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 03/18/2024

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

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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: 30 Number of tenants with cognitive impairment: 24 Total census: 54 The following regulatory insufficiencies were cited during the investigation into Incident #114856-I and Complaints #117929-C, 117926-C, 117654-C, 117399-C, 116585-C, 113210-C and 114084-C.	A 000	The Plan of Correction is attached	
A 130	481-67.2(1)e Program Policies and Procedures 67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following: e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to complete an incident report for 1 of 5 tenants reviewed (Tenant #2). Findings include: A physical therapy note dated 11/24/23 documented Tenant #2 reported a fall overnight on 11/22/23. She hit her head on the bathroom cabinet. Tenant #2 had bruising over the right	A 130		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 130	Continued From page 1 temporal area and a cut over her right eye. The Director of Nursing was unaware of the fall or cut to Tenant #2 but came to cleanse the wound. On 2/12/24 at 3:30 PM Tenant #2 reported falling the night before Thanksgiving. Tenant #2 went to turn off a light in the living room and fell into the door of the linen closet, hitting her head. There was a lot of bleeding. She had a roll of paper towels in her room and went through the roll trying to control the bleeding. There was no documentation in Tenant #2's record about a fall on 11/22/23 or receiving care from the nurse on 11/24/23. On 2/13/24 at 3:30 PM, the Director of Nursing reported she did not recall being involved in Tenant #2's fall on 11/24/23. Staff needed to complete an incident reports prior to the end of shift. The Director of Nursing confirmed there was no documentation of the fall, including an incident report, in the record.	A 130		
A 150	481-67.2(3) Program Policies and Procedures 67.2(3) The program shall follow the policies and procedures established by the program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to follow established policies and procedures regarding medications, food service and an alcohol free work place potentially affecting all tenants (census of 54). Findings follow:	A 150		

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1) On 2/4/24 a review of staff statements related to a medication theft revealed on 7/5/23 Staff A noticed Tenant C2's hydrocodone looked different. Staff A administered Tenant C2 a scheduled dose of hydrocodone at approximately 7:30 PM - 7:45 PM. Staff A documented she would contact the Director of Nursing (DON) when she came to work the following day.

The DON collected statements from staff who worked with Tenant C2 covering the period of 6/27/23 - 7/5/23. The hospice aide reported Tenant C2 was alert and talking on 6/27/23. Tenant C2 could pin point the location of her pain and it seemed somewhat managed. On 7/3/23, Tenant C2 was unable to stand or ambulate. When the hospice aide attempted to give Tenant C2 a bed bath, she was unable to tolerate it.

Staff B provided a written statement on 7/6/23 indicating Tenant C2 had worsening pain on 7/4/23. Staff H, who no longer worked for the program, did not want to complete the controlled substance count with Staff B, which was to occur at the end of each staff member's shift.

When interviewed on 2/6/24 at 11:05 AM, Staff A recalled staff reported to the DON Tenant C2's pain medication was not easing her discomfort. There were a couple of days when Tenant C2 was in excruciating pain prior to the discovery of the missing medication. Staff A then realized Tenant C2's pain medication was exchanged for Tylenol. There were times when Staff H would leave at the end of her shift before counting the controlled substances and documenting the number of pills on the controlled substance sheet.

The program had a Controlled Substance Count policy. Controlled substances were to be counted

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at each change of shift by both the departing and oncoming personnel responsible for medication administration and documented on the Controlled Substance Count Sheet. The Controlled Substance Count Sheet must be signed by both counting persons, noting the date and time in the verification column. Discrepancies in the controlled substance count must be reported to the DON immediately upon discovery.

When interviewed on 2/6/24 at 2:55 PM, the DON reported during the investigation of the medication theft they learned Staff H was not signing the Controlled Substance Count Sheet when she administered medication. Staff H would not stay in the building at the end of her shift to count the medication and sign the sheet. She confirmed the Controlled Substance Count Policy was not followed.

2) On 2/8/24 at 10:20 AM, Tenant #4 reported Staff C, the former shuttle driver smelled of alcohol when driving her in the program bus. Tenant #4 reported this to the former receptionist who said she smelled alcohol too. Tenant #4 reported Staff D smelled alcohol on Staff C as well. They met with the Executive Director and it seemed like nothing was done. Then several months later Staff C was driving her again in the program bus and smelled very strongly of alcohol. Tenant #4 was sitting close to the front. When Tenant #4 got off the bus, the driver was standing in the foyer. She wrote the former receptionist a note with the word "alcohol".

During an interview on 2/12/24 at 1:45 PM the former receptionist recalled hearing reports about Staff B drinking on the job. Tenant #4 was the only tenant who made complaints but it appeared other tenants were aware and did not want to talk

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about it. Tenant #4 sat close to the front of the bus and Staff C would buckle her in. There was a meeting with the Executive Director which included her, Tenant #4, and Staff D. A few days later, it did not appear anything was done. She talked with the Executive Director and was told the Executive Director could not bring Staff C in for a conversation based on the suspicion of substance abuse. The former receptionist kept watching Staff C and was increasingly concerned about Staff C driving the tenants. Toward the end of Staff C's employment, she smelled more strongly of alcohol, more often. The former receptionist finally went to the Assistant Executive Director one day and told her Staff C smelled of alcohol and either something needed to be done or she would quit. Staff C was terminated.

On 2/12/24 at 2:50 PM, Staff D reported Staff C smelled like alcohol a lot. Staff C was acting drunk and smelled of alcohol. This was an everyday situation. Once somebody in the community called the building to report Staff C as she cut someone off and then passed a semi. Staff D asked Staff C if she had cut someone off and Staff C replied she had to get to where she was going. Tenant #4 expressed concerns about Staff C and after this, Staff D was more aware of the alcohol smell on Staff C. They did have a meeting about this situation with the Executive Director. It did not seem like anything was done after the meeting as far as she could tell.

On 2/12/24 at 3:00 PM the Executive Director reported there were some concerns about Staff C not driving safely. If Staff C was in a bad mood she might drive aggressively. Two staff members reported they smelled alcohol on Staff C's breath. The Executive Director had a conversation with the human resources department about this. On

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the day of the report the Executive Director did not think it appeared Staff C was under the influence. The Executive Director did not recall talking with Staff C about the allegations of drinking on the job. The Executive Director did pay attention to signs of alcohol use when she was around Staff C after she received the report.

The Executive Director confirmed Staff C was terminated at the end of 2022. Staff C told them she would go home, drink wine, and then return to work. Staff C never appeared under the influence to the Executive Director.

On 2/12/24 at 12:10 PM the Assistant Executive Director confirmed she fired Staff C in Nov 2022 for drinking on the job. The former receptionist reported to her she could smell alcohol on Staff C's breath. The Assistant Executive Director thought there may have been other reports of Staff C drinking on the job, but this was the first she heard. On the day Staff C was terminated, she said she had gone home for lunch and had a glass of wine. Staff C said it was not unusual for her to have 1-2 glasses of wine on her lunch break.

The program had a policy on having a drug and alcohol free workplace. A team member whose faculties appeared to be impaired during work hours would not be allowed to work, regardless of the cause. A team member may be requested or required to submit to a drug or alcohol test if there was evidence a team member is or has used alcohol. The evidence may be drawn from reasonable inferences. Examples would include observations made at work such the physical symptoms of being impaired, abnormal conduct or erratic behavior while at work or a report by a reliable and credible source of alcohol use. Team

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members and administration had an important role to play in maintaining a drug-free workplace. Team members were to report dangerous behavior to the supervisor. The supervisor had a responsibility to observe team member performance, investigate reports of dangerous practices, document negative changes and problems in performance and clearly state consequences of policy violations.

On 2/14/24 at 1:00 PM the Corporate Nurse confirmed the findings.

3) A tour of the program kitchen was conducted on 2/6/24 at 10:50 AM with Staff E. There were boxes of food on the freezer compartment floor which were delivered the day before, not stored on pallets or shelves. Staff G reported the boxes should not be on the floor. One plastic package of tater tots in the freezer was not sealed and visibly open to the air. In the dry storage area, a box of couscous and package of spaghetti were open to the air.

On 2/8/24 at 9:45 AM, Staff G reported when she started work at the program in 8/2023, there was a mess in the kitchen. There were times the previous kitchen person would make the salads and leave them out instead of putting them in the cooler. Staff G told them food was to be thrown out after three days but this wasn't happening. When she worked, anything she felt like she would not eat she put in the garbage.

On 2/13/24 at 12:25 PM, Staff F was observed delivering two room trays. The food was in Styrofoam packaging. The server reported the meals had always been delivered in Styrofoam as far as she recalled, never on china. The Styrofoam trays were sitting on the cart, not in a

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A 150	Continued From page 7 warmer. Tenant #4 reported on 2/8/24 at 10:20 AM the room trays were often cold. They got a letter from the Executive Director at the beginning of the year saying room tray delivery would go from $5/meal to $10/meal but would include meals served "hotel style" on china on a tray with a lid. They raised the price but the food still came in a box. On 2/8/24 at 1:00 PM, Tenant #7 reported it took a long time to get food after you placed an order. The room trays were often cold and served in styrofoam. The program had a food service policy which noted meals would be served in a clean and welcoming environment. The Room Tray and To-Go meals policy noted room trays would be delivered on a professional, hotel-style serving tray with a dining room place-setting placed on the upscale room service tray. Meals would be served on a china plate with a plate cover on top. On 2/14/24 at 1:00 PM the Corporate Nurse confirmed the findings.	A 150		
A 275	481-67.5(2)f(2) Medications 67.5(2) Each program shall follow its own written medication policy, which shall include the following: f. When medications are administered traditionally by the program: (2) Medications shall be kept in a locked place or container that is not accessible to persons other	A 275		

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A 275	Continued From page 8 than employees responsible for the administration or storage of such medications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to keep a medication cart locked potentially affecting all 15 tenants living on the dementia specific unit. Findings follow: During a tour of the program's locked memory care unit on 2/8/24 at 9:30 AM with the Corporate Nurse it was observed the lock on the main medication cart was popped out, indicating the cart was not locked. The Director of Nursing (DON) came and looked at the cart. She stated the lock had been broken for about six months. The DON instructed staff to keep the cart in a locked room when not in use. About 1-2 weeks ago, a new lock was installed on the cart which worked at first but then did not. The DON placed the cart in a locked room. The program had a Medication Administration policy which noted all medications which were administered by community staff must be securely stored and locked. On 2/8/24 at 12:00 PM, the monitor observed recordings of the medication cart from 1/15/24, 1/22/24, 1/29/24 and 2/5/24 at approximately 7:00 AM and 10:00 PM each day. In each recording, the cart was in the dining area and not in use by staff. The DON confirmed these findings on 2/8/24 at 12:00 PM.	A 275		

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A 325	481-67.9(1) Staffing 67.9(1) Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to have a sufficient number of staff available to meet the needs of 3 of 8 tenants reviewed (Tenant #4, #7, #8). Findings include: 1) Record review on 1/23/24 revealed a progress note for Tenant #4 dated 11/17/23. The Licensed Practical Nurse (LPN) documented she received a call from staff reporting the tenant was experiencing excruciating back pain and went to the emergency room. The LPN called the hospital staff and learned Tenant #4 had a fracture of the L2 and stenosis of the spinal canal. Tenant #4 was fitted for a back brace. On 11/19/23, staff communicated to the LPN Tenant #4 experienced a change in her ability. She was unable to walk or transfer on her own. When seated in a wheelchair, Tenant #4 couldn't move it. Tenant #4 was unable to use the restroom on her own, pick up medication from the counter and needed assistance with all activities of daily living. The program received a new order on 11/27/23 for Tenant #4 to wear her back brace when upright at all times for twelve weeks. Device Activity Reports revealed when a tenant pushed their pendant for assistance and the length of time it took for staff to respond.	A 325		

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A 325	Continued From page 10 A review of the Device Activity Reports for Tenant #4 revealed from 11/17/23 - 11/30/23, Tenant #4 pushed her pendant 38 times when it took over 15 minutes for staff to respond. The amount of time over 15 minutes varied from 15 minutes and 4 seconds to 72 minutes. Tenant #4 pushed her pendant 54 times during the month of December 2023 during which it took staff 15 minutes or more to respond; and 67 times in January 2024 when it took staff more than 15 times to respond. 2) Review of the device activity report from 10/1/23 - 2/24/24 revealed Tenant #7 pushed his pendant 1 time in October 2023 when it took staff 19 minutes to respond; 4 times in November 2023 when it took staff over 15 minutes to respond (35 minutes to 166 minutes); twice in January 2024 (27-37 minutes) and three times in February 2024 (20-30 minutes). 3) A review of the device activity report from 10/1/23 - 2/24/24 for Tenant #8 revealed she received staff assistance after more than fifteen minutes on 4 occasions in January 2024 (15-24 minutes) and on 2 occasions in February 2024 (17-28 minutes). The program had a policy on pendant/emergency alert response. Each tenant's pendant emergency alert would be responded to in a timely manner. The expectation was each pendant alert would receive a staff response within 5 minutes. Responses of greater than 15 minutes were unacceptable and outside of regulatory compliance. These findings were confirmed by the Corporate Nurse on 2/14/24 at 1:00 PM.	A 325		

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A 330	481-69.25(1)q Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: q. When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to list hygiene needs on the task sheets for 2 of 5 current tenants (Tenant #3 and Tenant #5) and 1 of 2 discharged tenants (Tenant C1) reviewed. Findings include: 1) Record review on 2/7/24 revealed a service plan for Tenant #3 dated 3/24/23. Tenant #3 received services from a hospice agency until 12/16/23. She required moderate assistance with toileting. Staff were to ensure Tenant #3 was clean and dry at all times and assist with changing her incontinence brief. Tenant #3 did not get out of bed for changing her incontinence briefs and would not assist with rolling to get cleaned. A 10/10/23 entry in progress notes identified the hospice nurse visited Tenant #3 on 10/9/23. Tenant #3's incontinence brief was last changed at 5:00 AM and the visit was conducted after noon. On 11/1/23, Tenant #3's brief was wet when the hospice nurse arrived. Staff reported to	A 330		

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the Licensed Practical Nurse (LPN) on 12/12/23 Tenant #3 had a wound on her distal vaginal area. Staff were to apply barrier cream to the area.

A review of the November 2023 and December 2023 task sheets identified staff were to assist Tenant #3 with dressing, bed making and daily trash removal. There was not an entry for assistance with toileting.

On 2/6/24 at 11:03 AM Staff A reported Tenant #3 did not get out of bed to go to the bathroom. Periodically Tenant #3 had skin breakdown.

On 2/8/24 at 8:15 AM Staff I stated Tenant #3's task sheets did not list toileting although people knew she required help with toileting every two hours. Tenant #3 was combative when toileting care was provided. She did not like to be touched or have her incontinence briefs changed.

2) Review of progress notes for Tenant #5 revealed she began hospice services on 11/29/23. The program updated Tenant #5's service plan on 12/4/23 to identify the addition of these services. Tenant #5 scored a 6 on the Global Deterioration Scale at that time indicating a cognitive impairment.

Tenant #5's 12/4/23 service plan identified she required moderate assistance with toileting - one staff member provided physical assistance with parts of the toileting process.

A review of Tenant #5's December, 2023 and January 2024 tasks sheets revealed toileting was not identified as a chore with which Tenant #5 needed assistance.

3) A review of progress notes for Tenant C1

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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 330	Continued From page 13 revealed he was admitted to hospice on 11/27/23 due to protein calorie malnutrition. A progress note on 11/26/23 indicated staff communicated Tenant C1 had increased frequency in urination, refused to go to the dining room for meals and was not eating much in his room. Tenant C1 refused showers, medications and assistance with changing his incontinence brief. A 12/7/23 progress note identified Tenant C1 was up for breakfast but did not each lunch. The LPN got Tenant C1 lunch and had to put a peanut butter and jelly sandwich in his hand and then guide his hand to his mouth. On 12/16/23, Tenant C1 was combative with morning cares. It took two staff to change Tenant C1's incontinence brief. One staff held his hands and the other changed the brief. The hospice nurse visited Tenant C1 on 12/18/23 and found Tenant C1's brief saturated and his bed soiled. A review of Tenant C1's 12/4/23 service plan identified he was blind. Tenant C1 had a plate divider to assist with eating as he was unable to get food on his utensils. The service plan identified Tenant C1 wore adult briefs. The service plan identified a caregiver was to help with toileting. Tenant C1's December 2023 and January 2024 task sheets did not identify he required help with toileting or with meal set up. 4) On 2/8/24 at 2:30 PM the corporate nurse confirmed toileting and meal set up were not listed as tasks for the tenants.	A 330		
A 395	481-69.26(4)a Service Plans	A 395		

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 03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 395	Continued From page 14 69.26(4) The service plan shall be individualized and shall indicate, at a minimum: a. The tenant's identified needs and preferences for assistance This REQUIREMENT is not met as evidenced by: Based on interview and record review, the program failed to identify tenant's needs on the service plans for 2 of 5 current (Tenant #1, #2) and 1 of 4 discharged (Tenant C1) tenants reviewed. Findings include: 1) Record review on 2/7/24 revealed progress notes for Tenant C1 dated 11/27/23. Staff informed the Licensed Practical Nurse (LPN) Tenant C1 had increased frequency with urination, refused most of the time to go to the dining room for meals and was not eating much in his room. Tenant C1 had increased aggression and agitation. He was refusing showers, medication and assistance with changing his incontinence brief. Tenant C1 was admitted to hospice on 11/27/23 due to protein calorie malnutrition. A 12/7/23 progress note identified Tenant C1 was up for breakfast but did not each lunch. The Licensed Practical Nurse (LPN) got Tenant C1 lunch and had to put a peanut butter and jelly sandwich in his hand and then guide his hand to his mouth. On 12/16/23, Tenant C1 was combative with morning cares. It took two staff to change Tenant C1's incontinence brief. One staff held his hands and the other changed the brief. The hospice nurse visited Tenant C1 on 12/18/23 and found Tenant C1's brief saturated and his bed soiled.	A 395		

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A 395	Continued From page 15 The program developed a change of condition service plan for Tenant C1 on 12/4/23. Tenant C1's service plan noted he would maintain and/or maximize his current level of functioning with toileting. Tenant C1 wore incontinence briefs and staff were to assist with toileting. Tenant C1's urinary freuqency and refusal to change his brief were not identified on the plan. Tenant C1 did not require assistance with meal consumption according to his service plan. The plan identified Tenant C1 was blind and had a plate divider to assist with eating as he was unable to get food onto his utensils. The plan did not identify Tenant C1 refused to go to the dining room, had a decrease in appetite or interventions to assist with this. The service plan documented Tenant C1 did not have current disruptive or aggressive behavior, although aggression was noted in the progress notes. 2) A review of progress notes for Tenant #2 identified a pre-admission assessment was conducted on 11/1/23. Tenant #2 was independent with her walker and all activities of daily living. She would administer her own medication. Tenant #2 started occupational therapy on 11/13/23 to assist with strength, balance, fall prevention and safety with activities of daily living and transfers. Tenant #2 began physical therapy on 11/14/23 to help with transfers and strengthening due to right hip weakness, left wrist weakness and impaired balance. Staff checked on Tenant #2 on 11/17/23 at 12:30 PM and found her on the bathroom floor	A 395		

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A 395	Continued From page 16	A 395		

according to a progress note. Tenant #2 lost her balance and fell backwards on her bottom. Tenant #2 saw her Physical Therapist on 11/17/23. The physical therapist documented in her notes Tenant #2 required a minimum of one person to assist with transfers from her recliner and to the toilet due to increased pain with use of her right upper extremity. Tenant #2 went to a walk-in clinic on 11/17/23 according to her discharge records and was diagnosed with a broken rib on her right side.

A note from Tenant #2's physical therapy provider dated 11/24/23 identified the tenant reported a fall on 11/22/23 overnight in the bathroom. Tenant #2 hit her head on the cabinet and sustained a cut over her right eye and right-sided rib pain. The physical therapist reported the fall to the Director of Nursing (DON) who was not aware of Tenant #2's injuries. The DON reported the program was going to start administering Tenant #2's medications the following week. Tenant #2 was reportedly taking her medication incorrectly which could have contributed to the falls. The physical therapist documented in her note she instructed Tenant #2 to use the assistive device with all standing activities. She needed to have both hands on her walker at all times and to call staff for assistance with any activity requiring her to let go of her walker with one hand. Tenant #2 was to only transfer from sitting to standing with the assistance of another person.

A review of Tenant #2's service plan dated 11/16/23 revealed she was independent with dressing and toileting. Tenant #2 was noted to be independent with mobility. She used a walker and did not require assistance with transferring. Tenant #2 was also able to administer her own medication. The service plan was not updated

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A 395	Continued From page 17	A 395		

after her falls on 11/17/24 and 11/22/24 to list her need for assistance with mobility, transferring, dressing, medication management or toileting.

3) Review on 2/7/23 of progress notes revealed an entry on 4/17/23 in which staff communicated Tenant #1 was not getting any better in managing the pain in her back. Staff reported a lot of red spots. An appointment was scheduled with her primary care provider (PCP) on 5/1/23. A medication was prescribed for Tenant #1 to treat the rash. She returned to her PCP on 6/5/23 and was prescribed dressing changes to her back and new treatments to be applied to her rash.

Tenant #1's Power of Attorney called the program on 6/23/23 and shared frustration the bandage on her back did not cover the wounds. Tenant #1 was also wearing a sweater from the previous day with a stain. The DON called the PCP and reviewed treatment orders for Tenant #1. The PCP placed an order for Tenant #1 to receive wound care. Tenant #1 began treatment at the wound clinic on 7/7/23.

On 7/29/23, a progress note documented Tenant #1 and a male tenant kissed. Tenant #1 reported she was the wife of the male tenant (she wasn't). On 7/29/23, Tenant #1 came after staff with a metal fork. She then pulled a male tenant into his apartment and locked the door. On 7/30/23, staff reported Tenant #1 had an increase in wandering and put her arm around a second male's shoulder and squeezed his arm. The second male was trying to keep his boundaries. On 7/31/23, staff informed the LPN Tenant #1 was having issues with appropriate boundaries with other male tenants. Tenant #1 was rude and disrespectful to staff. Tenant #1 told her family men were initiating inappropriate behaviors but Tenant #1

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A 395	Continued From page 18 was actually following male tenants into their rooms and closing the door. Tenant #1 went to the PCP on 7/31/23 due to increased behaviors. The doctor prescribed new medication, including an antibiotic due to Tenant #1 experiencing a urinary tract infection. A review of progress notes revealed Tenant #1 refused to shower on the following dates: 1/2/23, 1/5/23, 1/16/23, 1/19/23, 1/23/23, 1/26/23, 2/2/23, 3/31/23, 7/11/23, 7/14/23, 7/18/23, 8/4/23, 9/1/23, 9/15/23 and 10/13/23. Tenant #1's service plan noted she could bathe with minimal assistance but might require reminders. The plan did not identify Tenant #1 refused showers. Tenant #1 had a service plan dated 10/18/22 (last modified 2/8/23). It was not updated to address her need for wound care. Tenant #1's service plan did not address her aggressive or sexualized behavior with male tenants when she had urinary tract infections. The DON confirmed these findings on 2/13/24 at 3:30 PM.	A 395		

Silvercrest Garner Farms
Plan of Correction In Response to
Investigation #114856
Complaints #113210, #114084, #116585, #117399, #117654, #117926 #117929, #111065
Dated May 24, 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.

Regulatory Insufficiency: Program Policies and Procedures 481-67.2(1)e: The program's policies and procedures on incident reports, at a minimum, shall include the following: All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents

1. **Elements detailing how the program will correct each regulatory insufficiency.**
   a. The program will follow the policies and procedures established by the program.
2. **What measures will be taken to ensure the problem does not recur.**
   a. All nursing team members re-educated on the policy and procedure for incident reports, including causes and timeline for completion.
   b. DON and/or designee to verify that an incident report has been completed for all appropriate incidents.
3. **How the Program plans to monitor performance to ensure compliance.**
   a. DON and/or designee to review and close all incident reports.
   b. Regional Nurse and/or designee to randomly audit charting notes to ensure incident reports are completed for all appropriate incidents.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. The regulatory insufficiency will be corrected by 5/31/2024

Regulatory Insufficiency: Program Policies and Procedures 481-67.2(3): The program shall follow the policies and procedures established by the program

1. **Elements detailing how the program will correct each regulatory insufficiency.**
   a. The program will follow the policies and procedures established by the Program.
   b. DON and/or designee to re-educate nursing staff on the controlled substance count policy.
   c. ED, DON, and/or designee to re-educate all staff regarding the drug and alcohol-free workplace policy.
   d. ED and/or designee to re-educate all dining team members on the food service policy.
2. **What measures will be taken to ensure the problem does not recur.**
   a. DON and/or designee to re-educate nursing staff that they are to notify the on-call nurse immediately if the narcotic count is off. Re-education also provided to nursing team members regarding narc count being completed on each shift.
   b. ED and/or designee to re-educate all team members to notify the ED immediately if a team member appears to be under the influence of drugs or alcohol.

c. ED and/or designee to re-educate all dining team members on proper food storage.
d. ED and/or designee to re-educate all dining team members regarding meal delivery process, including the packaging of the food and food temperature.

3. **How the Program plans to monitor performance to ensure compliance.**
   a. DON and/or designee to randomly review the narcotic count sheet to ensure completion at each shift.
   b. ED and/or designee to randomly observe food storage in the kitchen to ensure items are being stored appropriately.
   c. ED and/or designee to randomly observe meal tray delivery to ensure appropriate packaging and food temperature.
   d. Regional nurse and/or designee to randomly observe narcotic count sheets, food storage in the kitchen area, and meal tray delivery to ensure compliance.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. The regulatory insufficiency will be corrected by 5/31/2024

Regulatory Insufficiency: Medications 481-67.5(2)f(2): Each program shall follow its own written medication policy, which shall include the following: When medications are administered traditionally by the program: Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications.

1. **Elements detailing how the program will correct each regulatory insufficiency.**
   a. The lock to the bed cart in the secured memory unit was replaced on 2/8/2024 and is functioning properly.
2. **What measures will be taken to ensure the problem does not recur.**
   a. DON and/or designee to re-educate nursing team members on ensuring that the medication carts are locked at all times when not in use by a med aide.
3. **How the Program plans to monitor performance to ensure compliance.**
   a. DON and/or designee to randomly observe all medication carts to ensure they are locked when not in use.
   b. Regional DON and/or designee to randomly observe all medication carts when in the community to ensure compliance.
4. **The date by which the regulatory insufficiency will be corrected.**
   a. The regulatory insufficiency will be corrected by 5/31/2024

Regulatory Insufficiency: Staffing 481-67.9(1): Number of staff. A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

1. **Elements detailing how the program will correct each regulatory insufficiency.**
   a. DON and/or designee to re-educate all nursing team members on the emergency response policy.
2. **What measures will be taken to ensure the problem does not recur.**
   a. DON and/or designee to routinely review pendant response times to ensure they are being answered in the appropriate timeframe.
3. **How the Program plans to monitor performance to ensure compliance.**
   a. Regional DON and/or designee to randomly review pendant response times to ensure they are being answered in the appropriate timeframe.

4. **The date by which the regulatory insufficiency will be corrected.**
    a. The regulatory insufficiency will be corrected by 5/31/2024

Regulatory Insufficiency: Tenant Documents 481-69.25(1)q: Documentation for each tenant shall be maintained by the program and shall include: When the tenant is unable to advocate on the tenant's own behalf or the tenant has multiple service providers, including hospice care providers, accurate documentation of the completion of routine personal or health-related care is required on task sheets. If tasks are doctor-ordered, the tasks shall be part of the medication administration records (MARs).

1. **Elements detailing how the program will correct each regulatory insufficiency.**
    a. Resident task sheets to be updated to include an area for documentation for ADL's requiring staff assistance.
2. **What measures will be taken to ensure the problem does not recur.**
    a. DON and/or designee to review charting and include necessary documentation for ADL's upon completion of a new service plan.
3. **How the Program plans to monitor performance to ensure compliance.**
    a. DON and/or designee to randomly review resident charts to ensure documentation is being completed on staff assisted ADL's.
    b. Regional DON to randomly review resident charts to ensure documentation is being completed on staff assisted ADL's.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. The regulatory insufficiency will be corrected by 5/31/2024

Regulatory Insufficiency: Service Plans 481-69.26(4)a: The service plan shall be individualized and shall indicate, at a minimum: The tenant's identified needs and preferences for assistance.

1. **Elements detailing how the program will correct each regulatory insufficiency.**
    a. DON and/or designee to update resident service plans to ensure they accurately reflect resident needs and behaviors.
2. **What measures will be taken to ensure the problem does not recur.**
    a. DON and/or designee to complete a change of condition assessment in a timely manner when they are notified of new resident needs or behaviors.
3. **How the Program plans to monitor performance to ensure compliance.**
    a. Regional DON and/or designee to perform random chart audits to ensure documented needs or behaviors are indicated on the resident service plan.
4. **The date by which the regulatory insufficiency will be corrected.**
    a. The regulatory insufficiency will be corrected by 5/31/2024.

Sincerely,

Nicole Nice, Executive Director