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 03/04/2026

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. Tenants without cognitive impairment: 46 Tenants with cognitive impairment: 19 Total census: 65 The following regulatory insufficiencies were cited during the investigation of Complaint #130362-C, Complaint #131164-C and Incident #131585-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 Program failed to provide adequate services to 2 of 6 current tenants reviewed (Tenant #1 and Tenant #2) and 1 of 2 discharged tenants reviewed (Tenant C1) also potentially affecting all tenants. Findings follow: 1. Record review on 2/23/26 revealed Tenant #2's incident report dated 11/13/25 indicated at 12:30 p.m. staff reported to the Director of Nursing (DON) they observed Tenant #2's hands around	A 160		

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Tenant C2's neck. Staff A immediately separated the two tenants. Tenant #2 was easily redirected back to his apartment. Per witness statements, Tenant C2's cell phone rang, which triggered Tenant #2, leading him to put his hands on the other tenant. Tenant #2 had no recollection of why he grabbed Tenant C2 and no injuries were noted. An intervention was put in place to have Tenant #2 sit at a private table in the dining room.

When interviewed on 2/25/26 at 10:20 a.m., Tenant #1 reported being present for the incident when Tenant #2 put his hands on Tenant C2. Tenant C2's phone rang then Tenant #2 started swearing. Tenant #2 stood up, approached Tenant C2 and put his hands around his neck. Tenant #7 attempted to intervene. Tenant #1 believed he saw Tenant #2 hit Tenant #7. Tenant #1 described Tenant #2 as unpredictable. He did not know what the tenant would do from minute to minute in the dining room. Tenant #1 would get up multiple times throughout a meal. Tenant #1 described an incident in which Tenant #2 moved his drink to Tenant #1's spot. He then left the table. On Tenant #1's return, he became angry he didn't have a drink. Tenant #1 stood up, clenched his fists and began to swear. It was not unusual for Tenant #1 to angrily follow the staff into the kitchen when he did not get his food right away.

During an interview on 2/26/26 at 8:00 a.m., Staff A recalled sitting at the front desk when she heard Tenant C2's phone ring and then saw Tenant #2 push his chair back. Tenant #2 then pushed Tenant C2's chair against the wall and began choking him. She went running from the front desk into the adjacent dining room and told Tenant #2 to stop. When Tenant #2 let go of his neck, Tenant C2 got up as if he wanted to fight

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Tenant #2. Tenant #7 then attempted to stop the fight. Staff A reported staff were supposed to be in the dining room to monitor things and keep attendance. On that day, there were only three caregivers working so no one was present to monitor the dining room. Staff A described Tenant #2 as someone who yelled at everyone. He had spit on others. He called female staff stupid and swear words. Tenant #1 tried to hit her in the head once. Every day she worked he would go into the kitchen and yell curse words if he didn't get his food served first.

When interviewed on 2/24/26 at 2:15 p.m., Tenant #8 reported being concerned about Tenant #2's actions because one never knew what he would do. Tenant #8 described a situation when the tenant received breakfast, ate it and the staff removed his plate. Tenant #2 remained at the table and forgot he received food. He then yelled at staff as he did not think he was served breakfast. Tenant #8 reported he would speak in a stern voice to Tenant #2 and his anger was not generally directed at him. However he was troubled as other tenants and staff were frightened by Tenant #2's anger.

Tenant #9 stated she was on edge at mealtime due to Tenant #2's presence. She sat at a table near Tenant #2. He would yell at servers and get up from his seat 10-15 times during a meal. She did not know why he was allowed to live at the Program.

During an interview on 2/24/26 at 9:22 a.m, Staff B reported Tenant #2 became easily agitated if his food wasn't delivered within about three minutes. If a server was present when he wanted something, he yelled across the dining room. There were times he got out of his chair and

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physically intimidated a server. Tenant #2 would use a big voice and swear at the servers. There were a couple of staff who were scared to be around him. Tenant #2 went around to different tables and told the tenants things were so f-ing stupid.

During an interview on 2/26/26 at 9:35 a.m., Staff C recalled a situation when Tenant #2 was upset that his food wasn't coming out quickly enough. He ordered an item which needed to be specially prepared. Staff C turned her back on Tenant #2 and walked to the kitchen. Tenant #2 followed her without her knowledge and began yelling at her. This happened before, but was worse this time. Staff C did not want to work in his section for about a week. Tenant #2 had loud verbal outbursts about one to two times a week.

When interviewed on 2/26/26 at 10:00 a.m., Staff D reported she often saw Tenant #2 in the afternoon and evening. He increasingly used harsh words with staff and tenants. On 2/22/26, he got in the face of a staff member because it took too long for him to get food. She'd heard him swear as she walked by him. This happened at least every other night. There did not seem to be a pattern other than he didn't get what he wanted immediately. Tenant #2 got in close proximity to her and there were servers who did not want to be in his section. There were tenants who were visibly upset by his actions. She heard him tell a tenant in a wheelchair, can you move any f-ing slower?

During an interview on 2/25/26 at 8:40 a.m., the DON and the Assistant Director of Nursing (ADON) confirmed they were aware Tenant #2 could become irritable in the dining room and moved him to his own table following the 11/13/25

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A 160	Continued From page 4 incident. 2) Review of an incident investigation report, dated 1/27/26, indicated on 1/20/26 Tenant #1 alleged he was left in the shower for an extended period of time on an unknown date by a caregiver. The investigation revealed the incident likely occurred on 11/11/25. Tenant #1's bathroom pull cord was alarming for 27 minutes on 11/11/25. Tenant #1 did not report the incident until 1/20/26 because he did not think anything of it at the time. No injury occurred. During an interview on 2/25/26 at 10:20 a.m., Tenant #1 recalled a situation when he was showering with help from an employee. Tenant #1 was reliant on staff to get him in and out of the shower as he was wheelchair bound. When he was ready to get out of the shower, the employee was no longer in his apartment. Tenant #1 scooted himself over on the shower bench, reached over to the emergency pull cord and waited for an employee to respond to his apartment. This was especially troubling to Tenant #1 due to a situation he experienced about five years ago where he fell getting out of the shower, laid on the floor for 15-16 hours and became disabled. On 2/25/26 at 1:05 p.m. the DON and ADON confirmed a caregiver left Tenant #2's apartment when he was in the shower without telling him she was doing so. The caregiver told them she felt as if she would fall asleep so she left. The caregiver asked a co-worker to go to Tenant #1's apartment but this person had not shown up yet. They confirmed it was not acceptable for an employee to leave a tenant alone in the shower. During an exit meeting on 2/26/26 at 11:10 a.m.	A 160		

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A 160	Continued From page 5 the Executive Director, the DON and the ADON confirmed the Program failed to provide appropriate services to tenants in their care related to these events.	A 160		
A 285	481-67.5(2)f(4) 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: (4) Medications and treatments shall be administered as prescribed by the tenant's physician, advanced registered nurse practitioner or physician assistant. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to administer medication as prescribed to 1 of 1 current tenants reviewed who moved in within the previous 5 months (Tenant #3). Finding follows: Record review on 2/25/26 revealed a move-in medication list for Tenant #3 dated 9/16/25. The list included the following medications: Multivitamin, Lisinopril 40 milligrams (mg)., Cranberry 250 milliliters (ml) three times daily, Amlodipine, 2.5 mg and Calcium with Vitamin D 600-20. Tenant #3's physician signed admission orders on 9/23/25 for her to move to the Program. These orders included the 9/16/25 list of medication.	A 285		

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A 285	Continued From page 6 A review of Tenant #3's service plan, dated 9/30/25, indicated she required extensive assistance with medication. Qualified staff were to administer medications as ordered by the provider and stated on the Medication Administration Record (MAR). The Program had an October MAR for Tenant #3 which failed to include the Multivitamin, Lisinopril, Amlodipine or Calcium with Vitamin D. According to the MAR, Tenant #3 received Theracran Max Cranberry (no dose listed), two capsules by mouth once daily from 10/2/25 to 10/9/25 and Theracran Max Cranberry, one capsule by mouth twice daily from 10/10/25 to 10/31/25. She did not receive cranberry 250 ml three times daily. A progress note dated 11/18/25 indicated the Program received a clarifying fax from Tenant #3's primary care provider for Amlodipine, Multivitamin, Calcium and Lisinopril. This order was faxed to the pharmacy. A review of the November MAR revealed Tenant #3 was administered Amlodipine 2.5 mg., Calcium/Vitamin D3, Certavite (a Multivitamin) and Lisinopril beginning on 11/20/25. Tenant #3 received Theracran Max Cranberry twice daily (no dose provided) from 11/1/25 to 11/24/25. Staff quit giving her the AM dose of Theracran Max Cranberry from 11/25/25 to 11/30/25. She began on 11/20/25 at 8:00 a.m. receiving a Cranberry tablet 500 mg. from 11/20/25 to 11/30/25. During an interview on 2/25/26 at 3:00 p.m. the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) confirmed they failed to ensure Tenant #3 received all prescribed medication at the time of her admission. The DON indicated the pharmacy failed to reconcile	A 285		

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A 285	Continued From page 7 the list and put all medications on the MAR. The DON failed to review Tenant #3's medications to make sure they matched the admission list when she moved to the Program. The DON indicated she contacted the primary care provider in November to make sure the medications were being administered correctly, even though it was six weeks after Tenant #3's admission. She confirmed Tenant #3 still did not receive her Cranberry tablet as prescribed.	A 285		
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 ensure a sufficient number of trained staff were present to meet the needs of 2 of 6 tenants reviewed (Tenant #5 and Tenant #6), potentially affecting all 18 tenants residing in the secured memory care unit. Findings follow: Record review on 2/23/26 of an incident report dated 2/20/26 at 3:30 p.m. (time at which the event ended) revealed staff reported they heard yelling coming from the memory care unit. Upon entry Tenant #5 was found standing over Tenant #6, who was on the floor. Staff intervened, checked Tenant #5 for injuries and none were found. Tenant #6 had scratches on her face. The Assistant Director of Nursing (ADON) and the Director of Nursing (DON) reviewed camera	A 325		

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footage which showed Tenant #6 standing next to Tenant #5 who was seated at a dining room table. It appeared Tenant #6 had napkins in her hand and was speaking with Tenant #5. Tenant #5 was pushing Tenant #6's hand away. Tenant #6 drew her arm back as if she was going to strike Tenant #5 but did not do so. Tenant #5 then pushed Tenant #6, stood up and both tenants pushed at each other. Tenant #5 then pushed Tenant #6 to the floor. Tenant #5 then pushed Tenant #10 into a chair. Tenant #5 refocused on Tenant #6 and scratched her on the face. Staff H entered the dining room and attempted to deescalate Tenant #5 along with Staff E. Staff were directed to ensure one staff member was present in the dining room or common area at all times when tenants were present.

Review of Tenant #5's service plan, dated 2/4/26, indicated she had a history of occasional verbal and physical agitation. At times she had a difficult time understanding other tenants around her and was not aware of their actions, which caused her frustration. Staff were to reassure Tenant #5 they would help the other tenant in need and redirect Tenant #5 to her apartment or another activity. Tenant #5 was known to display some of this behavior during meals and activities when sitting at a table with other tenants. Staff should direct her to sit with tenants with whom she could easily communicate to help decrease behaviors. A staff member should sit at her table during meals to assist in deescalating any behavioral situations.

Tenant #6's service plan, dated 2/19/26 noted she would become fixated on certain things causing her increased anxiety. If such behaviors arose, staff should redirect her to an activity, food, drink, take her on a walk or call family. Tenant #6 should not be left alone in rooms with other

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tenants. Staff should redirect Tenant #6 or other tenants out of an apartment or common area. A staff member should sit at a specific table during meals to assist in deescalating behavioral situations at meal times.

A further review of the video of the incident showed the following:
3:19:27 - Staff F and Staff G left the dining room and walked down the hall. Staff H left the dining room walking into a common area. There were no staff in the dining area.
3:20:01 - Tenant #5 sat down at a table in the dining room. Tenant #6 stood next to her with napkins in her hand.
3:20:15 - Tenant #6 raised her hand as if she would hit Tenant #5.
3:20:19 - The women scuffled, Tenant #5 stood up and they continued to struggle.
3:20:22 - Tenant #6 was pushed to the ground, Tenant #10 stood up from her chair, Tenant #5 bent over Tenant #6.
3:20:34 - Tenant #5 walked away from Tenant #6. She looked toward Tenant #10, pointed her hand at her, appeared to be yelling, walked over and pushed her into a chair.
3:20:41 - Staff H viewed walking toward the dining room holding a chair.
3:20:52 - Staff H verbally engaged with Tenant #5. Tenant #6 was on the ground but sitting up.
3:20:56 - Staff E entered the unit.
3:21:04 - Tenant #5 stood by her table but still pointed at tenants, appearing agitated.
3:21:09 - Tenant #5 sat down, Staff E and Staff H assisted Tenant #6.
3:21:45 - Tenant #6 got up from the floor assisted by Staff E and Staff H.
3:21:51 - Staff G walked into the dining room.
3:22:16 - Staff H and Tenant #6 left the unit. Staff G was at the sink.

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3:21:44 - Staff G was at the sink, Staff E left the dining room and walked down the hall toward tenant apartments.
3:22:30 - Staff G left the dining room, Tenant #5 remained in the dining room with seven other tenants. No staff were present.
3:22:56 - Staff E walked in, then out of the dining room.
3:23:09 - Staff I entered the dining room, walked around, left at 3:23:27.
3:24:00 - Tenant #5 was walking around the dining room, other tenants up and moving around with walkers or in wheelchairs.
3:24:31 - Staff E left the unit, Staff F walked through the dining room to a common area, still no staff in the dining area.
3:25:41 - Tenant #5 exited the dining room, walked down the hall, out of sight, no staff in the dining room.
3:25:53 - Tenant #5 returned to the dining room where five tenants remained. She walked around the dining room and the common area next to the dining room.
3:26:31 - Staff F walked through the dining room, continued down the other hall out of sight.
3:27:20 - Tenant #5 walked back into the dining room, then down a hallway.
3:27:32 - Staff E walked back into the dining room, looked in the medication cart, and walked down the hall
3:28:16 - Staff E, Staff F and Staff G returned to the dining room and then exited, Tenant #5 stood in the dining room.
3:29:01 - Staff G walked through the dining room and Tenant #5 followed her out of the area.
3:30:01 - Staff F entered the dining room and remained there.

During an interview on 2/25/26 at 1:57 p.m. Staff H recalled straightening up the unit because it

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A 325	Continued From page 11 was close to the end of the day. Staff H was in the left hall (not in the dining room) when she heard arguing. She went to the dining room and saw Tenant #5 push Tenant #10 into a chair. Tenant #6 was down on the floor. Tenant #5 talked about wanting to smack Tenant #6. She told Tenant #5 to "stop it". There were no staff present when she entered the dining room. Staff E entered after she got there. They assisted Tenant #6 off the floor. Staff H was never told there was a requirement to remain in the room when Tenant #6 was present. When interviewed on 2/23/26 at 4:00 p.m. Staff E reported she went to the secured memory care unit because it sounded as if there was a chaotic situation taking place. She saw Tenant #6 on the ground upon opening the door. Staff E and Staff H helped Tenant #6 off the ground. When she arrived Tenant #5 sat at a table and the tenants ate a snack. There were about 8 to 10 tenants present. She did not see any other caregivers in the vicinity. She believed staff showed up after about five to 10 minutes. Staff F and Staff G were in an apartment assisting another tenant. Staff I was taking out the trash. Tenant #5 seemed calm following the incident but the other tenants were upset. During an interview on 2/26/26 at 9:10 a.m., the Director of Nursing indicated staff absolutely should not have left the tenants alone following the incident with Tenant #5. Staff had the option of calling for assistance from other employees in the building if needed.	A 325		
A 160	481-69.23(1)c(1) Criteria for Admission / Retention of Tenants	A 160		

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A 160	Continued From page 12 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: c. Is dangerous to self or other tenants or staff, including but not limited to a tenant who: (1) Despite intervention chronically elopes, is sexually or physically aggressive or abusive, or displays unmanageable verbal abuse or aggression This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program retained two of six current tenants who displayed verbal or physical aggression (Tenant #2 and Tenant #5). Findings follow: 1) Record review on 2/23/26 of Tenant 5's progress notes revealed the following: - On 4/20/25, staff reported Tenant #5 grabbed another tenant and hit her in the arm. Tenant #5 said she hit the tenant because the other person would not remove her foot from under the table. - On 4/28/25, Tenant #5 repeatedly told a tablemate to shut up. She then stood up and attempted to strike the tablemate. Staff got in between the two tenants. - On 6/6/25, Tenant #5 was found pushing another tenant out of the laundry room as she was attempting to leave. No injuries were noted. - On 6/9/25, Tenant #5's Primary Care Provider (PCP) was notified of her increased aggression with others. - On 6/22/25, Tenant #5 walked up to another tenant and slapped her across the face. The other tenant did nothing to provoke or upset Tenant #5. - On 6/23/25, Tenant #5 came out of her apartment and walked up to a tenant in a	A 160		

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wheelchair near her spot in the dining room. Tenant #5 pulled the wheelchair toward her and the other tenant fell to the floor. Tenant #5 yelled the other tenant was in her way. Staff told the tenant she would have assisted her but Tenant #5 continued to yell. Staff redirected her to another chair while a nurse assisted the other tenant off the floor. The nurse spoke with Tenant #5's son about the incident who said he was not opposed to starting medication to offset the behaviors. The nurse would contact the PCP. Tenant #5 had a history of behaviors and had interventions in place for staff to utilize.
- The PCP ordered Sertraline (an antidepressant), 25 milligrams (mg). at bedtime.
- On 7/17/25 at 11:56 a.m. Tenant #5 was noted pulling on another tenant's wheelchair to move her out of the way.
- On 9/14/25 at 12:30 p.m., Tenant #5 stood up from the table to empty her plate. When doing so another tenant attempted to sit in her chair. Tenant #5 grabbed the other tenant's upper right arm and told her not to sit in her chair.
- When waiting for lunch on 9/16/25 at 12:15 p.m. Tenant #6 was messing with her own silverware and Tenant #5 told her to stop. Staff intervened and asked Tenant #6 to move. Tenant #6 got up and grabbed her own silverware. Tenant #5 grabbed Tenant #6 by the hair and told her to leave the silverware. Tenant #6 grabbed Tenant #5 by the wrist as she tried to get loose, which resulted in some scratches to Tenant #5's arm.
- Tenant #5's PCP increased her Sertraline to 50 mg. daily.
- On 9/22/25, Tenant #5 sat at the dining room table when Tenant #6 approached the table to sit next to her. Tenant #5 told the other tenant she could not sit by her and to get out of the way. Tenant #5 stood up, grabbed Tenant #6 by the chin and hit her in the nose with her closed fist.

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Staff intervened and no visible injuries were noted. Staff talked with Tenant #5 who agreed to walk away or ask for assistance if someone was bothering her.
- The PCP started Tenant #5 on Aricept 10 mg at night and Memantine 10 mg. twice daily.
- On 1/28/26 at 5:30 p.m. Tenant #5 was sitting, waiting for dinner to be served when Tenant #6 walked up and started touching things in front of her. Tenant #5 asked Tenant #6 to move and shooed her away with her hand. Tenant #6 then struck her in the shoulder. Tenant #5 stood up and struck Tenant #6 in the lower lip. A discretionary change was added to Tenant #5's service plan to reflect having a staff member sit at her table during meals.
- An incident occurred on 2/20/26 during which staff heard yelling. Upon entry Tenant #5 was found standing over Tenant #6, who was on the floor. Staff intervened, checked Tenant #5 for injuries and none were found. Tenant #6 had scratches on her face.
The Assistant Director of Nursing (ADON) and Director of Nursing (DON) reviewed camera footage which showed Tenant #6 stood next to Tenant #5 who was seated at a dining room table. It appeared Tenant #6 had napkins in her hand and was speaking with Tenant #5. Tenant #5 was pushing Tenant #6's hand away. Tenant #6 drew her arm back as if she was going to strike Tenant #5 but did not do so. Tenant #5 then pushed Tenant #6, stood up and both tenants pushed at each other. Tenant #5 pushed Tenant #6 to the floor. Tenant #5 then pushed Tenant #10 into a chair. Tenant #5 refocused on Tenant #6 and scratched her on the face. Staff H entered the dining room and attempted to deescalate Tenant #5 along with Staff E. Staff were directed to ensure one staff member was present in the dining room or common area at all times when

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A 160	Continued From page 15 tenants were present. A review of service plans for Tenant #5 dated 4/16/25 and 2/4/26, both plans noted she had a history of occasional verbal and physical agitation. She had a difficult time understanding other tenants around her and was aware of their actions which caused her frustration. Staff were to reassure her they would help other tenants in need and redirect Tenant #5 to her apartment or another activity. Tenant #5 was known to display some of this behavior during meals and activities when sitting at a table with other tenants. Staff should direct Tenant #5 to sit with tenants she could easily communicate with to help decrease this behavior. A staff member should sit at her table during meals to assist in deescalating any behavioral situations. During an interview on 2/23/26 at 9:56 a.m. Staff J described Tenant #5 as physically aggressive. Tenant #5 put her hands on the tenants, hit and yelled at them. Staff J felt as if she had to be careful in how she approached Tenant #5 for fear she would be hit. Tenant #5's aggression was worse in the dining room when individuals got loud. She also got upset with Tenant #6 who wandered or tried to be her friend. Tenant #5 acted out in a verbally or physically aggressive manner about twice a week. On 2/23/26 at 1:40 p.m. Staff K indicated Tenant #5 became physical with other tenants about three times a week. She was present when Tenant #5 pushed a tenant and her wheelchair into the table just the other day. When asked to list any tenants who were physically aggressive on 2/23/26 at 9:50 a.m., the DON identified Tenant #5.	A 160		

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A 160	Continued From page 16 The Program had interventions in Tenant #5's service plan as far back as 4/16/25 to address her behaviors. They made medication changes to assist with these issues as well. The Program retained Tenant #5 as she continued to act out toward other tenants in a physical manner. 2) Record review of progress notes for Tenant #2 revealed the following: - On 10/16/25, Tenant #2 became agitated, yelled, cursed at staff and a student who was in the building. Staff were able to redirect the tenant however it took a while for the aggression to decrease. - On 10/17/25, Tenant #2 started yelling and cursing at a fellow tablemate. Staff were able to intervene and redirect. The ADON spoke with his power of attorney (POA) to request an increase in his scheduled Alprazolam (an anti-anxiety medication). She reported this time of year was typically difficult for him and the POA was agreeable with an increase. - On 10/29/25, the PCP increased the Alprazolam to 0.5 mg. twice daily. - On 11/10/25, the PCP increased Citalopram (an antidepressant) to 20 mg. daily. - On 11/12/25, the PCP added Alprazolam to 0.25 mg. twice daily as needed. Tenant #2's incident report, dated 11/13/25 at 12:30 p.m. noted staff observed Tenant #2's hands around Tenant C2's neck. Staff A immediately separated the two tenants. Tenant #2 was easily redirected back to his apartment. Per witness statements, Tenant C2's cell phone rang, which triggered Tenant #2, leading him to put his hands on the other tenant. Tenant #2 had no recollection of why he grabbed Tenant C2 and no injuries were noted. An intervention was put in	A 160		

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place to have Tenant #2 sit at a private table in the dining room.

A progress note from 2/23/26 indicated staff reported Tenant #2 showed an increase in behaviors and agitation in the afternoon. Staff administered Alprazolam around 2:00 p.m. most days.

An interview conducted on 2/25/26 at 10:20 a.m, Tenant #1 reported being present for the incident when Tenant #2 put his hands on Tenant C2. Tenant C2's phone rang and then Tenant #2 started swearing. Tenant #2 stood up, approached Tenant C2 and put his hands around his neck. Tenant #7 attempted to intervene. Tenant #1 believed he saw Tenant #2 hit Tenant #7. Tenant #1 described Tenant #2 as unpredictable. He did not know what the tenant would do from minute to minute during mealtime. Tenant #1 would get up multiple times throughout a meal. Tenant #1 described an incident in which Tenant #2 moved his drink to Tenant #1's spot. He then left the table. On Tenant #1's return, he became angry he didn't have a drink. Tenant #1 stood up, clenched his fists and began to swear. It was not unusual for Tenant #1 to angrily follow the staff into the kitchen when he did not get his food quickly.

During an interview on 2/26/26 at 8:00 a.m., Staff A recalled sitting at the front desk when she heard Tenant C2's phone ring and Tenant #2 pushed his chair back. Tenant #2 then pushed Tenant C2's chair against the wall and began choking him. She went running from the front desk and told Tenant #2 to stop. When Tenant #2 let go of his neck, Tenant C2 got up as if he wanted to fight Tenant #2. Tenant #7 then attempted to stop the fight. Staff A reported staff

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were supposed to be in the dining room to monitor things and keep attendance. On that day, there were only three caregivers working so no one was present to monitor the dining room. Staff A described Tenant #2 as someone who yelled at everyone. He spit on others. He called female staff stupid and swear words. Tenant #1 tried to hit her in the head once. Every day she worked he went into the kitchen and yelled curse words if he didn't get his food served first.

When interviewed on 2/24/26 at 2:15 p.m. Tenant #8 reported being concerned about Tenant #2's actions because one never knew what he would do. Tenant #8 described a situation when the tenant received breakfast, ate it and the staff removed his plate. Tenant #2 remained at the table and forgot he received food. He then yelled at staff as he did not think he was served breakfast. Tenant #8 reported he would speak in a stern voice to Tenant #2 and his anger was not generally directed at him. However he was troubled as other tenants and staff were frightened by Tenant #2's anger.

Tenant #9 indicated she was on edge at mealtime due to Tenant #2's presence. She sat at a table near Tenant #2. He yelled at servers and got up from his seat 10 to 15 times during a meal. She did not know why he was allowed to live at the Program.

When interviewed on 2/24/26 at 9:22 a.m., Staff B reported Tenant #2 became easily agitated if his food wasn't delivered within about three minutes. If a server was present, he yelled across the dining room. There were times he got out of his chair and physically intimidated a server. Tenant #2 would use a big voice and swear at the servers. There were a couple of

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staff who were scared to be around him. Tenant #2 went around to different tables and told the tenants things were so f-ing stupid.

During an interview on 2/26/26 at 9:35 a.m., Staff C recalled a situation when Tenant #2 was upset that his food wasn't coming out quickly enough. He ordered an item which needed to be specially prepared. Staff C turned her back on Tenant #2 and walked to the kitchen. Tenant #2 followed her without her knowledge and yelled at her. This happened before, but was worse this time. Staff C did not want to work in his section for about a week. Tenant #2 had loud verbal outbursts about one to two times a week.

When interviewed on 2/26/26 at 10:00 a.m., Staff D reported she often saw Tenant #2 in the afternoon and evening. He increasingly used harsh words with staff and tenants. On 2/22/26, he got in the face of a staff member because it took too long for him to get food. She heard him swear as she walked by him. This happened at least every other night. There did not seem to be a pattern other than he didn't get what he wanted immediately. Tenant #2 got physically close to her and there were servers who did not want to be in his section. There were tenants who were visibly upset by his actions. She heard him tell a tenant in a wheelchair, can you move any (swear word) slower?

On 2/23/26 at 4:00 p.m., Staff E indicated she only experienced Tenant #2's outbursts in the dining room. She generally saw them one to two times a week. He would get loud and in a person's face. These outbursts were generally directed toward tenants, but it could be toward anyone. When Tenant #2 yelled it worried her because she never knew what caused the

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A 160	Continued From page 20 behavior. Tenant #2's service plan dated 7/15/25 noted he had a history of anxiety. Staff were to notify a nurse if he displayed restlessness, irritability, racing thoughts, unwanted thoughts, excessive worry or fear. He could become frustrated. He had occasional behaviors and could become frustrated. Staff were to notify his wife if interventions were unsuccessful. The program retained Tenant #2 after he displayed repeated verbal aggression and a few episodes of physical aggression. His service plan included interventions to address anxiety and behavior. The Program attempted to address his behavior with pharmacological interventions. Following the incident on 11/13/25 in which Tenant #2 choked another tenant, an intervention was put in place for him to sit at his own table in the dining room. Tenant #2 was retained despite displaying dangerous behavior to tenants and staff. During an exit interview with the Executive Director, the DON and the ADON confirmed the Program failed to discharge Tenant #5 and Tenant #2 despite them placing others at risk due to their verbal and physical aggression.	A 160		
A 290	481-69.25(1)i Tenant Documents 69.25(1) Documentation for each tenant shall be maintained by the program and shall include: i. When any personal or health-related care is delegated to the program, the medical information sheet; documentation of health professionals' orders, such as those for	A 290		

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A 290	Continued From page 21 treatment, therapy, and medication; and nurses' notes written by exception This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to make entries of significant events in the progress notes of 1 of 6 current tenants reviewed (Tenant #2) and 1 of 2 discharged tenants reviewed (Tenant C2). Findings follow: 1) Record review on 2/23/26 revealed Tenant #2's incident report, dated 11/13/25 indicated at 12:30 p.m. staff reported to the Director of Nursing (DON) they observed Tenant #2's hands around Tenant C2's neck. Staff A immediately separated the two tenants. Tenant #2 was easily redirected back to his apartment. Per witness statements, Tenant C2's cell phone rang, which triggered Tenant #2, leading him to put his hands on the other tenant. Tenant #2 had no recollection of why he grabbed Tenant C2 and no injuries were noted. An intervention was put in place to have Tenant #2 sit at a private table in the dining room. During an interview on 2/26/26 at 9:10 a.m. the Executive Director reported escorting Tenant #2 back to his apartment following the incident. He was easy to direct. Tenant #2 had no recall of the incident and no injuries. There were no progress notes documenting the 11/13/25 incident. 2) An incident report for Tenant C2 dated 11/13/25 noted staff found Tenant #2's hands around his neck. Tenant #2 was removed from the dining room while Tenant C2 remained there	A 290		

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A 290	Continued From page 22 to finish his lunch. The Director of Nursing (DON) assessed Tenant C2 and no injuries were noted. No progress notes were found documenting the 11/13/25 incident. On 2/25/26 at 8:40 a.m. the DON and the Assistant Director of Nursing assessed Tenant C2 following the incident on 11/13/25. Tenant C2 was not concerned or fearful following the event. They did not think he remembered the incident. They also assessed Tenant #2 who did not recollect what occurred on 11/13/25. They reported there was no reason the events were not documented in the progress notes but confirmed they failed to notate the information as required.	A 290		
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 ensure the documentation of health-related care for 1 of 2 discharged tenants (Tenant C1). Finding follows: 1) Record review on 2/24/26 revealed a Change	A 330		

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of Condition progress note for Tenant #1 on 7/15/25 indicated his admission to hospice. A service plan created on 7/15/25 identified he required minimal care with grooming and personal hygiene. He was able to perform most hygiene tasks but may need staff to help with set up.

A review of the task sheet for August, 2025 and September, 2025 identified there were entries for the task that staff were to ensure teeth and mouth were cleaned and free from food. The task noted the tenant had been pocketing food. The task was added 8/1/25. Staff were not able to document the completion of this task as the task was marked "INF".

2) Tenant C1's Hospice IDG Comprehensive Assessment and Plan of Care, dated 9/10/25, noted Tenant C1 had a stage II pressure ulcer to his left lower buttock. He was bed bound with a foley catheter. The plan was updated and signed by a physician on 9/24/25 to indicate Tenant C1 should maintain bed bound with repositioning every two hours for comfort.

There was no documentation on Tenant C2's task sheets or the Medication Administration Record for completion of two hour repositioning.

On 2/25/26 at 3:00 p.m. the Director of Nursing (DON) and the Assistant Director of Nursing indicated the "INF" on task sheets let staff know the entry was "Information only". The DON did not know why the entry was put in this way. Staff failed to document the completion of Tenant C1's oral cares and repositioning.

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A 340	Continued From page 24	A 340		
A 340	481-69.25(2) Tenant Documents 69.25(2) The program records relating to a tenant shall be retained for a minimum of three years after the transfer or death of the tenant. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to maintain records on the completion of tasks for 1 of 2 discharged tenants for three years (Tenant C1). Finding follows: Tenant C1's Hospice IDG Comprehensive Assessment and Plan of Care, dated 9/10/25, noted Tenant C1 had a stage II pressure ulcer to his left lower buttock. He was bed bound with a foley catheter. The plan was updated and signed by a physician on 9/24/25 to indicate Tenant C1 should maintain bed bound with repositioning every two hours for comfort. On 2/25/26 at 3:00 p.m. the Director of Nursing (DON) and the Assistant Director of Nursing stated they believed they had task sheets documenting the repositioning of Tenant C1 but could not locate them.	A 340		
A 350	481-69.26(1) Service Plans 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed.	A 350		

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SILVERCREST GARNER FARMS	1575 W 53RD DAVENPORT, IA 52806

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A 350	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Program failed to update the service plans for 1 of 6 current tenants when they experienced a significant change (Tenant #2). Finding follows: Record review of Tenant #2's progress notes revealed the following: - On 10/16/25, Tenant #2 became agitated, yelled, cursed at staff and a student who was in the building. Staff were able to redirect the tenant however it took a while for the aggression to decrease. -On 10/17/25, Tenant #2 started yelling and cursing at a fellow tablemate. Staff were able to intervene and redirect. The ADON spoke with his power of attorney (POA) to request an increase in his scheduled Alprazolam (an anti-anxiety medication). She reported this time of year was typically difficult for him and the POA was agreeable with an increase. - On 10/29/25, the PCP increased the Alprazolam to 0.5 milligrams (mg) twice daily. - On 11/10/25, the PCP increased Citalopram (an antidepressant medication) to 20 mg daily. - On 11/12/25, the PCP added Alprazolam to 0.25 mg twice daily as needed. An incident report for Tenant #2 dated 11/13/25 at 12:30 p.m. noted staff observed Tenant #2's hands around Tenant C2's neck. Staff A immediately separated the two tenants. Tenant #2 was easily redirected back to his apartment. Per witness statements, Tenant C2's cell phone rang, which triggered Tenant #2, leading him to	A 350		

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put his hands on the other tenant. Tenant #2 had no recollection of why he grabbed Tenant C2 and no injuries were noted. An intervention was put in place to have Tenant #2 sit at a private table in the dining room.

A progress note from 2/23/26 indicated staff reported Tenant #2 displayed an increase in behaviors and agitation in the afternoon. Staff administered Alprazolam around 2:00 p.m. most days.

An interview conducted on 2/25/26 at 10:20 a.m. Tenant #1 reported being present for the incident when Tenant #2 put his hands on Tenant C2. Tenant C2's phone rang and then Tenant #2 started swearing. Tenant #2 stood up, approached Tenant C2 and put his hands around his neck. Tenant #7 attempted to intervene. Tenant #1 believed he saw Tenant #2 hit Tenant #7. Tenant #1 described Tenant #2 as unpredictable. He did not know what the tenant would do from minute to minute during mealtime. Tenant #1 got up multiple times throughout a meal. Tenant #1 described an incident in which Tenant #2 moved his drink to Tenant #1's spot. He then left the table. On Tenant #1's return, he became angry he didn't have a drink. Tenant #1 stood up, clenched his fists and began to swear. It was not unusual for Tenant #1 to angrily follow the staff into the kitchen when he did not get his food quickly.

During an interview on 2/26/26 at 8:00 a.m. Staff A recalled sitting at the front desk when she heard Tenant C2's phone ring and Tenant #2 pushed his chair back. Tenant #2 then pushed Tenant C2's chair against the wall and choked him. She went running from the front desk and told Tenant #2 to stop. When Tenant #2 let go of

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his neck, Tenant C2 got up as if he wanted to fight Tenant #2. Tenant #7 then attempted to stop the fight. Staff A reported staff were supposed to be in the dining room to monitor things and keep attendance. On that day, there were only three caregivers working so no one was present to monitor the dining room. Staff A described Tenant #2 as someone who yelled at everyone. He spit on others. He called female staff stupid and swear words. Tenant #1 tried to hit her in the head once. Every day she worked he went into the kitchen and yelled curse words if he didn't get his food served first.

When interviewed on 2/24/26 at 2:15 p.m. Tenant #8 reported being concerned about Tenant #2's actions because one never knew what he would do. Tenant #8 described a situation when the tenant received breakfast, ate it and the staff removed his plate. Tenant #2 remained at the table and forgot he received food. He then yelled at staff as he did not think he was served breakfast. Tenant #8 reported he would speak in a stern voice to Tenant #2 and his anger was not generally directed at him. However he was troubled as other tenants and staff were frightened by Tenant #2's anger.

Tenant #9 indicated she was on edge at mealtime due to Tenant #2's presence. She sat at a table near Tenant #2. He yelled at servers and got up from his seat 10 to 15 times during a meal. She did not know why he was allowed to live at the Program.

When interviewed on 2/24/26 at 9:22 a.m. Staff B reported Tenant #2 became easily agitated if his food wasn't delivered within about three minutes. If a server was present, he yelled across the dining room. There were times he got out of his

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chair and physically intimidated a server. Tenant #2 would use a big voice and swear at the servers. There were a couple of staff who were scared to be around him. Tenant #2 went around to different tables and told the tenants things were so f-ing stupid.

During an interview on 2/26/26 at 9:35 a.m. Staff C recalled a situation when Tenant #2 was upset that his food wasn't coming out quickly enough. He ordered an item which needed to be specially prepared. Staff C turned her back on Tenant #2 and walked to the kitchen. Tenant #2 followed her without her knowledge and yelled at her. This happened before, but was worse this time. Staff C did not want to work in his section for about a week. Tenant #2 had loud verbal outbursts about one to two times a week.

When interviewed on 2/26/26 at 10:00 a.m. Staff D reported she often saw Tenant #2 in the afternoon and evening. He increasingly used harsh words with staff and tenants. On 2/22/26, he got in the face of a staff member because it took too long for him to get food. She heard him swear as she walked by him. This happened at least every other night. There didn't seem to be a pattern other than he didn't get what he wanted immediately. Tenant #2 got physically close to her and there were servers who did not want to be in his section. There were tenants who were visibly upset by his actions. She heard him tell a tenant in a wheelchair, can you move any (swear word) slower?

On 2/23/26 at 4:00 p.m. Staff E indicated she only experienced Tenant #2's outbursts in the dining room. She generally saw them one to two times a week. He got loud and in a person's face. These outbursts were generally directed toward

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A 350	Continued From page 29 tenants, but it could be toward anyone. When Tenant #2 yelled it worried her because she never knew what caused the behavior. Tenant #2's service plan, dated 7/15/25, noted he had a history of anxiety. Staff were to notify a nurse if he displayed restlessness, irritability, racing thoughts, unwanted thoughts, excessive worry or fear. He could become frustrated. He had occasional behaviors and could become frustrated. Staff were to notify his wife if interventions were unsuccessful. The Program failed to update Tenant #2's service plan after he displayed increasing episodes of physical and verbal aggression (updated on 2/24/26). During an interview on 2/25/26 at 3:00 p.m. the Director of Nursing and the Assistant Director of Nursing confirmed the Program failed to update Tenant #2's service plan to address his acts of aggression.	A 350		
A 395	481-69.26(4)a Service Plans 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 include the needs and preferences for assistance in the service plans for	A 395		

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A 395	Continued From page 30 2 of 6 current tenants reviewed (Tenant #3 and Tenant #2). Findings follow: 1) Record review on 2/23/26 revealed the following progress notes for Tenant #3: - On 9/23/25, Tenant #3 moved to the program. She had right-sided weakness from a stroke four years ago. She required the assistance of one staff member for mobility, ambulation, bathing and dressing. She used a wheelchair for mobility and ambulation. - On 10/9/25, she met with a physical therapist and had goals to work on transfer training, strengthening, standing and balance. - On 10/13/25, Tenant #3 had a fall. She reported sliding out of bed. Two staff assisted her off the floor. - On 10/15/25, she met with her physical therapist. The physical therapist recommended a gait belt and assistance with all transfers. - On 11/4/25, Tenant #3 discharged from physical therapy. - A care conference was held on 12/12/25 with the Executive Director, the Director of Nursing (DON) and Tenant #3's daughter/power of attorney (POA). The POA expressed concerns over the manner in which staff transferred her mother and the toileting schedule. The administration discussed the possibility of Tenant #3 moving to the secured memory care unit. - On 12/23/25 the POA reported she was not interested in having her mom move to the memory care unit but requested a change in the toileting schedule to add bathroom reminders at 10:00 a.m. and 2:00 p.m. Tenant #3's service plan, dated 12/22/25, identified she required moderate assistance with toileting from one person. There was no mention of staff helping her to the toilet at 10:00 a.m. and	A 395		

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2:00 p.m. Tenant #3 required hands-on assistance with transfers or changes in position from one person. There was no mention of staff using a gait belt.

During an interview on 2/26/26 at 8:00 a.m. Staff A reported all staff received training from the DON on transferring Tenant #3 with the use of a gait belt.

When interviewed on 2/23/26 at 11:15 a.m. Staff L recalled when some staff were directed to take Tenant #3 to the bathroom at 10:00 a.m. and 2:00 p.m., but she did not know this was required and wasn't doing it.

2) Record review on 2/23/26 revealed Tenant #2's incident report, dated 11/13/25 at 12:30 p.m. Staff reported to the Director of Nursing (DON) they observed Tenant #2's hands around Tenant C2's neck. Staff A immediately separated the two tenants. Tenant #2 was easily redirected back to his apartment. Per witness statements, Tenant C2's cell phone rang, which triggered Tenant #2, leading him to put his hands on the other tenant. Tenant #2 had no recollection of why he grabbed Tenant C2 and no injuries were noted. An intervention was put in place to have Tenant #2 sit at a private table in the dining room.

When interviewed on 2/24/26 at 9:22 a.m. Staff B reported Tenant #2 became easily agitated if his food wasn't delivered within about three minutes. If a server was present when he wanted something, he yelled across the dining room. There were times he got out of his chair and physically intimidated a server. Tenant #2 would use a big voice and swear at the servers. There were a couple of staff who were scared to be around him. Tenant #2 went around to different

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tables and told the tenants things were so f-ing stupid.

During an interview on 2/26/26 at 9:35 a.m. Staff C recalled a situation when Tenant #2 was upset that his food wasn't coming out quickly enough. He ordered an item which needed to be specially prepared. Staff C turned her back on Tenant #2 and walked to the kitchen. Tenant #2 followed her without her knowledge and yelled at her. This happened before, but was worse this time. Staff C did not want to work in his section for about a week. Tenant #2 had loud verbal outbursts about one to two times a week.

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During an interview on 2/25/26 at 8:40 a.m. the DON and the Assistant Director of Nursing (ADON) confirmed they were aware Tenant #2 could become irritable in the dining room and moved him to his own table following the 11/13/25 incident.

A review of Tenant #2's 7/15/25 service plan noted he was independent with meal

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A 395	Continued From page 33 consumption and provided a meal three times a day. He had a history of anxiety, excessive worry and fear. He became frustrated if unaware of his location or unfamiliar with new faces. There was no mention of sitting Tenant #2 at a private table in the dining room due to his anger or frustration with not getting his food in a timely manner or unexpected sounds. During an interview on 2/25/26 at 3:00 p.m. the DON and the ADON confirmed the service plans of Tenant #2 and Tenant #3 failed to include their individual needs and preferences.	A 395		