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

Date: March 18, 2024
Program Name: Silvercrest Garner Farms
Address: 1575 West 53rd Street Davenport, Iowa 52806
Type of Action: Complaint 119292-C
Date(s) of Action: 3/4/24, 3/5/24
Citation # 10245

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.** Record review on 3/4/24 revealed an incident report for Tenant #1. The incident report dated 3/2/24 noted staff found Tenant #1 on the floor at 6:45 a.m. Tenant #1's oxygen saturation level measured in the 90s. Staff noted they left a message for the on-call nurse and Tenant #1's Power of Attorney. No response was received from the on-call nurse. Record review on 3/4/24 revealed an incident report for Tenant #1. The incident report dated 3/2/24 noted staff found Tenant #1 on the floor at 1:45 p.m. Tenant #1's oxygen saturation level measured in the 80s. Staff noted they left a message for the on-call nurse. No response was received from the on-call nurse. Record review on 3/5/24 revealed an incident report for Tenant #1 dated 3/3/24 at 9:45 a.m. The IR noted the daughter found Tenant #1 on the floor of her apartment and got her up. Tenant #1's oxygen saturation level measured in the 80s. Staff noted low oxygen due to a medical procedure, left a message for the on-call nurse and sent her to the ER (Emergency Room). During an interview on 3/4/24 at 2:40 p.m. the Director of Nursing (DON) explained the Program sent Tenant #1 to the hospital on 3/3/24 for low oxygen saturation rate. She said the family found Tenant #1 on the floor of her apartment. When the staff completed vital signs Tenant #1's oxygen saturation level measured in the 80s. The DON said she initiated an investigation of the incident. During the investigation Staff B said upon arriving for her shift she checked on Tenant #1 who looked purple. Staff B asked Tenant #1 if she felt ok and sought assistance from Staff A. Tenant #1 said her toe hurt. Around 8:00 a.m. Staff C took Tenant #1 to the bathroom where she said her throat hurt. The tenant was given ice cream and it noted she coughed up phlegm. Staff laid Tenant #1 in bed. When the tenant's family arrived later that morning they requested help to take her to the bathroom. They said Tenant #1 had fallen and they picked her up. Staff B took Tenant #1's vitals and oxygen measured 80%. Family requested Tenant #1 be sent to the hospital. Staff B called 911 at approximately 9:49 a.m.	**$3500.00**

	Based on her investigation the DON concluded Program staff should have contacted Emergency Medical Services (EMS) sooner. Her investigation also found the Program failed to ensure the correct on-call schedule for nurses was available to staff which contributed to the delay in response regarding the need to seek additional medical care for Tenant #1. The on-call nurse on the list staff had called on 3/2/24 and 3/3/24 no longer worked at the Program. Record review on 3/5/24 revealed the Program Emergency Care of Resident policy revised 2/2024. The policy directed staff to immediately call 911 when they became aware of tenant emergency. Record review on 3/5/24 revealed Staff A's skills checklist dated 7/19/22 and signed by Staff A. The skills checklist included vital signs including oxygen. Further review revealed Staff B's skills checklist including vital signs and oxygen signed and dated 7/21/22. When interviewed on 3/5/24 at noon the DON said Tenant #1 had been admitted to the hospital with a COVID diagnosis. She confirmed staff failed to follow up when the on-call nurses contacted did not respond. She said staff involved had and would receive additional training regarding when to seek additional medical care for tenants and how to follow up if on-call nurses failed to answer telephone calls. Review of Tenant #1's record on 3/5/24 revealed an admission date of 12/30/23. Her service plan, effective 2/6/24, directed staff to complete regularly scheduled safety checks per memory care protocol. Tenant #1's Global Deterioration Scale score was four (moderate cognitive decline). Review of Tenant #1's health evaluation revealed no falls within the prior 90 days. .	