

TERRY E. BRANSTAD
GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

KIM REYNOLDS
LT. GOVERNOR

Complaint/Incident Intake #: 46412-I

January 13, 2014

Mr. Quinn Adair, Administrator
Spring Valley Retirement Community
501 12th Street
Perry, IA 50220

**RE: Final Complaint/Incident Investigation Report – Spring Valley Retirement
Community, Perry, IA**

Dear Mr. Adair:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of January 7, 2014, 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. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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

Assisted Living Program:

Complaint/Incident Intake #: 46412-I

Quinn Adair, Administrator
Spring Valley Retirement Community
501 12th Street
Perry IA 50220

Date of Complaint/Incident Investigation:

January 7, 2014

Monitor(s):

Lori Miner, RN BSN

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:	35
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	36
Dementia-Specific Program by Dedication	
Number of tenants without cognitive disorder:	3
Number of tenants with cognitive disorder:	1
Total Population of Program at time of on-site	4
TOTAL census of Assisted Living Program	40

Program History – During the Recertification on-site of August 1, 2013, the Program received regulatory insufficiencies in the areas of: evaluation, service plan, nurse review and criteria for admission and discharge.

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

A. Tenant Rights

Complaint/Incident Allegation: The program reported Tenant #1 was missing jewelry, a credit card, and money.

- **Monitoring Observation:** Tenant #1, an 86 year-old, was admitted on 5-18-13, and had diagnoses of: Chronic Obstructive Pulmonary Disease and Macular Degeneration. In a fax to the physician dated 9-11-13, Tenant #1 was complaining of nightmares including seeing kids in the apartment. The fax indicated Tenant #1 was most likely experiencing a side effect to a medication. On 9-25-13, Tenant #1 was evaluated by a registered nurse and found to be alert and oriented to person, place, and time. On 12-4-13 a cognitive screening was completed with no indications of cognitive impairment.

Tenant #1 was interviewed and stated sometime in October 2013, jewelry was missing. Tenant #1 also stated in September 2013, a credit card and cash was also missing from the apartment. Tenant #1 stated, and a family member confirmed, the credit card had not been used since missing. Tenant #1 was unclear as to a specific date as to when the items were discovered missing, and was unclear as to when the items may have gone missing, as the location of the cash and credit card was not accessed often by Tenant #1, and the jewelry had been out about two weeks. Tenant

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#1 stated the missing items were reported to the former administrator, who did search the apartment for the missing items.

Tenant #1 reported always keeping the door to the apartment locked, however, Tenant #1 required assistance with dressing and undressing, and with showers. Tenant #1 reported two different staff members were in the apartment daily, and that all staff had a key to the apartment. Tenant #1 reported some of the staff members who were working in October are no longer working at the program. Tenant #1 also reported he/she had visitors but none of the visitors saw the jewelry which was kept in the bedroom.

The Administrative Assistant who has been with the program about 10 years, reported she and the previous administrator were aware of the missing items. The Administrative Assistant reported she was aware of the missing credit card and cash. The Administrative Assistant stated the family member was contacted and there was no concern about the missing cash and the credit card had not been used. This event occurred around the end of September 2013.

The Administrative Assistant indicated it was after the credit card and cash were missing, that Tenant #1 reported the jewelry was missing. The Administrative Assistant stated Tenant #1 did not seem "quite right" and thought it was in relation to problems with medications. The apartment was searched in October and none of the missing items were found. The Administrative Assistant stated Tenant #1 did not want police notified.

The Administrative Assistant stated a temporary staffing agency was used at the time.

The program reported ownership changed hands on November 1, 2013. The current Administrator stated the temporary staffing agency had not been used since the transfer of ownership.

The current Administrator provided documentation to the department of the investigation completed. The Administrator stated he was unaware of the missing items until Tenant #1 brought it up during a discussion on 11-5-13. Tenant #1 gave an accounting of the events, and the Administrator noted Tenant #1 had been consistent in relaying the events over time. Tenant #1 and the family member requested an internal investigation be completed and did not wish to have the police notified. Again the family member reported little concern over the missing cash and the credit card which had not been used.

The Administrator spoke with several staff members and found no answers into the missing items. The Administrator noted any staff member on duty would have a key to the apartment. After again speaking with Tenant #1, the local police department was notified on 11-27-13. No other tenants were identified who were missing items. The Administrator adopted a new policy and procedure for missing items. The Department of Inspections and Appeals was notified of the incident.

The RN was interviewed and stated Tenant #1 had been consistent in the accounting of the details of the incident.

Staff #1 reported she was aware jewelry was missing but did not know whose, since she usually works in the memory care unit. Staff #1 was not aware of anyone that might have taken the missing items.

Staff #2 reported items were missing at the end of October to the first of November 2013. Staff #2 recalled seeing jewelry laid out that Tenant #1 was sorting. Staff #2 was not aware of anyone that may have taken the jewelry. Staff #2 stated no other tenants had reported missing items after Tenant #1 reported missing items.

Staff #3 reported she was approached by the previous administrator to "keep her eyes open" following Tenant #1's report of missing items. Staff #3 reported she helped Tenant #1 with dressing and undressing, and medications. Staff #3 reported she did not recall seeing any jewelry. Staff #3 reported a staffing agency had been used, and that lots of employees had come and gone. Staff #3 was not aware of anyone who would have taken the jewelry. No other tenants had reported missing items.

An officer from the local police department was contacted and stated the case was ongoing.

When the Administrator learned of the missing items, the Administrator completed an internal investigation, and completed a Misappropriation Report Form. With tenant approval, the local police department was notified. The Administrator provided documentation of a new policy and procedure for alleged misappropriation of a tenant's belongings. The Administrator reported the incident to the Department.

- Regulatory Insufficiency: None noted.