IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

February 2, 2015

Complaint Intake #: 50952-C

Ms. Rachel Richardson, RN
Springvale Assisted Living
1050 15th Street North
Humboldt, IA 50548

RE: Final Complaint Investigation & Recertification Monitoring Evaluation Report – Springvale Assisted Living, Humboldt, IA

Dear Ms. Richardson:

Enclosed is the **Final Complaint Investigation & Recertification Monitoring Evaluation 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 complaint #50952-C was not substantiated.
Level of Care

Based on record review, staff interviews and observation, the program completed on going assessments of tenants and their ability to complete or participate in the completion of their individual activities of daily living. For one tenant reviewed, documentation revealed the tenant sustained several falls. The Program completed appropriate assessments and implemented the services of physical therapy, occupational therapy and speech therapy. The Program also followed physician's orders for obtaining a urine sample for analysis, orders for blood work as well as consults for the tenant with other physician specialists. Level of care concerns were also reviewed with family members. **No Regulatory Insufficiencies were found during this evaluation.**

The review of the recertification documents you submitted has been completed and the documents are accepted. In addition, the State Fire Marshal's (SFM) inspection report has been received as well as the Facility Engineer's approval of the Evacuation Plans for your program.

Enclosed you will find the Assisted Living Program Certificate **S0203** with effective dates of **December 13, 2014** through **December 12, 2016**.

If you have any questions in regard to this certification, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**.

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

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
	S0203	A. BUILDING: _____ B. WING _____	C 01/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVALE ASSISTED LIVING	1050 15TH STREET NORTH HUMBOLDT, IA 50548

(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 000	481-69 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. General Population Program Number of tenants without cognitive disorder: 12 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site: 13 TOTAL census of Assisted Living Program: 13 No insufficiencies were cited during the investigation of incident # 50952-C and the recertification conducted to determine compliance for an Assisted Living Program.	A 000		