IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

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GOVERNOR

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RODNEY A. ROBERTS, DIRECTOR

**Incident Intake #: 34402-I**

July 25, 2011

Mr. Gary Troth, Administrator
Northern Hills Assisted Living
4002 Teton Trace
Sioux City, IA 51104

**RE: Final Incident Investigation Report – Northern Hills Assisted Living, Sioux City, IA**

Dear Mr. Troth:

Enclosed is the **Final Incident Investigation Report** from the on-site monitoring visit of July 14, 2011, completed by the Department of Inspections and Appeals ("DIA") in accordance with Iowa Code chapter 231C and Iowa Administrative Code ("IAC") chapters 481—67 and 481—69. **No Regulatory Insufficiencies were identified.**

If you have any questions regarding the enclosed Report, please contact me at 515/281-4116.

Sincerely,

*Jim Berkley*

Jim Berkley
Program Coordinator
Adult Services Bureau

Enclosure

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

**Assisted Living Program:** **Incident Intake #:** 34402-I

Gary Troth, Administrator
Northern Hills Assisted Living
4002 Teton Trace
Sioux City, IA 51104

**Date of Incident Investigation:**

July 14, 2011

**Monitor(s):**

Lori Miner, RN BSN

**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 Northern Hills Assisted Living on July 14, 2011. 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: | 66 |
| Current number of tenants with cognitive disorder: | 2 |
| Total Population: | 68 |

***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.**

**Tenant/Family Satisfaction Results** – A tenant meeting was not held.

**Program History** – The program received a regulatory insufficiency in the area of service plan during this certification period.

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

**A. Criteria for exclusion of tenant:**

Incident Allegation: It was reported Tenant #1 eloped from the program.

- Monitoring Observation: Tenant #1 (the Tenant), an 85 year-old, was admitted on 9-4-10 with diagnoses of: Vascular Dementia, Hypertension, Chronic Renal Failure, and Hyperlipidemia. The Tenant was staged at four on the Global Deterioration Scale which indicated moderate cognitive decline. The program reported to the department on 6-6-11 that the Tenant had eloped from the program on 6-5-11, a Sunday. On 6-5-11, around 4:00 p.m., the Tenant was noted to be sitting in a lounge chair just outside the front doors of the building. It was noted the Tenant frequently sat outside. At approximately 4:45 p.m., the Tenant was not seen outside. On the way to the Tenant's apartment, staff received a phone call from the Tenant's family which indicated the Tenant was two to three blocks away at a care center. The family member had received a phone call from a friend that worked at the care center. The family returned the Tenant to the program. A review of the resident care notes from 9-5-10 to 6-7-11 revealed no documentation of any other elopements or any exit-seeking behavior. The notes indicated the Tenant enjoyed visiting with other tenants, and would often sit near the fireplace, a common area, to crochet. The evaluations and service plan did not indicate any concerns with behavior or exit-seeking. The notes indicated the family stayed with the Tenant after the elopement and every 30-minute checks were started. The service plan indicated the Tenant was independent with eating, mobility and transfers, and toileting. The Tenant needed reminders for bathing and grooming, and staff administered medications. The Nurse Review dated 5-20-11 indicated the Tenant enjoyed being outside and there were no concerns.

An interview was conducted with Staff #1 who was working at the time of the elopement. Staff #1 noted the Tenant sitting outside at 3 p.m. and 4 p.m. While walking to the Tenant's apartment, he received a phone call from the Tenant's family indicating the Tenant had left the building and had walked to another facility. The Tenant was returned to the Program by family. Staff #1 indicated the Tenant did not appear to have any injuries upon return. Staff #1 reported the incident to the Program Nurse. Staff #1 requested the family stay with the Tenant throughout the night, which the family did. Every half-hour checks were instituted the following day. Staff #1 indicated the Tenant had never left the program before. Since the weather had warmed, the Tenant frequently sat outside.

An interview was conducted with Staff #2 who was also working at the time of the elopement. Staff #2 indicated at the beginning of her shift the Tenant was sitting in the lobby. Staff #2 also indicated the Tenant sat outside. The Tenant had never attempted to leave before. Staff #2 noted the Tenant had complained of a toothache in the month prior to the elopement, but was fine the day the incident occurred. The Tenant did not appear to be harmed in any way after returning to the program. Staff #2 indicated the Tenant was appropriately dressed, including shoes. The family stayed with the Tenant until bedtime. The family returned the next day.

An interview was conducted with Staff #3, whose shift ended at 3:00 p.m. just prior to the elopement. Staff #3 indicated the Tenant did not require much care. The Tenant was awakened for breakfast, and needed reminders as to the location of crochet needles. The Tenant would often sit by the fireplace to crochet. The Tenant would sometimes go outside and then come back in. Staff #3 noted no recent changes to the Tenant's behavior and described the Tenant as "usual self." Staff #3 indicated the Tenant had never left the building before.

An interview was conducted with Staff #4, the Nurse. The Nurse described the Tenant as independent with ambulation and required minimal cueing for personal cares. The Nurse reported having no concerns about the Tenant leaving the building unattended. The Tenant frequently sat outside and would always come back in. The Tenant spent the majority of time in common areas, visiting with others, reading the newspaper, and crocheting. The Nurse reported last seeing the Tenant the Friday before the incident. The Nurse had no concerns at that time, and noted no changes in the Tenant's behavior. The Nurse noted no signs of physical harm on the day after the event.

The incident was appropriately reported to the department within 24 hours. The Tenant was transferred to a higher level of care on 6-7-11.

- Regulatory Insufficiency: None noted.

Dated this 22nd day of July, 2011.