DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0066	A. BUILDING: _____ B. WING _____	C 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERCREST GARNER FARMS	1575 W 53RD DAVENPORT, IA 52806

(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	Initial Comments Assisted Living Programs for People with Dementia are defined by the population served. The census numbers were provided by the Program at the time of the on-site. General Population Number of tenants without cognitive disorder: 37 Number of tenants with cognitive disorder: 3 Memory Care Unit Number of tenants without cognitive disorder: 5 Number of tenants with cognitive disorder: 10 Total Census: 55 There were no regulatory insufficiencies cited during the investigation of Incident #95254-I, Complaint #92858-C and Complaint #92957-C or the onsite infection control survey. The following regulatory insufficiencies were cited during the investigation of Incident #95392-I and Incident #98803-I.	A 000		
A 160	481-67.3(2) Tenant Rights 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 160	Plan of Correction is attached DD	

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A 160	Continued From page 1 program failed to provide adequate care to 1 of 3 tenants reviewed (Tenant #3). Findings follow: Record review on 7/26/21 revealed an Incident Investigation Report created by the Director of Nursing (DON) dated 2/1/21 for Tenant #3. Tenant #3 was observed standing outside the memory care Northwest door at approximately 4:15 AM on 1/30/21 by Staff C. The investigation determined Tenant #3 pushed the crash bar to exit the Northwest door. Staff D was in another tenant's room with the door shut and did not hear the alarm sound. On 7/27/21 at 12:20 PM, Staff C reported she was taking the garbage out on 1/30/21 and heard a noise. She realized it was the door alarm and saw Tenant #3 standing by the dumpster next to the Northwest door of the building. Staff C called Staff D and asked if she knew where Resident #3 was located. Staff D informed her Tenant #3 had been pacing through the halls prior to Staff D entering another tenant's apartment to provide him assistance. Staff D reported on 7/27/21 at 12:00 PM, she was in a tenant's room when she got a call from Staff C informing her Tenant #3 was by the dumpster. Staff D said she was unable to hear the alarm and did not know Tenant #3 was out of the building until receiving the call from Staff C. Staff D assessed Tenant #3 and determined her hands were cold but otherwise she was not injured. On 7/27/21 at 8:47 AM, Staff E stated when other staff went out the Northwest door and set off the alarm, she was unable to hear it when standing in the dining room. On 7/27/21 at 9:05 AM, Staff F reported she was	A 160		

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A 160	Continued From page 2 only able to hear the alarm on the Northwest door from about half-way down the hallway. Staff F said if she was in a tenant's apartment she would not be able to hear the door alarm unless she was listening for it. On 7/26/21 at 10:50 AM the Executive Director demonstrated the alarm system. She stated the alarm system in place when Tenant #3 eloped from the building should have been louder. A new alarm system had since been installed which was much louder and could be heard through the entire unit.	A 160		
A 530	481-69.29(4) Staffing 481-69.29(231C) Staffing. 69.29(4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenants' service plans. A non-dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be able to respond to a call light or other emergent tenant needs and be in the proximate area 24 hours a day on site. The staff shall check on tenants as indicated in the tenants' service plans. This REQUIREMENT is not met as evidenced by: Based on interview and record review the	A 530		

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A 530	Continued From page 3 program failed to check on 1 of 3 tenants reviewed as outlined in the service plans (Tenant #1). Findings follow: Record review on 7/27/21 revealed a summary of an incident which occurred on 7/25/21 involving Tenant #1. She exited the building at approximately 3:23 PM and was escorted back into the building by two women at 3:45 PM. The high temperature on 7/25/21 according to Wunderground.com was 74 degrees. There was no precipitation. Staff A provided a statement to the program dated 7/25/21 noting she saw Tenant #1 on 7/25/21 at 2:30 PM and again at 3:00 PM. Staff B provided a statement to the program dated 7/25/21 documenting she saw Tenant #1 on 7/25/21 at 2:30 PM and at 3:00 PM. Staff B noted she witnessed Tenant #1 in the building at approximately 3:30 PM. Staff B confirmed this information on 7/27/21 at 12:30 PM. The receptionist documented her recollections from 7/25/21 in an email. She spoke with the two women who walked Tenant #1 back to the building when they came to the front desk to express their concerns. She went to the memory care unit and relayed the conversation to Staff B. Staff B reportedly said she saw the women talking with Tenant #1, thought they were family and did not disturb them. When interviewed on 7/27/21 at 1:05 PM the receptionist confirmed this information. Tenant #1's service plan dated 5/26/21 identified she had a history of dementia. She was noted to wander and exit-seek, so staff members were to complete safety checks every half hour around	A 530		

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A 530	Continued From page 4 the clock. Staff were to document they completed the checks at the end of their shifts. Staff B signed a Task Log at the end of her shift indicating she checked on Tenant #1 every half hour during her 2:30 PM - 11:00 PM shift. According to the summary of the incident report, Tenant #1 was out of the building from 3:23 PM until 3:45 PM. The last time she was seen by staff was at 3:00 PM. Therefore a check could not have been completed at 3:30 PM. The Executive Director, Director of Nursing and Assistant Director of Nursing confirmed these findings on 7/27/21 at 2:45 PM.	A 530		
A 635	481-69.32(2) Life Safety - Emergency Policies / Structure 69.32(2) An operating alarm system shall be connected to each exit door in a dementia-specific program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to have an operating alarm system connected to one door, potentially effecting all tenants. Findings follow: Record review on 7/26/21 revealed an Incident Investigation Report dated 7/26/21 for Tenant #1 created by the Director of Nursing (DON). On 7/25/21 Tenant #1 exited a door to the outside and was brought back to the building by two women who live in the area. According to a written statement from the receptionist, the women reported they observed Tenant #1 walk	A 635		

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A 635	Continued From page 5 around a pond behind their houses several times. During an investigation the DON discovered Tenant #1 exited the building via the South patio door which did not alarm when staff opened it. Maintenance came to the facility and found both door alarms were turned off. It could not be determined when the alarms were turned off. The program had no policy in place at the time for routine checks of door alarms On 7/27/21 at 2:45 PM the Executive Director, DON and Assistant Director of Nursing confirmed these findings.	A 635		

In Response to
Final Complaint/Incident Investigation
Dated September 30th, 2021

10/14/21

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: Tenant Rights 481-67.3 (2) – All tenants have the right to receive care, treatment and services which are adequate and appropriate.

1. Elements detailing how the program will correct each regulatory insufficiency.
    a. Team members re-educated on door alarm system and checking of system each shift.
    b. Re-education with team members on the use of nurse communication sheets and when to utilize.
2. What measures will be taken to ensure the problem does not recur.
    a. Updated alarm system being implemented on doors.
    b. Monitoring of safety check documentation by DON.
3. How the Program plans to monitor performance to ensure compliance.
    a. Doors checks will be completed at the and end of each shift and reviewed sheets reviewed by DON.
4. The date by which the regulatory insufficiency will be corrected.
    a. The regulatory insufficiency will be corrected by 7.30.21

Evaluation

Regulatory Insufficiency: Staffing 481-69.29 (4) A dementia-specific assisted living program shall have one or more staff persons who monitor tenants as indicated in each tenant's service plan. The staff shall be awake and on duty 24 hours a day on site and in the proximate area. The staff shall check on tenants as indicated in the tenant's service plan.

1. Elements detailing how the program will correct each regulatory insufficiency.
    a. Implementation of new process as it relates to documentation of safety checks.
    b. Staff to verify location and safety of memory care residents and document appropriately per service plan.
2. What measures will be taken to ensure the problem does not recur
    a. Resident safety checks to be completed and documented appropriately.
    b. Random checks to be completed by management team to ensure the forms and checks are being completed.
3. How the Program plans to monitor performance to ensure compliance.
    a. Safety check forms to be reviewed by DON

10/8/21

b. Elopement drills will be completed at random by management team and/or Regional Team at minimum bi-annually.

4. The date by which the regulatory insufficiency will be corrected.
    a. The regulatory insufficiency will be corrected by end of week 7.30.21

Evaluation

Regulatory Insufficiency: Life Safety-Emergency Policies/Structure 481-69.32 (2) – An operating alarm system shall be connected to each exit door in a dementia- specific program.

1. Elements detailing how the program will correct each regulatory insufficiency.
    a. Re-education provided to team members on the door alarms and how/what to check each shift.
    b. Staff to complete door checks at the beginning and end of each shift to ensure they are functioning properly.
2. What measures will be taken to ensure the problem does not recur.
    a. Documentation of door checks will be completed each shift with ongoing and leaving team member signatures.
    b. Education provided on response to door alarms if a pendant is alarming
    c. New alarm system being implemented on doors.
3. How the Program plans to monitor performance to ensure compliance.
    a. DON will review door alarm checks for completion
    b. DON will reinforce door checks with team members
4. The date by which the regulatory insufficiency will be corrected.
    a. The regulatory insufficiency will be corrected by end of week 7.30.21