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
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

November 25, 2015

Complaint Intake #: 54790-C

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

RE: Final Complaint Investigation & Recertification Monitoring Evaluation Report – Spring Valley Retirement Community, Perry, IA

Dear Mr. Adair:

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, following a survey by DIA on **November 17, 2015.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation of Tenant, Service Plans, Food Service and Structural Requirements.

Based on observations, the allegations of Complaint #54790-C were unsubstantiated.
Allegation: Structure - It was alleged the kitchen was unclean
Findings: Unsubstantiated
Comments: The kitchen was observed to be generally clean and staff was observed cleaning the kitchen following breakfast during the onsite visit. The floors and storage shelves were generally clean.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference or a contested case hearing must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

If you have any questions in regard to this 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

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
	S0129	A BUILDING: _____ B WING _____	C 11/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY SENIOR AL	501 12TH STREET PERRY, IA 50220

(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	481-67 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: 31 Number of tenants with cognitive disorder: 1 Total Population of Program at time of on-site. 32 Dementia-Specific Program by Dedication Number of tenants without cognitive disorder: 3 Number of tenants with cognitive disorder: 2 Total Population of Program at time of on-site: 5 TOTAL census of Assisted Living Program: 37 No regulatory insufficiencies were cited during the investigation of Complaint #54790-C. The following regulatory insufficiencies were cited during the recertification conducted to determine compliance with certification for an Assisted Living Program:	A 000		
A 036	481-69.22(1) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant ' s functional, cognitive and health status prior to the tenant ' s signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant ' s eligibility for the program, including whether the services needed are available. The cognitive evaluation shall	A 036		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 036	Continued From page 1 utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant ' s mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional. This REQUIREMENT is not met as evidenced by: Based on tenant file review, evaluations were not completed prior to admission, and a scored, objective tool or GDS was not used for cognitive evaluation. 1. Tenant #1, an 86 year-old, was admitted on 8-14-14 and had diagnoses of: dementia, hypertension, anxiety, gastroesophageal reflux disease, and arrhythmia. Tenant #1 resided in the dementia unit. Tenant #1 was staged at five on the global deterioration scale (GDS) which indicated moderately severe cognitive decline on the cognitive evaluation completed 8-14-15. Evaluations completed on 8-21-15, identified as the annual assessment, did not include the used of a scored, objective tool or the use of the GDS. 2. Tenant #3, age unknown, was admitted on 4-1-15 and had diagnoses of: dementia and history of seizures. The clinical record lacked a face sheet; a sheet which gave general information about the tenant. According to the list of tenants provided by the Program, Tenant #3 was staged at three on the GDS which indicated mild cognitive decline. Tenant #3 resided in the	A 036		

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A 036	Continued From page 2 dementia unit. The clinical record lacked documentation of evaluations completed prior to admission.	A 036		
A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69 22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant ' s functional, cognitive and health status within 30 days of occupancy. A program shall also 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 when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by Based on tenant file review, evaluations were not completed within 30 days of admission and were not completed with a change of condition. 1. Tenant #3, age unknown, was admitted on 4-1-15 and had diagnoses of: dementia and history of seizures. The clinical record lacked a face sheet; a sheet which gave general information about the tenant. According to the list of tenants provided by the Program, Tenant #3 was staged at three on the GDS which indicated mild cognitive decline. Tenant #3 resided in the	A 037		

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A 037	Continued From page 3 dementia unit. The clinical record lacked documentation of evaluations completed within 30 days of admission. 2. The nursing narrative sheet for Tenant #3 contained an entry dated 10-8-15. which indicated Tenant #3 stated "I want to go." "If I had a gun I would use it now." Documentation in the narrative dated 10-10 through 10-12-15 contained documentation staff continued to observe for expressions of suicide. Narrative dated 10-13-15 documented Tenant #3 stated "I will be so goddamn glad when I can die." Evaluations were not completed with a change of condition, expression of suicide.	A 037		
A 083	481-69.26(1) Service Plans 481-69.26(231C) 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. This REQUIREMENT is not met as evidenced by: Based on tenant file review, service plans were not completed annually, were not based on evaluations, and did not meet specific tenant needs. 1. Tenant #1, an 86 year-old, was admitted on	A 083		

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A 083	Continued From page 4 8-14-14 and had diagnoses of: dementia, hypertension, anxiety, gastroesophageal reflux disease, and arrhythmia. Tenant #1 resided in the dementia unit. Tenant #1 was staged at five on the global deterioration scale (GDS) which indicated moderately severe cognitive decline on the cognitive evaluation completed 8-14-14. The service plan, dated 8-14-14, was not updated annually. 2. Tenant #2, an 83 year-old, was admitted on 10-5-12 and had diagnoses of: dementia, arthritis, and history of breast cancer. Tenant #2 was staged at four on the GDS which indicated moderate cognitive decline. Tenant #2 resided in the dementia unit. Annual evaluations were completed on 10-5-15. The clinical record lacked documentation of an annual service plan. 3. Documentation on the service plan for Tenant #2 dated 11-17-15, the date of the onsite visit, documented the service plan was found unsigned and signatures were acquired on 11-17-15. The service plan was signed and dated 11-17-15 by the registered nurse (RN) who began employment as the RN coordinator of the Program on 11-7-15. The clinical record lacked documentation of evaluations completed on 11-17-15. The service plan was not based on evaluations. 4. Tenant #3, age unknown, was admitted on 4-1-15 and had diagnoses of: dementia and history of seizures. The clinical record lacked a face sheet; a sheet which gave general information about the tenant. According to the list of tenants provided by the Program, Tenant #3 was staged at three on the GDS which indicated mild cognitive decline. Tenant #3 resided in the dementia unit. The nursing narrative sheet for	A 083		

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A 083	Continued From page 5 Tenant #3 contained an entry dated 10-8-15 which indicated Tenant #3 stated "I want to go." "If I had a gun I would use it now." Documentation in the narrative dated 10-10 through 10-12-15 contained documentation staff continued to observe for expressions of suicide. Narrative dated 10-13-15 documented Tenant #3 stated "I will be so goddamn glad when I can die." The service plan was not updated with a change of condition to meet the specific needs of Tenant #3, interventions for Tenant #3 with suicidal thoughts. 5. The nursing narrative sheet for Tenant #3 with entries dated 10-10 and 10-13-15 documented Tenant #3 "got aggressive" and too close to staff, was punching walls and doors in another tenant's apartment, and was yelling and cursing. The service plan was not updated with a change of condition to meet the specific needs of Tenant #3, interventions for aggressive behavior. 6. Tenant #4, an 86 year-old, was admitted on 9-5-14 and had diagnoses of: Lung Cancer. Tenant #4 was not cognitively impaired and resided in the general population. The clinical record contained a service plan dated 11-17-15, the day of the onsite visit. The service plan was not based on evaluations.	A 083		
A 084	481-69.26(2) Service Plans 481-69.26(231C) Service plans 69.26(2) Prior to the tenant ' s signing the occupancy agreement and taking occupancy of a dwelling unit, a preliminary service plan shall be developed by a health care professional or human service professional in consultation with the tenant and, at the tenant ' s request, with other individuals identified by the tenant, and, if	A 084		

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A 084	Continued From page 6 applicable, with the tenant ' s legal representative. All persons who develop the plan and the tenant or the tenant ' s legal representative shall sign the plan. This REQUIREMENT is not met as evidenced by: Based on tenant file review, service plans were not signed prior to admission, and were not signed by the tenant. 1. Tenant #3, age unknown, was admitted on 4-1-15 and had diagnoses of: dementia and history of seizures. The clinical record lacked a face sheet; a sheet which gave general information about the tenant. According to the list of tenants provided by the Program, Tenant #3 was staged at three on the GDS which indicated mild cognitive decline. Tenant #3 resided in the dementia unit. The service plan was signed and dated 4-2-15. The service plan was not signed prior to admission to the Program. 2. Tenant #4, an 86 year-old, was admitted on 9-5-14 and had diagnoses of: Lung Cancer. Tenant #4 was not cognitively impaired and resided in the general population The initial service plan dated 9-5-14 was not signed by Tenant #4.	A 084		
A 104	481-69.28(5) Food Service 481-69.28(231C) Food service. 69.28(5) Personnel who are employed by or contract with the program and who are responsible for food preparation or service, or both food preparation and service, shall have an orientation on sanitation and safe food handling	A 104		

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A 104	Continued From page 7 prior to handling food and shall have annual in-service training on food protection. This REQUIREMENT is not met as evidenced by: Based on observation, staff file review, and interview, staff who were responsible for food service did not have an orientation on sanitation and safe food handling prior to handling food or did not have an annual inservice on food protection. 1. Staff C, certified nursing assistant (CNA), was hired 6-18-14. The Program was unable to provide any documentation of an annual inservice on food protection. 2. Staff D, health care aide (HCA), was hired 9-28-15. The Program was unable to provide any documentation of an orientation on safe food handling. 3. The noon meal was observed on 11-17-15. Staff D was observed serving food to tenants. 4. Staff D was interviewed on 11-17-15 at 11:15 a.m. and stated she served food.	A 104		
A 155	481-69.35(1)c Structural Requirements 481-69.35(231C) Structural requirements. 69.35(1) General requirements. c. Programs shall have private dwelling units with a single-action, lockable entrance door. This REQUIREMENT is not met as evidenced by:	A 155		

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A 155	Continued From page 8 Based on observation and interviews, an apartment in the dementia unit occupied by a tenant was not a private dwelling space. 1. On 11-17-15 at 8:30 a.m. a tour of the dementia unit was taken. The staff office was observed to be located in one of the bedrooms of a two-bedroom apartment. The apartment had a central living room located between the two bedrooms. The apartment was occupied by Tenant #1. 2. Staff A was interviewed at the time of the tour and stated other tenants came into Tenant #1's apartment to watch TV but had to leave the apartment early because Tenant #1 liked to go to bed early 3. Staff B was interviewed on 11-17-15 at 3:24 p.m. and stated one to two times per week, two or three tenants are in Tenant #1's apartment to play cards as there was no common area in the dementia unit. Staff B stated Tenant #1 was usually not present in the apartment at the time of the card games, as Tenant #1 participates in activities in the general population section of the building.	A 155		

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TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

December 4, 2015

Complaint Intake #: 54790-C

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

Dear Mr. Adair:

DIA has completed the review of your Plan of Correction (POC) in response to the **Final Complaint Investigation & Recertification Monitoring Evaluation Report**. Based upon a complete review of the Report and your actions to correct the identified Regulatory Insufficiencies, DIA accepts your POC.

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 **S0129** with effective dates of **November 20, 2015** through **November 19, 2017**. This certificate is to be posted in the building for public viewing.

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

481-69.22 Tag A 036

1. Tenant #1 and #3 will be reevaluated with a full health, functional, and cognitive assessments completed by Friday, December 11, 2015. The face sheet for Tenant #3 has been updated and added to the chart on Thursday, December 03, 2015.
2. We have a new RN Coordinator in position with a clear understanding of the evaluation process and timelines. She has demonstrated proficiency to the administrator in tracking these evaluations and evaluating GDS scores.
3. The RN Coordinator will provide bi-weekly updated evaluation calendars to administration. Our survey findings have been shared and reviewed with our nurse consultant, who will continue to audit the identified areas of concern.
4. All insufficiencies relating to Tag A 036 will be corrected by December 11, 2015.

481-69.22 Tag A 037

1. Tenant #3 will be reevaluated with a full health, functional, and cognitive assessments completed and service plan updated accordingly by Friday, December 11, 2015. An in-service has been scheduled for December 9, 2015 at 1:45p to educate staff on the protocol in handling the expression of suicide ideations by tenants. An updated policy on this matter will be rolled out at this time. Suicidal ideations will be documented and addressed in tenant service plans.
2. Staff shall follow the policy set in place.
3. Staff shall follow the policy set in place.
4. This regulatory insufficiency has been corrected immediately. One-to-one education has been done making sure that any potential suicidal ideations are communicated immediately and directly to the RN Coordinator. The in-service has been scheduled for review on December 9, 2015.

481-69.26 Tag A 083

1. Tenant #1, #2, #3, and #4 will be reevaluated with a full health, functional, and cognitive assessments completed and service plan updated accordingly by Friday, December 11, 2015. Proper signatures will be obtained to reflect these updates.
2. We have a new RN Coordinator in position with a clear understanding of the evaluation process and timelines. She has demonstrated proficiency to the administrator in tracking these evaluations and evaluating GDS scores.
3. The new RN Coordinator will provide bi-weekly updated evaluation calendars to administration. Our survey findings have been shared and reviewed with our nurse consultant, who will continue to audit the identified areas of concern.
4. All insufficiencies relating to Tag A 083 will be corrected by December 11, 2015.

481-69.26 Tag A 084

1. We are unable to correct the errors in the timing of Tenant #3 and #4 but have the correct process in place moving forward. Our new RN Coordinator has demonstrated proficiency in understanding of the necessary order to the Administrator.
2. All evaluations and service plans shall be completed prior to the signing of the occupancy agreement. These must be dated and time stamped to reflect this proper order.
3. The Marketing Coordinator or designee, who is responsible for coordinating the review and signing of the occupancy agreement, has been educated and demonstrated proficiency in ensuring the evaluation and service plan have been completed prior to the occupancy agreement being signed.
4. This process has been put in place and is ongoing from December 3, 2015.

481-69.28 Tag A 104

1. Staff person C and D will complete the food protection review by December 11, 2015.
2. We have amended our orientation process to include the necessary food safety training prior to working on the floor. In addition, we have established regular chart audits to ensure the annual training does not lapse for any employee.
3. We have amended our orientation process to include the necessary food safety training prior to working on the floor. In addition, we have established regular chart audits performed by our Marketing Coordinator or designee to ensure the annual training does not lapse for any employee.
4. The regulatory insufficiency relating to Tag A 104 shall be corrected by December 11, 2015.

481-69.35 Tag A 155

1. The office has been relocated out of the private dwelling of Tenant #1. The new office space is in a separate private dwelling, which is not occupied by a tenant.
2. This problem shall not recur with the new location of the office space.
3. This compliance is ensured as we will not allow the office space to be shared with a private dwelling.
4. This regulatory insufficiency will be corrected on 12/4/15.