IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

December 8, 2008

Complaint #20489-I

Jim Wallace, Administrator
Afton Oaks Assisted Living Program
405 9th Street
Elma, IA 50628-8376

RE: Complaint Investigation Report, Afton Oaks, Elma, IA

Dear Mr. Wallace:

The Department of Inspections and Appeals (DIA) has reviewed your Request for Reconsideration in response to the **Complaint Investigation Report** and denies the Request for Reconsideration as it relates to Nurse Review The Program Manager did not notify the Registered Nurse when the tenant made the comment to her denoting suicidal ideation. The Plan of Correction is accepted.

The program displayed prompt action to correct the identified Regulatory Insufficiency The Department's findings must be based on the current situation, including but not limited to: staff interviews, documentation, monitor observation and tenant interviews.

We thank you and your staff for your cooperation in the investigation of this Complaint. If you have any questions, please contact me at 515-281-5003

Sincerely,
Connie Schaffer

Connie Schaffer
Certification Coordinator – Central Iowa
Health Facilities Division
Adult Services Bureau

Enclosure

Iowa Department of Inspections and Appeals
Assisted Living Program
Final Incident Investigation Report

Assisted Living Program: **Incident Intake #20489-I**

Jim Wallace, Administrator
Afton Oaks Assisted Living Program
405 9th Street
Elma, IA 50628-8376

Date of Investigation:

November 6, 2008

Monitor(s):

Hal L. Chase, RN BSN MPH

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 revisit 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:

An incident investigation on-site visit was conducted at Afton Oaks Assisted Living Program on November 6, 2008. 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	11
Current number of tenants with cognitive disorder	0
Total Population:	11

Dementia Specific Program (DSP)* – Not applicable.

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Program History – There have been no substantiated Regulatory Insufficiencies during the certification period.

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

A. Nurse Review - Program provides a registered nurse to ensure the appropriate administration and documentation of medications, ensure that physician orders are current, and assess and document the tenants' health related activities. [321 IAC 25.30]

Incident Allegation: The Program reported Tenant #1 attempted to cut his/her wrist multiple times because he/she wanted to die.

- Monitoring Observation: Tenant #1, an 81 year old, was admitted on 7-1-08 and has diagnoses of: Coronary Artery Disease with History of Myocardial Infarction, Carotid Artery Disease, Dyslipidemia, Chronic Obstructive Pulmonary Disease, Hypertension, History of Renal Insufficiency, History of Flash Pulmonary Edema, Hiatal Hernia, Cataracts and Urinary Retention.

  Nurse's notes of 10-20-08 at 2:00 p.m. indicated the tenant left his/her apartment looking for the Program Manager in the nursing facility adjacent to the program. The tenant stated "I'm ready to die, I'm tired of living with asthma." The Program Manager asked the tenant about his/her nebulizer and if he/she needed another nebulizer treatment. The tenant stated the nebulizer treatments work for about 20 minutes and would ask the nurse for a treatment. Nurse's notes of 10-20-08 stated, "The tenant's comment to me of being ready to die, I [Program Manager] did not think was a suicide statement."

  Nurse's notes of 10-20-08 at 3:05 pm indicated the Manager checked on the tenant, in the tenant's apartment and asked the tenant how he/she was doing. The tenant responded "Look at this." The manager observed the tenant had cut marks on his/her left wrist. The manager asked the tenant what had happened. The tenant stated " I cut myself because I want to die." The manager took the box cutter, knife and scissors from the kitchen counter and immediately contacted the Director of Nursing. The Manager stayed with the tenant until nursing staff arrived. Hospital physician's consultation of 10-20-08 indicated the tenant was seen for a self inflicted cut to the left wrist.

  Nurse's notes of 10-20-08 at 3.21 pm indicated the Registered Nurse (RN) spoke with the tenant's daughter and related the tenant's comments about wanting to die. The daughter indicated the tenant had been saying this for two weeks. The RN told the daughter this information should have been relayed to staff and the program could have contacted the tenant's physician. Nurse's notes of 10-20-08 at 4.10 pm indicated hospital staff informed the program the tenant was transferred for a psychiatric evaluation. The RN and program manger confirmed and provided written statements of the events recorded in the nurse's notes. The RN stated the tenant had not returned to the program but plans were in place to discharge the tenant from assisted living and place the tenant in a nursing facility

- Regulatory Insufficiency: The program did not assess and document the health status of each tenant, make recommendations and referrals as appropriate, and monitor progress on previous recommendations at least every 90 days or if there are changes in health status. 25.30(3)

Dated this 4th day of December, 2008.