

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

Date: November 8, 2017
Program Name: Silvercrest Garner Farms
Address: 1575 W. 53rd Street Davenport, IA 52806
Type of Action: Investigation
Date(s) of Action: October 23, 2017 to October 25, 2017

State Rule #	State Rule	Amount of Civil Penalty
67.2	<p><u>481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.</u></p> <p>Based on interviews and record reviews, staff failed to follow the Program's policy on door alarm systems which potentially affected all 51 tenants in the general population of the Program. Findings include:</p> <p>An incident report dated 8/27/17 revealed Tenant #1 eloped from the Program. According to a fax sent to Tenant #1's physician on 8/28/17 and an interview with Staff A on 10/23/17 at 1:33 PM , Tenant #1 was last seen at approximately 7:15 PM by Staff A in the secured court yard going back into the building. Shortly after that, Staff A went to Tenant #1's apartment to administer Tenant #1's medications. Tenant #1 was not in the apartment. After a thorough search of the building and grounds by 6 staff members on duty, it was determined Tenant #1 had eloped. Tenant #1 was found at 8:20 PM by Staff B in the parking lot of a local business located 2.7 miles away from the Program.</p> <p>On 10/24/17, a review of the Program's Wander Management System Policy and Procedure revealed the following statement: "If a door alarms, staff will be notified by sound and/or pager and will immediately perform a physical check of the area that is outside of door that alarmed. The team member will ensure that no tenant/resident is outside of the building. The team member will then perform a physical check of each tenant/resident in the community to ensure tenant/resident safety and that no tenant/resident has exited through the alarmed door."</p> <p>On 10/23/17 at 1:00 PM, the Maintenance Director stated the Program's east door had a magnet alarm system on it that would page all staff members if the door opened. The page to staff would indicate what door opened but not who opened the door. The page/alarm to staff would reset and stop beeping on their pagers once the door closed.</p> <p>On 10/23/17 at 1:33 PM, Staff A stated it was common for staff to use the east door of the Program to leave work and go on break. Staff A</p>	\$3000.00 total

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<p>67.3(2)</p>	<p>added staff did not check the east door each time they were alerted of it opening on a pager because of its high usage. She could not recall if the door alarm paged on the night of the Tenant #1's elopement because it was so common.</p> <p>On 10/24/17 at 3:00 PM, Staff B stated she could not recall if the east door alerted to pagers on the night of 8/27/17. She stated that if an alert did come over the paging system for the east door, it likely was ignored by staff because certain doors were not always checked when pagers were alerted. Staff B stated the east door was one door staff regularly went in and out of and staff did not always go to see who opened it when their pager went off.</p> <p>On 10/23/17 at 2:50 PM, Staff C stated she could not recall a page for the east door on 8/27/17 but if there was one, staff likely ignored it as it was common for staff to do so due to the high volume of use the door received.</p> <p>On 10/25/17 at 11:57 AM, Staff D (who did not work on the night of 8/27/17) confirmed it was common prior to Tenant #1's elopement to ignore the east and south door page alerts because staff frequently used these doors for leaving as well as breaks. Staff D stated the doors were close to staff parking.</p> <p>On 10/25/17 at 12:03 PM, Staff E (who did not work on the night of 8/27/17) confirmed it was common prior to Tenant #1's elopement to ignore the east and south door page alerts because staff often used these doors on a regular basis.</p> <p>On 10/24/17 during an observational tour, the Corporate Nurse confirmed at the time of Tenant #1's elopement, staff had become non-compliant with responding to alarms due to the frequency of the alarmed doors being used by staff to enter and exit the building.</p> <p>On 10/23/17 at 11:00 AM, the Director of Marketing and Lifestyles confirmed she believed staff had received the page alert for the east door on 8/27/17 (per the alert report) but didn't physically go to the door and check to see who went out.</p> <p><u>481-67.3 Tenant rights. All tenants have the following rights:</u> <u>67.3(2) To receive care, treatment and services which are adequate and appropriate.</u></p> <p>Based on interviews and record reviews, the Program failed to provide adequate care and services for 1 of 5 tenants reviewed (Tenant #1). Findings include:</p> <p>Tenant #1 was admitted on 7/24/17 with a diagnosis of hypertension, hyperlipidemia, pulmonary emphysema, histoplasmosis, dementia, forgetfulness, Vitamin D deficiency, insomnia, prostate problems and coronary artery disease. Tenant #1 received a cognitive evaluation on 8/17/17 revealing a Global Deterioration Scale (GDS) of 4. The</p>	
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	<p>evaluation dated 8/17/17 indicated Tenant #1 had the following deficits: "decreased knowledge of current and recent events, using denial as a defense mechanism, exhibits some deficit in memory of own personal history, decreased ability to travel, and problems handling finances." Tenant #1's service plan dated 8/17/17 revealed the following information: "[Tenant] has a history of wandering and has exited the building. [Tenant] has a wanderguard bracelet that staff need to check every shift to ensure bracelet is on and working." The service plan documented the tenant was ambulatory without the use of any assistive devices.</p> <p>An incident report dated 8/27/17 revealed Tenant #1 eloped from the Program. According to a fax sent to Tenant #1's physician on 8/28/17 and an interview with Staff A on 10/23/17 at 1:33 PM, Tenant #1 was last seen at approximately 7:15 PM by Staff A in the secured court yard going back into the building. Shortly after, Staff A went to Tenant #1's apartment to administer medications. Tenant #1 was not in the apartment. After a thorough search of the building and grounds by 6 staff members on duty, it was determined Tenant #1 had eloped. Tenant #1 was found at 8:20 PM by Staff B in the parking lot of a local business located 2.7 miles away from the Program. The tenant was appropriately dressed for the weather and had no injuries.</p> <p>Although the tenant's exact path could not be determined, the most likely route would have been to walk .2 of a mile from the Program to N. Division Street, then 2.5 miles south on N. Division to the destination where the tenant was found. N. Division is a heavily traveled 4 lane street with a speed limit of 35 miles per hour (25 miles per hour in a school zone).</p> <p>On 10/23/17 at 11 AM, the Director of Marketing and Lifestyles stated after the internal investigation was completed it was believed Tenant #1 exited the building using the southeast door (commonly called the east door) on 8/27/17. The Director of Marketing and Lifestyles stated the southeast exit door did not have a wanderguard system attached to it so Tenant #1's wanderguard bracelet would not have activated and warned staff members of his/her exiting the building. During an observational tour the Program's Corporate Nurse confirmed the Program had 7 exits with only 2 of the 7 exits having a wanderguard system attached.</p> <p>On 10/23/17 at 11 AM, the Director of Marketing and Lifestyles confirmed Tenant #1's wanderguard alert system would only work if Tenant #1 exited the front door or the beauty salon door. The wanderguard alarm would not alert staff if Tenant #1 used any of the other 5 exits.</p>	
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