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11/29/17

PRINTED: 11/08/2017  
FORM APPROVED

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>S0066</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/25/2017</b>
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NAME OF PROVIDER OR SUPPLIER <b>SILVERCREST GARNER FARMS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1575 W 53RD DAVENPORT, IA 52806</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>481-67 Initial Comments</p> <p>General Population Program</p> <p>Number of tenants without cognitive disorder: 48 Number of tenants with cognitive disorder: 3 Total Population of Program at time of on-site: 51</p> <p>Dementia-Specific Program by Dedication</p> <p>Number of tenants without cognitive disorder: 2 Number of tenants with cognitive disorder: 12 Total Population of Program at time of on-site: 14</p> <p>TOTAL census of Assisted Living Program: 65</p> <p>No regulatory insufficiencies were cited regardig the investigation of Complaint #70191-C and Complaint #70190-C.</p> <p>The following regulatory insufficiencies were cited during the investigation of Incident #70645-I.</p>	A 000		
A 003	<p>481-67.2 Program policies and procedures</p> <p>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.</p>	A 003	<p>see attached Plan of Correcti Da</p>	

DIVISION OF HEALTH FACILITIES - STATE OF IOWA  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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A 003	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: 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>	A 003		

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A 003	<p>Continued From page 2</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 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</p>	A 003		

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A 003	<p>Continued From page 3</p> <p>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>	A 003		
A 013	<p>481-67.3(2) Tenant Rights</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the</p>	A 013		

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A 013	<p>Continued From page 4</p> <p>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 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</p>	A 013		

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A 013	<p>Continued From page 5</p> <p>#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>	A 013			

OK  
11/29/17

**In Response to  
Final Complaint/Incident Investigation  
Dated November 8<sup>th</sup> 2017**

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared is prepared and/or executed solely because it is required by the provisions of state law.

**Evaluation**

**Regulatory Insufficiency:** 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 481-67.2(231B,231C,231D)

1. Elements detailing how the program will correct each regulatory insufficiency.
  - a. Staff educated at time of incident on use of doors with in property.
  - b. Wander guard alarm system added to all doors with in property
2. What measures will be taken to ensure the problem does not recur.
  - a. All doors equipped with dual alarm system which includes wander guard and audible alarm with key pad to reset doors.
  - b. Review of Wander guard/Elopement policy and procedures completed during orientation
  - c. Review of Wander guard/Elopement Policy and Procedure with current staff
3. How the Program plans to monitor performance to ensure compliance.
  - a. 5% of random employee files will be reviewed monthly for the next 6 months for compliance.
  - b. Doors will be checked monthly for next six months for functionality.
4. The date by which the regulatory insufficiency will be corrected.
  - a. The regulatory insufficiency will be corrected by December 8<sup>th</sup>, 2017

**Evaluation**

**Regulatory Insufficiency:** Tenant rights. All tenants have the following rights: To receive care, treatment and services which are adequate and appropriate (IAC r. 481-67.3(2)).

1. Elements detailing how the program will correct each regulatory insufficiency.
  - a. Wander guard alarm system has been installed on remaining 5 doors with in program that were currently without.
2. What measures will be taken to ensure the problem does not recur
  - a. Wander guard alarm system installed
  - b. Current staff trained on new door alarm system
  - c. New staff trained on door alarms during new member orientation

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3. How the Program plans to monitor performance to ensure compliance.
  - a. Doors will be checked random monthly for the next 6 months by Regional Team for functionality.
  - b. Elopement drills will be completed at random by management team and/or Regional Team Bi-annually.
4. The date by which the regulatory insufficiency will be corrected.
  - a. The regulatory insufficiency will be corrected by December 8<sup>th</sup>, 2017.