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

Date: August 12, 2024
Program Name: Legacy Pointe
Address: 1020 S. Scott Blvd Iowa City, IA
Type of Action: Investigations 119223-C & 120010-C
Date(s) of Action: 5/6/24 – 5/14/24
Citation #10526

State Rule #	State Rule	Amount of Civil Penalty
Iowa Administrative Code 481-67.3(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 provide care, treatment and services that were adequate and appropriate related to COVID-19 diagnosis with symptoms and pre-existing comorbities. This pertained to 1 of 2 discharged tenants reviewed (Tenant C1). Findings follow: 1. Record review on 5/8/24 and 5/13/24 of Tenant C1's file revealed Progress Notes indicated the following: a. On 2/17/24 it was noted Tenant C1 had a mild cough and congestion. Tenant C1 was tested for COVID-19 and tested positive. Tenant C1 said he felt tired with a little cough. Tenant C1 denied shortness of breath (SOB) and fluids were encouraged. b. On 2/20/24 it was noted a change of condition assessment was completed related to Tenant C1 testing positive for COVID-19. Tenant C1 was staged at a three on the Global Deterioration Scale, which indicated mild cognitive decline. c. On 2/22/24 it was noted Tenant C1 was retested positive for COVID-19 and had another positive result. He was encouraged to quarantine for the full 10 days. Fluids were encouraged. Tenant C1 said he felt fine but was a little tired. d. On 2/28/24 it was noted at 10:10 a.m. Tenant C1 pulled his bathroom call light and staff responded. He was observed on the floor in his bathroom on the left side. Staff called the Director of Nursing to his apartment and she responded. Tenant C1 was alert; however, his speech was garbled. Tenant C1 said he was in	**$2500.00**

	pain. Tenant C1's hands and feet were blue and purple in color. Staff called 911 and paramedics arrived. Tenant C1 was transported to the hospital. Tenant C1's family was contacted and updated. e. On 2/28/24 it was noted the Director of Nursing received a telephone from the medical examiner (ME) who said Tenant C1 had died at the hospital and the medical examiner asked questions and the questions were answered. f. On 2/29/24 it was noted on 2/28/24 at 10:10 a.m. Tenant C1 used his call light and staff went to the apartment and found him laying on the bathroom floor. He had a small cut next to the left eyebrow and some blood on his lower lip. Staff called 911 due to pain, his speech and abnormal vitals. His vitals were as follows: blood pressure 116/67, temperature was 97 degrees, pulse was 113, respiration rate was 32 and his oxygen saturation was 51% on room air. He was transported to the hospital via ambulance and they received a call later that afternoon that he had died at the hospital. 2. Continued record review revealed an Incident Report dated 2/28/24 at 10:15 a.m. Tenant C1 called for assistance, when staff arrived he was observed on the floor. He was bleeding and had a cut on bottom lip and his left eyebrow. Tenant C1 was sent to the hospital via ambulance. The legal representative and nurse were notified. 3. Record review revealed Tenant C1's diagnoses included essential hypertension, seizures, hyopthyroidism, hypopituitarism, unspecified mental disorder, due to unknown physiological condition, alcohol abuse, epilepsy, obstructive sleep apnea, Athersclerotic heart disease of native coronary artery without angina pectoris, unspecified atrial fibrilation, cerebrovasuclar diseases, acute cystitis without hematuria, arteriovenous malformation. Further record review the service plan updated on 2/20/24 reflected Tenant C1 was independent with cares and medications, except staff assisted with applying his CPAP at night as needed. The service plan was updated after his COVID-19 diagnosis; however, did not include any changes related to COVID-19 positivity or cares.	

	Evaluations were last completed on 2/20/24 related to a change in condition (COVID-19 positive). The evaluations did not indicate anything related to Tenant C1's COVID-19 symptoms. Continued record review revealed an All Vitals document reflected vitals were taken on 2/3/24 and 2/28/24. His vital signs on 2/3/24 were as follows: blood pressure 114/62, pulse was 66, respiration rate was 16 and oxygen saturation was 97%. On 2/28/24 his vital signs were as follows: blood pressure was 116/67, pulse was 113, respiration rate was 32, temperature was 97 degrees and oxygen saturation was 51%. There were no other recorded vitals signs for February including when Tenant C1 tested positive for COVID-19, during his 10 day isolation or at the end of this COVID-19 positivity. Further record review revealed the Resident Face Sheet indicated Tenant C1 was a full code. The evaluations dated 2/20/24 indicated Tenant C1 was a full code. An IPOST provided dated 1/25/23 indicated his designation was a do not resuscitate (DNR) with limited interventions including do not intubate (DNI). 4. Record review of hospital records indicated Tenant C1's date and time of death was 2/28/24 at 11:49 a.m. The history and physical indicated per emergency medical services (EMS) report he was normal at 10:00 a.m. and at 10:15 a.m. he was found on the floor in the bathroom with blood on his face and unresponsive. When EMS arrived he was hypoxic and hypotensive. EMS reported there were no breath sounds bilaterally. A bilateral needle decompression was completed and a large gush of blood came from the right side needle. The program had him listed as a full code; however, his IPOST indicated that he was DNR and DNI. Emergency department (ED) staff were present and were beginning the resuscitation at the time the trauma team arrived. Tenant C1 was being oxygenated via a bag mask. Tenant C1 continued to be hypoxic and it was noted at that time Tenant C1's code status came into question as conflicting information was provided. Tenant C1 was listed as a full code per the program but was listed on as a DNR/DNI per hospital PCP notes. The IPOST scanned dated 2/13/23 indicated DNR with minimal interventions including intubation. Tenant C1's PCP and legal representative were called and both confirmed he was DNR/DNI. His pulse was lost at 11:40 a.m. and time of death was 11:49 a.m. The medical decision making section indicated Tenant C1 had recently been quarantining due to COVID and had a fall. He was hypoxic (oxygen saturation in the 70's) upon arrival to	

	the hospital. They initially prepared for intubation but verified the IPOST and he was a DNR and DNI. A chest x-ray was obtained did not show pneumothorax, rib fractures or hemothorax. At that point it was noted it was not sure what the cause of the hypoxia the following were considered: ACS, pneumothorax, hemothorax, pulmonary embolism, brainstem bleed, underlying lung disease and COVID. An autopsy was completed; however, it was limited to the brain. The manner of death was natural and the cause of death was "atherosclerotic and hypertensive cardiovascular disease." 5. When interviewed on 5/14/24 at 11:09 a.m. the Assistant Director of Nursing she did not believe Tenant C1 received a lot of cares from nursing staff. She said he isolated for a full 10 days and was agreeable to do so. He had tested positive and had some slight congestion. His meals were delivered. She said his oxygen was checked but it was not documented. On 2/20/24 she saw him and he said he felt okay and denied shortness of breath. On 2/28/24 the Director of Nursing asked her to print off of his paperwork and it went with him to the hospital. She said it was face sheet. She went to his apartment and there were two paramedics in the door and she was not able to see much. Tenant C1 was taken to the ED. She said the Director of Nursing spoke with the ME. When interviewed on 5/14/24 at 9:30 a.m. the Director of Nursing said Tenant C1 had very mild symptoms with COVID-19, he had a mild cough, congestion and was tired. He was in isolation for 10 days and there were no routine vital signs during that time. He was pretty independent and had meals delivered. Staff found Tenant C1 in the bathroom after he pushed his pendant. They called her and she responded. When she observed him, his skin color was off and it was gray in color and he was not doing well. He verbalized he had pain but could not verbalize the location of his pain. He had a cut on his left eyebrow and lower lip. His pulse was very high and oxygen saturation was very low (51%). She said he would have been out of isolation and she did not recall if any vital signs were documented when he left isolation. Staff reported he had been seen earlier in the day, approximately one to two hours before out by the fireplace. She believed it was a product of the fall or whatever was going on with him, regarding his oxygen saturation. The ME called and she did not recall what the ME asked her. She said Tenant C1 did not have issues with oxygen saturation previously. She said his code status was DNR. When a tenant was sent to the hospital a face sheet, medication list (if	

	they administered medications) and the IPOST were sent. She confirmed there were no documented vitals, including oxygen saturation during COVID positivity. In summary, Tenant C1 was primarily independent with cares, he tested positive for COVID-19 on 2/17/24 and isolated for 10 days in his apartment. There were no vital signs, including oxygen saturation, documented with his COVID-19 positive test, during the isolation period or at end of the 10 days. Evaluations were completed on 2/20/24 related to his COVID-19 positive result; however, did not include information related to his symptoms. The service plan was updated; however, did not include information related to his symptoms and any changes in services during isolation. Tenant C1 paged for assistance on 2/28/24 at about 10:10 a.m. (first day out of isolation) and was found with injuries to his left eyebrow and lower lip. He had garbled speech and said he was in pain. His oxygen saturation was 51%, his pulse was 113 and his respiration rate was 32. Staff called 911 and when they arrived no breath sounds were heard bilaterally. He was noted to be hypoxic. Staff sent the face sheet with Tenant C1 to the hospital. Hospital staff were starting the resuscitation process when the trauma team arrived. It was reported in hospital records the records provided by the Program indicated Tenant C1 was a full code and there was conflicting information with the hospital IPOST dated 2/13/23. It was confirmed with the PCP and legal representative that Tenant C1 was a DNR/DNI. He died at 11:49 a.m. It indicated Tenant C1 had been quarantining due to COVID. He was hypoxic and the cause of hypoxia could not be determined but considerations included a number of health concerns (noted above). Additionally, the Program information related to his resuscitation status when he was sent out to the ED that was in conflict with the IPOST and information on file at the hospital and the IPOST provided by the Program at the time of the investigation. Tenant C1 did not receive care, treatment and services adequate and appropriate related to his COVID-19 positive result with symptoms and related to not providing the correct code designation to the hospital when he was transported.	