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 03/05/2024

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. Number of tenants without cognitive impairment: 35 Number of tenants with cognitive impairment: 23 Total census: 58 The following regulatory insufficiencies were cited during the investigation of Complaint 119292-C.	A 000	The Plan of Correction is attached.	
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: 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	A 160		

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A 160	Continued From page 1	A 160		

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.

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A 160	Continued From page 2	A 160		

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

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A 160	Continued From page 3 decline). Review of Tenant #1's health evaluation revealed no falls within the prior 90 days.	A 160		

Silvercrest Garner Farms
Plan of Correction In Response to
Complaint/Incident Investigation #119292-C
Dated March 25th, 2024

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. All nursing team members will be re-educated on Emergency Care of Resident policy.
    b. All nursing team members will be re-educated on contacting the on-call nurse and process if unable to get in touch with nurse on-call immediately.
    c. Verbal/written disciplinary action taken on 3/6/2024 with both team members involved in initial complaint/incident
2. What measures will be taken to ensure the problem does not recur.
    a. All team members will review and state understanding of tenant rights, process for emergency care of residents, and nurse on call process upon hire and at least annually.
3. How the Program plans to monitor performance to ensure compliance.
    a. DON and/or designee to randomly and periodically discuss emergency care of residents, nurse on call, and resident vital signs with staff.
4. The date by which the regulatory insufficiency will be corrected.
    a. The regulatory insufficiency will be corrected by 3/30/24