IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

June 24, 2009

Incident #23147-I

Janet Mau, Administrator
Petersen Commons
1607 W 12th St.
Davenport, IA 52804-4086

RE: Incident Investigation Report, Petersen Commons, Davenport, IA

Dear Ms. Mau:

The Department of Inspections and Appeals (DIA) has reviewed the Plan of Correction (POC) in response to the Incident Investigation Report dated May 12 & 14, 2009. Based on the information provided, DIA accepts the POC. No further action on the part of the program is necessary.

We appreciate your prompt action in correcting the Regulatory Insufficiency. If you have questions, please contact me at 515-281-4116.

Sincerely,

Chris Nothaft
Certification Coordinator – Eastern Iowa
Adult Services Bureau

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

Assisted Living Program:

Incident Intake #: 23147-I

Janet Mau, Administrator
Petersen Commons
1607 W 12th St.
Davenport, IA 52804-4086

Date of Incident Investigation:

May 12 & 14, 2009

Monitor(s):

Stephanie Cummins, MA

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 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 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 on-site visit was conducted at Petersen Commons on May 12 & 14, 2009. 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:	38
Current number of tenants with cognitive disorder:	3
Total Population:	41

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 was a substantiated Regulatory Insufficiency this certification period in the area of Nurse Review.

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

A. Medications – Program has a comprehensive written medication policy that allows tenant self-administration, but accommodates the need for tenant medication assistance via nurse delegation. The medication assistance is appropriately supervised and administered. Medications are appropriately stored. [231C.16A]

Incident Allegation: It was reported by the program that the PRN narcotics box was removed from the locked cabinet in the unlocked nurse's station between 3:00 p.m. on 4-14-09 and 8:10 a.m. on 4-15-09. It was reported the box contained 64 pills divided into 4 cassettes of 16 pills each.

Monitoring Observation: The nurse indicated, before the incident, there were four cassettes of narcotics in the lock box and the narcotic box was a portable steel cash type box that had one key and was locked at all times. This box was kept in a cupboard that was locked at all times and the key for the lock box was kept in a key holder within the locked cupboard. The cupboard is located in the nurse's office and at the time the lock box came up missing the nurse's office was not always locked when unoccupied. All the CNA's and the nurse have keys to the cupboard. The nurse last saw the narcotic box on 4-14-09 at 4:00 p.m. when she checked the medication supply. The next morning when the nurse arrived, she opened the cupboard and reached for the lock box on the top shelf and it was not there. The key for lock box was still in the holder. The nurse and staff searched for the lock box and it was not found. The nurse called the second and third shift staff and asked them what they might remember about getting narcotics or if any non-staff people were in the building the previous day. The Administrator was then notified as were the police. The nurse reported the police arrived and looked at the cupboard. When the police officer saw the lock he stated it would be very difficult to get anyone in the police department interested in investigating because almost any key could open the lock. The police officer demonstrated this by using a key on his key chain which opened the lock easily. The nurse reported that after she discovered the lock box was missing she heard from staff that other keys would open the cupboard and not just the key designed to open it. The nurse indicated in the course of her investigation she discovered most, if not all, of the CNA's knew that other keys would work in the lock on the cupboard. Staff stated this had been brought to the attention of maintenance staff and the previous nurses.

The Administrator stated when she was notified of the missing narcotic box she called her supervisor, the police department, DIA, ASB staff and the pharmacy. The pharmacy billed the program for the missing medications.

Staff #1, #2, #3, #4, #5, #6 and #7 were interviewed. These staff worked on first, second and third shift on 4-14-09, when the PRN narcotic box was last seen. It could not be determined from interviews with these staff, the nurse or the Director what happened to the PRN narcotic box. Staff #1, #2, #3, #4 and #5, all CNA's, knew that a key other than the key designed for the medication cabinet opened the cabinet. The monitor and the Administrator went to two unoccupied tenant apartments to determine if the locks on the medication cabinets in the individual apartments could be opened with a key not designed to open them and the Administrator was able unlock the medication cabinets in both apartments.

Pharmacy records show 32 tablets of Propoxy-N and 32 tablets of Endocet were replaced by the pharmacy.

Tenant #1, a 73 year old, was admitted on 8-25-07 and diagnoses include: Congestive Heart Failure (CHF), Hypertension (HTN), Neuropathy, Non Hodgkin's Lymphoma and Cerebral Vascular Accident (CVA). According to the tenant's service plan, the tenant received program assistance with medication administration. The tenant had an order for Propoxy-N, one to two tablets by mouth every six hours, as needed (PRN), for pain.

Tenant #2, a 72 year old, was admitted on 10-31-08 and diagnoses include: Fatigue, Malaise, Atrial Fibrillation and L4 Compression fracture. According to the tenant's service plan, the tenant received program assistance with medication administration. The tenant had an order for Endocet 5/325 tablet, one tablet to be taken by mouth every eight hours for pain.

The nurse reported within two days of the incident a small safe was installed that is bolted through the back of the cabinet and into a concrete wall. There is only one key to the safe and it is kept in the key holder and only the nurse knows where it is. The lock on the cupboard was changed but the nurse was not satisfied with the lock and a new lock was installed on 5-11-09. The nursing office is now locked, on all shifts, whenever it is unoccupied.

- Regulatory Insufficiency: The program did not consistently provide the administration of medications by an Iowa-licensed registered nurse or advanced registered nurse practitioner registered in Iowa or the authorized agent in accordance with 655-subrule 6.2(5) and 655-subrule 6.3(1) and Iowa Code chapter 155A and in executing the medication regimen as prescribed by the physician, the registered nurse shall exercise professional judgment in accordance with minimum standards of nursing practice as defined in these rules. (25.29(a)), 655-6.2(5)(e)(152)

Dated this 24th day of June, 2009.