29/24 indicated around 12:30 p.m. in the dining room, she was clearing dishes when she noticed Tenant C1's face was purple. She told Staff H and Staff I she believed Tenant C1 was choking. They checked for a pulse. Staff H called the DON and Staff I called 911. Staff B arrived and helped with the Heimlich maneuver. Staff B and Staff H switched off doing the Heimlich maneuver. Tenant C1 became unresponsive and 911 directed staff to start compressions whether Tenant C1 was a DNR or not. EMTs came and continued compressions.

When interviewed on 10/23/24 at 10:00 a.m. Staff H said she was passing medications and came to the dining room. Staff G told her Tenant C1 did not look good. She thought the tenant's skin appeared to be purple. Staff H called the tenant's name but got no response. She was at the table in her wheelchair. Staff H immediately started the Heimlich maneuver as she believed Tenant C1 was choking. It did not dislodge anything. The tenant then became completely unconscious. Staff called 911 and hospice. The 911 dispatch told Staff I to do chest compressions so she did. Staff H called hospice and the DON. She confirmed brussels sprouts were served that day. It was her belief everyone in the memory care unit should have their food chopped or cut up, but stated there were no mechanical or special diets at the Program. She confirmed the EMTs asked for the tenant's IPOST (Iowa Physician Orders For Scope Of Treatment) or DNR form but they could not be located by any of the staff.

When interviewed on 10/29/24 at 4:30 p.m. Staff I said during lunch one of the aides noticed a blue tint to Tenant C1's mouth and it was realized she was choking. She told the medication aide on the other side of the building and EMTs were called. She looked for the DNR form in Tenant C1's file but could not find it. The EMTs revived the tenant and took her to the hospital. Staff I remembered brussels sprouts were served and said Tenant C1 did not have a special diet. She said in general, the staff walked around and cut up food in memory care but there was not an ordered diet for Tenant C1. She did not remember if her food was cut up that day.

On 10/23/24 at 10:21 a.m. Staff B said she was working on the other side of the building and Staff I came over and asked her to come to the memory care unit. It was lunch time. When she got there, Tenant C1 was standing up with staff behind her. When staff put her on the floor, the tenant's lips were purple/blue in color. She and Staff I alternated completing chest compressions. Staff called 911 and were told to keep doing CPR until EMS arrived. She said Tenant C1 did not have a pulse until EMS got one back. Tenant C1 was not on a special diet.

When interviewed on 10/24/24 at 9:50 a.m. Staff J said she was cook that day and prepared the lunch meal. She did not recall the entire menu but said brussels sprouts were served. Tenant C1 was not on a special diet. After lunch, one of the staff said paramedics were called because a tenant was choking on brussels sprouts in memory care.

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She said the brussels sprouts were not cut for the tenant. Staff J said she had stressed to the Dining Director on the day of the incident before the meal was served that the brussels sprouts should be cut in half for those tenants in the memory care unit. She was told those tenants could eat what the assisted living tenants ate. Staff J stated there was not a registered dietician involved to go over food preparations and techniques. Since that incident she chopped up food for the folks in the memory care unit before it was plated.

During interviews on 10/22/24 at 9:46 a.m. and 10/31/24 at 2:27 p.m. the Dining Director said there was no special diet order for Tenant C1 that had been provided to him. He said they did not offer special diets. They served brussels sprouts, a hamburger and potatoes for lunch that day. He did not cook that day but said if it was a bigger vegetable it would have been cut up. He had heard in passing that someone choked on brussels sprouts. He had not seen the food that day and no concerns were brought to him prior to the serving of the meal regarding the brussels sprouts.

When interviewed on 10/24/24 at 11:10 a.m. the DON said she had been out to lunch when she was called by staff to come back to the building. She was told staff did the Heimlich maneuver until she was unconscious, then CPR was started. When the DON arrived Tenant C1 was getting CPR from EMS and was being loaded into the ambulance. The DON reported the tenant's diet order at the time of the incident was for cut-up food. She said in general, the kitchen plated the food and put a cover on it. The cart was transported to the memory care unit and direct care staff took it to the tables and uncovered it. Direct care staff cut up her food. She did not know if dietary staff or direct care staff cut up Tenant C1's food that day. She said direct care staff were aware of her order and they generally cut up her food. She believed she had either told the Dining Director or one of the chefs of Tenant C1's diet order for cut up food, but could not recall exactly who she had told. The meals served were all regular diets. They had never had a special diet or a pureed diet at the Program. She explained that not only Tenant C1 needed her food cut up but almost all other tenants in memory care had their food cut up as well. She did not recall how long Tenant C1 had swallowing issues. Regarding life saving measures, the DON stated staff were not required to be CPR certified. The staff working that day were following the 911 dispatcher's directive. When staff first started at the Program, she demonstrated how to do the Heimlich maneuver and it was also shown during the skills fair.

When interviewed on 10/23/24 at 1:07 p.m. the Executive Director said she was not involved with the incident but was called about it. She said staff were told by the 911 dispatch to start CPR. She did not know Tenant C1's diet orders and did not know what was served to her that day. She said Tenant C1 was DNR, and staff followed the direction given by 911 dispatch and provided CPR. She believed staff handled it to the best of their ability. She said it was a combination of direct care and dietary staff regarding who was responsible to ensure diet orders were followed. Diet orders were given to the Dining

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Director who would tell the dietary staff. She said sometimes chefs would go ahead and cut foods and other times staff in memory care would do it. It was a combined effort. She did not know if dietary staff or direct care staff confirmed Tenant C1's food was served per her diet.

A review of ambulance records revealed on 3/29/24 at 12:30 p.m. Tenant C1 was choking on food and was in cardiac arrest. Tenant C1 had an airway obstruction, was unresponsive, and her skin was cold and pale. The ambulance was dispatched related to a tenant choking. She was found in the memory care dining room receiving CPR by staff. Staff reported she started choking on her lunch but they were not sure what was stuck. Abdominal thrusts were attempted without success. Tenant C1 went into cardiac arrest so they started CPR. Staff reported Tenant C1 was a DNR but staff could not produce the form and said they did not have access until the nurse returned from lunch. Resuscitation was continued as no IPOST or DNR was provided. A paramedic attempted to visualize the airway and was able to remove some food with suction and forceps. A scene survey was completed and there were brussels sprouts present. Removal was not successful. Cricoid pressure was applied and the brussels sprout was moved to a position where it could be removed. At a later pulse check, a pulse was found so CPR was stopped but ventilations continued. Tenant C1 was placed on a stretcher. The ambulance arrived at the hospital and Tenant C1's care was turned over to the Emergency Department (ED) staff.

Hospital records indicated Tenant C1 was admitted on 3/29/24 and discharged (death) on 3/30/24. Tenant C1, who had a history of dysphagia, went into cardiac arrest after choking on brussels sprouts. Due to an unclear code status, CPR was started and return of spontaneous circulation (ROSC) was obtained. It was noted she received two rounds of epinephrine with ROSC. CPR was performed for an estimated 20 minutes. Tenant C1 was brought to the ED where she was unresponsive. The plan was for comfort measures and to hold all non-essential medications. A transition would occur to acute hospice care for end of life treatment after a discussion with Tenant C1's family. The Death Record documented Tenant C1 died on 3/30/24 at 10:03 a.m. The primary cause of death was acute asphyxiation.

On 10/9/24 further review of the tenant's file revealed Tenant C1 was staged at a six on the Global Deterioration Scale (GDS), which indicated severe cognitive decline. Service plans dated 2/5/24 and 3/18/24 reflected she had a regular diet, meals were provided three times per day and she needed her food cut up into small bite sized pieces. Tenant C1 had a code status form dated 10/4/23 that indicated DNR which was signed by the attending physician. She also had an IPOST that indicated the DNR was signed by the provider on 3/18/24. Tenant C1 had a signed diet order for small bite sized pieces cut up. It indicated the program could accommodate when meals were served. It also stated the tenant did have access to food and made her own decisions. The order was signed 10/10/23.

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Progress Notes revealed the following:

- On 1/5/24 a call was made to Tenant C1's legal representative regarding a decline, difficulty swallowing and poor intake.
- On 3/12/24 staff reported Tenant C1 was not eating much solid food and preferred soft foods. Family and the provider were notified.
- On 3/14/24 Tenant C1 was admitted to hospice.
- On 3/29/24 at 12:30 p.m. Tenant C1 had a choking episode that led to her being unconscious. Staff completed the Heimlich Maneuver but were not successful. Staff were instructed by 911 to begin CPR after she lost consciousness. She was transported to the hospital.
- On 3/30/24 staff reported Tenant C1 had died at the hospital.

Staff Communications Reports indicated the following:

- On 1/4/24 Tenant C1 had difficulty swallowing and was coughing. It sounded like she had fluid in her lungs that could be from swallowing wrong.
- On 1/5/24 Tenant C1 had decreased appetite and difficulty swallowing. Two reports were made: one at 8:30 a.m. and one at 12:14 p.m.
- On 3/11/24 Tenant C1 had decreased appetite and difficulty swallowing. It was noted she was not eating as many solid foods and went towards soft foods like applesauce and jello.

In summary, Tenant C1 had a diet order for foods to be cut up into small pieces that was in place since October 2023 and included in her service plans. She had a history of swallowing difficulties and decreased appetite per nurse's notes and staff communication documents that was noted in January 2024. She was admitted to hospice on 3/14/24 for weight loss and dysphagia. None of the direct care staff or dietary staff interviewed had knowledge of Tenant C1's diet order to have foods cut up in small bite sized pieces even though it was in her service plan. On 3/29/24 she was served a meal that included brussels sprouts. Per interview with the staff who cooked the meal that day the brussels sprouts were not cut up for her. At lunch, staff noted Tenant C1 appeared to be choking and turning blue/purple in color. Tenant C1 choked and went into cardiac arrest. Staff started the Heimlich maneuver and, at the direction of 911, started CPR. While at the Program EMTs were able to remove some food from Tenant C1 which was identified as a brussels sprout. She was transported to the hospital. Per interview, family withdrew care and she died on 3/30/24. Hospital records indicated the cause of death was acute asphyxiation.

In addition, Tenant C1 began receiving hospice services on 3/12/24. She had a code status form dated 10/4/23 that indicated DNR which was signed by the attending physician. She also had an IPOST indicating the DNR was signed by the provider on 3/18/24. Tenant C1 was on hospice but staff were not able to find her DNR or IPOST form to provide to the EMTs when they arrived at the Program. time of this incident. The DNR forms were located by the DON. The internal investigation indicated corrective action was required and all tenant charts were re-organized with code status forms in a consistent

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	<p>location in all charts. Direct care staff were re-educated on where to locate code status paperwork.</p>	
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