Iowa Department of Inspections and Appeals
Assisted Living Program
Complaint Investigation Report

Assisted Living Program: **Complaint Intake #:** 7995

Nancy Ketchum, Administrator
Riverview Terrace
1301 St. Luke Drive
Spencer, IA 51301

Date of Investigation:

September 30, 2004

Monitor(s):

Jan O'Briant, LISW

Definitions:

The following definitions are relevant:

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

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may re-visit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Riverview Terrace on September 30, 2004. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP) **– A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.**

Current number of tenants without cognitive disorder:	57
Current number of tenants with cognitive disorder:	8
Total General Population:	65

Dementia Specific Program (DSP) **–** Not applicable.

Accreditation Status – Not applicable.

Complaint History – There were no substantiated complaints this certification period.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Evaluation of Tenant - The program evaluates each tenant's functional and cognitive abilities and health status and the determination of needed services as required. [321 IAC 25.23(1) and/or (2)]

- Monitoring Observation: During the course of the investigation, it was noted the program did not formally evaluate Tenant #1 within 30 days of admission or as needed with status change following hospitalizations. When Tenant #1 returned to the program July 28 and September 16, the program did not formally reevaluate the tenant's cognitive, functional and health status as required.

- Regulatory Insufficiency: The program did not formally evaluate the tenant within 30 days of admission or with status change.

B. Service Plan – Program has an individualized service plan developed and updated for each tenant as required. [321 IAC 25.28]

Complaint Allegation: It is alleged the program did not address the emotional health needs of a tenant who subsequently left the program and committed suicide off-site.

Monitoring Observation**:** The complaint investigation involved interviews with the program administrator, RN, caregiver and local sheriff's deputy. The tenant's record was also reviewed.

Tenant #1, an 82-year-old married tenant, was admitted to the program on July 6, 2004. At admission, tenant had diagnoses of Recurrent Bowel Obstruction with a colostomy, Congestive Heart Failure, Hypertension, Hypothyroidism, Chronic Obstructive Pulmonary Disease, Pleural Effusions, History of Hernia Repair, and Anemia and was hard of hearing. The tenant's spouse has a diagnosis of dementia and resides in a long-term care facility in Spencer.

A preliminary service plan based on assessments of cognitive, functional and health status was developed prior to admission on July 2, 2004. The assessments showed no cognitive impairment and a high level of functionality despite the above noted health problems. At admission, the program staff provided the following personal and health-related care: weekly medication set-up, assistance with Ted hose and minimal assistance with bathing. The tenant managed tenant's own colostomy and managed tenant's diabetes care. Tenant also took the responsibility of weighing self daily and kept track of tenant's weight on a calendar in tenant's apartment. Tenant did not request night checks by staff. The tenant had signed a DNR document, had a Living Will and had designated tenant's daughter as tenant's DPOA.

Tenant #1 was hospitalized for physical ailments at the Veterans Administration Hospital in Sioux Falls, SD from July 23, 2004 to July 28, 2004. Tenant returned to the program on July 29th and was rehospitalized for physical ailments at the VA Hospital from August 7 to September 16 and again returned to live at the program after receiving therapies at the VA Transitional Care Unit. It was after this second hospitalization, records show the tenant's discontinued request for assistance with tenant's Ted hose.

On the night of Saturday, September 25, the tenant left the program and drove tenant's own car to a location on the property tenant farmed and committed suicide by hanging

from a bridge. The tenant signed out of the program from 11:00 am to about 1:30 pm on that Saturday and was visited by tenant's daughter in the evening. She reported tenant was in good spirits and she left about 9:30 pm. It is believed by law enforcement that the tenant left the program between 11:00 pm and 12:00 midnight and drove alone to the bridge. Death is estimated to have occurred between 11:30 pm and 12:00 am.

Staff #1, a Personal Service Aide, interviewed during the investigation was a neighbor and had known the tenant for many years. This staff reported the tenant was happy with the services provided at the program and was very appreciative of the care tenant received. Tenant did not exhibit signs and symptoms of depression. Although tenant was not close to other tenants, tenant was reported to be friendly and talkative with peers during mealtimes. The tenant visited tenant's spouse regularly at the long-term care facility and took spouse out to eat on Sundays.

It is noted by the RN that tenant's weight was 195 lbs. upon return to the program on September 16 and again on September 20. According to the program RN, tenant's weight had increased to 204 lbs. by September 25, indicating tenant was retaining fluid due to tenant's Congestive Heart Failure. The tenant was scheduled to return to the VA Hospital on Monday, September 27 for treatment of fluid retention.

Investigation reveals the tenant did not exhibit depressive symptoms and did not give any clues to family or to staff that tenant was suicidal. Tenant had continued tenant's usual activities and routine prior to tenant's death. It was reported by those interviewed that tenant frequently voiced tenant's appreciation of the care tenant received at the program. It appears tenant knew tenant's health would not improve and tenant told staff tenant did not want to return to the VA Hospital on September 27 for further treatment. The caregiver interviewed stated, "If you knew the tenant, it makes sense".

At the time of discharge from the VA on September 16, the tenant was prescribed an antidepressant medication, Fluoxitine 20 mg. QD. It is noted on tenant's medication profile tenant refused to take this medication because tenant said it made tenant ill. The investigator found no documentation that the tenant had ever been prescribed antidepressant medication prior to September 16.

The investigator noted that on September 16, changes were made to the tenant's service plan of the tenant's request to discontinue assistance with Ted hose needs. Staff wrote this change on the existing service plan and a nursing note was written upon the tenant's return to the program. Staff and tenant did not develop a new service plan addressing all requests for assistance and did not obtain the required three staff and tenant signatures.

- Regulatory Insufficiency: The program did not formally update the tenant's service plan within 30 days of occupancy or with status change as required.

- Regulatory Insufficiency: The program did not obtain the required three staff signatures and tenant signature on the service plan update.

Dated this 19th day of October, 2004.