Iowa Department of Inspections and Appeals
Health Facilities Division
Adult Services Civil Penalty Citation

Date: April 23, 2024
Program Name: River Valley Place of Ottumwa
Address: 173 East Rochester Street Ottumwa, IA 52501
Type of Action: 117180-C
Date(s) of Action: 3/19/24 – 3/26/24
Citation #: 10320

State Rule #	State Rule	Amount of Civil Penalty
67.2(3)	**67.2(3) The program shall follow the policies and procedures established by the program.** Based on interview and record review, the program failed to follow established policies related to reporting potential dependent adult abuse for 5 of 7 current tenants (Tenant #2, #3, #4, #5 and #7) and 3 of 3 discharged tenants (Tenant C1, C2 and C3) reviewed. Findings include: 1. A review of police department records revealed the following: - On 7/14/23 at 12:53 PM, a supervisor from the program reported during a routine audit of patients' medication it was discovered one patient had about 40 Tizanidine taken since 7/3/23. According to drugs.com, Tizanidine is a short-acting muscle relaxer. Another audit showed a patient in the memory care unit had several Trazodone missing. Trazodone is a selective serotonin reuptake inhibitor indicated for the treatment of major depressive disorder according to Drugs.com. The Trazodone may have been taken over night on 7/14/23. a) the nurse wrote an email to the Assistant Director on 7/13/23 identifying Tenant #2 was missing 12 pills of Trazodone. Tenant #5 was missing the Tizanidine. b) on 8/3/23, the former Executive Director sent an email to the police officer stating it was not the first time in recent weeks a medication came up missing. He had several complaints from other staff reporting a specific employee had been tampering with medication. - On 11/27/23, the police received a report the medication cart was left unlocked on 11/22/23. Staff discovered the cart was unlocked on 11/23/23 at the evening medication pass. During the course of the investigation, staff members reported the following: a) there were issues with a previous manager stealing medication numerous times, including more so than what's being reported to police now. b) since August there have been a few thefts. Morphine was taken sometime in September but no police report was made. - On 1/4/24 the Health and Wellness Director (HWD) reported to the police Tenant #3 had 9 clonazepam pills missing from her pill organizer. Tenant #3 dispensed her own pills. The HWD reported a hospice employee set up Tenant #3's medication for her on 1/1/24	**$500.00**

	which was the last time they were aware all pills were present. The HDW reported they had some pills thefts, but this was the first narcotic that was taken. When interviewed on 3/19/24 at 5:30 PM, Staff C reported Morphine went missing for Tenant C3. The former Registered Nurse (RN) did not count the narcotic pain medication for Tenant C2 when he moved to the program. Tenant C2 moved to the program on a Tuesday with 16 or 17 pills. By Friday, there were 3 pills left in the bottle. Tenant #2 and Tenant #4 had missing medication which was discovered on 7/12/23. A report was made to the police about this and staff wrote statements about what occurred. When interviewed on 3/18/24 at 1:30 PM, Tenant #5 reported she was informed someone stole Tramadol, a narcotic medication, from her. Her medication was administered by the program. On 3/18/24 at 4:47 PM, Staff D recalled Tenant C3 had syringes of morphine provided by hospice. When she was counting narcotics with Staff F they discovered one syringe containing morphine was empty. Tenant C2's daughter dropped off a bottle of narcotics to the program, although she was unsure what kind. Pills from the bottle went missing. Tenant #7 stored her medication in a lock box in her apartment. Tenant #7 reported someone came in during the middle of the night and took the pills. Tenant #4 had muscle relaxers stolen. Tenant #2 had Trazodone stolen from her apartment from an unlocked medication box and cabinet stored in the tenant's apartment. During an interview on 3/19/24 at 8:10 AM Staff E reported being aware of the medication thefts. The Abuse, Neglect and Exploitation policy identified the program developed the policy and procedure to prohibit the exploitation or misappropriation of property by any perpetrator. All employees were educated alleged or suspected violations involving misappropriation of elder property should be reported immediately to the Administration, but not later than two hours after the alleged incident. The Chief Executive Officer and/or Administrator would ensure all incidents of misappropriation of elder property were investigated and reported immediately to the State Department for Aging and Disability Services Complaint Hotline. Staff would interview the person making the report, individuals alleged to have been involved in the incident, the elder, team members on duty when the alleged incidents occurred and other elders who received care from the individual alleged to have committed the abuse. Following each interview, the individual interviewed would complete a witness statement summarizing the events related to the incident. It would be emphasized to each person they were to write a statement in their own words. Each individual would sign and date their witness statements in front of a Notary Public. Within five days of the incident, the Administrator would review the information from the investigation and prepare a written report to include a list of findings, a summary of conclusions of the investigation, recommendations for changes in policies and procedures to prevent a similar event from occurring and	

	recommendations for employee education when the report indicates employees did not follow the policies and procedures. The Managing Controlled Medications policy noted if a major discrepancy or pattern of discrepancies occurs or if there is apparent criminal activity, the Director of Nursing would notify the Health Services Administrator and Consultant Pharmacist immediately. They would determine if law enforcement should be notified. On 3/25/24 at 3:30 PM the HWD (who began employment in October, 2023) stated she could not find investigations into the thefts or evidence the program reported these possible cases of dependent adult abuse to the department.	