# Investigation of the Iowa Veterans Home


**Ruth H. Cooperrider**

**Ombudsman**

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## Ombudsman's Role

The Office of Ombudsman (Ombudsman) is an independent and impartial agency in the legislative branch of Iowa state government which investigates complaints against most Iowa state and local government agencies. Its powers and duties are defined in Iowa Code chapter 2C.

The office can investigate to determine whether an agency's actions are unlawful, contrary to policy, unreasonable, unfair, oppressive, or otherwise objectionable. However, it is prohibited from investigating complaints regarding an employee's employment relationship with an agency.

The Ombudsman may make recommendations to the agency and other appropriate officials to correct a problem or to improve government policies, practices, or procedures. If the Ombudsman determines a public official has acted in a manner warranting criminal or disciplinary proceedings, the Ombudsman may refer the matter to the appropriate authorities.

If the Ombudsman decides to publish a report of the investigative findings, conclusions, and recommendations, and the report is critical of the agency, the agency is given opportunity to reply to the report and the unedited reply is attached to the report.

## Complaint

On June 21, 2013, Senator Daryl Beall asked the Ombudsman to conduct an investigation into "the behaviors, practices, policies and conditions at the Iowa Veterans Home." Prior to his request, a number of former employees at the Iowa Veterans Home (IVH) had raised concerns to several newspapers and a few legislators about staff morale and resident care at the facility after David Worley became its Commandant in August 2010.[1] Senator Beall, as Chair of the Veterans Affairs Committee, called a special meeting of the Committee on May 6, 2013, to address complaints about the quality of care at the IVH. Thirteen individuals, including Worley and several former IVH employees, provided testimony at the meeting.[2]

Specifically, Senator Beall's request asked our office to investigate the following issues:

1. Quality of care for residents;
2. Health and safety of residents and staff;
3. Involuntary discharge of 42 residents without adequate follow-up;
4. Questions involving contracts and purchasing agreements entered into by the Iowa Veterans Home;
5. Charges of sexual harassment and a possible hostile work environment;

[1] The Commandant of the Iowa Veterans Home is appointed by the Governor, subject to Senate confirmation. Worley served as Commandant from August 1, 2010, until his resignation on October 2, 2014.

[2] Minutes of the meeting state that "there will be a follow up meeting" but no additional meeting was ever held. See Appendix A. Senate Resolution 13 was filed on May 22, 2013, to confer authority upon the Senate Government Oversight Committee "to conduct an investigation of issues relating to the care, treatment, and safety of the Iowa veterans home, and contracts and purchasing agreements entered into by the Iowa veterans home." The resolution was not brought up for vote.

6. Intimidation, coercion, and bullying by the Commandant against residents and staff; and
7. Other examples of safety violations, and illegal, unethical, and abusive management behavior toward residents and staff.

For the purpose of our investigation, we organized these issues into four main areas of concern:

1. Care, health and safety of residents;
2. Involuntary discharge of 42 residents without adequate follow-up;
3. Questions involving contracts and purchasing agreements entered into by the Iowa Veterans Home; and
4. Sexual harassment, hostile work environment, and abusive management behavior toward staff.

## Investigation

We interviewed or received written documentation from ten current or former Iowa Veterans Home (IVH) staff. We also interviewed Commandant Jodi Tymeson;[3] Mike Croskey, IVH Resident Council President; and Melanie Kempf, the local Long Term Care Ombudsman serving central Iowa.

We reviewed applicable law, rule, and policy, as well as documentation from regulatory agencies and the IVH, media articles, audio of the May 2013 Legislative Veterans Affairs Committee meeting, and other relevant resources. We also reviewed personnel investigations conducted by the Iowa Department of Administrative Services (DAS) in response to workplace complaints against former Commandant Worley.

## Background about the Iowa Veterans Home

The IVH was established in 1887 and is governed by Iowa Code chapter 35D. Section 35D.1(1) states:

> 1. The Iowa veterans home, located in Marshalltown, shall be maintained as a long-term health care facility providing nursing and residential levels of care for honorably discharged veterans and their dependent spouses, surviving spouses of honorably discharged veterans, and gold star parents. Eligibility requirements for admission to the Iowa veterans home shall coincide with the eligibility requirements for care and treatment in a United States department of veterans affairs facility pursuant to 38 U.S.C. §1710, and regulations promulgated under that section, as amended. For the purposes of this subsection, *"gold star parent"* means a parent of a deceased member of the United States armed forces who died while serving on active duty during a time of military conflict or who died as a result of such service.

[3] Jodi Tymeson was named Chief Operating Officer at the IVH on May 28, 2013. She was appointed Commandant upon Worley's resignation on October 2, 2013.

The IVH's webpage identifies its mission and purpose as follows:

> **Purpose:** Provide individualized quality health care in a community atmosphere where everyone is treated with respect and dignity.
>
> **Mission:** To provide a continuum of care to Iowa's veterans and their spouses in an environment focusing on individualized services to enhance their quality of life.

The IVH is the largest long-term care facility in Iowa, with 563 residents, 950 staff, and a 150-acre campus. The budget for FY 2016 is $80 million: 65 percent of which comes from Medicaid and insurance; 25 percent from the U.S. Department of Veterans Affairs (DVA) and veteran per diem; and 10 percent in direct appropriations by the Iowa Legislature from the state's general fund.

Veterans are eligible for admission to the IVH based on conditions set forth in the IVH's administrative rules, contained in 801–Chapter 10 of the Iowa Administrative Code (IAC):

> a. The individual is disabled by reason of disease, injury or old age and meets the qualifications for nursing or residential level of care available at IVH.
> b. The individual cannot be competitively employed on the day of admission or throughout the individual's residency.
> c. The individual shall have met the residency requirements of the state of Iowa on the date of admission to IVH.
> d. An individual who has been diagnosed by a qualified health care professional as acutely mentally ill, as an acute alcoholic, as addicted to drugs, as continuously disruptive, or as dangerous to self or others shall not be admitted to or retained at IVH.
> e. The individual must be eligible for care and treatment at a DVA medical center (excluding financial eligibility).
> f. Individuals admitted to the domiciliary level of care must meet DVA criteria stated in Department of Veterans Affairs, State Veterans Homes, Veterans Health Administration, M-1, Part 1, Chapter 3.11(h) (1), (2), and (3), and have prior DVA approval if the individual's income level exceeds the established cap.
> g. Homelessness does not disqualify persons otherwise eligible for admission to IVH. 10.2(2)

The IVH's rule also lists eligibility conditions for spouses, widowed spouses, and gold star parents of a veteran.

## Regulatory and Advocacy Agencies

In addition to the authority our office has to review complaints regarding the IVH, there are other state and federal agencies that have oversight of the IVH. The Iowa Department of Inspections and Appeals (DIA), the U.S. Department of Veterans Affairs (DVA), and the U.S. Department of

Health and Human Services' Centers for Medicare and Medicaid Services investigate complaints and conduct compliance surveys at IVH.
Iowa's Office of the State Long-Term Care Ombudsman (LTCO) is authorized by law to serve as an advocate for the residents and tenants of the IVH. According to its website, the LTCO's mission is to "protect the health, safety, welfare and rights of individuals residing in long-term care by investigating complaints, seeking resolutions to problems and providing advocacy with the goal of enhancing quality of life and care." IVH residents can contact the LTCO with concerns about their rights, the quality of life at the facility, and involuntary discharges.

Melanie Kempf is the local Long Term Care Ombudsman for 13 counties in central Iowa, including Marshall County, where the IVH resides.

## Issues

### 1. Care, health and safety of residents

We gathered and reviewed information from a number of sources in an attempt to determine conditions at the IVH related to the health, care, and safety of residents from 2010 through 2014.

**Findings**

Hearings and Media Reports

Comments shared in public forums indicated that some residents no longer felt at home at the IVH and were fearful of retaliation. Kempf testified at the May 6, 2013, special meeting of the Iowa Senate's Veterans Affairs Committee that residents were fearful of reprisal if they spoke up.[4] According to minutes of the special meeting, other presenters made similar comments about resident care, as specified below:

- Veterans with disabilities, mental health issues, and other medical problems have been discharged, although they still needed assistance.
- Residents feel treatment is poor, and they feel humiliated. Meals and hygiene are not delivered on time, and disabled veterans are unable to get to religious services.
- Activities were reduced for veterans, leading to diminished morale and worsening moods for veterans.
- Resident veterans feel bored more often.
- IVH's goal is to get residents in and out as quickly as possible without regard for the veterans' needs.
- Resident advocacy is absent within the current administrative structure.
- Although unit-based teams were adopted, lower-level employees' decisions are often quashed by administration.
- Residents will not speak up for themselves out of fear of being discharged.

[4] See Appendix A - Minutes of the May 6, 2013, Senate Veterans Affairs Committee.

- Residents are no longer allowed input, and many privileges they previously enjoyed are no longer allowed.
- The Commandant closed the Clothes Closet, where the community used to donate clothing that veterans could purchase.
- Residents and staff had stories of fear and bullying by administrators.

Some media reports told a different story of resident satisfaction at the IVH. A September 27, 2013, Des Moines Register article quoted two IVH residents who said the care they received was "very, very good." Similar sentiments were expressed months earlier in an April 28, 2013, letter to the editor in the Marshalltown Times Republican from former IVH employees:

> It's important to note here, even during these trying, highly stressful times under the current administration, the staff of the IVH deserves credit and praise. Their professional competency and caring hearts make it so that most of the residents are insulated during this hard time. Residents continue to receive care from warm and loving hands. This is to the staff's enduring credit and this is why we are speaking up on their behalf. Their loving care continues to be rendered in spite of the current leadership, not because of it. However, the staff does not have the power to change an administration whose policies and practices continue to restrict and narrow resident lives and create what many call a hostile work environment.

Senator Beall stated the following in a Radio Iowa interview prior to Worley's departure:

> I want to point out that by voicing concerns about the quality of care, I heard no complaints and I do not mean those hard-working direct care workers. I have found them to be very dedicated and passionate in caring for the veterans. It has been very clear that they take their jobs very seriously. In fact, I came away feeling it's not merely a job with them, it is a ministry and a mission.

<u>Contact from Residents and Their Families</u>

Our office was contacted directly by only one IVH resident during the course of our investigation, even though the IVH staff and the Resident Council were aware of our interest in the subject. We received six contacts from relatives of IVH residents. Their complaints were as follows:

- The wife of a resident complained that the IVH was taking too long to send her a copy of an incident report related to her husband falling while at the IVH. Since the IVH is required to report falls to the Department of Inspections and Appeals (DIA), we referred the complainant to DIA for a copy of the report and an investigation if the fall had not yet been reported.
- A caller complained that the IVH was unable to locate artifacts he had loaned the IVH. We encouraged the caller and his estate to work with the IVH.
- The son of a former IVH resident wanted staff to "suffer and be fired" for their role in the death of his mother. DIA had previously reviewed the circumstances surrounding his

mother's death and had fined the facility. We did not have the authority to provide the caller with the remedy he was seeking.

- A letter from an IVH resident was forwarded to our office from another state agency. The resident complained that staff continually complained the room she occupied with her husband smelled like urine. When we contacted the resident to get her permission to share her letter with the LTCO, she informed us "things are going very, very well," and she withdrew her complaint.
- The relatives of a resident called to complain that the resident was not getting prompt dental care or regular physicals. They also expressed concerns that there were no laundry services on Friday, Saturday, or Sunday at the IVH. Our office referred the callers to the LTCO.
- A daughter of a resident emailed our office to inform us she heard that the IVH was no longer going to require potential employees to take drug tests. "How is that possible?" she asked. We referred her to a division administrator at the IVH to get answers to her questions.
- The wife and daughter of a resident who died at the IVH alleged that his death was the result of poor care by the IVH. With their permission, we shared the information they provided with the DIA for review and investigation. We later emailed the resident's family and asked whether they had received a copy of DIA's findings and whether they had any questions or concerns about DIA's findings. We received no further communication from the family, but we learned ten months later from a media report that the family had filed a wrongful-death lawsuit against the IVH.

Resident Satisfaction Surveys

We also reviewed the IVH's Resident Satisfaction Surveys for 2010, 2012, 2013, and 2014.[5] Resident responses across those years appeared to be relatively consistent—within plus or minus five percentage points for most of the questions. The biggest improvement over those years was a 10 percent increase in satisfaction in regard to the mental-health provider helping residents to "cope better." The most significant decline in satisfaction was in the area of rehabilitation therapy, with a 5.9 percentage-point drop between 2010 and 2014.

The following chart compares the 2010 survey to the 2013 survey, the time during which Worley served as Commandant. Satisfaction levels fell in 15 of the 20 questions, but none declined by more than 4.3 percentage points. It is important to note that the **bolded** responses require a negative answer to be a positive response; the chart reflects positive responses to all questions:

| Questions | **2010** | **2013** |
|---|---|---|
| I feel that the choices I make for my life are respected. | 94% | 91.5% |
| I am satisfied with the nursing care I receive. | 95% | 92.9% |
| I believe that the recreational activities offered meet my leisure needs. | 87% | 86.3% |
| **I feel like I am treated like a child.** | 81% | 87.4% |
| **I do not feel safe at IVH.** | 95% | 93.4% |
| When I suffer loss, I receive the support I need | 94% | 93.9% |

[5] No survey was conducted in 2011. A list of the questions and answers, and a comparison of those surveys can be found in Appendix B.

| | | |
|---|---|---|
| I am satisfied with the food served at meals | 84% | 82.4% |
| I have confidence in my primary care provider. | 94% | 92.7% |
| I am satisfied with laundry services. | 91% | 87.3% |
| I have had opportunities to meet my Spiritual needs. | 98% | 96.8% |
| I am satisfied with the rehabilitation therapy I receive. | 92% | 90.0% |
| **I fear my health care information is not kept confidential.** | 89% | 93.3% |
| I am pleased with the variety of snacks I am offered. | 91% | 92.3% |
| **I do NOT believe the staff listens to me.** | 84% | 81.4% |
| I am satisfied with the availability of my social worker. | 96% | 96.2% |
| The staff handling my finances treats me with respect and dignity. | 98% | 96.7% |
| My mental health provider has helped me cope better. | 85% | 93.0% |
| My health care needs are addressed in a timely fashion. | 84% | 83.9% |
| I am satisfied with housekeeping services. | 98% | 97.0% |
| I believe I am treated with care and consideration. | 96% | 95.6% |

Resident Council Meetings

Upon admission to the IVH, every resident becomes a voting member of the Resident Council and is eligible to hold office. Article III of the Resident Council bylaws states its objectives:

1. To be a self-governing body for the benefit of the residents.
2. To present questions and suggestions to the necessary administrative staff offices in a timely manner and reply to the residents as soon as possible.
3. To actively promote the involvement of the residents in all phases of the Iowa Veterans Home and the community.

The Resident Council at the IVH has regularly scheduled meetings from January to November. Only residents and their families are allowed to attend the Resident Council meetings without invitation and approval by the Resident Council Executive Board. IVH staff (including the Commandant) and the LTCO attend the meetings as guest speakers on a rotating basis. The Commandant and select IVH staff receive copies of the meeting minutes.

Our review of the Resident Council meeting minutes from 2010 to 2014 identified the following complaints from residents about their care, health and safety. In some instances, these issues were raised at multiple meetings:

**2010**

None

**2011**

1. Not enough staff, staff changes frequently.
2. Getting a motorized cart.
3. Resident asked about Heinz Hall residents being forced out.

**2012**

1. Food complaints—quality and food selections.

2. Staffing complaints.
3. Bed bugs.
4. No pharmacist on weekends.
5. A resident said they seem to be losing their rights as residents.
6. Cold in Heinz Hall.

**2013**

1. Too long to respond to call lights.
2. Lack of trust between staff and residents.
3. Problems with needles for medications.
4. Poor quality catheter bags.
5. Skin issues that will not heal.
6. Cut back on professional staff, the specialist doctors, the dentist, optometrist.
7. Staff turnover.
8. Quality of nursing care from some nurses.

**2014**

None

In most instances, IVH staff who were present at the meeting agreed to look into the problems or referred the resident to a specific staff member or process to have the problem addressed.

IVH Formal Complaint Process

The Resident Rights handbook includes a section on filing complaints:

> 37. Residents have a right to file a complaint regarding care or services; recommend changes in policies, care, and services; and have complaints and recommendations reviewed and, when possible, resolved. Residents will receive a documented response that fully addresses the complaint at issue. Residents are able to exercise these rights without threat or use of discrimination or reprisal.

The established procedures for filing a complaint are listed in the Resident Complaint Procedure and Form document. Forms are available on each unit, in the Resident Council office, and on the housing units. The following table enumerates the numbers of complaints filed with this form by residents between 2010 and 2014:

| Year | Number of complaint forms | Number of Complaints related to care, health, or safety |
|---|---|---|
| **2010*** | 11 | 3 |
| **2011** | 9 | 5 |
| **2012** | 6 | 5 |
| **2013** | 2 | 1 |
| **2014** | 4 | 2 |

*All the complaints filed in 2010 preceded Worley's arrival at the IVH in August 2010.

The IVH coded all of these complaints as "resolved."

Long Term Care Ombudsman

Melody Kempf testified at the May 6, 2013, special meeting of the Iowa Senate's Veterans Affairs Committee that she received a letter in December of 2012 that had been forwarded by Representative Dave Heaton regarding issues at the IVH. In response, on January 25, 2013, Kempf held a private meeting with 11 residents, 1 resident advocate, 1 citizen, and Long Term Care Ombudsman Deanna Clingan-Fischer. According to Kempf, the meeting lasted 3 hours and 15 minutes. Residents told Kempf that the IVH which they had considered to be their home was now "a prison." Residents told her that staff who used to advocate for them are gone. Allegations were made that Worley controlled staff and residents through threats and fear. The residents said they felt Worley was nice to them only during tours by visitors. Kempf said that many residents did not speak during the meeting due to fear of reprisals. After the meeting, Clingan-Fischer said she met with Governor Terry Branstad to discuss the residents' concerns.

On March 14, 2013, Kempf and Clingan-Fischer followed up with Worley and other supervisors, seeking responses to each of the concerns raised at the January resident meeting. The Resident Council later asked Kempf to speak at its May meeting to share what she had learned during her meeting with Worley and IVH staff. During her presentation, Kempf said she also spoke about how to get people with a fear of retaliation to come forward with their concerns. Kempf testified that, "because I don't have a lot of specific concerns myself, we decided a flyer would get sent out" at IVH with her phone number, and that of DIA. After the flyers were distributed, Kempf said, "I had no residents call me with concerns." Kempf later confirmed in a June 19, 2013, interview with our office that she had not received any calls.

When we spoke to Kempf again in July of 2013, she said she had searched out residents to confide in her with their complaints. Eventually, she concluded that the issues being raised were old, had long been remedied, or were petty. Kempf said the IVH had been "pretty good" about meeting residents halfway on their complaints, and she had no outstanding or ongoing concerns. She agreed that Worley's "bedside manner" was lacking and may have exacerbated residents' discontent. We confirmed in a 2015 visit to the IVH that Kempf's contact information is prominently displayed on bulletin boards at the home. Kempf also attends Resident Council meetings periodically throughout the year.

Kempf provided our office with statistics on the number of complaints and cases opened by the LTCO related to IVH residents, along with the complaint categories. One case can often include multiple complaints (see Appendix C). The following table contains a statistical summary of the complaints the LTCO received about IVH:

| | **2010** | **2011** | **2012** | **2013** | **2014** |
|---|---|---|---|---|---|
| Total Number of Cases Opened | 18 | 18 | 5 | 14 | 14 |
| Total Number of Complaint Categories within the Cases | 36 | 24 | 14 | 29 | 22 |

Oversight by Other Agencies

Another measurement of the health and safety of residents at the IVH are the inspections and surveys conducted by the Iowa Department of Inspections and Appeals (DIA), the U.S. Department of Veterans Affairs, and the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services. Of note were three serious incidents in 2012 that resulted in fines. According to the documents and media reports we reviewed, the IVH was fined $2,000 in June of that year for failing to prevent pressure sores on the foot of a resident who sustained a broken leg while being helped into bed. In August 2012, the IVH was fined $5,500 after a resident fell and suffered multiple injuries, including a broken hip. And in October 2012, the federal government imposed a $250-per-day fine and restrictions on new admissions after the death of a resident who fell and suffered fractures while getting out of bed. The restrictions were lifted when IVH was able to demonstrate its ability to meet care standards.

Our review of the federal survey results showed improvements after 2012. According to Commandant Tymeson's message in the IVH's 2014 annual report:

> The IVH team successfully completed FY 2014, as evidenced by 3 excellent comprehensive surveys – two from the Federal VA and one from the Iowa Department of Inspections and Appeals. These surveys identify our areas of strength and help us to focus on areas where we can improve care, services, and activities for our residents. In FY 2015, we will continue to set the standard for high quality care and exceptional quality of life for our residents. We will work to consistently achieve deficiency-free surveys from the federal, state, and local agencies that provide regulation to protect our residents.

Advocacy and Oversight by Staff, Family, and Friends

It is important to note that IVH staff are mandatory reporters. This means they are required by law to report suspected dependent adult abuse if they reasonably believe the dependent adult has suffered abuse. Abuse includes financial exploitation, physical abuse, sexual abuse or exploitation, denial of critical care, and neglect. It is unlawful to discharge, suspend, or discipline an employee for reporting suspected abuse or cooperating with an investigation. Mandatory reporters who willingly and knowingly fail to report abuse commit a simple misdemeanor.

At the time of hire and at annual performance evaluations, employees are provided a copy of IVH's Policy #168, *Recognizing, Responding To, And Preventing Abuse*. The policy requires IVH employees to:

- Sign an acknowledgement of the policy upon hire.
- Attend mandatory two-hour training at their time of hire and every five years thereafter.
- Immediately report any complaint or evidence of resident abuse (witnessed, suspected, or received from another source) to a supervisor.

DIA investigates dependent adult abuse reports. Statistics on DIA's investigations of these reports at the IVH are listed below. We do not know whether the reporters and/or perpetrators were staff members, families, or friends:

| Date of Intake* | Abuse Type | Victim # | Findings |
|---|---|---|---|
| **2010** | | | |
| 4/13/2010 | Assault | Victim #1 | Confirmed, Not Registered |
| | Physical Injury | Victim #1 | Confirmed, Not Registered |
| 8/23/2010 | Neglect | Victim #1 | Confirmed, Not Registered |
| 10/7/2010 | Exploitation | Victim #1 | Founded |
| 11/15/2010 | Assault | Victim #1 | Unfounded |
| 12/02/2010 | Exploitation | Victim #1 | Founded |
| | Exploitation | Victim #2 | Founded |
| **2011** | | | |
| 1/4/2011 | Exploitation | Victim #1 | Unfounded |
| 3/16/2011 | Exploitation | Victim #1 | Unfounded |
| 4/11/2011 | Exploitation | Victim #1 | Unfounded |
| **2012** | | | |
| NONE | | | |
| **2013** | | | |
| NONE | | | |
| **2014** | | | |
| 1/7/2014 | Exploitation | Victim #1 | Founded |
| | Exploitation | Victim #2 | Founded |
| | Exploitation | Victim #3 | Founded |
| 6/26/2014 | Assault | Victim #1 | Unfounded |
| | Unreasonable punishment | Victim #1 | Unfounded |
| 9/22/2014 | Neglect | Victim #1 | Unfounded |
| 10/13/2014 | Exploitation | Victim #1 | Unfounded |
| | Exploitation | Victim #2 | Unfounded |
| | Exploitation | Victim #3 | Unfounded |
| | Exploitation | Victim #4 | Unfounded |
| | Exploitation | Victim #5 | Unfounded |
| | Exploitation | Victim #6 | Unfounded |
| | Exploitation | Victim #7 | Unfounded |
| | Exploitation | Victim #8 | Unfounded |
| **2015** | | | |
| None as of 9/8/2015 | | | |

*Each intake by date equals one perpetrator, but may include multiple victims and/or multiple abuse types.

In addition, DIA determined that the following reports did not rise to the level of abuse:

| Year | # of intakes that did not rise to the level of abuse |
|---|---|
| 2010 | 3 |
| 2011 | 2 |
| 2012 | 1 |
| 2013 | 2 |
| 2014 | 2 |
| 2015 (as of 9/8/15) | 0 |

Interviews with Staff

The consensus among current and former staff we interviewed was that staff provided quality care to residents and shielded them from management conflicts and "drama." Resident Council President Mike Croskey also told us that front-line staff did a very good job at providing care for residents; his concern was with "upper management." Interviewees said that the management style under Worley made it more difficult to advocate for residents, but none provided specific examples that had resulted in harm to a resident.

Much of our discussion with current and former IVH staff centered on the unit-based management system installed by Worley. The system was established following a three-day Lean[6] event of almost 20 staff members in May 2011. One worker who attended told us that the decision to reorganize from a top-down system to a unit-based, team approach received support from a majority of the group. The new unit-based system was described as follows: "Each unit is autonomous and is empowered to decide how to use available resources to meet the mission of the IVH to most positively impact residents and staff."

Many IVH staff members later concluded that the unit-based system curtailed their ability to advocate for residents and shifted power and control to Worley and his deputy, Shauna Callaway.

Interviews with Residents

In an attempt to identify specific concerns raised by residents through interviews, complaint files, and other records, we compiled a list of activity and program changes. We also took steps to learn whether and how those concerns had been addressed by IVH management. The status of each of those concerns follows:

1. **Complaint:** There are not any Alcoholic Anonymous meetings at the IVH.
   **Current status:** Narcotics Anonymous and Alcoholics Anonymous both meet at the IVH weekly.

2. **Complaint:** The Clothes Closet was closed.
   Current status: The Clothes Closet is open by appointment and is staffed by laundry personnel.

3. **Complaint:** The Woodworking/Woodshop was closed.
   **Current status:** Much of the woodworking activity was stopped prior to the appointment of Worley for safety concerns and remains closed for liability and staffing reasons. Residents can continue to engage in woodworking activities through the arts-and-crafts program.

[6] "Lean" is a collection of principles, methods and tools that improve the speed and efficiency of any process by eliminating waste. The Iowa Department of Management maintains a website on the concept at: http://lean.iowa.gov/index.html.

4. **Complaint:** Access to the Arts/Crafts room was reduced due to retirement of staff.
   **Current status:** Staff positions have been refilled and hours have been expanded to five days a week.

5. **Complaint:** Residents are no longer allowed to sell concessions at baseball games and/or are restricted to selling only pre-packaged food.
   **Current status:** Resident Council meeting minutes indicated that residents were limited to selling pre-packaged foods after a resident almost set the concession stand on fire while grilling food for resale. The Resident Council is required to have a license from the Department of Public Health to sell any items if they are handling food requiring temperature control such as ice cream, popcorn, or hot dogs. Annual license renewals are based on gross sales from the previous year, and can run in the hundreds of dollars. The Resident Council chose not to sell concessions at the IVH ballfield during the summer of 2015 as there were only five baseball games scheduled.

6. **Complaint:** The IVH stopped printing the resident newsletter, *Stars and Stripes*.
   **Current status:** The IVH resumed printing the resident newsletter.

7. **Complaint:** Resident Council officers are no longer allowed cash boxes for pop, candy, and T-shirts in their possession. IVH is also trying to put rules in place to give the IVH more control over how the Resident Council spends their monies.
   **Current status:** The Iowa Auditor of State recommended in a June 30, 2013, audit that IVH implement procedures to ensure that withdrawals of Resident Council funds are only made after a request with the proper number of signatures. The audit stated that procedures require proper support of each withdrawal to ensure the withdrawn funds are used for the purpose stated on the receipt. IVH's response to the recommendation stated:

   > The Iowa Veterans Home Administration and Resident Council elected officers will work together to implement a system of accountability that ensures: 1) Resident Council submits the proper number of signatures for expenditures, 2) an inventory control system is implemented and used by the Resident Council, 3) very limited access to cash is possible by using proper control procedures, and 4) the Resident Council will establish a standardized process for determining assistance provided to residents.

   It is our understanding that the LTCO is continuing to work with the IVH and the Resident Council on this issue.

8. **Complaint:** Residents no longer have input prior to implementation of policy and practice changes; there is an overall lack of communication by IVH administration. Residents want to be involved in committees like they were in the past.
   **Current status:** The following staff committees are currently in place at the IVH:
   1. REAL Committee
   2. Pharmacy Therapeutic Committee
   3. Administrative Policy

4. Budget Committee
5. Records Management Committee
6. Clinical Policy Council
7. IRCC Coordinating Committee
8. Admissions Committee
9. Quality Assurance and Performance Improvement Committee
10. Credentialing and Privileging Committee
11. IT Steering Committee
12. Facilities Management Committee Labor Management Committee
13. Infection Control Committee
14. Employee Wellness Committee
15. Safety Committee

Currently, there are no resident representatives on any of these committees.

Because of our previous reviews of the IVH in 2002 and 2005, we know that 6 of the 31 committees then in existence had a resident representative: Ethics; Infection Control; Pharmacy Therapeutic; Quality Council; and Research Review; and the Resident Advocate [Committee].[7]

Tymeson said confidential patient records and situations are discussed at committee meetings, thereby preventing residents from serving on most of the committees.

9. **Complaint:** Residents no longer have access to the kitchens, including the Kopper Kettle[8] and Heinz Hall.[9] Residents are also not allowed to use outside grills to cook.
**Current status:** There are numerous regulations for resident and facility safety. The Kopper Kettle is not used by residents because there are kitchens on the units for food activities; however, staff and family can use the area for resident activities. The kitchen in Heinz Hall has since been reopened. Changes have been made to the grill area; tanks are now locked up, and a staff person has been added in Heinz Hall to assist residents who want to grill.

10. **Complaint:** Residents have some food-related concerns about special requests, special diets, and the variety of food served.
**Current status:** A new food service director started work on October 24, 2014. The IVH has a suggestion box and a Resident Food Council that meets every other month.

11. **Complaint:** The greenhouse used by residents was closed due to concerns about the use and storage of unsafe chemicals.
**Current status:** Locked cabinets for fertilizer and plant food have been installed. The greenhouse is now open for residents from 8 a.m. to 8 p.m. daily.

[7] The Resident Advocate Committee was once required by the Code of Iowa, but it is no longer required by law.
[8] The Kopper Kettle is an auxiliary space with a full kitchen and several tables and chairs.
[9] Heinz Hall is a residential care facility.

**Analysis and Conclusions**

There are several complaint-reporting options and multiple regulatory oversight agencies that monitor the care, health, and safety of the 565 residents at the IVH. Data from these resources indicate there are relatively few complaints filed against the IVH. Both residents and staff have stated repeatedly in public forums and in interviews with our office that the quality of care they received at the IVH was "very, very good." Senator Beall said in an interview that he felt IVH's direct-care workers considered their jobs a ministry and a mission. We found complaints actually decreased during Worley's tenure.

It has been alleged by some that residents and staff feared retaliation if they complained. If true, that might explain why complaints decreased while Worley was Commandant. However, we have not learned of *any* specific examples where any resident faced *actual* consequences for reporting concerns about quality of care or quality of life at IVH.

This is not to say the IVH has not had any problems; it is impossible for an operation the size of IVH to operate without problems. IVH was fined in 2012 for serious care violations. The good news is that recent comprehensive surveys by independent oversight agencies have shown improvement.

There is no disputing that Worley made some operational changes during his tenure. Staff we interviewed admitted that change is never easy.

The changes in activities and programs that directly affect the daily lives of residents generated significant discontent for residents. Our analysis of the activity and program changes show that some of the modifications were due to safety concerns, while others were due to staffing or resource problems. Some of the changes were even made prior to Worley's appointment as Commandant. We believe that most of the dissatisfaction with activity and program changes have been resolved satisfactorily, or were implemented for valid, stated reasons.

We were not provided any evidence that the changes made by Worley to a unit-based management system adversely affected *residents*. Staff had input into this transition through the "Lean" event held in May of 2011. This change unexpectedly shifted power and control to Worley and his deputy and ultimately caused much dissent among staff. Some staff members were also upset that the team leader on every unit must be a nurse; they did not feel that nurses understood or were trained to supervise their counterparts in dietary, recreation, and social work. Regardless, everyone we interviewed agreed that staff shielded residents from the ongoing management conflicts. It was also the prevailing opinion among interviewees that Worley was the source of most of the problems.

It is our opinion the dissatisfaction and the dissent that generated complaints to legislators, the media, and others were primarily due to Worley's demeanor and manner and the management changes he made affecting staff alignment and resident programs and services. In reviewing the complaints of actual incidents related to resident care, health, or safety, we were not able to determine that any adverse effects were a direct result of Worley's managerial style and changes.

**Recommendation**

It is understandable for residents at the IVH to become distrustful and discontented, when they perceive changes to programs and services are being made without their input. It is also understandable that the IVH may not always be able to involve residents in every decision due to confidentially issues and safety concerns. We believe including residents in decision-making processes could help the IVH prevent or minimize complaints, regardless of how problems arise.

> *The Ombudsman recommends that the IVH, when feasible, include residents in the decision-making process on matters affecting their programs and services, either through representation on committees or through consultation with the executive committee of the Resident Council.*

## 2. Involuntary discharge of residents

Senator Beall's request referred to the involuntary discharge of 42 residents without adequate follow-up. We reviewed records to verify the number of involuntary discharges. We also reviewed relevant statutes and administrative rules to determine if the IVH complied with involuntary discharge requirements.

Iowa Law

Iowa Code section 35D.15(2) allows for the involuntary discharge of residents for these specific reasons:

> 2. *a.* The commandant shall, with the input and recommendation of the interdisciplinary resident care committee, involuntarily discharge a member for any of the following reasons:
> (1) (a) The member has been diagnosed with a substance use disorder but continues to abuse alcohol or an illegal drug in violation of the member's conditional or provisional agreement entered into at the time of admission, and all of the following conditions are met:
> (i) The member has been provided sufficient notice of any changes in the member's collaborative care plan.
> (ii) The member has been notified of the member's commission of three offenses and has been given the opportunity to correct the behavior through either of the following options:
> (A) Being given the opportunity to receive the appropriate level of treatment in accordance with best practices for standards of care.
> (B) By having been placed on probation by the Iowa veterans home for a second offense.
> (b) Notwithstanding the member's meeting the criteria for discharge under this subparagraph (1), if the member has demonstrated progress toward the goals established in the member's collaborative care plan, the interdisciplinary resident care committee and the commandant may exercise discretion regarding the

discharge. Notwithstanding any provision to the contrary, the member may be immediately discharged under this subparagraph (1) if the member's actions or behavior jeopardizes the life or safety of other members or staff.

(2) (a) The member refuses to utilize the resources available to address issues identified in the member's collaborative care plan, and all of the following conditions are met:

(i) The member has been provided sufficient notice of any changes in the member's collaborative care plan.

(ii) The member has been notified of the member's commission of three offenses and the member has been placed on probation by the Iowa veterans home for a second offense.

(b) Notwithstanding the member's meeting the criteria for discharge under this subparagraph (2), if the member has demonstrated progress toward the goals established in the member's collaborative care plan, the interdisciplinary resident care committee and the commandant may exercise discretion regarding the discharge. Notwithstanding any provision to the contrary, the member may be immediately discharged if the member's actions or behavior jeopardizes the life or safety of other members or staff.

(3) The member no longer requires a residential or nursing level of care, as determined by the interdisciplinary resident care committee.

(4) The member requires a level of licensed care not provided at the Iowa veterans home.

Iowa Code section 35D.15(2)(c)(1) explains the process that should take place if a resident is going to be involuntarily discharged:

> An involuntary discharge of a member under this subsection shall be preceded by a written notice to the member. The notice shall state that unless the discharge is an immediate discharge due to the member's actions or behavior which jeopardizes the life or safety of other members or staff, the effective date of the discharge is thirty calendar days from the date of receipt of the discharge notice, and that the member has the right to appeal the discharge. If a member appeals such discharge, the member shall also be provided with the information relating to the appeals process as specified in this paragraph "c".

The LTCO receives a copy of all involuntary discharge notices sent to residents.

IVH's administrative rule 801—10.43(3) contains specific criteria for the written notice:

> The notice shall state that, unless the discharge is an immediate discharge due to the member's actions or behavior which jeopardizes the life or safety of other members or staff, the effective date of the discharge is 30 calendar days from the date of receipt of the discharge notice, and that the member has the right to appeal the discharge. In addition, the discharge notice shall contain:
>
> *a.* The stated reason for the proposed discharge or transfer.

*b.* The actual effective date of the proposed discharge or transfer.

*c.* A statement in not less than 12-point type which reads: "You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may request a hearing in writing or verbally with the Commission of Veterans Affairs (hereinafter referred to as "Commission") within five (5) calendar days after receiving this notice. You have a right to be represented at the hearing by an attorney or any other individual of your choice. If you request a hearing, it will be held, and a decision rendered within ten (10) calendar days of the filing of the appeal. Provision may be made for extension of the ten (10) day requirement upon request to the Commission designee. If you lose the hearing, you will not be discharged or transferred before the expiration of 30 days following receipt of the original notice of the discharge or transfer, or no sooner than five (5) days following final decision of such hearing. To request a hearing or receive further information, call the Commission or write to the Commission to the attention of: Chairperson, Commission of Veterans Affairs."

The Veterans Affairs Commission (Commission) must render a decision on the appeal and notify the resident in writing within ten calendar days of the filing of the appeal. If a resident is not satisfied with the decision of the Commission, the member may appeal the decision by filing an appeal with the DIA within five calendar days of receiving the Commission's written decision. DIA is required to render a decision and notify the resident in writing within 15 calendar days of the filing of the appeal with the DIA.

Iowa Code section 35D.15(2)(c)(2)(e) also provides a specific timeframe for the process:

> (e) The maximum time period that shall elapse between receipt by the member of the discharge notice and actual discharge shall not exceed fifty-five days, which includes the thirty-day discharge notice period and any time during which any appeals to the commission or the department of inspections and appeals are pending.

**Findings**

Numbers of Involuntary Discharges

Senator Beall referred to 42 involuntary discharges in his request to our office. We do not know the source for the number 42, and no time frame was given for these purported discharges.

Worley testified before the Senate's Veterans Affairs Committee on May 6, 2013, that there had been only seven involuntary discharges since his appointment as Commandant.
We obtained two reports from the Legislative Services Agency (LSA) documenting IVH's involuntary discharges for calendar years 2010, 2011, and 2012. IVH is required by Iowa Code

section 35D.15(2)(d)[10] to file such reports annually. The first of the reports from Worley, addressed to the President of Senate and the Speaker of the House of Representatives, was dated January 28, 2013.[11] The second report from Worley, addressed to an analyst in the Legislative Services Agency, is dated February 25, 2013.[12]

It is not known why these reports were not sent to the legislative committees as specified by law.

Tymeson addressed IVH's 2013 report to the House Veterans Affairs and subsequently provided our office with a copy.[13]

The numbers from these three reports are listed in the first column of the table below. The numbers listed in the second column were provided by Tymeson in response to our office's request for these statistics in our August 30, 2013, notice of investigation.[14]

| Calendar Year | Involuntary Discharges Reported to Legislature | Involuntary Discharges Reported to Ombudsman |
|---|---|---|
| **2010** | 7* | 10 |
| **2011** | 2** | 35 |
| **2012** | 4 | 3 |
| **2013** | 2 | 2 |
| **2014** | 1 | 1 |

* Dates of separation were all prior to former Commandant Worley's beginning his job on August 1, 2013.
** We believe we may be missing a second page of the report provided to LSA but neither the LSA or the IVH has been able to locate it.

We reviewed the involuntary-discharge reports issued to residents in 2010, 2011, and 2012. The discharges in 2010 and 2012 were prompted by the residents' non-compliance with care plans. Four of the 35 involuntary discharges in 2011 were for non-compliance or behavioral problems. The remaining 31 discharges, according to a separate memo written by IVH, were initiated because those residents "no longer met level of care." These 31 involuntary discharges will be the focus of our review and analysis from this point forward.

[10] Iowa Code section 35D.15(2)(d) states, "Annually, by the fourth Monday of each session of the general assembly, the commandant shall submit a report to the veterans affairs committees of the senate and house of representatives specifying the number, circumstances, and placement of each member involuntarily discharged from the Iowa veterans home under this subsection during the previous calendar year."
[11] See Appendix D. This report lists four involuntary discharges.
[12] See Appendix E. This report lists seven involuntary discharges in 2010 and two involuntary discharges in 2011.
[13] See Appendix F. The report states there were two involuntary discharges during calendar year 2013.
[14] See Appendix G. IVH's compilation of "Discharges from Iowa Veterans Home" from 2010 to 2012.

Discharges of Residents Who "No Longer Met Level of Care"

The IVH provides residents with two levels of care: residential care and nursing care. Residents qualifying for residential care are able to meet their own needs, with the exception of medication and/or meals. These residents lived in Heinz Hall. Residents in the nursing level of care required continuous nursing supervision or assistance in one or all areas of physical needs and activities of daily living.

We learned during our investigation that the Department of Veterans Affairs determined in 2009 that at least 30 residents did not meet the criteria for nursing home level of care at the IVH. The DVA outlined its finding in a survey:

| | | |
|---|---|---|
| 3. Review of Assessments. The nursing facility management must examine each resident no less than once every 3 months, and as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment. | (N) Not Met | User: Jessica VanVark<br>Date: 11/06/2009<br>Rating: (N) Not Met<br>Comments: Twenty veterans (51, 52, 54, 76-92) were identified by IVH prior to the survey as not meeting the criteria for nursing home care. New 10-10SH forms have been submitted to VA Central Iowa and will be reviewed by the Chief of Staff in a timely manner.<br>An additional ten veterans (55, 93-101) were identified by VA reviewers to not meet the nursing home level of care. VA requests new 10-10SH forms be submitted for these veterans.<br>There are additional veterans on the same floor (Malloy 2N/2S) as well as other units that will require additional review by IVH staff and submission of new 10-10SH forms.<br>VA recommends submission of new 10-10SH forms for Cat 4 veterans (IVH classification). Criteria that VA uses to exclude a residents from meeting the nursing home level of care include but is not limited to: independence in ADL's, owning and operating a car, leave days in excess of 12 per year, taking vacations and camping. Independence in ADL's or the above criteria would suggest a lower level of care to be more appropriate. |

We do not know what, if any, action was taken by IVH to correct this problem before Worley was named Commandant in August of 2010. In an October 23, 2011, article in the Marshalltown Times Republican, Worley said that the IVH had not been previously enforced the DVA's rules: "We had a lot of residents here who had been here for many years who never should have been here." Stan Freeborn, Former Adjutant Director, confirmed in the same article that admission and retention standards at the IVH had been "relaxed" over the years:

> "Over the years we kind of let things slide. Worley was the first one as a commandant that did a little more enforcing," Freeborn said. "Whether they wanted to be discharged or not is immaterial, it's whether they met the qualifications to be there."

According to Susan Wilkinson, IVH Resident Support Division Administrator, many of the residents who did not qualify for nursing level of care probably qualified for residential level of

care in Heinz Hall. The need for beds triggered a review in 2010 of all Heinz Hall residents in residential and domiciliary (DOM) levels of care. Wilkinson said Worley decided that the IVH would no longer house DOM residents. The IVH is not prohibited by law from housing DOM residents, but according to staff, there was a need for residential level of care beds.

IVH Handling of the Discharges

On October 29, 2010, Worley notified residents in residential care by memo that "after assessing our resident population it is clear there are residents at the residential level of care who no longer require these services."[15] The memo went on to state that staff would work with residents to evaluate their level of need and assist in making discharge plans appropriate to their particular situation.

Wilkinson met with the 31 residents during a ten-day period in November of 2010. She advised these residents that they no longer met the eligibility requirements to remain at the IVH, and they were directed to work with their social worker to develop a discharge plan. The 31 residents began discharging in January of 2011; the last resident left in November of that same year. The progress notes provided to our office from the files of these residents described the discharge planning efforts made by staff and residents. Those efforts included apartment searches, furniture and grocery shopping, and counseling.

Iowa Code section 35D.15(2) states that a member who no longer requires a residential or nursing level of care generally shall be involuntarily discharged. Individual written notices that identify a resident's appeal rights are required for an involuntary discharge. Of the 31 residents who were discharged because they no longer met the level-of-care requirements, the IVH produced copies of notices for only four residents. The LTCO received copies of the written notices. A September 27, 2013, Des Moines Register article quoted Worley as saying the residents were provided opportunities to appeal, but we could find no evidence to support his statement in the case of 27 of those residents. IVH records indicate that one of the residents who received a written notice unsuccessfully appealed his discharge.

IVH Responsibilities Upon Discharge

Iowa Code section 35D.15(b) outlines the IVH's responsibilities when a resident is involuntarily discharged. It requires the IVH to develop a discharge plan which includes placing the resident in a suitable living situation and ensuring that the resident does not become homeless. It states:

> b. (1) If a member is discharged under this subsection, the discharge plan shall include placement in a suitable living situation which may include but is not limited to a transitional living program approved by the commission or a living program provided by the United States veterans administration.
> (2) If a member is involuntarily discharged under this subsection, the commission shall, to the greatest extent possible, ensure against the veteran being homeless and ensure that the domicile to which the veteran is discharged is fit and habitable

[15] See Appendix H.

> and offers a safe and clean environment which is free from health hazards and provides appropriate heating, ventilation, and protection from the elements.

Dr. Mark Minear, Director of the IVH Mental Health Department, testified at the May 6, 2013, Veterans Affairs Committee meeting that he disagreed with only a handful of the involuntary discharges.[16] He later informed our office that he took action to postpone those discharges so the residents could assemble an acceptable discharge plan. It appears from the progress notes we reviewed that Dr. Minear exchanged phone numbers and emails with some of the involuntarily discharged residents, and even made plans to visit them after they discharged. He confirmed in an interview with our office that he followed up with some of the residents; some reportedly did well, while others found the transition difficult.

Statutory Reporting Requirements for Involuntary Discharges

Iowa law requires the IVH Commandant to report all involuntary discharges:

> 35D.15(2)(d) - Annually, by the fourth Monday of each session of the general assembly, the commandant shall submit a report to the veterans affairs committees of the senate and house of representatives specifying the number, circumstances, and placement of each member involuntarily discharged from the Iowa veterans home under this subsection during the previous calendar year.

The only report of involuntary discharges for 2010 and 2011 was a letter from Worley to the Legislative Services Agency dated February 25, 2013. According to Tymeson, there is no record that Worley filed timely reports for those years as required by law. Worley submitted the mandated report for 2012 on January 28, 2013. Tymeson submitted reports for 2013 and 2014.

**Analysis and Conclusions**

Involuntary Discharge Process

Many of the public comments about IVH's involuntary discharges focused on the large number of discharges and second-guessing about whether the residents should have been discharged. As stated earlier in this report, we focused our review on the 31 residents who were involuntarily discharged after the IVH's determination that these residents no longer met residential level of care.

Wilkinson met with the 31 residents in November of 2010 to inform them that they no longer met the level of care to remain at the IVH and must find alternative housing. This decision by IVH administrators should have resulted in written notices to the residents that explained their appeal rights. The written notice would have triggered a 30-day deadline for the residents' discharges.

[16] Dr. Minear resigned from the IVH in February of 2012. He testified that he "resigned due to conflicts with Commandant [Worley]" and that his "major issues with the Commandant came during the decision-making process regarding elderly and mental-health patients who did not want to be discharged."

At some point, an IVH doctor wrote orders for 4 of the 31 residents. The order stated that the four residents did not meet the level of care and directed staff to initiate the 30-day discharge process. There is no indication, however, that those residents received any written notice. Wilkinson said the threat of a written notice often motivated residents to get serious about finding housing alternatives. Records show that these four residents remained at the IVH beyond 30 days. The first of those residents to be discharged stayed six weeks; the others remained longer—up to five months, in one case.

Four other residents of the 31 facing involuntary discharge ultimately received a written notice of discharge. Wilkinson said these four residents did not want to leave and did not cooperate with discharge planning. She said issuing notices to them was IVH's last resort.

Wilkinson stated that residents who worked with staff on a discharge plan were not actually treated as involuntary discharges. This explains why those residents did not receive the written notices required by law, even though they met the legal definition of an involuntary discharge.

We found the IVH identified these 31 residents as involuntary discharges in its discharge reports, and the circumstances of their departures met the definition of involuntary discharges under Iowa law. We also found, in the progress notes in the discharge files of the 31 residents, that many of them were anxious about leaving or did not want to leave. By law, once written notice was issued, the residents only had 30 days to find alternate housing. Questions arose in our minds about application of that law: Must a formal discharge notice be issued immediately once the IVH determines a resident no longer meets the level of care to remain there? Can the IVH first try to develop a discharge plan with a resident before issuance of the written notice? If the IVH works out a plan for the resident to leave the facility, can that be treated as a voluntary discharge that excuses the IVH from issuing a written notice? Is that within IVH's authority to decide?

Separately, we have this concern: Had the IVH provided written notices in November of 2010 to these 31 residents, it is highly unlikely that they would have had time to find acceptable housing and health care alternatives within the 30-day deadline specified by law. Progress notes indicate that many of these residents were on waiting lists for apartments. Many had lived at the IVH for over ten years and needed time to transition to new surroundings. Residents would not have time under the rigid timeline of the statute to participate in the IVH's Living In Balance class,[17] designed to help transition residents back into the community. As it was, it took six weeks to a year for the involuntarily discharged residents to leave the IVH.

We do not know if the residents who failed to receive written notices of their discharges were advised of their appeal rights. It is impossible to surmise how many of these residents would have filed appeals, and perhaps won their appeals, had they been given written notice. Regardless, it is difficult to criticize the IVH for failing to give written notice to these residents, given the practicalities of the situation. The progress notes show that these long-time IVH residents needed time to transition back into the community. If we must assign any blame, the fault lies with past IVH administrators for relaxing admission and retention standards over the

[17] The classes focus on financial goals, budgeting, understanding insurance, money management, and behavior issues.

years. Worley was quoted in an October 23, 2011, article in the Marshalltown Times-Republican as saying, "We just weren't enforcing the rules. We had a lot of residents here who had been here for many years that should have never been here." While previous administrations may have viewed their actions as compassionate, in the end, these residents' evictions from IVH could be viewed as far from compassionate.

Discharge Follow-up

Iowa law requires the IVH to develop a discharge plan which includes placing the resident in a suitable living situation and ensuring that the resident does not become homeless. It does not require the IVH to do additional follow-up with residents after their discharge. Our review of the discharge files leads us to conclude that some of the residents likely did not need follow-up. One of the residents who was discharged attended community college and talked about pursuing graduate courses. Another resident admitted that he knew he did not qualify for a residential level of care. If Dr. Minear or staff was concerned about a resident's transition into the community, it appears that they made plans to stay in contact with the resident. In one case, a resident requested Dr. Minear's continued support. Dr. Minear wrote, "I will likely start to [S]kype live over the internet after [resident] has purchased the hardware necessary to utilize his program. In the meantime, we will make some connections via email. I will also make an effort to visit him in his apartment in two weeks." For this same resident, a social worker wrote in his discharge plan: "Will plan to contact resident in 30 days to see how he is doing unless called upon for assistance prior to then." Wilkinson could not definitively confirm that staff had followed up with any residents who were involuntarily discharged because there was no way to document such contacts once a resident's file was closed.

Statutory Reporting Requirements for Involuntary Discharges

The Legislature apparently wanted to monitor the numbers and causes of involuntary discharges at the IVH since section 35D.15(2)(d) of the Code of Iowa requires the IVH Commandant to report the discharges annually. We requested these reports for 2010 through 2014. The IVH could not provide us with evidence that Worley had timely submitted reports for 2010 and 2011; the only document about discharges for those two years was his letter to the Legislative Services Agency in February of 2013. We conclude that Worley failed to submit the required discharge reports for 2010 or 2011, the two years with the highest numbers of involuntary discharges.

## 3. Contracts and purchasing agreements

Several current and state employees testified before the Senate Government Oversight Committee on June 9, 2014, that Governor Branstad's administration "allowed a contractor to work [at the IVH] without a contract in an effort to derail contracts" that were already in place there. The contractor dispute purportedly began after the contract of one of the design firms for a four-phase project at the IVH was terminated. A Des Moines Register report on the meeting detailed some of the employees' testimony:

> Greg Wright, a former executive of the veterans home, said he believes Branstad officials unfairly blamed the company as a way to derail the project labor agreements. Wright also described multiple attempts by veterans home staff to inform the governor's office of improprieties, which he said were ignored.

An audio recording provided to our office by Wright dealt only with his complaints about Worley's behavior and management. He made no mention in the recording of contract irregularities.

As a result of the testimony provided to the Oversight Committee, the committee made several recommendations on state contracting[18]:

- Require all state entities to follow formal competitive bidding procedures for construction projects above $100,000, including [the cost of] preliminary architectural and engineering services.
- Require that architectural and engineering services adhere to the same level of bidding and procurement requirements as any other construction service.
- Require all major infrastructure changes to be approved by the legislative committee that originally appropriated the money.
- Reinstate the Vertical Infrastructure Advisory Committee.
- Review the state construction cost benefit analysis by the LSA and act on its recommendations.
- The Legislature should reexamine the duties of the DAS to reign in its ability to control and hide unacceptable government practices from the Legislature and Iowa taxpayers.

Because these issues were vetted by the Government Oversight Committee, we chose not to further pursue any issues involving contracting or purchasing agreements at the IVH.[19]

**4. <u>Sexual harassment, hostile work environment, and abusive management behavior toward staff.</u>**

The vast majority of the oral and written testimony provided to the Ombudsman dealt with allegations of intimidation, coercion, and bullying by former Commandant Worley and former Deputy Director Callaway. One former employee who testified before the Veterans Affairs Committee railed against what he called "the illegal, unethical, intolerable work conditions at the IVH."

Section 2C.9(1) of the Code of Iowa prohibits the Ombudsman from investigating employee complaints about the employee's employment relationship with an agency.

[18] Senators Janet Petersen, Matt McCoy, and Brian Schoenjahn voted in favor of the recommendations, while Senators Julian Garrett and Charles Schneider voted against them.
[19] The Iowa General Assembly has not taken any action on these recommendations to date.

**2C.9 Powers.**
The ombudsman may:
1. Investigate, on complaint or on the ombudsman's own motion, any administrative action of any agency, without regard to the finality of the administrative action, except that the ombudsman shall not investigate the complaint of an employee of an agency in regard to that employee's employment relationship with the agency except as otherwise provided by this chapter. A communication or receipt of information made pursuant to the powers prescribed in this chapter shall not be considered an ex parte communication as described in the provisions of section 17A.17. (Emphasis added.)

Allegations of sexual harassment, hostile work environment, and abusive behavior by IVH management towards employees fall within this employment relationship exception. Therefore, our office did not investigate these complaints.

We did confirm that DAS opened two investigations into these allegations. Although we reviewed the DAS files to ensure that investigations were conducted, we are unable to share the details, because the files are considered personnel matters that are confidential by law.

Despite our lack of authority in this area, we feel it is important to note that Tymeson has implemented a number of changes that may address past concerns raised by staff:

- Effective earlier this year, a new organizational chart was implemented. The changes eliminated the unit-based management model which was a common thread of criticism in interviews and documents. The new structure created a Resident Support Division with six bureau chiefs overseeing recreation, pharmacy, medical clinic and therapies, food service, resident services, and social work. This reorganization appears to address a request from social workers to the Ombudsman in 2013 for the "re-establishment of the interdisciplinary model for all professions at IVH."
- New supervisor orientation training has been put into place. In addition, leadership classes are required for all IVH supervisors. Those classes include Harassment in the Workplace, Shaping Effective and Engaged Teams, and Advanced Principles of Communication. IVH senior leadership is required to participate in additional training, with classes that include Leading through Change and Strategic Planning and Systems Thinking.
- A Commandant suggestion box was installed in January 2015 for use by residents and staff.
- In November of 2014, IVH conducted its first-ever employee survey. A copy of the survey results can be found in Appendix I.

Despite the departure of Worley, concerns persisted that some members of Worley's executive team remain in positions of authority at IVH. One staff member did offer, however, that the attitude of some of these remaining team members had improved under Tymeson's leadership. Another issue that was repeatedly addressed in interviews and documentation was the allegation that staff was forced or coerced into changing their employment status from merit to at-will.

According to a January 19, 2014, Des Moines Register article, the Branstad administration reclassified 198 jobs statewide to at-will status in 2013:

> The at-will reclassifications took place after the state initiated a rules change and expanded the definition of a "confidential employee" in December 2012. Confidential employees – those workers who interact with and share privileged information with executive-level department officials–have traditionally been classified as at-will positions. Expanding the definitions meant that potentially thousands of employees could be reclassified as at-will, state officials acknowledged last year.
>
> Among those state jobs considered "confidential" and now classified as at-will positions are 16 nurse supervisors at the Iowa Veterans Home …

We did not conduct any further review into the reclassification of IVH employees, as we consider this to be an employment matter outside our jurisdiction.

## Summary and Recommendation

1. It is the Ombudsman's opinion that the dissatisfaction and the dissent that generated complaints to legislators, the media, and others were primarily due to Worley's demeanor or mannerisms and management changes he made affecting staff alignment and resident programs and services. The incidents related to resident care, health, or safety in the complaints that were reviewed could not be directly attributed to Worley's managerial style and changes.

   Regardless of how problems arise, including residents in decision-making about programs and services could help the IVH prevent or minimize complaints. For that reason, the Ombudsman makes the following recommendation:

   > *The Ombudsman recommends that the IVH, when feasible, include residents in the decision-making process on matters affecting their programs and services, either through representation on committees or through consultation with the executive committee of the Resident Council*

2. The Ombudsman found the IVH identified 31 residents as involuntary discharges in its discharge reports, and the circumstances of their departures met the definition of involuntary discharges under Iowa law. By law, once written notice was issued, the residents only had 30 days to find alternate housing. Questions arose about application of that law, but had the IVH provided written notices to these 31 residents, it is highly unlikely that they would have had time to find acceptable housing and health care alternatives within the 30-day deadline specified by law. If blame is to be assigned to the fact these residents were required to leave, the fault lies with past IVH administrators for relaxing admission and retention standards over the years.

3. Section 35D.15(2)(d) of the Code of Iowa requires the IVH Commandant to report the discharges annually. The Ombudsman concludes that Worley failed to submit the required discharge reports for 2010 or 2011, the two years with the highest numbers of involuntary discharges.

4. The Ombudsman chose not to pursue any issues involving contracting or purchasing agreements at the IVH as these issues were vetted by the Government Oversight Committee in June, 2014.

5. The Ombudsman does not have the statutory authority to review complaints related to an employee's employment relationship with an agency. For this reason, the Ombudsman did not investigate the allegations of sexual harassment, hostile work environment, and abusive behavior by IVH management towards its employees.

# APPENDIX A

*Senate Committee*

**COMMITTEE MINUTES for**
**VETERANS AFFAIRS**

Date: *May 6, 2013* Location: *Room 22*

Convened: *1:30 PM*

Adjourned: *3:55 PM*

Attendance Roll Call:
Present: Senators Beall-CH, Danielson-VC, Rozenboom-RM, Ernst, Hart, Horn, Ragan, Schneider, Sodders

Absent: None

Excused: Senators Black, Chelgren

Senator Beall called the Veterans Affair Committee Special Meeting to order at 1:30 pm on May 6, 2013.

The special meeting was called to discuss the Iowa Veterans Home.

Minutes from the last meeting, April 2nd were approved.

Committee members present were: Senator Beall, Senator Danielson, Senator Rozenboom, Senator Ernst, Senator Hart, Senator Horn, Senator Ragan, Senator Schneider, Senator Sodders.

The following non-committee members were present: Senators: Petersen, Hatch, McCoy, Bolkcom, Dotzler and Dvorsky; Representatives Alons, M. Smith, Salmon, Maxwell and Fisher.

Senator Beall introduced the purpose of the meeting was to address complaints about the quality of care at the Iowa Veterans Home.

Presenters spoke in the following order:

The Reverend Ken Briggs, former Air Force chaplain and Lt. Colonel, currently represents Iowa Mental Health Planning Council. Rev. Briggs comments as follow:

IVH staff has excelled in service in relation to how current administration has supported the staff. Long term staff has left, staff still remaining feel humiliated or threatened and afraid to speak up due to risk of retaliation. Veterans with disabilities, mental health issues and other medical problems have been dismissed, although they still needed assistance. Residents feel treatment is poor; they feel humiliated, meals and hygiene regularly not on time, disabled veterans are unable to get to religious services. Commandant manages staff and residents with threat and control. Veterans feel ashamed at the home. IVH will become more important in the future due to veterans with PTSD returning from Iraq and Afghanistan.

Bill Rakers, former director of recreational therapy, retired in 2011 after 29 years with IVH. Mr. Rakers comments as follows:

Recreational therapists provide activities such as meals out of IVH, visiting sports and musical events and other public outings. Previous Mr. Raker felt support from administration to help the veterans through therapeutic recreation. After 2011 therapists were put on own without

leadership help from supervisors. Activities were reduced for veterans which lead to diminished moral and worsening moods for veterans. Veterans have shared they feel bored more often. Further no overtime is approved for therapists, this prevents extra activities for residents and residents are frustrated. IVH has changed from a helping, loving place to a place where control is key and residents and staff believe they would be gotten rid of if they do not cooperate. The goal is to get the residents in and out as quickly as possible without regard for the veteran's needs. A story was told of an employee who had long term health issue and told to get back to work as soon as possible without regard for his medical condition. In summary IVH was formerly a source of joy and pride for residents and staff now they feel fear and threatening.

Questions to Mr. Raker:

- Senator Danielson – Is there an internal process available to bring issues to management? Raker – None
- Senator Sodders –The structure went from team leadership to unit leadership from team, please describe and expand on the change? Raker – Nurses at head of unit do not have training in recreational therapy and cannot provide leadership.
- Senator Ernst – Expand on the employee with cancer, we have federal laws and regulations that you must follow but I understand IVH must still care for residents. Raker – My fellow employee not retained because of cancer even though good employee.
- Senator Hart - If not cooperative staff and residents are gotten rid of then right? - Raker – The administration won't go to extra mile to help someone (staff or resident) overcome a difficulty. Residents are told their stay was long enough and they can move on.
- Senator McCoy - Can you talk about your own situation, why did you determine it was time to leave? Raker – I was removed from leadership, given bad office, staff were told not to talk about recreation therapy with me. I was moved to a job in security and switchboard management from recreational therapist, so my salary was disproportionate with security position; I was then told my salary would be cut. My former position at home was not filled. Responsibilities were taken up by nurses who may or may not have done the duties. I left in October 2011.
- Senator Rozenboom - What was a loving caring environment is now an institution – how was it before the change of commandant? Raker – All facilities have problems, but leadership at IVH now approaches problems with no discussion with staff, they act like a dictatorship.

Robby Corum, former social worker at Iowa Veterans Home, retired in 2012 after 28 years with IVH. Ms. Corum's comments are as follows:

Corum only feels like she can speak because she is retired and cannot be threatened for speaking. Commandant Worley has had overall effect on care residents receive. Commandant broke down the structure, removed key leadership and demolished departments, so that now no check and balance occurs. No residence advocacy left in the current structure. Unit based teams were adopted; this has led to decisions about residents at unit level, supposedly not top administration leave, however unit decision are often squashed by administration. Staff is now at will employees. No staff meetings are allowed even when requested. Differences of opinion between staff and administration is met with anger, hostility, and more control, in general there is fear and lack of trust of in the administration. Commandant should be removed. Long term employees have left early due to fear and bullying. Corum recommends an investigation is conducted in such a way that it is done without fear of retaliation toward staff and residents.

- Senator Beall - You used word hostel and intimidating, can you give an example? Corum – I was asked about supervisor by Commandant and felt like I was being bullied into saying bad things about supervisor, my supervisor was then fired. Commandant told inappropriate personal stories to show he is tough and was not to be messed with.
- Senator Ragan – Were you part of discussion when supervisor was asked to leave? Corum – No
- Senator Hart – You mentioned a lack of transparency and secretive hearings, could you

expand? Corum – Previously I felt like part of facility and knew what was happening and when it was happening as to table of organization changes. Sudden changes made are made now and we never knew who to call and what was happening. I was told changes were shared on a need to know basis.

Mike Croskey (president of the IVH Resident Council) and Sherry Tichey (retired after 28 years as ward clerk and mother is a resident at IVH), presented by Mike Schlesinger presented by publisher of Marshalltown Times-Republican. Mr. Schlesinger comments on behalf of Mr. Croskey and Ms. Tichey as follows:

Schlesinger: As a former manager I was approached by multiple people in the area to tell complaints and hosted a March meeting to hear the stories. Many staff read comments from filed DAS reports. Reports showed the Commandant threatened and screamed at people with inappropriate language, sexually inappropriate words also used. Employees told not to come for fear of Commandant.

Croskey – Worked with 6 different commandants at Iowa Veterans Home. The staff used to be proud to be at IVH, now best staff feels forced or intimidated to leave. Residents never know from one day to next who will provide care because of high staff overturn. One resident said following: I would never have served in army if I had known I would have been treated so poorly at IVH. Residents won't speak up for fear of being discharged. As residents we used to have input on home administration, no longer allowed input and many privileges we used to enjoy are no longer allowed.

Tichey – IVH used to have the Clothes Closet which was where the community used to donate clothing to veterans to shop from, the commandant closed the operation. Tichey's mother was also a resident and reported staff shortages which effect feeding time and help calls. Her mother denied her request to put up a poster for program for residents.

- Representative Alons – Grievances were filed, can you elaborate? Schlesinger – I cannot answer, only reading from letters. Alons – Need to follow up on this.

Col. Todd Jacobus, chair of the Iowa Commission of Veterans Affairs, and member of Iowa Army Guard since 1988. Comments by Col. Jacobus are as follows:

Iowa Commission of Veterans Affairs has the responsibility supervise the commandant. I am pleased with openness and transparency in the process. Worley is knowledgeable about nursing home administration, proud of his service to US Army and has a passion about those who served our nation. He is on first name basis with the residents and knows the resident's family, Dan Gannon agrees as do others on Commission. Worley has been open with me (Jacobus) about incidents in IVH, and I am confident incidents mentioned to me were resolved. Worley does not want IVH to be a last resort for veterans, but the first choice for veterans and a first class home. Everyone at IVH is working together as team. I want to walk away from this meeting with a shared vision of how to move forward to best serve the residents.

- Senator Ernst – We have heard many concerning testimonies, are these incidents that were brought to commission and aware you of the problems? Jacobus – There have been many administration changes in past two years. We know about these changes, but the commission is not involved in daily workings of IVH. There are always multiples sides to a story and Worley has always presented a good explanation to the commission about issues.
- Senator Hart - It is hard to coincide your (Jacobus's) testimony with previous presenters, is their high turn-over at IVH and does it exist? Jacobus – I am concerned about turn over in general. I attended a leadership meeting with IVH supervisors in January and asked for feedback on any issues they had. Problems areas were followed up on, but no issues with Worley were presented. The only management issues were frustrations of specific veterans stemming from administration of policy.
- Senator McCoy – Expand on your January meeting with supervisors? Jacobus – Every month leadership at IVH gets together with Commandant. I joined to make a presentation in January because some veteran service organizations have shared frustration with Commandant.

McCoy – Can you share for specific instances of frustration? Jacobus – One situation was alleged abuse, I told staff they must pursue the incident through specific processes in place. American Legion also was one of complainers, recently Dick Schrad as well. McCoy - You said enormous changes have taken place in last 2 years, can you expand? Jacobus – The residents no longer live in shared room, now single dwelling and this has spread out staff. McCoy - So you are not versed in day to day operations, but staff turnover and elimination of vocational rehab program has not sparked a question as to why are these decisions were made? Jacobus - I want to see veterans have a lively social life and no reduction in opportunities, things are just managed differently now. McCoy - Did employees speak at January meeting and was Commandant present? Jacobus – The Commandant was present, employees were asked to identify strengths and weaknesses in their department; the meeting was 2 hours long.

- Representative Alons – Grievances were noted by previous speaker, does commission get involved in these charges? Jacobus – DOM vets these grievances, there is a separate process internally through state government. Alons - Significant charges about threats and sexual harassment have been made, have you seen any documentation? Jacobus – I have no knowledge of sexual harassment, only rumors about threats. I wanted to speak to individuals about the allegations, but I was told individuals do not want to speak for fear of reprisal.
- Senator Sodders – I have seen non-union employee reports on employment, did you know all employees were forced to sign an at will agreement about employment? The agreement says "if the employee does not consent to changes made, then result be a reduction of employment. Jacobus – Thank you for sharing.
- Senator Rozenboom – I am also trying to reconcile two pictures of IVH, if you could give me two or three adjectives prior to Commandant Worley and after what would they be? Jacobus - I don't see what others have seen, I see happy and comfortable veterans. IVH is not an institution but a home because of the entire team. IVH has not been poor in past and it is not poor now.

Melanie Kempf, long-term care ombudsman with the Iowa Department on Aging. Ms. Kempf's comments are as follows:

My department advocates for residents' rights, for quality of care and choice. We try to resolve IVH problems. We became involved recently; in Dec 2012 I received a letter from Representative Heaton's office. Residents said IVH was a home, but now is a prison. Staff that previously advocated for the residents are now gone. Commandant is nice during tours with public, but not the rest of the time. Residents and staff fear reprisal if they voice concerns. The Ombudsman's office also received a letter on concerns, but we cannot not speak with a resident if the resident does not wish to be spoken to about the issue. In March, I had meeting with staff and Ombudsman office, clarification was provided about resident concerns. Later in March I met with residents' council on issues who also had fear of retaliation when speaking to me. I asked how to get people with concerns to come forward and left flyer to be given out with how to contact me.

- Senator Beall – Have you had any contact off campus with residents? Kempf – Residents will only speak in groups. I provided business cards and one has called.
- Senator Hart – I am hearing fear of retaliation, what is your take on what the residents are afraid will happen? Kempf – They are afraid they will be forced to leave IVH.
- Senator Beall – Were any residents at March staff meeting? Kempf – No
- Representative Alons – Of residents who spoke with you in January, are they still residents? Kempf – I assume so, but I am unsure.

Dr. Mark Minear, former director of the IVH Mental Health Department, left in February 2012. Dr. Minear's comments are as follows:

I resigned due to conflicts with Commandant. My major issues with the Commandant came during the decision making process regarding elderly and mental health patients who did not want to be discharged. I wanted to ensure the discharged veterans were able to take care of themselves after they left IVH. Worley unhappy when I prevented or slowed the discharge, one

resident was bated by Worley to become angry and then threatened if he did not leave. A female veteran with PTSD was discharged, I did not agree, I was then told I would be removed from work with veterans because I was being an obstructionist. Worley and I had a meeting on this matter, the meeting was uncalled for; threats were made during them including staff employment discharge. Staff members were told they had to beg to keep their job and they were also told would be physically hit. Credentialed people were questioned and jobs threatened by supervisors uncredentialed in that field. I left due to threats and my personal ethical obligations, had I not left I would have had to compromise my professional ethics. In summary inappropriate control and treats are made by Worley as a matter of staff management.

- Senator McCoy – What steps professionally did you take to raise alarm? Such as contact with Governor or formal complaints? Minear – I contacted DAS and submitted complete report. You can get the report from DAS.
- Senator Sodders – Did anyone in supervisor position or management ever say they did not believe in PTSD? Minear – Worley once said he only believe in PTSD from a combat situation, not other perceived or real life threats that people experience.
- Representative Smith – A discharge system was developed through policy for veterans at one time, can you comment? Minear – The policy was meant to be case by case with each veteran's needs considered.
- Senator Schneider – What are the typical grounds and procedure for discharging a mentally unstable veteran or one with substance abuse and who makes the request? Minear – The teams made list of qualifications for discharge for involuntary discharge cases, but it was still to be case by case. Some successful discharges did happen, some were just not ready. Anxiety about discharge drove one person to a suicide attempt and this person would have needed more preparation. Schneider – If a person was deemed not ready for discharge, what is the process and does your ruling stand? Minear – Typically we rely on physician's decision, a supervisor can overrule a team's decision.
- Senator Beall – What is the hierarchy of professional medical staff? Minear – Previously to the top medical staff reported to the Commandant, this is not the case now.

Richard Schrad, former director of Resident and Family Services Department and resident advocate at IVH. Mr. Schrad's comments are as follows:
Residents and staff contacted me with stories of fear and bullying and that employees were leaving. The complaints were not just residence whining or disgruntled employees seeking revenge. Examples of inappropriate behavior by management I have heard: sexual harassment, verbal abuse, temper, threats, stories of past violent behavior, stories of gun collection, inappropriate touching, denigrating remarks about staff and residents. Accounts I have heard are not just hearsay, they are an established matter of record. These staff and residents are not here today because they are afraid and afraid no results will happen. I want action by Governor. The most unqualified person on staff is the deputy director, but the staff still fear her anyway. Director Tymeson defends Worley and deputy director.

Dr. Ann Touney, M.D., former staff physician at IVH, recently left after eight years. Comments by Dr. Touney are as follows:

Formerly excellent care, but now the changes made are troubling. Employees are pressured to resign when they do not agree with administration; this causes loss of strong advocates for residents. Direct care persons previously went to the commandant with issues, but they do not feel they will find a response. Staff is told to make decisions at lowest level possible, but often administration will override the lower level decision with no explanation. WE need transparency to have a team, but now there is no transparency or team feeling. The teams are tense and stressful.

- Senator Beall – What is the hierarchy of medical staff? Tourney – The top medical staff director (Dr. Brule??) is often not on campus. There was a director of nursing and director of residence family services. Formerly all reported to Dr. Brule, now not so.

Director Jodi Tymeson, director of The Iowa Department of Veteran's Affairs and retired brigadier general in the Iowa Army National Guard, former state representative. Director Tymeson's comments are as follows:

I am a non-voting member of commission and receive updates from Commandant. I find the Commandant open to the commission and other veteran groups. On the last federal report from the VA on IVH, IVH met all 158 standards of nursing home care. IVH is larger than most nursing homes, but I am typically impressed with care. I have picked up on issues today regarding a lack of training and staff shortage.

- Representative Alons – Are you aware of threats and bulling grievances that are being brought up? Tymeson – I am not aware, I know a process is in place though.
- Senator Hatch – Are you a liaison for different veterans' groups? Tymeson – Yes Hatch – Do these groups share concerns with you or have you heard of the complaints? Tymeson – I have only heard though the media. Hatch – As director you have never wanted to take on the issue? Tymeson – I only heard of it recently.
- Senator Petersen – Have you seen the DAS investigations Representative Alons mentioned? Tymeson – No, but I don't supervise IVH.
- Senator Ragan – You serve on commission Tymeson – Yes Ragan – And none of this was brought up at any meeting? Tymeson – Not that I recall. We have talked about construction, new buildings, private rooms, but not personnel and not attitudes and issues at IVH. It is not unusual for discontent at IVH because of the large size. Ragan – I do not remember sensing this problem in our discussions earlier this year in Veterans Affairs committee, but I am surprise commission has not discussed this problem.
- Representative Smith – I am trying to reconcile the reference by Jacobus that the commission has responsibility over IVH, and even as non-voting member, you have responsibility over IVH then also? Tymeson – True, but we talk in broad terms in the commission about changes being made.

Commandant David Worley, commandant of the IVH since 2010 and retired Army veteran. Commandant Worley's comments are as follows:

I am willing to be open to discussion and I always so to feel free to visit. The staff does a wonderful job at IVH. Veterans and families are most important to me. I used to do this same job in Kentucky and because of the nature of the job I became licensed nursing home administrator. On major change we have made was to change the construction plan to include all single rooms. I believe in new ideas, but not change for change sake.

- Senator Beall – Can you respond to the questions and charges made? Worley – I am required to submit a report on all involuntary discharges. We have only 7 actual involuntary discharges total since I came, but have discharged many people voluntarily. When I started many residents were in the wrong care level and I changed this. I have to adhere to state and federal regulations for nursing homes and veterans' affairs.
- Senator Beall – Describe the process for complaints. Worley – The grievance process, first it goes to a supervisor, then DAS and Union, then arbitration.
- Senator Beall – Talk more about some of the discussion today? Worley – I am not going to respond to direct personal attacks. I am a direct leader and make decisions people are not always happy with. However we have no deficiencies found by inspection by Feds. Only the Iowa DIA only found 4 minor problems. Two problems were with direct care workers, two were structural regarding fire alarms. I believe decisions should be made a lowest level possible. I can't discuss resident or employee specific issues. Medical provider makes decision about level of care and a team makes other decisions, the Commandant can't override medical doctor's decision. I can't intermingle different level of care patients, unless they are spouses.
- Senator Sodders – PTSD, do you believe it is real? Worley – yes, it is a very serious illness, but I do not believe it is a disorder because that implies something wrong with you. PTSD should be treated aggressively. I believe in all types, not just combat PTSD. I am not aware of another veterans' facility with this level of mental health treatment.
- Senator Sodders – What happened to last 7 vets involuntarily discharged? Worley – One

is in a long term care facility, two are in non-veteran related facilities, one went home, I do not know about the other three.

- Representative Smith – Do you follow turnover rates and are they higher under your leadership? Worley – Turnover is high in all long-term care facilities. I have not seen any drastic increase in turnover. I give an exit interview when someone leaves to discuss issues any issues. I work to provide safe happy work. Any investigation about the commandant would go through DAS, other management level issues go to the commandant. I have had some management level issues that were investigated lately. Legislation did not change care at IVH, we are still a licensed residential care facility.
- Representative Smith – Some wanted to add money to IVH, if IVH has extra money where does it go – Medicaid? Worley – Without language, it does back to DAS. Smith – Then if you are turning back money, how do you explain cutting services for Veterans such as newsletter? Worley – Residents chose to discontinue the newsletter, otherwise it would have been diminished and it was not cut by administration choice.
- Senator Horn – We have heard a lot of testimony regarding bad issues today, but now we hear a different story from you, do you think this issue should be dropped? Worley – Please come spend time at IVH, see motivated happy residents and great care. Ask questions of vets and residents. I do agree that there are some issues to be worked on.

Worley's closing statement. Thank you to all past and current employees. If people have questions come to IVH.

Senator Beall stated there will be a follow up meeting.

Meeting adjourned at 3:55pm.

_____

Senator Daryl Beall

_____

Erica L. Shannon Stueve, Committee Secretary

APPENDIX B

# Compilation of Resident Survey Results

NOTE: **Bolded** responses require a negative answer to be a positive response. The chart reflects positive responses to all questions.

| | 2010 | 2012 | 2013 | 2014 |
|---|---|---|---|---|
| I feel that the choices I make for my life are respected. | 94% | 94% | 91.5% | 92.3% |
| I am satisfied with the nursing care I receive. | 95% | 95% | 92.9% | 93.8% |
| I believe that the recreational activities offered meet my leisure needs. | 87% | 87% | 86.3% | 90.6% |
| **I feel like I am treated like a child.** | 81% | 81% | 87.4% | 88.2% |
| **I do not feel safe at IVH** | 95% | 95% | 93.4% | 93.7% |
| When I suffer loss, I receive the support I need | 94% | 94% | 93.9% | 92.6% |
| I am satisfied with the food served at meals | 84% | 84% | 82.4% | 84.0% |
| I have confidence in my primary care provider. | 94% | 94% | 92.7% | 94.0% |
| I am satisfied with laundry services. | 91% | 91% | 87.3% | 88.0% |
| I have had opportunities to meet my Spiritual needs. | 98% | 98% | 96.8% | 98.6% |
| I am satisfied with the rehabilitation therapy I receive. | 92% | 92% | 90.0% | 86.1% |
| **I fear my health care information is not kept confidential.** | 89% | 89% | 93.3% | 91.8% |
| I am pleased with the variety of snacks I am offered. | 91% | 91% | 92.3% | 90.1% |
| **I do NOT believe the staff listens to me.** | 84% | 84% | 81.4% | 83.5% |
| I am satisfied with the availability of my social worker. | 96% | 96% | 96.2% | 97.6% |
| The staff handling my finances treats me with respect and dignity. | 98% | 98% | 96.7% | 96.8% |
| My mental health provider has helped me cope better. | 85% | 85% | 93.0% | 95.4% |
| My health care needs are addressed in a timely fashion. | 84% | 84% | 83.9% | 83.9% |
| I am satisfied with housekeeping services. | 98% | 98% | 97.0% | 97.0% |
| I believe I am treated with care and consideration. | 96% | 96% | 95.6% | 95.6% |

# APPENDIX C

## Long Term Care Ombudsman Complaint Statistics for the IVH*

| | 2010 | | 2011 | | 2012 | | 2013 | | 2014 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | NF | RCF | NF | RCF | NF | RCF | NF | RCF | NF | RCF |
| Sexual Abuse | | | | | | | | | 1 | |
| Financial Exploitation | | | | | | | | | 1 | |
| Access to Own Records | | | 1 | | | | | | | |
| Discharge/eviction - planning, notice, procedure, implementation, including abandonment | 5 | 7 | 2 | 9 | | 2 | 1 | | | |
| Room assignment, room change, intra facility transfer | 1 | | | | | | | | | |
| Dignity, respect - staff attitudes | 1 | | | | 1 | | 2 | | 1 | |
| Exercise preference/choice and/or civil/religious rights, individual's right to smoke | 1 | | | | | | 2 | | | |
| Exercise right to refuse care/treatment | | | | | | | 1 | | | |
| Participate in care planning by resident and/or designated surrogate | 1 | | 1 | | 1 | | 2 | | 1 | |
| Response to complaints | | | 1 | | | | | | | |
| Reprisal, retaliation | 2 | | | | 1 | | | | | |
| Billing/charges - notice, approval, questionable, accounting wrong or denied (includes overcharge of private pay residents) | | 1 | 2 | | | | | 1 | | |
| Personal property lost, stolen, used by others, destroyed, with-held from resident | | | | | 1 | | | | 1 | |
| Failure to respond to requests for assistance | | | | | 1 | | | | 2 | |
| Care plan/resident assessment - inadequate, failure to follow plan or physician orders | 1 | | | | | | | | 2 | |
| Medications - administration, organization | | | 1 | | 1 | | 2 | | 1 | |
| Personal hygiene (includes nail care & oral hygiene) and adequacy of dressing & grooming | 1 | | 1 | | 1 | | | | 2 | |
| Physician services, including podiatrist | 1 | | | | | | 3 | | 1 | |
| Symptoms unattended, including pain, pain not managed, no notice to others of changes in condition | | | | | | | 1 | | 1 | |
| Toileting, incontinent care | 1 | | | | | | | | | |
| Assistive devices or equipment | 2 | | | | | | 4 | | 2 | |
| Range of motion/ambulation | | | | | | | 2 | | | |
| Physical restraint - assessment, use, monitoring | 1 | | | | | | | | | |
| Activities - choice and appropriateness | | | | | 1 | | 1 | | | |
| Community interaction, transportation | 1 | | | | | | 1 | | | |
| Resident conflict, including roommates | | | 1 | | | | | | | |
| Assistance in eating or assistive devices | | | | | | | | | 1 | |
| Fluid availability/hydration | | 1 | | | | | | | | |
| Food service - quantity, quality, variation, choice, condiments, utensils, menu | 1 | 1 | | | 1 | | | | | |
| Equipment/Buildings - disrepair, hazard, poor lighting, fire safety, not secure | 1 | | 1 | | | | | | | |
| Infection control | 1 | | | | | | | | | |
| Laundry - Lost, condition | | | | | | | 1 | | | |
| Abuse investigation/reporting, including failure to report | | | 1 | | | | | | | |
| Administrator(s) unresponsive, unavailable | 1 | | | | 1 | | | | | |
| Inappropriate or illegal policies, practices, record-keeping | 1 | | | | | | | | | |
| Resident or family council/committee interfered with, not supported | | | | | | | | | 1 | |
| Staff training | | | | | | | | | 1 | |
| Staff unresponsive, unavailable | 1 | | 1 | | | | | | | |
| Legal - guardianship, conservatorship, power of attorney, wills | 1 | | 1 | | 1 | | 3 | | 2 | |
| SSA, SSI, VA, other benefits/agencies | | | 1 | | | | | | | |
| Request for less restrictive placement | | | | | 1 | | 2 | | 3 | |
| | 26 | 10 | 15 | 9 | 12 | 2 | 28 | 1 | 22 | 0 |
| **Total Cases | 18 | | 18 | | 5 | | 14 | | 14 | |

*NF is Nursing Facility RCF is Residential Care Facility. **Cases could include multiple complaints.

APPENDIX D


# IOWA VETERANS HOME

1301 Summit Street
Marshalltown, Iowa 50158-5485
Ph: (641) 752-1501
Fax: (641) 753-4278

Terry E. Branstad, Governor
Kim Reynolds, Lt. Governor
State of Iowa
David G. Worley, Commandant


January 28, 2013

President of the Senate Pam Jochem
Speaker of the House Kraig Paulsen
Iowa Legislative Leadership
1007 E. Grand Ave
Des Moines, IA 50319

Dear President and Speaker,

This report is in response to the Iowa Code 35D.15, Rules Enforced – Power To Suspend and Discharge Members, paragraph 2d which states: Annually, by the fourth Monday of each session of the general assembly, the commandant shall submit a report to the veterans affairs committees of the senate and house of representatives specifying the number, circumstances, and placement of each member involuntarily discharge from the Iowa Veterans Home under this subsection during the previous calendar year.

Edward C. W. – Inappropriate conduct (violence). West Care Facility, Independence, IA

Thomas H. M - Inappropriate conduct. Lexington Place, Keokuk, IA

Guy B. – Refusal to pay bill. Had income he wasn't reporting. Swayze Street, Marshalltown, IA

Leland L. V - Continued substance abuse. Lakeside Village, Penora, Iowa

Sincerely,

David G. Worley
Commandant
Iowa Veterans Home

APPENDIX E


# IOWA VETERANS HOME

1301 Summit Street
Marshalltown, Iowa 50158-5485
Ph: (641) 752-1501
Fax: (641) 753-4278

Terry E. Branstad, Governor
Kim Reynolds, Lt. Governor
State of Iowa
David G. Worley, Commandant


February 25, 2013

Jennifer Acton
Sr. Legislative Analyst
Legislative Services Agency
Ola Babcock Miller Building
515-281-7846
Fax: 515-281-6625

Dear Jennifer:

Here are the administrative separation listings for calendar year 2010 and 2011.

**From 1/1/2010 through 12/31/2010 (what we reported for 2011)**

| Name | Date of Separation | Reason for Discharge | Re-Location Site |
|---|---|---|---|
| Henry M. H. | 1/5/2010 | Administrative | Marshalltown, Iowa |
| Craig A. K. | 4/2/2010 | Administrative | Mason City, Iowa |
| Jeffrey D. C. | 4/6/2010 | Administrative | Morgantown, W.V. |
| James M. G. | 6/23/2010 | Convicted of a crime | Marshalltown, IA |
| Jacob C. K. | 7/14/2010 | Administrative | Marshalltown, IA |
| Rockford J. B. | 9/28/2010 | Convicted of a crime | Marion Illinois |
| Markin C. A. | 4/15/2010 | Administrative | Des Moines, IA |

**From 1/1/2011 through 12/31/2011 (what we reported for 2012)**

| Name | Date of Separation | Reason for Discharge | Re-Location Site |
|---|---|---|---|
| Darwin M.L. | 6/19/2011 | Administrative | Marshalltown, IA |
| David A. H. | 2/25/2011 | Administrative | Marshalltown, IA |

# APPENDIX F

**IOWA VETERANS HOME**
1301 Summit Street
Marshalltown, Iowa 50158-5485
Ph: (641) 752-1501
Fax: (641) 753-4278

Terry E. Branstad, Governor
Kim Reynolds, Lt. Governor
State of Iowa
Jodi S. Tymeson, Commandant

January 21, 2014

House Veterans Affairs Committee
ATTN: Rep. Dwayne Alons, Chair
State Capitol
Des Moines, IA 50319

Dear Committee Members:

1. This report is made in order to comply with the following Administrative Rule:

**801-10.43(6)** *By the fourth Monday of each session of the general assembly, the commandant shall submit a report annually to the senate veterans affairs committee and the house veterans affairs committee specifying the number, circumstances and placement of each member involuntarily discharged from IVH under this rule during the previous calendar year.*

2. During Calendar Year 2013, there were 2 administrative (involuntary) discharges from the Iowa Veterans Home.
    a. One resident was discharged 01/17/2013 for unsafe smoking. This resident discharged to a nursing care facility in Waterloo.
    b. One resident was discharged 02/07/2013 for non-payment for care. This resident discharged to an apartment in West Des Moines.
3. Please contact my office at 641-753-4309 if you have questions or need additional information. I can also be reached by email at Jodi.tymeson@ivh.state.ia.us.

Jodi S. Tymeson, Commandant
Iowa Veterans Home

APPENDIX G

## DISCHARGES FROM IOWA VETERANS HOME

| | |
|---|---|
| **2010** | |
| **VOLUNTARY DISCHARGES** | **58** |
| Reason for Discharge: | |
| Discharge to community/family | 45 |
| Discharge to another facility | 11 |
| Discharged to jail | 1 |
| Chose to continue education/find work | 1 |
| **INVOLUNTARY DISCHARGES** | **10** |
| Reason for Discharge: | |
| Continued alcohol abuse | 7* |
| Discharged to jail | 1* |
| Behavior | 1* |
| Non-compliance w/treatment plan | 1* |
| **APPEALS** | **2** / 1 withdrawn |
| **2011** | |
| **VOLUNTARY DISCHARGES** | **31** |
| Reason for Discharge: | |
| Discharge to community/family | 19 |
| Discharge to another facility | 12 |
| **INVOLUNTARY DISCHARGES** | **35** |
| Reason for Discharge: | |
| No longer met level of care | 30** |
| Non-compliance w/treatment plan | 4* |
| Behavior | 1* |
| **APPEALS** | **1** |
| **2012** | |
| **VOLUNTARY DISCHARGES** | **22** |
| Reason for Discharge: | |
| Discharge to community/family | 16 |
| Discharge to another facility | 6 |
| **INVOLUNTARY DISCHARGES** | **3** |
| Reason for Discharge: | |
| Continued alcohol abuse | 1* |
| Behavior | 1* |
| Non-compliance w/financial policies | 1* |
| **APPEALS** | **0** |

***These residents received the standard 30-day involuntary discharge letter that outlines their specific reason for discharge.**

**** All residents in the Residential Care Facility (Heinz Hall) received the attached letter dated October 29, 2010. The assigned care teams, of those residents who no longer met the level of care, worked through a discharge plan that may have been longer than the standard 30-day involuntary discharge process. These residents did not receive an individual discharge letter.**

APPENDIX H

# Iowa Veterans Home

## Interoffice Memo

**Date:** October 29, 2010

**To/Office:** Residential Level of Care Residents

**From/Office:** David Worley, Commandant

**Subject:** Discharge Plans

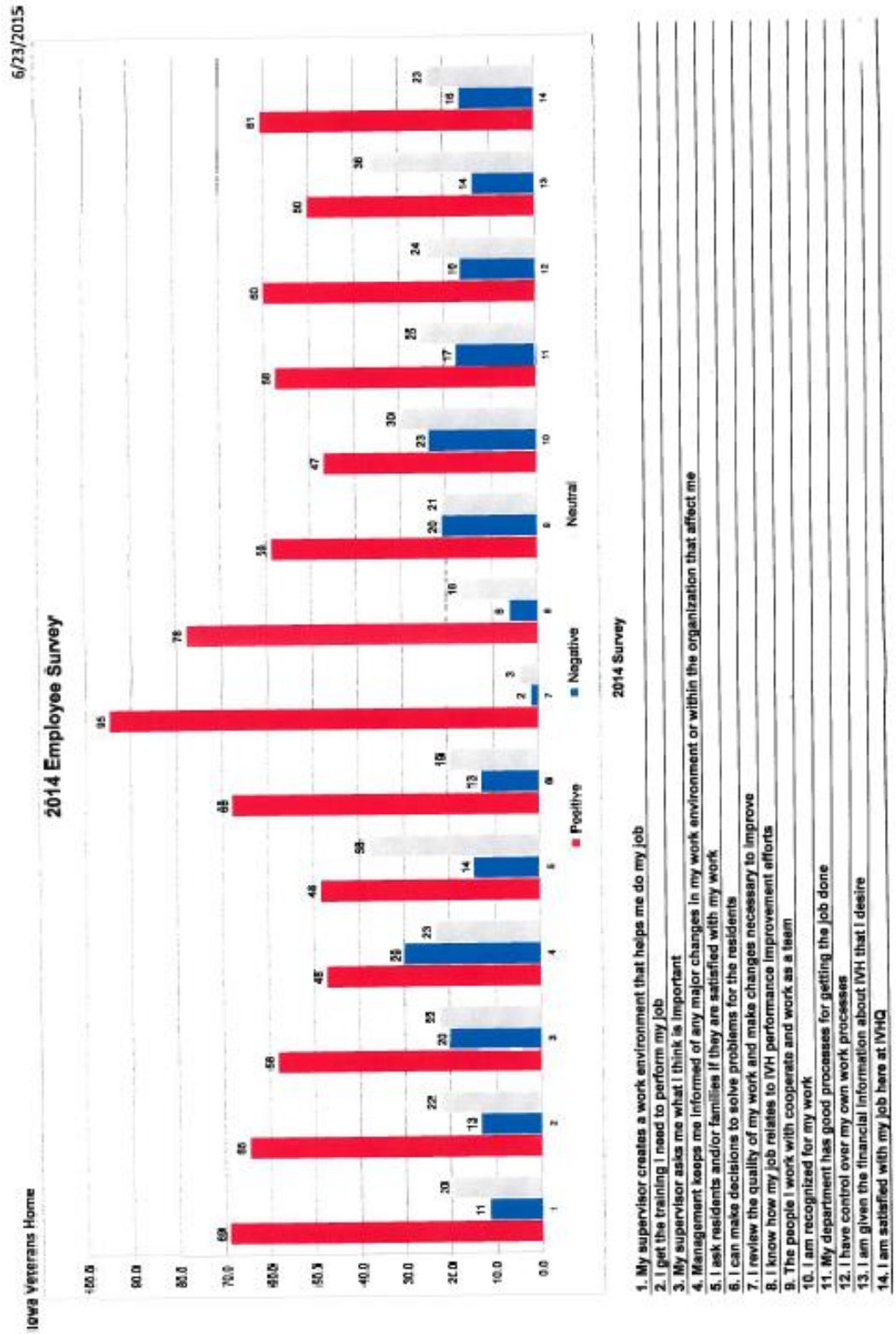
This is to inform you that after assessing our resident population it is clear there are residents at the residential level of care who no longer require these services. In light of this, I am informing you that your IRCC team will be working with you to evaluate your level of need and to assist you in making discharge plans appropriate to your situation.

> Section 35D.15, of the Iowa code reads "*The commandant shall, with the input and recommendation of the interdisciplinary resident care committee, involuntarily discharge a member for any of the following reasons: (3) The member's medical or life skills needs have been met to the extent possible through the services provided by the Iowa veterans home and the member no longer requires a residential or nursing level of care, as determined by the interdisciplinary resident care committee.*"

I realize some of you will be anxious about transitioning back into the community. I encourage you to take advantage of the services being offered to help you make this move. I assure you that we will do everything we can to assist you with developing a discharge plan that meets your needs.

Undoubtedly, you will have questions and/or concerns that need addressed. Your social worker and primary nurse are good resources as is Susan in Heinz Hall or Randy in Resident and Family Services. Let them know how they can be of assistance. If you have further questions, you can contact the Adjutant or Commandant.

# APPENDIX I


6/23/2015
Iowa Veterans Home
2014 Employee Survey
Positive
Negative
Neutral
2014 Survey
1. My supervisor creates a work environment that helps me do my job
2. I get the training I need to perform my job
3. My supervisor asks me what I think is important
4. Management keeps me informed of any major changes in my work environment or within the organization that affect me
5. I ask residents and/or families if they are satisfied with my work
6. I can make decisions to solve problems for the residents
7. I review the quality of my work and make changes necessary to improve
8. I know how my job relates to IVH performance improvement efforts
9. The people I work with cooperate and work as a team
10. I am recognized for my work
11. My department has good processes for getting the job done
12. I have control over my own work processes
13. I am given the financial information about IVH that I desire
14. I am satisfied with my job here at IVHQ

# COMMANDANT JODI S. TYMESON'S REPLY


**IOWA VETERANS HOME**
1301 Summit Street
Marshalltown, Iowa 50158-5485
Ph: (641) 752-1501
Fax: (641) 753-4278

Terry E. Branstad, Governor
Kim Reynolds, Lt. Governor
State of Iowa
Jodi S. Tymeson, Commandant


December 2, 2015

Ruth H. Cooperrider, Ombudsman
Office of Ombudsman
Ola Babcock Miller Building
1112 E. Grand Avenue
Des Moines, IA 50319

Dear Ombudsman Cooperrider:

I received a copy of your investigative report regarding the Iowa Veterans Home dated November 12, 2015.

I would like to thank you and your staff for the time and attention you dedicated to the investigation of concerns raised regarding the care, health, and safety of residents at the Iowa Veterans Home. In addition, I appreciate your thorough review of our involuntary discharge process. The information you provided can only serve to help us continue to improve our operations.

I do not disagree with any material findings of fact or conclusions in your report.

You included one recommendation in your report:
*The Ombudsman recommends that the IVH, when feasible, include residents in the decision-making process on matters affecting their programs and services, either through representation on committees or through consultation with the executive committee of the Resident Council.*
I first want to outline all the ways a resident can currently provide input:

1. Individual interdisciplinary care team, to include social worker, nursing team, medical provider, recreation therapist, dietician, chaplain
2. Commandant's open door policy
3. Commandant's suggestion box
4. Commandant "rounds"
5. Resident Council – Senior Administration Staff always attend and speak when invited.
6. Commandant and her Administrative Assistant serve as the Resident Council liaisons.
7. Resident Food Council

I do believe this is a sound recommendation and will work to implement additional avenues for residents to provide input into matters that affect their programs or services. We will first explore adding resident members to the IVH Safety Committee, as this committee typically doesn't discuss confidential information.

Again, thank you for your thorough investigation into the concerns reported to your office.

Jodi S. Tymeson

Jodi S. Tymeson, Commandant