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

Date: April 21, 2025
Program Name: Navigate MC at Featherstone at Hickory Trail
Address: 2450 Hickory Trail Iowa City, Iowa 52245
Type of Action: initial cert, 127296-C
Date(s) of Action: 3/17/25 to 3/25/25
Citation #: 10794

State Rule #	State Rule	Amount of Civil Penalty
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 adequate care and services to 2 of 7 tenants reviewed (Tenant #1, Tenant #7). Findings include: 1) Record review on 3/19/25 revealed Tenant #7 moved to the program on 1/27/25. He was diagnosed with Parkinson's Disease, unspecified abnormalities of gait and mobility, neurocognitive disorder with Lewy bodies and dementia. A review of incident reports and progress notes revealed he experienced falls on the following dates: - Tenant #7 was found lying face down on the floor of his room on 1/28/25 at 8:40 PM. He damaged a table during the fall and had bleeding on the back of his head. His family took him to the emergency room where he was treated for a 5 cm. laceration to the back of his head. - On 2/2/25 at 11:51 PM during safety checks, staff found Tenant #7 with blood all over his head. His wife came and took him to the emergency room. Tenant #7 had a 2.5 inch laceration to the back of his scalp which was treated with staples. - Tenant #7 was found on the floor next to his recliner on 2/26/25. He reported sliding out of his recliner. - Staff heard Tenant #7 calling out for help from the sun room on 3/1/25. He reported he skidded and fell on his left side. He had a scrape to the left side of his head. - Tenant #7 was found with a small cut to the back of head on 3/7/25. - On 3/15/25, Tenant #7's wife came to take him to the emergency room to see if he needed to get a head and neck CT due to an unwitnessed injury. The CT was performed with no injury found. He got two staples to his wound. - On 3/18/25, Tenant #7 was found outside of another tenant's room in the hallway on the ground. No injuries were noted. - Tenant #7 was found on the floor in the dining room by staff after they heard a crash on 3/19/25. Tenant #7's 2/28/25 service plan noted he was able to ambulate independently without a mobility device. He had a walker should he	**$2500.00**

	need to use it. The plan was amended on 3/9/25 to add that staff were to ensure his room was clutter free and easy to navigate. However, there was no information as to how often staff were to provide supervision checks for Tenant #7. On 3/18/25 at 3:20 PM, Staff F reported she provided extra supervision checks for Tenant #7 due to his tendency to fall, although the program RN had not directed her to do so. On 3/18/25 at 2:55 PM, Staff G stated Tenant #7 had experienced 3-4 falls and received stitches, so he liked to check on the tenant more often, although he had not been directed to do so. 2) a. On 3/17/25 review of an incident report dated 3/7/25 revealed Tenant #1 was found on the floor in front of her bed propping herself up on her left elbow. Her walker was beside her. She reported she lost her balance. Her vitals were obtained, the Interim Registered Nurse (RN) was notified and the physician was sent a faxed copy of the incident report. The program completed a 72 hour-post incident follow-up sheet, in which staff were to check her vitals each shift for 3 days. Abnormal readings were as follows: - 3/7/25 on 2nd shift: pulse 129 - 3/8/25 on 3rd shift: pulse 122 - 3/8/25 on 1st shift: pulse 121 On 3/8/25, the Licensed Practical Nurse (LPN) documented Tenant #1's heart rate was 112 and she was in A-Fib. A progress note dated 3/10/25 indicated while the RN was reviewing the 72 hour alert follow-up report, she noted Tenant #1's high pulse rate. The hospice nurse came to her door at that moment and the RN told her of the high heart rate and need for evaluation, if the tenant's family agreed. The hospice nurse arranged for transportation to the hospital and notified the family. A review of Tenant #1's hospital record for 3/10/25 revealed she was a 90-year old female with a history of Parkinson's disease and Lewy body dementia and she was on hospice. She presented to the emergency department due to a high heart rate (pulse). While at the hospital, her blood pressure was 141/103 with a pulse of 103. She was noted to be tachycardic. Tenant #1 was diagnosed with atrial flutter and prescribed Cardizem ER. Tenant #1 and her family chose not to pursue a hospital admission as she would have to be discharged from hospice. She returned to the program on 3/10/25. A review of Tenant #1's pulse rates revealed between the dates of 8/26/24 and 2/1/25, her heart ranged from 51 to 98. Beginning on 3/1/25, her heart rate rose above 120 on the following dates: - 3/1/25: pulse 128 - 3/12/25: pulse 123 - 3/14/25: pulse 122	

	- 3/16/25: pulse 121 - 3/18/25: pulse 127 - 3/19/25: pulse 122 - 3/20/25: pulse 121 The program contacted the hospice nurse on 3/20/25 to notify her they were continuing to get occasional elevated heart rate readings since she returned from the hospital the previous week. The hospice nurse said yesterday (3/19/25) she received a heart rate of 94. She thought it appeared Tenant #1 was flipping in and out of Atrial Flutter and it might take another week for the new medication, Cardizem ER, to work. She spoke with Tenant #1's primary care provider (PCP) who would meet with the tenant on that date. The program had a procedure for alert values for vital signs. It was the licensed nurse's responsibility to review the results of vital signs at the beginning of their assigned shift and any time during their assigned shift when vital signs were taken. It was the responsibility of the nurse to manually re-check the vital signs at any time such values were unusual for the tenant or were critical values, such as a resting pulse greater than 120. If a tenant had a pulse rate of 120 or higher, the health care provider should be notified immediately. On 3/19/25 at 9:15 AM, Staff E reported she filled out the incident report on 3/7/25 when Tenant #1 experienced a fall. She recalled Tenant #1 had an elevated heart rate. Staff E notified the RN about her fall and elevated vitals, but was informed it was normal for a person to have a high pulse following a fall. On 3/25/25 at 8:40 AM the LPN reported when she took Tenant #1's heart rate on 3/8/25 she noted it was irregular. She believed Tenant #1 was in A-Fib. The LPN called and left a message for the former Assistant Director of Nursing. The LPN said she only worked at the program about once a month. She could not recall if she wrote a progress note about this (she did not), but believed she should have. On 3/18/25 at 3:51 PM the RN could not recall exactly when she was notified about Tenant #1's elevated heart rate. She knew she would have addressed this condition as soon as she learned of it. b. A review of incident reports from the previous 3 months revealed Tenant #1 experienced falls on the following dates: - Tenant #1 fell on 1/29/25 at 11:15 AM while trying to put her shoes on. She was found on the floor in her bathroom. She had blood coming from her fingernail area. - When staff was assisting Tenant #1 from her wheelchair to her recliner on 2/7/25 at 7:30 AM, she lost her balance and was lowered to the ground. - On 2/14/25 at 4:15 AM, staff found Tenant #1 on the floor during hourly safety checks. She fell out of bed. - Tenant #1 was walking in the hallway and fell on 2/24/25. She was ambulating with her wheelchair instead of her walker.	

	- She was found on the floor in front of her bed on 3/7/25 after losing her balance. - On 3/14/25, Tenant #1 was heard crying in her room. She was found on her left side by her closet door with her legs tangled up around her walker. Her walker was removed from her legs. She appeared to have hit the left side of her head and reported pain. A review of Tenant #1's service plan dated 12/16/24 revealed there was no indication it was typical for her to have an elevated heart rate. The plan identified she was a fall risk due to her cognitive level. There were no recommendations for how frequently staff should check on her. On 3/18/25 at 10:45 AM, Staff E stated staff were supposed to complete safety checks on tenants every two hours. She generally checked on Tenant #1 more frequently due to her history of falling, but she was not directed to do so by the nurse. On 3/18/25 at 3:20 PM, Staff F said while she was never told by a nurse to check on tenants more than hourly, she liked to check on Tenant #1 more frequently as she experienced a lot of falls. She believed tenants were to be checked on each hour. On 3/18/25 at 2:55 PM, Staff G reported he tried to check on individuals who were at a high risk for falls more often than other tenants. 3) On 3/18/25 at 9:10 AM the Director of Clinical Services reported they do not specify how often tenants should receive safety checks in their care plans. Every tenant should receive safety checks every two hours, but tenants who are a high falls risk should be checked on more frequently. On 3/25/25 at 11:15 AM the Executive Director confirmed the program failed to provide services which met the needs of tenants.	