IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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RODNEY A. ROBERTS, DIRECTOR

DEMAND LETTER
CERTIFIED
Complaint Intake #: 41319-C

December 3, 2012

Mr. Derrick Johnson, Director
Spring Valley
501 12th Street
Perry, IA 50220

RE: I. Final Complaint/Incident Investigation Report
II. Civil Penalty
III. Appeals/Hearings
IV. Conclusion

Dear Mr. Johnson:

I. Final Complaint/Incident Investigation Report – Spring Valley Senior AL, Perry, IA

Enclosed is the **Final Complaint/Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code chapter 231C and Iowa Administrative Code (IAC) chapters 481—67 and 481—69. The Report notes Regulatory Insufficiencies in the area(s) of: Nurse Review, Evaluation, Service Plans and Food Service. **Spring Valley Senior AL** ("Program") is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a).

II. Civil Penalty

If, within 30 days of the receipt of this demand letter, you (1) do not request a formal hearing or withdraw your request for formal hearing, and (2) pay the civil penalty, the assessed penalty will be reduced by thirty-five percent (35%) pursuant to IAC rule 481—67.12(3)d. If you do not wish to request a formal hearing or wish to withdraw your request for formal hearing, please send a cover letter to the attention of **Rose Boccella** and remit the civil penalty assessed by check or money order to the State of Iowa in the amount of six hundred and fifty dollars ($650) within 30 business days after the receipt of this demand letter.

III. Appeals/Hearings

The Program may appeal the DIA decision in accordance with IAC rule 481—67.13 within thirty (30) days of this notice, by submitting a request for appeal to DIA. A contested case hearing will be held pursuant to Iowa Code chapter 17A and IAC chapter 481—10. If the Program appeals the DIA decision, the civil penalty will be suspended pending the appeal process. If the Program does not appeal, the civil penalty is due within 30 days of notice.

IV. Conclusion

The Program is being assessed a $1,000 civil penalty pursuant to Iowa Code section 231C.14 and 481 IAC 67.12(3)(a). The Plan of Correction (POC) submitted on November 26, 2012, has been reviewed and will constitute the final POC related to the on-site visit of October 25, 2012.

DIA may revisit the Program to confirm compliance in fulfilling the POC's corrective measures. If the Program wishes to appeal the final findings, the Program may do so within 30 days of this letter.

If you have any questions in regard to this letter and enclosed Report, please contact your Program Coordinator, Rose Boccella, at 515/281-7039.

Sincerely,

Ann Martin

Ann Martin, Bureau Chief
Adult Services Bureau

Enclosure

IOWA DEPARTMENT OF INSPECTIONS AND APPEALS
Assisted Living Program
Final Complaint/Incident Investigation Report

Assisted Living Program:

Spring Valley
Derrick Johnson, Director
501 12th St.
Perry, IA 50220

Complaint/Incident Intake #:

#41319-C

Date of Complaint/Incident Investigation:

October 25, 2012

Monitor(s):

Joyce Kix, RN

Definitions: *The following definitions are relevant:*

Assisted Living Program – A program certified under 481 IAC 69 that provides housing with contracted services to three or more tenants in a physical structure that provides a homelike environment. Services may include but are not limited to health-related care, personal care, and assistance with instrumental activities of daily living. A General Population Program is an Assisted Living Program that is not dementia-specific but may have tenants with cognitive disorder.

Dementia-Specific Assisted Living Program - An assisted living program certified under 481 IAC 69 that serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale (GDS), or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the GDS, or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Regulatory Insufficiency - A violation of a statutory or rule provision within the Code of Iowa (2011) or the Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to and approved by the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are statutory or rule violations. The plan should identify how and by what date each regulatory insufficiency will be corrected, and what measures will be taken to ensure the problem does not recur. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint/Incident Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Overview: *In preparing this report, the following information was considered:*

Current Program Census

Assisted Living Programs are defined by the type of population served. The census numbers below were provided by the Program at the time of the on-site visit.

General Population Program	
Number of tenants without cognitive disorder:	20
Number of tenants with cognitive disorder:	0
Total Population of Program at time of on-site	20

Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	0
Number of tenants with cognitive disorder:	3
Total Population of Program at time of on-site	3
TOTAL census of Assisted Living Program	23

Program History – The program received regulatory insufficiencies in the areas of Service Plan and Nurse Review during the September 20, 2011 Recertification on-site.

Complaint/Incident Investigation – The Complaint/Incident investigator made the observations detailed in the following areas:

The following information was identified during the investigation completed 10-25-12.

A. Nurse Review

- Monitoring Observation: Tenant #1, an 89 year old, was admitted to the memory care unit on 10-18-12 with diagnoses of: Dementia, Depression, Anxiety, Anemia, Chronic Renal Insufficiency, Gastric Reflux Disease, Hypertension (HTN), and Osteoporosis. A preadmission assessment completed 10-3-12 scored Tenant #1 at "6" on the Global Deterioration Scale (GDS) indicating severe cognitive decline, however; the form failed to indicate the specific criteria of each category of the GDS which indicated Tenant #1's abilities. The service plan dated 10-3-12 documented Tenant #1 was to be assisted in the shower and cued with hygiene to do as much able. The service plan also directed that Tenant #1 was able to eat finger foods and drink independently but would need assistance cutting food. Tenant #1 was able to ambulate independently within his/her apartment. Tenant #1 was dependent on medication administration with medication crushed by staff. Staff members were instructed to toilet Tenant #1 every 2 to 3 hours to prevent incontinence. On 10-25-12 at 11:40 a.m., the monitor observed Tenant #1 seating at the dining table in the memory care unit. Staff #1, had crushed medications and was attempting to feed Tenant #1 oatmeal which she had prepared in the memory care kitchen. Tenant #1 sat with eyes closed and refused to open his/her mouth. Tenant #1 made no attempt to eat or drink independently. Staff #1 reported that this behavior occurred occasionally.

Observation of toileting revealed Tenant #1 was unable to understand Staff #1's instruction to sit on the toilet. Tenant #1 had voided into a brief and made no attempts to assist with removing or cleansing. Tenant #1 did void on the toilet. Staff #1 stated Tenant #1 was totally dependent with bathing, toileting and eating.

Tenant #2, a 74 year old, was admitted on 7-8-09 to the general population with diagnoses of: Alzheimer's Dementia, HTN, Diabetes, Atrial Fibulation, and Anxiety. The undated GDS documented Tenant #2 at 5 which indicated moderately severe cognitive decline. Staff #1 reported that Tenant #2 was incontinent once a day usually in the morning upon waking. The service plan dated 6-27-12 documented Tenant #2 was independent with toileting, bathing, and dressing. Up-dates to the service plan dated 8-30-12 included directions to assist with showers, shaving and dressing. A nursing narrative sheet dated 10-9-12 at 5:00 p.m. documented Tenant #2 was incontinent of bowel and required staff assistance with clean up and changing soiled clothing. On 10-15-12 the apartment in which Tenant #2 resided was included in renovation to a secured memory care unit. The clinical record lacked evidence of completion of a nurse review coinciding with the service plan changes of 8-30-12 and the change from an open unit to a secured one.

The program failed to complete a nurse review when Tenant #1 displayed changes in cognitive and functional capabilities from the preadmission assessment. The clinical record of Tenant #2 lacked evidence of completion of a nurse review coinciding with service plan changes 8-30-12, functional changes or the change to a secured unit 10-15-12.

- Regulatory Insufficiency: To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant's health status. (IAC r. 481-69.27(3))

B. Evaluation

- Monitoring Observation: A preadmission assessment completed 10-3-12 scored Tenant #1 at "6" on the GDS indicating severe cognitive decline, however; the form failed to indicate the specific criteria of each category of the GDS which indicated Tenant #1's abilities. The service plan of 10-3-12 documented Tenant #1 was to be assisted in the shower and cued with hygiene to do as much able. Tenant #1 was able to eat finger foods and drink independently but would need assistance cutting food. Tenant #1 was able to ambulate independently within his/her apartment. Tenant #1 was dependent on medication administration with medication crushed by staff. Staff members were instructed to toilet Tenant #1 every 2 to 3 hours to prevent incontinence. On 10-25-12 at 11:40 a.m., the monitor observed Tenant #1 seating at the dining table in the memory care unit. Staff #1, had crushed medications and was attempting to feed Tenant #1 oatmeal which she had prepared in the memory care kitchen. Tenant #1 sat with eyes closed and refused to open his/her mouth. Tenant #1 made no attempt to eat or drink independently. Observation of toileting revealed Tenant #1 was unable to understand Staff #1's instruction to sit on the toilet. Tenant #1 had voided into a brief and made no attempts to assist with removing or cleansing.

Tenant #1 did void on the toilet. Staff #1 stated Tenant #1 was totally dependent with bathing, toileting and eating.

The undated GDS documented Tenant #2 at 5 which indicated moderately severe cognitive decline. Staff #1 reported that Tenant #2 was incontinent once a day usually in the morning upon waking. The service plan dated 6-27-12 documented Tenant #2 was independent with toileting, bathing, and dressing. Up-dates to the service plan dated 8-30-12 included directions to assist with showers, shaving and dressing. A nursing narrative sheet dated 10-9-12 at 5:00 p.m. documented Tenant #2 was incontinent of bowel and required staff assistance with clean up and changing soiled clothing. On 10-15-12 the apartment in which Tenant #2 resided was included in renovation to a secured memory care unit. The clinical record lacked evidence of completion of a health, functional or cognitive assessments coinciding with the service plan changes on 8-30-12, functional changes or the change from an open unit to a secured one 10-15-12.

The program failed to complete cognitive, health and functional evaluations when Tenant #1 displayed changes in cognitive and functional capabilities from the preadmission assessment. The clinical record of Tenant #2 lacked evidence of completion of cognitive, functional or health evaluations coinciding with service plan changes 8-30-12, functional changes or the change to a secured unit 10-15-12.

- Regulatory Insufficiency: A program shall evaluate each tenant's functional, cognitive and health status within 30 days of occupancy. A program shall evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant's continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation with the tenant has not exhibited a significant change. (IAC r. 481-69.22(2))

C. Service Plans

- Monitoring Observation: A preadmission assessment completed 10-3-12 scored Tenant #1 at "6" on the GDS indicating severe cognitive decline, however; the form failed to indicate the specific criteria of each category of the GDS which indicated Tenant #1's abilities. The service plan of 10-3-12 documented Tenant #1 was to be assisted in the shower and cued with hygiene to do as much able. Tenant #1 was able to eat finger foods and drink independently but would need assistance cutting food. Tenant #1 was able to ambulate independently within his/her apartment. Tenant #1 was dependent on medication administration with medication crushed by staff. Staff members were instructed to toilet Tenant #1 every 2 to 3 hours to prevent incontinence. On 10-25-12 at 11:40 a.m., the monitor observed Tenant #1 seating at the dining table in the memory care unit. Staff #1, had crushed medications and was attempting to feed Tenant #1 oatmeal which she had prepared in the memory care kitchen. Tenant #1 sat with eyes closed and refused to open his/her mouth. Tenant #1 made no attempt to eat or drink independently. Observation of toileting revealed Tenant #1 was unable to understand Staff #1's instruction to sit on the toilet. Tenant

#1 had voided into a brief and made no attempts to assist with removing or cleansing. Tenant #1 did void on the toilet. Staff #1 stated Tenant #1 was totally dependent with bathing, toileting and eating.

The undated GDS documented Tenant #2 at 5 which indicated moderately severe cognitive decline. Staff #1 reported that Tenant #2 was incontinent once a day usually in the morning upon waking and staff assisted him/her with cleaning up. The service plan dated 6-27-12 documented Tenant #2 was independent with toileting, bathing, and dressing. Up-dates to the service plan dated 8-30-12 included directions to assist with showers, shaving and dressing. A nursing narrative sheet dated 10-9-12 at 5:00 p.m. documented Tenant #2 was incontinent of bowel and required staff assistance with clean up and changing soiled clothing. On 10-15-12 the apartment in which Tenant #2 resided was included in renovation to a secured memory care unit. The service plan was not up-dated with the Tenant #2's toileting status or the change to a secured unit.

The program failed to up-date the service plan with interventions to meet the specific needs when Tenant #1 displayed changes in cognitive and functional capabilities from the preadmission assessment. The program failed to maintain a service plan with specific interventions based on evaluations to meet the needs of Tenant #2.

- Regulatory Insufficiency: 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 needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. (IAC r. 481-69.26 (1))

D. Occupancy Agreement

Complaint/Incident Allegation: It was alleged that tenants are charged for a higher level of care than what they require.

- Monitoring Observation: Tenants or their legal representatives sign individual occupancy agreements prior to taking occupancy at the program. The amount charged is not regulated by rule.

- Regulatory Insufficiency: None noted.

E. Staffing

Complaint/Incident Allegation: It was alleged that the program did not have a nurse on call when the program nurse was out.

- Monitoring Observation: The Administrator reported that there was no set schedule for which nurse was on call but there was always a nurse available 24 hours a day, seven days a week by phone. He stated that the telephone numbers of the program nurse or the current agency nurse, the corporate nurse in Iowa City, and his number were posted for all staff to call when necessary. Staff #1 and #2 reported there had been no instances when they had attempted to call a nurse without response.

- Regulatory Insufficiency: None noted.

F. Criteria for Admission and Retention

Complaint/Incident Allegation: It was alleged that a tenant in the memory care unit does not belong there.

- Monitoring Observation: On 10-15-12, the program renovated an area of the open population into a secured memory care unit. Two tenants and one respite tenant resided in the secured unit. Staff #1 and #2 reported there were no tenants who exceeded the level of care for assisted living housed in the secured unit. The clinical records for the two tenants who resided in the unit were reviewed. The monitor found that neither Tenant #1 or #2 exceeded the level of care for assisted living.

- Regulatory Insufficiency: None noted.

G. Food Service

Complaint/Incident Allegation: It was alleged that tenants don't receive appropriate diets.

- Monitoring Observation: Tenant #1's clinical record contained a transfer form dated 10-18-12, which documented the diet order for Tenant #1 was mechanical soft. A Diet Order form dated 10-17-12, completed by Staff #3, registered nurse, documented Tenant #1 with an order for mechanical soft consistency diet. Staff #1, a certified nurse aide, prepared the breakfast meal for Tenant #1 in the kitchen of the memory care unit on 10-25-12. Staff #1 stated that she was told initially when Tenant #1 was admitted on 10-18-12, that Tenant #1 would eat finger foods; however, recently Tenant #1 did not make any attempt to eat or drink independently and would refuse to open his/her mouth to be fed at times. Staff #1 stated that she had prepared bacon, sausage, waffles, toast and oatmeal for the tenants in the memory care unit at breakfast. Staff #1 did not have training in modified diets and did not have access to an approved menu for mechanical soft diet consistency. Staff #1 stated that on 10-24-12 she had sent a note to the kitchen that Tenant #1 needed meat chopped and they had started doing that. Staff #4, the culinary coordinator did not have a menu for modified diets but was able to provide one at the direction of the monitor. The menu was not signed as approved by a dietitian. Staff #4 stated she was going to meet with the program dietitian next week but in the mean-time had been serving soup and soft cut up foods for Tenant #1.

  The Director stated the memory care unit had opened 10-16-12 and currently had three tenants. When the unit opened, breakfast meals were prepared and served from the kitchen of the unit by unit staff. The Director reported the kitchen of the unit was not licensed.

- Regulatory Insufficiency: Therapeutic diets may be provided by a program. If therapeutic diets are provided, they shall be prescribed by a physician, physician assistant, or advanced nurse practitioner. A current copy of the Iowa Simplified Diet

Manual published by the Iowa Dietetic Association shall be available and used in the planning and serving of therapeutic diets. A licensed dietitian shall be responsible for writing and approving the therapeutic menu and for reviewing procedures for food preparation and service for therapeutic diets. (IAC r 481-69.28(4))

- Regulatory Insufficiency: Programs engaged in the preparation and service of meals and snacks shall meet the standards of state and local health laws and ordinances pertaining to the preparation and service of food and shall be licensed pursuant to Iowa Code chapter 137F. (IAC r 481-69.28(6))

H. Structural Requirements

Complaint/Incident Allegation: It was alleged that the facility needs repairs and the rooms were filthy.

- Monitoring Observation: A tour of the program grounds and building was completed. The common areas were clean and had no offensive odors present. Two tenant rooms were toured and two tenants were interviewed. They reported the rooms were cleaned to their satisfaction and the monitor noted no offensive odors present.

- Regulatory Insufficiency: None noted.