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

Date: January 13, 2022
Program Name: Hansen House
Address: 2331 Nash Blvd Council Bluffs, IA 51501
Type of Action: Investigations #100295-A
Date(s) of Action: 10/13/21 – 11/18/21
Citation #: 5526

State Rule #	State Rule	Amount of Civil Penalty
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 consistently ensure tenants received appropriate and adequate treatment and services. This affected 1 of 4 tenant reviewed (Tenant C1). Finding follows: Record review on 10/13/21 revealed an incident report (IR) for Tenant C1, dated 10/2/21, noted Tenant C1 walked out of his room and notified staff he hit his head while getting up from the floor after a fall. The IR further included a resident statement, "Resident walked out of his room and notified staff that he fell in his room when trying to get up. When he was getting up on his own, he state he hit his head on the bed frame." The report documented a skin tear to Tenant C1's scalp and noted range of motion (ROM) was within normal limits. Vitals were completed and documented as follows: blood pressure (BP) 168/90, pulse 84, pulseox 97, temperature 97.7, and respirations 20. According to the IR, the supervisor was notified 10/2/21 at 4:45 p.m., the family was notified on 10/5/21 at 8:00 a.m. and the physician was notified on 10/5/21 at 10:45 a.m. Continued record review revealed a documented observations of Tenant C1 completed by Registered Nurse A: a. On 10/4/21 at 2:00 p.m. RN A noted, "Staff members informed this nurse that his resident was having a hard time walking today and was not acting himself. Staff reported that he was just 'off.' When eating he was drooling. When coming back to the other cottage after lunch staff members used a wheelchair to take him to his apartment. VS (vital signs);	**$4000.00**

	171/93 (BP), 84 (pulse), 20 (respirations), 97.7 (temperature), 97% RA (room air - oxygen). Staff reported that he was out of breath but they had just assisted him to transfer to bed. As he was laying gin bed his breathing was returning to normal. Hand grasps equal. Leg strength equal. He is responding to staff at this time. This nurse placed a call to POA (Power of Attorney)... to inform her of his status. POA stated that he can become sick at times if his blood sugars or triglycerides are high. POA asked this nurse if resident face was red. Staff report this resident face is not red and daughter verified per picture message. POA requested that staff and this nurse continue to monitor resident for any changes and call with any concerns. This nurse stated understanding and will follow up as needed." b. On 10/5/21 at 11:12 a.m. RN A completed a review of Tenant C1's incident report on 10/2/21 at 4:45 p.m. RN A noted, "Staff members notified this nurse that this resident walked out of his room with his assistive device and notified staff members that he had fell in his room and got himself up. When trying to get up, he struck his head on the frame of the bed causing a laceration. Resident was alert and oriented per his normal. PERRLA (pupils equal round reactive to light accommodation). No N/V (nausea/vomiting) or loss of consciousness. VS (vital signs) within normal limits for this resident. ROM WNL (within normal limits). No complaints of pain or discomfort. This nurse deferred head monitor due to the nature of the injury. Area to scalp was cleaned with normal saline and steri strips applied. This resident continued per his normal routine. c. On 10/5/21 at 12:15 p.m. RN A noted, "Staff members notified this nurse this morning that this resident was not responding per his normal. Staff stated that they walked him out to the chair in the living room, he started breathing heavy and was not responding. This nurse assessed this resident: VS 128/76 (BP), 74 (pulse), 16 (respirations), 97.7 (temperature), BS (blood sugar) 196. LSTCA (lung sounds clear to auscultation), HRR (heart rate respirations) with no extra sounds, BS + x 4 (bowel sounds in all four quadrants), abdomen round and nontender, Pupils are reactive to light but unable to track the light. He is restless in the chair. He is not responding to this nurse. He is not talking to this nurse. Call placed to POA of injury to scalp. Per her request, this nurse sent resident to ER. 911 was contacted, they arrived and transported resident... This nurse spoke with... social worker... to explain fall. This nurse explained that resident fall occurred Saturday, he was able to get himself up and he reported that	

	he hit his head while getting up. Hew as up, walking and talking per his normal (until) yesterday..." d. On 10/5/21 at 2:15 p.m. RN A noted, "This nurse called (the hospital) for a follow up on this resident. Resident was found to have a brain bleed on his CT. He has been admitted... Family at his bedside at this time..." e. On 10/11/21 at 1:15 p.m. RN A noted, "Resident is transferring to... skilled level of care. Per daughter he is awake and eating with assistant. She reported that he has had a stroke as well. All personal items and medications provided to daughter. All nursing cares have ended at this time." Record review revealed Tenant C1, 90 years old, was admitted to the Program in May 2017. He had diagnoses including Alzheimer's dementia, coronary artery disease, type 2 diabetes, osteoarthritis, transient ischemic attacks, sick sinus syndrome, hypertension, and hyperlipidemia. When interviewed 9/13/21 at 3:40 p.m. and 11/15/21 at 10:35 a.m. Staff A reported she worked with Tenant C1 on 10/2/21 when he had a fall. According to Staff A, she was in the common area working with other tenants and heard someone yell for help. She walked around the corner and found Tenant C1 standing in the doorway of his apartment. When asked what happened, Tenant C1 replied that he had fallen and hit his head on the bed frame while trying to get up. Staff A explained she took Tenant C1 into his room and cleaned up his skin tear and took his vitals. He was able to tell her his name and answer questions. His vitals were normal and he acted per his usual. She said she texted RN A who told her she did not need to do anything else at this time, but to notify her if anything changed. According to Staff A, she worked with Tenant C1 on 10/3/21 and he carried out activities of daily living and acted per himself. When interviewed on 11/15/21 at 11:30 a.m. Staff B said she worked with Tenant C1 on 10/5/21 and helped him get up for the day. She said she had to have other staff assistance to get Tenant C1 up and he was not acting normal. Staff B said once he was ready they walked with him to the living room area and he sat in a recliner. Soon after being seated Tenant C1 began breathing heavily and was not responding. Staff B said she called RN A to tell her that Tenant C1 was breathing heavily and could not respond. According to Staff B, RN A told her to have someone sit with Tenant C1 as she was on her way and would assess him as soon as she arrived.	

	When interviewed on 11/15/21 at 1:50 p.m. Staff C confirmed she worked on 10/4/21 in Cottage #2 when staff accompanied Tenant C1 to join the group for breakfast and activities. According to Staff C, Tenant C1 was acting per usual during breakfast and activities. During lunch she noticed Tenant C1 was drooling while he ate. Then he got up and walked towards the hallway and told her that he wanted to go lay down in his apartment. She said she helped him get turned around to the right direction to help him to his apartment. Tenant C1 talked but his words were not making sense. Staff C noted Tenant C1 was winded and tired. Another staff accompanied Tenant C1 back to Cottage #1 and asked her to contact RN A to let her know Tenant C1 was not feeling well. Staff C said she called RN A to notify her that Tenant C1 wasn't feeling well and was on his way back to his apartment to take a nap. When interviewed on 11/16/21 at 1:00 p.m. Staff D reported she worked with Tenant C1 on 10/4/21. She said when she arrived she was helping to get people up and ready for the day. He dressed himself per his normal and walked out to the activity room where he usual sat to take his medications. When Staff D asked him how he was he told her he had a fall over the weekend and hit his head. After taking his medications Staff D walked with Tenant C1 to Cottage 2. After lunch the staff from the other cottage walked Tenant C1 back to his Cottage (1) because he was tired and wanted to lay down. The staff member who accompanied Tenant C1 said he seemed a little more confused than normal and wanted to take a nap. The staff told her that Tenant C1 had been breathing more heavily and drooled while eating his lunch. Staff D said she went to Tenant C1's room to check on him and noted his breathing was more normal while he was laying down. According to Staff D she got a set of vitals and texted RN A. During the text exchange Staff D told RN A that Tenant C1 was able to squeeze both of her hands and move both of his legs. RN A text her back and let her know that the other staff had also contacted her about Tenant C1 being off and she was in contact with Tenant C1's POA and she wanted to know if his face was red. Staff D explained she told RN A she didn't think his face was red and sent her the requested photo. RN A instructed her to push fluids and keep her updated with changes. When interviewed on 11/16/21 at 1:10 p.m. Staff E reported she worked at Cottage 2 on 10/4/21 where Tenant C1 attended the activity program on that day. She said staff accompanied Tenant C1 to Cottage 2 from Cottage 1 as	

	usual. Tenant C1 ate breakfast and attended activities with other tenants like he normally did. She said while Tenant C1 ate lunch they noticed he was drooling. Then he got up and started walking and said he wanted to go home and lay down. According to Staff E, she and another staff could not understand Tenant C1 when he talked. He was not making sense. She noted he seemed to be tired and out of breath. Staff E said she told Tenant C1 she would take him home and the other staff notified RN A. She assisted Tenant C1 to his room where he laid down so he could rest. Staff E notified staff he was not feeling well. When interviewed on 10/13/21 and 10/14/21 RN A admitted she failed to complete an assessment of Tenant C1's condition following his incident on 10/2/21 until the morning of 10/5/21. She also confirmed she failed to notify the POA of Tenant C1's fall and injury on 10/4/21 when she contacted her regarding Tenant C1's confusion.	