IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint Intake #: 34036-C

July 7, 2011

Jim Lambert, Executive Director
Silvercrest Garner Farms
1575 W 53rd Street
Davenport, IA 52806

RE: Final Complaint Investigation Report, Silvercrest Garner Farms, Davenport, Iowa

Dear Mr. Lambert:

Enclosed is the **Final Complaint Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69.

DIA has reviewed the Plan of Correction (POC) submitted in response to the **Preliminary Complaint Investigation Report**. Based upon a complete review of the Report and the Program's proposed actions to correct the identified Regulatory Insufficiency, DIA accepts the POC.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-4116.

Sincerely,

Jim Berkley

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

LUCAS STATE OFFICE BUILDING, 321 EAST 12TH STREET, DES MOINES, IOWA 50319-0083

ADMINISTRATION
(515) 281-5457
FAX: (515) 242-6863

ADMINISTRATIVE HEARINGS
(515) 281-6468
FAX: (515) 281-4477

HEALTH FACILITIES
(515) 281-4115
FAX: (515) 242-5022

INVESTIGATIONS
(515) 281-5714
FAX: (515) 242-6507

Telephone Number for the Hearing Impaired: (515) 242-6515

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Complaint Investigation Report

Assisted Living Program: **Complaint Intake #: 34036-C**

Jim Lambert, Executive Director
Silvercrest Garner Farms
1575 W 53rd Street
Davenport, IA 52806

Date of Investigation:

June 1, 2011

Monitor(s):

Stephanie Cummins, MA
Margaret Kaltefleiter, RN MS

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to, and approved by, the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations. IAC r. 481-67.10(5). The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 481 IAC chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Silvercrest Garner Farms on June 1, 2011. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* – Not applicable.

Dementia Specific Program (DSP)* – A program that is a Dementia Specific Program by definition but may have tenants without cognitive disorder.

Current number of tenants in a DSP that serves fewer than 55 tenants and has 5 or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS):	8
Current number of tenants without cognitive disorder:	44
Total Population:	52

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Program History – There was a substantiated Regulatory Insufficiency this certification period in Food Service.

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Other

Complaint Allegation: It was alleged a tenant was abused by staff.

- Monitoring Observation: Three tenant files were reviewed.

  Tenant #1, an 88 year old, was admitted on 9-27-10 and diagnoses include: Diverticulosis, History of Cerebral Vascular Accident (CVA) (Left Hemiparesis) and Hypertension (HTN). Review of the tenant's file did not reveal any documented occurrences of abuse.

  Tenant #2, an 89 year old, was admitted on 12-20-10 and diagnoses include: HTN, Atrial Fibrillation, Congestive Heart Failure (CHF), Type II Diabetes, High Cholesterol, Gastroesophageal Reflux Disease (GERD) and Left Knee Replacement. Review of the tenant's file did not reveal any documented occurrences of abuse.

Tenant #3, a 95 year old, was admitted on 5-21-10 and diagnoses include: Rheumatoid Arthritis, Coronary Artery Disease (CAD), HTN, Hypothyroidism, Hyperlipidemia, Depression and History of CVA. The tenant was staged at a five on the Global Deterioration Scale (GDS), which indicated moderately severe cognitive decline. Review of the tenant's file did not reveal any documented occurrences of abuse.

Three months of incident reports were reviewed. None of the incident reports indicated any documented occurrences of abuse towards tenants.

Tenant council meeting minutes from December 2010 through June 2011 were reviewed. The tenants did not voice any complaints regarding staff treatment towards the tenants.

Three tenants were interviewed. Two tenants reported staff treated the tenants well and stated staff were great. They did not identify any concerns with staff. One tenant reported most of the staff were pleasant and treated him/her well; however, he/she identified two situations where the tenant expressed concerns. One incident involved a contracted employee. The contracted employee got upset, yelled and jerked the tenant back into a salon chair to wash the tenant's hair after the tenant made a comment about the color of the tenant's hair. The tenant stated it hurt his/her back. Another situation involved a staff who assisted the tenant with buttoning a shirt while wearing gloves and the tenant told the staff she did not need to wear gloves. The tenant reported the staff went on and on about wearing gloves and how it was the law. The staff came back and apologized, according to the tenant. The tenant requested the staff involved not come back to his/her apartment.

The Executive Director provided notes regarding two alleged incidents. The notes for the first alleged incident involved Tenant #1 and Staff #1. The tenant reported Staff #1 chose to wear gloves as she assisted the tenant with dressing. Staff #1 attempted to button the top button of the tenant's shirt with gloves and had difficulty. The tenant told Staff #1 it would be easier if she removed the gloves at which time Staff #1 became angry and raised her voice. Staff #1 explained in an agitated manner that gloves were for the safety of the tenant and had to remain on, according to the notes. The nurse spoke with the tenant and Staff #1 and the information given to the nurse was similar to the discussion with the Executive Director. Staff #1 agreed the discussion became elevated; however, she stated the tenant became angry with her; the tenant raised his/her voice and the tenant was very argumentative. Staff #1 excused herself from the apartment when the discussion became elevated and asked another staff to assist the tenant with the button. The Executive Director and the nurse agreed Staff #1 needed to be reminded to remain professional. Staff #1 excused herself from the apartment in order to diffuse the problem and at no time became physically involved with the tenant in a manner other than providing requested care. The Executive Director and the nurse did not feel discipline was warranted.

The nurse was interviewed and stated there was a heated discussion between Staff #1 and Tenant #1. The tenant did not feel he/she was talked to kindly and Staff #1 felt the same. Staff #1 was doing cares for Tenant #1 and the tenant asked for the top button to be buttoned.

Staff #1 was not comfortable providing the care without gloves. The nurse stated she did not feel the situation was abuse. She said there were no physical or verbal threats of abuse.

A monitor attempted to contact Staff #1; however, several attempts were unsuccessful.

The Executive Director provided notes regarding two alleged incidents. The notes for the second alleged incident involved Tenant #1 and Contracted Staff #1. The tenant stated he/she simply stated the color of his/her hair was too dark and Contracted Staff #1 went "crazy on ..." and yelled at the tenant. The tenant felt that Contracted Staff #1 had acted unprofessionally and the tenant wanted the contracted staff removed from the building. The tenant noted Contracted Staff #1 rinsed and reset the tenant's hair after the discussion. The Contracted Staff #1 told the Executive Director she had become upset with the tenant over the color of the tenant's hair. The discussion began when the tenant stated the week prior the tenant's hair was too light, which lead Contracted Staff #1 to darken the color she added. After finishing, the tenant stated the color was too dark. Contracted Staff #1 noted she became frustrated and asked the tenant what exactly he/she wanted and the tenant replied he/she did not know but that was not it. The Contracted Staff #1 stated her frustration to the tenant and mentioned she felt no matter what she did it was always wrong as far as the tenant was concerned. After the discussion, Contracted Staff #1 rinsed out, dried and set the tenant's hair. The Executive Director's notes indicated Staff #2 heard Contracted Staff #1 raise her voice and indicated she seemed frustrated by the tenant. Staff #3 also heard Contracted Staff #1 raise her voice. She noted both the tenant and Contracted Staff #1 seemed upset with one another.

Staff #2 was interviewed and stated Tenant #1 was getting his/her hair done and the hair color was too dark. She witnessed Contracted Staff #1 get very angry and she whipped the chair around.

Staff #3 was interviewed and stated Contracted Staff #1 had a mean look on her face. She asked what was going on and Contracted Staff #1 said the tenant did not like the color of his/her hair. She did not observe any physical contact with the tenant.

Contracted Staff #1 was interviewed. She stated the tenant brought in his/her own hair color and the week before the color was too light. She added more color and dried it and Tenant #1 said he/she did not like the color as it was too dark. She asked the tenant what he/she wanted and she was frustrated. She washed it out, blow dried and re-curled the hair. She wanted to make the tenant happy.

It was not found that any tenants were abused by staff; however, tenant rights were not upheld for Tenant #1.

- Regulatory Insufficiency: All tenants have the following rights: To be treated with consideration, respect, and full recognition of personal dignity and autonomy. (IAC r. 481-67.3(1))

Dated this 6th day of July, 2011.