IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

April 8, 2010

Incident #27057-I

Kathleen Jacobsen, Manager
Cottage Grove Place
2115 1st Ave SE
Cedar Rapids, IA 52402-6353

RE: Final Incident Investigation Report, Cottage Grove Place, Cedar Rapids, IA

Dear Ms. Jacobsen:

Enclosed is the **Final Incident Investigation Report** completed by the Department of Inspections and Appeals (DIA) in accordance with Iowa Code section 231C.7 (2009) and Iowa Administrative Code, chapters 481 – 67 and 69. **No Regulatory Insufficiencies were identified.**

If you have questions, please contact me at 515-281-4116.

Sincerely,

Chris Nothaft
Certification Coordinator – Eastern Iowa
Adult Services Bureau

Enclosure

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

Assisted Living Program: **Incident Intake #: 27057-I**

Kathleen Jacobsen, Manager
Cottage Grove Place
2115 1st Ave SE
Cedar Rapids, IA 52402-6353

Date of Incident Investigation:

March 31 and April 1, 2010

Monitor(s):

Joyce Kix, RN

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. IAC r. 481-67.10(5). 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 an Incident 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 481 IAC - chapter 69 that: serves fewer than fifty-five (55) tenants and has five (5) or more tenants who have dementia between Stages 4 and 7 on the Global Deterioration Scale or serves 55 or more tenants and 10 percent or more of the tenants have dementia between Stages 4 and 7 on the Global Deterioration Scale or holds itself out as providing specialized care for persons with dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

An on-site visit was conducted at Cottage Grove Place on March 31 and April 1, 2010. 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:	15
Current number of tenants with cognitive disorder:	3
Total Population:	18

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.**

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

On-Site Monitoring Evaluation – The monitor(s) made the observations detailed in the following areas.

A. Other

Incident Allegation: The program reported on 1-12-10 that staff identified Tenant #1's bubble pack containing Lortab, 2.5/500 milligrams (mg), had evidence of tampering and two tablets were found loose in the drawer. Closer observation revealed that eight tablets had been removed, replaced with a similar looking tablet and taped over.

- Monitoring Observation: Tenant #1, 91 years old, was re-admitted on 9-21-09 following a hospital stay. Diagnoses include: Trans Cerebral Ischemia, Anxiety, Depression, Hypertension, Chronic Obstructive Pulmonary Disease, Osteoarthritis, Convulsions, and Anemia. The cognitive assessment dated 2-2-10 indicated the tenant was cognitively intact. The service plan dated 2-2-10 documented the program provided medication management for the tenant. The medication, Hydrocodone, was ordered by the physician on an as needed basis and the tenant did not request the medication frequently.

  The incident investigation completed by the program included documentation of interviews with all staff with no information discovered. The program had released two of Tenant #1's bubble packs of Hydrocodone to the police for fingerprinting. One fingerprint was isolated, but the police did not correlate this to a perpetrator.

  According to the program manager, a time of the misappropriation could not be pinpointed and multiple staff had opportunity and access to the medication box. Prior to the loss, the program did not document the count of the narcotics.

  According to the staff schedule, approximately 23 staff members had access to the keys to the narcotic box and had worked during the months of December 2009 through January 12, 2010, when the loss was discovered.

  The monitor was unable to identify a perpetrator. The program did not complete random drug testing at the time of the loss. The program reported the medication loss to the Department appropriately.

- Regulatory Insufficiency: None noted

Dated this 8th day of April, 2010.