IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
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GOVERNOR

KIM REYNOLDS
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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
48413-C
48205-C
48206-I

December 12, 2014

Ms. Stephanie Johnson, Manager
Northern Hills
4002 Teton Trace
Sioux City, IA 51104

RE: Final Complaint/Incident Investigation Report, Northern Hills, Sioux City, Iowa

Dear Ms. Johnson:

Enclosed is the **Final Complaint/Incident Investigation Report** 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, following an investigation by DIA on **December 1 and 2, 2014.** The Report notes Regulatory Insufficiencies in the area(s) of: Evaluation of Tenant, Service Plans and Nurse Review.

Each Regulatory Insufficiency requires that the Program submit a written Plan of Correction (POC).

In preparing the POC, please use the tenant identifiers from the Report, i.e. Tenant #1, when reference is made to specific tenants. If your response includes a specific tenant's assessment or service plan, it is the Program's responsibility to conceal the tenant's name in order to maintain the tenant's anonymity. Your response shall include the following:

1. Elements detailing how the Program will correct each regulatory insufficiency.
2. What measures will be taken to ensure the problem does not recur.
3. How the Program plans to monitor performance to ensure compliance.
4. The date by which the regulatory insufficiency will be corrected.

Please note that all regulatory insufficiencies must be **corrected within 30 days of the date of the exit conference**; however, there may be situations where the timeframe may be shortened or lengthened, at the discretion of the department.

The POC must be submitted/emailed to DIA to my attention within ten (10) working days of receipt of this letter. It may be necessary for DIA to revisit the Program to confirm progress in fulfilling the POC's corrective measures.

As provided by IAC rule 481-67.14, you are afforded one opportunity to refute cited regulatory insufficiencies through the informal conference process. A request for an informal conference must be made within 20 working days of the notice or service of this letter and the final report. Please refer to rule 67.14 for more information.

An investigation was completed for Complaint # 48205-C and Incident #48206-I which alleged Tenant Rights issues related to a tenant injury. Tenant rights violations were not substantiated.

An investigation was completed for Complaint #48413-C which alleged a Nurse Review was not completed to determine tenants exceeded criteria for admission, alleged initial Evaluations were not completed by a registered nurse, alleged Service Plans were not completed upon admission, and alleged bed bugs may have been present at the program. The complaint was not substantiated. While the complaints were not substantiated, other regulatory insufficiencies were identified during the course of the investigation.

If you have any questions in regard to the enclosed Report, please contact me at 515/281-7039 or **Rose.Boccella@dia.iowa.gov**

Sincerely,

Rose Boccella

Rose Boccella
Program Coordinator
Adult Services Bureau

Enclosure

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0058	A BUILDING: _____ B WING _____	C 12/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN HILLS	4002 TETON TRACE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 036	481-69.22(1) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(1) Evaluation prior to occupancy. A program shall evaluate each prospective tenant ' s functional, cognitive and health status prior to the tenant ' s signing the occupancy agreement and taking occupancy of a dwelling unit in order to determine the tenant ' s eligibility for the program, including whether the services needed are available. The cognitive evaluation shall utilize a scored, objective tool. When the score from the cognitive evaluation indicates moderate cognitive decline and risk, the Global Deterioration Scale shall be used at all subsequent intervals, if applicable. If the tenant subsequently returns to the tenant ' s mildly cognitively impaired state, the program may discontinue the GDS and revert to a scored cognitive screening tool. The evaluation shall be conducted by a health care professional or human service professional. This REQUIREMENT is not met as evidenced by: Five tenant files were reviewed. Based on file review, policy review, and interview, evaluations were not completed prior to admission. 1. Tenant #3, an 81 year-old, was admitted on 5-14-14 and had diagnoses of: atrial fibrillation, congestive heart failure, dementia, and hypothyroidism. Tenant #3 was staged at three on the Global Deterioration Scale which indicated mild cognitive decline. Tenant #3 was admitted on 5-14-14. Evaluations of cognition and health were completed by a registered nurse on 5-14-14. The clinical record contained an unsigned and undated evaluation	A 036		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 036	Continued From page 1 form, and the functional evaluation was not completed on the form. According to the "Nursing Evaluation Policy and Procedure" every area on the nursing evaluation was to be completed. Blank areas are not allowed on the nursing evaluation. On 12-2-14 at 9:30 a.m. Staff A, the Corporate Director of Health, was interviewed and stated there was no specific form for a functional evaluation. Information was entered into the computer, and the service plan was generated. The program did not provide documentation of a functional evaluation completed on 5-14-14. An evaluation of Tenant #3's function was not completed prior to admission. 2. Tenant #4, an 81 year-old, was admitted on 5-14-14 and had diagnoses of: Alzheimer's Disease, hypertension, diabetes type II with neuropathy, and congestive heart failure. Tenant #4 was staged at four on the Global Deterioration Scale which indicated moderate cognitive decline. Tenant #4 was admitted on 5-14-14. Evaluations of cognition and health were completed by a registered nurse on 5-14-14. The clinical record contained an evaluation form which contained a functional evaluation; however, the form was unsigned and undated. According to the "Nursing Evaluation Policy and Procedure" every area on the nursing evaluation was to be completed. Blank areas are not allowed on the nursing evaluation. The program did not provide documentation of a functional evaluation completed on 5-14-14.	A 036		

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A 037	481-69.22(2) Evaluation of Tenant 481-69.22(231C) Evaluation of tenant. 69.22(2) Evaluation within 30 days of occupancy and with significant change. A program shall evaluate each tenant ' s functional, cognitive and health status within 30 days of occupancy. A program shall also evaluate each tenant's functional, cognitive and health status as needed with significant change, but not less than annually, to determine the tenant ' s continued eligibility for the program and to determine any changes to services needed. The evaluation shall be conducted by a health care professional or human service professional. A licensed practical nurse may complete the evaluation via nurse delegation when the tenant has not exhibited a significant change. This REQUIREMENT is not met as evidenced by: Five tenant files were reviewed. Based on interviews, record review and policy review, evaluations were not completed within 30 days of admission or with a significant change of condition. 1. Tenant #1, an 81 year-old, was admitted on 6-23-14 and had diagnoses of: history of cerebrovascular accident with residual right-sided weakness, diabetes mellitus, hypertension, and gout. Tenant #1 was staged at three on the global deterioration scale which indicated mild cognitive impairment. A Clinical Transfer Report with a discharge date of 7-8-14 documented Tenant #1 was admitted to the hospital on 7-4-14 for complaints of swelling	A 037		

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A 037	Continued From page 3	A 037		

and redness of the right elbow. The report documented Tenant #1 had experienced a cut to the elbow a week prior which had worsened to the point of causing much discomfort and swelling. Tenant #1 was admitted to the hospital for intravenous antibiotic administration and monitoring. The elbow was incised and drained. The culture of the drainage showed Methicillin Resistant Staphylococcus Aureus (MRSA).

The clinical transfer report contained documentation dated 7-7-14 which indicated Tenant #1 had a drain replaced in the elbow wound.

According to the Clinical Transfer Report, Tenant #1 was discharged from the hospital on 7-8-14 with an intravenous line and was to receive home health services including visits from a nurse, physical, occupational and speech therapy. The report also indicated Tenant #1 was to contact the physician for a fever.

The evaluations of 7-7-14 did not assess the right elbow, did not define the area of cellulitis, did not assess the incision site on the right elbow, whether drainage continued, or the presence of a wound drain. The evaluations did not assess the intravenous site. Tenant #1's temperature was not documented on the evaluation form. The evaluation form for function and health was not signed.

On 12-2-14 at 9:30 a.m. Staff A, the Corporate Director of Health, was interviewed and stated she would expect to see detail about wound size and documentation of a healed wound.

Evaluations were not completed by a registered nurse with a significant change of condition.

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A 037	Continued From page 4 A fax to the physician dated 8-8-14 documented Tenant #1 was reported to have a hemoglobin of 5.8 grams per deciliter (g/dL). Low normal is approximately 12 g/dL Resident Quick Notes dated 8-11-14 documented Tenant #1 had a blood pressure of 98/56, a dry cough and crackles on the left side of the lungs. Resident Quick Notes (nurse's notes) dated 8-12-14 for 8-11-14 documented Tenant #1 had a "declining condition" and was unresponsive. Tenant #1 was sent to the hospital by ambulance. Notes dated 8-12-14 documented Tenant #1 had a perforated bowel, lost four pints of blood, and the kidneys had started to shut down. Tenant #1 had been moved from intensive care and was expected to return to the program. Resident Quick Notes dated 8-27-14 documented a nurse review was completed for a change of condition following hospitalization. The program did not provide documentation of the completion of evaluations of function, cognition, and health with a significant change of condition. 2. Tenant #3, an 81 year-old, was admitted on 5-14-14 and had diagnoses of: atrial fibrillation, congestive heart failure, dementia, and hypothyroidism. Tenant #3 was staged at three on the Global Deterioration Scale which indicated mild cognitive decline. Documentation from the emergency department dated 7-5-15 documented Tenant #3 was seen and diagnosed with failure to thrive. Documentation indicated Tenant #3 received a 500 milliliter fluid bolus. Resident Quick Notes dated 7-8-14 documented Tenant #3 had been refusing to get out of bed, bathe, or eat over the	A 037		

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A 037	Continued From page 5 last week. The documentation revealed the physician at the hospital wanted to admit Tenant #3 on 7-5-14, but the family refused. The notes documented Tenant #3 ate a little, and staff members were to offer supplements, and offer lunch and supper. The notes documented staff members encouraged Tenant #3 to be up and attend activities and meals but Tenant #3 "continuously" refused. Tenant #3 exhibited a significant change of condition which resulted in an emergency room visit for a diagnosis of failure to thrive. Evaluations of function, cognition, and health were not completed with a significant change of condition. A discharge summary dated 7-21-14 documented Tenant #3 had been hospitalized in a behavioral unit on 7-15-14 for crying spells, diminished interest, and decreased activity level with fatigue. The discharge summary indicated Tenant #3 also displayed verbal aggression and had a history of depression. Tenant #3 had been admitted to the behavioral unit as Tenant #3 was considered a danger to self and others, had failed outpatient medication management and non-medication interventions. The summary documented Tenant #3 required a safe and secure environment which led to the admission to behavioral health. Tenant #3 was discharged from behavioral health on 7-21-14 and returned to the program. Evaluations of function, cognition, and health were not completed upon return to the program on 7-21-14. Evaluations were not completed with a significant change of condition. 3. Tenant #5, an 85 year-old, was admitted on 6-23-14 and had diagnoses of: diabetes and	A 037		

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A 037	Continued From page 6 chronic obstructive pulmonary disease. Evaluations of cognition and health were completed on 8-1-14 and the Resident Quick Notes documented the event as a 30-day update. The evaluations were not completed within 30 days of admission on 6-23-14. On 12-2-14 at 9:30 a.m. Staff A, the Corporate Director of Health, was interviewed and stated there was no specific form for a functional evaluation. Information was entered into the computer, and the service plan was generated. The program did not provide documentation of a functional evaluation completed on 8-1-14.	A 037		
A 083	481-69.26(1) Service Plans 481-69.26(231C) Service plans. 69.26(1) A service plan shall be developed for each tenant based on the evaluations conducted in accordance with subrules 69.22(1) and 69.22(2) and shall be designed to meet the specific service needs of the individual tenant. The service plan shall subsequently be updated at least annually and whenever changes are needed. This REQUIREMENT is not met as evidenced by: Five tenant files were reviewed. Based on interviews, record review and policy review, service plans did not meet identified tenant needs.	A 083		

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A 083	Continued From page 7 1. Tenant #1, an 81 year-old, was admitted on 6-23-14 and had diagnoses of: history of cerebrovascular accident with residual right-sided weakness, diabetes mellitus, hypertension, and gout. Tenant #1 was staged at three on the global deterioration scale which indicated mild cognitive impairment. A Clinical Transfer Report with a discharge date of 7-8-14 documented Tenant #1 was admitted to the hospital on 7-4-14 for complaints of swelling and redness of the right elbow. The report documented Tenant #1 had experienced a cut to the elbow a week prior which had worsened to the point of causing much discomfort and swelling. Tenant #1 was admitted to the hospital for intravenous antibiotic administration and monitoring. The elbow was incised and drained. The culture of the drainage showed Methicillin Resistant Staphylococcus Aureus (MRSA). The clinical transfer report contained documentation dated 7-7-14 which indicated Tenant #1 had a drain replaced in the elbow wound. According to the Clinical Transfer Report, Tenant #1 was discharged from the hospital on 7-8-14 with an intravenous line and was to receive home health services including visits from a nurse, physical, occupational and speech therapy. The report also indicated Tenant #1 was to contact the physician for a fever. Resident Quick Notes (nurse's notes) dated 7-8-14 documented Tenant #1 requested hourly checks between 3:00 p.m. and 6:00 p.m. daily due to incontinence related to medication. The notes also documented Tenant #1 was to continue to receive physical and occupational	A 083		

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A 083	Continued From page 8 therapy. The service plan of 6-23-14 was not updated following the hospitalization of 7-4-14. The service plan did not identify a right elbow wound or wound care or signs to report to the nurse, did not identify the presence of an intravenous line, did not direct staff on the care of the intravenous line as Tenant #1 received bathing assistance, and did not identify hourly checks between 3:00 p.m. and 6:00 p.m. The service plan did not identify Tenant #1 had MRSA and appropriate staff interventions during the care of the elbow wound. The service plan did not meet the specific service needs of Tenant #1. Resident Quick Notes (nurse's notes) dated 7-23-14 documented a 30-day review was completed. The notes documented Tenant #1 was to have blood pressures checked on the left arm only due to a history of mastectomy on the right. Tenant #1 was continuing to receive dressings to the right elbow. A service plan was created for Tenant #1 on 7-23-14. The service plan of 7-23-14 did not identify the continued wound care to the elbow, the diagnosis of MRSA, and did not identify the need to have blood pressures checked on the left arm only. The service plan of 7-23-14 did not meet the specific service needs of Tenant #1. Tenant #1 had a service plan created on 10-21-14. According to Staff A, Corporate Director of Health, the program did not utilize separate forms for functional, cognitive, and health evaluations. As the data was put into the computer, a service plan was generated. The program did not provide data collection tools for the functional, cognitive, and health evaluations.	A 083		

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A 083	Continued From page 9 The service plan of 10-21-14 was not based on evaluations. 2. Tenant #3, an 81 year-old, was admitted on 5-14-14 and had diagnoses of: atrial fibrillation, congestive heart failure, dementia, and hypothyroidism. Tenant #3 was staged at three on the Global Deterioration Scale which indicated mild cognitive decline. A physician's order dated 6-27-14 documented Tenant #3 had sleep apnea and should be using a CPAP at night. The service plan of 6-17-14 did not identify the use of the CPAP and did not identify staff member's role in the use of the CPAP. The service plan did not meet the identified needs of Tenant #3. Documentation from the emergency department dated 7-5-15 documented Tenant #3 was seen and diagnosed with failure to thrive. Documentation indicated Tenant #3 received a 500 milliliter fluid bolus. Resident Quick Notes dated 7-8-14 documented Tenant #3 had been refusing to get out of bed, bathe, or eat over the last week. The documentation revealed the physician at the hospital wanted to admit Tenant #3 on 7-5-14, but the family refused. The notes documented Tenant #3 ate a little, and staff members were to offer supplements, and offer lunch and supper. The notes documented staff members encouraged Tenant #3 to be up and attend activities and meals but Tenant #3 "continuously" refused. The service plan of 6-17-14 was not updated to include staff direction to assist Tenant #3 who refused to bathe, get out of bed, or eat. The service plan did not identify the use of nutritional supplements, or to direct staff to offer lunch and	A 083		

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A 083	Continued From page 10 supper. The service plan did not meet the identified needs of Tenant #3. A discharge summary dated 7-21-14 documented Tenant #3 had been hospitalized in a behavioral unit on 7-15-14 for crying spells, diminished interest, and decreased activity level with fatigue. The discharge summary indicated Tenant #3 also displayed verbal aggression and had a history of depression. Tenant #3 had been admitted to the behavioral unit as Tenant #3 was considered a danger to self and others, had failed outpatient medication management and non-medication interventions. The summary documented Tenant #3 required a safe and secure environment which led to the admission to behavioral health. The service plan of 6-17-14 was not updated following hospitalization for behavioral issues. The service plan did not identify interventions for crying episodes, anger, anxiety, or aggression, and did not identify behaviors staff members were to report to the nurse. The service plan did not meet the identified needs of Tenant #3. Resident Quick Notes dated 9-9-14 documented Tenant #3 continued to refuse cares, and that Tenant #3 was having crying spells throughout the day, and Tenant #3 didn't know what was wrong. Notes of 9-17-14 documented Tenant #3 had been hospitalized in July of 2014 for increased anger and anxiety issues, as well as aggression. The service plan dated 9-15-14 did not identify interventions for crying episodes, anger, anxiety, or aggression, and did not identify behaviors staff members were to report to the nurse. The service plan did not meet the identified needs of Tenant #3.	A 083		

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A 083	Continued From page 11 Tenant #3 had a service plan created on 9-15-14. Staff A was interviewed on 12-2-14 at 9:30 a.m. According to Staff A, Corporate Director of Health, the program did not utilize separate forms for functional, cognitive, and health evaluations. As the data was put into the computer, a service plan was generated. The program did not provide data collection tools for the functional, cognitive, and health evaluations of 9-15-14. The service plan of 9-15-14 was not based on evaluations. 3. Tenant #4, an 81 year-old, was admitted on 5-14-14 and had diagnoses of: Alzheimer's Disease, hypertension, diabetes type II with neuropathy, and congestive heart failure. Tenant #4 was staged at four on the Global Deterioration Scale which indicated moderate cognitive decline. Tenant #4 had a service plan created on 9-16-14. Staff A was interviewed on 12-2-14 at 9:30 a.m. According to Staff A, Corporate Director of Health, the program did not utilize separate forms for functional, cognitive, and health evaluations. As the data was put into the computer, a service plan was generated. The program did not provide data collection tools for the functional, cognitive, and health evaluations of 9-15-14. The service plan of 9-15-14 was not based on evaluations.	A 083		
A 094	481-69.27(1) Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant ' s condition occurs, a nurse review shall be conducted. If a tenant receives personal or	A 094		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S0058	A. BUILDING: _____ B. WING _____	C 12/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN HILLS	4002 TETON TRACE SIOUX CITY, IA 51104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 094	Continued From page 12	A 094		

health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation:

69.27(1) To monitor, at least every 90 days, or after a significant change in the tenant ' s condition, any tenant who receives program-administered prescription medications for adverse reactions to the medications and to make appropriate interventions or referrals, and to ensure that the prescription medication orders are current and that the prescription medications are administered consistent with such orders.

This REQUIREMENT is not met as evidenced by:
Five tenant files were reviewed. Based on record review, a nurse review was not completed with a change of condition to determine medication effectiveness. In addition, a 90-day nurse review was not completed to document medication orders were current, medications were administered consistent with orders, or to document the presence or absence of adverse effects to medications..

1. Tenant #1, an 81 year-old, was admitted on 6-23-14 and had diagnoses of: history of cerebrovascular accident with residual right-sided weakness, diabetes mellitus, hypertension, and gout. Tenant #1 was staged at three on the global deterioration scale which indicated mild cognitive impairment.

A fax to the physician dated 10-3-14 documented Tenant #1 had urinary frequency and a urinalysis was requested. On 10-6-14, according to the Resident Quick Notes, an antibiotic was ordered. The antibiotic was changed on 10-7-14 and the antibiotic was ordered for seven days. A nurse review was not completed to determine the

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A 094	Continued From page 13 effectiveness of the antibiotic or to document any adverse reactions to the antibiotic. 2. According to the Resident Quick Notes dated 10-27-14, a 90-day review was completed on 10-21-14. The program administered medications to Tenant #1 according to the service plan of 10-21-14. The review did not document a review of medications for adverse reactions, did not document medication orders were current, or that medications were administered consistent with the orders. A 90-day nurse review was not completed.	A 094		
A 096	481-69.27(3) Nurse Review 481-69.27(231C) Nurse review. If a tenant does not receive personal or health-related care, but an observed significant change in the tenant ' s condition occurs, a nurse review shall be conducted. If a tenant receives personal or health-related care, the program shall provide for a registered nurse or a licensed practical nurse via nurse delegation: 69.27(3) To assess and document the health status of each tenant, to make recommendations and referrals as appropriate, and to monitor progress relating to previous recommendations at least every 90 days and whenever there are changes in the tenant ' s health status This REQUIREMENT is not met as evidenced by: Five tenant files were reviewed. Based on record reviews and interview, nurse reviews were not completed to document health status with a change of condition. 1. Tenant #1, an 81 year-old, was admitted on	A 096		

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A 096	Continued From page 14	A 096		

6-23-14 and had diagnoses of: history of cerebrovascular accident with residual right-sided weakness, diabetes mellitus, hypertension, and gout. Tenant #1 was staged at three on the global deterioration scale which indicated mild cognitive impairment.

Resident Quick Notes (nurse's notes) dated 8-12-14 for 8-11-14 documented Tenant #1 had a "declining condition" and was unresponsive. Tenant #1 was sent to the hospital by ambulance. Notes dated 8-12-14 documented Tenant #1 had a perforated bowel, lost four pints of blood, and the kidneys had started to shut down. Tenant #1 had been moved from intensive care and was expected to return to the program.

According to the Resident Quick Notes dated 10-27-14, a 90-day review was completed on 10-21-14. The notes documented a review of functional status. The 90-day review did not document a review of health and did not monitor progress of Tenant #1's health status over the last 90 days and following the August 2014 hospitalization.

2. Tenant #2, an 88 year-old, was admitted on 1-2-13 and had diagnoses of: anxiety, Parkinson's Disease, depression, gastroesophageal reflux disease, and chronic obstructive pulmonary disease. Tenant #2 was staged at three on the Global Deterioration Scale which indicated mild cognitive decline.

The program reported to the department Tenant #2 sustained a skin tear on 4-20-14 as a staff member was assisting Tenant #2 in the restroom. The skin tear, according to resident care notes dated 4-22-14, was on the right lower leg, and the skin was well approximated with steri-strips. The

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A 096	Continued From page 15	A 096		

documentation does not include an assessment of the wound. The resident care notes and Resident Quick notes were reviewed. There was no documentation as to the healing progress of the skin tear. There was no documentation the skin tear on the right lower leg healed.

On 12-2-14 at 9:30 a.m. Staff A, the Corporate Director of Health, was interviewed and stated she would expect to see detail about wound size and documentation of a healed wound.

A nurse review was not completed to document the progress of the wound.

Tenant #2's health was reviewed as part of an evaluation on 5-12-14. The Resident Quick Notes dated 5-12-14 documented a medication review. A review of health and medications was not completed until 9-29-14. A nurse review was not completed every 90 days for Tenant #2 who received personal and health cares from the program.

Physician orders noted on 10-20-14 documented Tenant #2 was started on an antibiotic for a urinary infection. Resident Quick Notes dated 10-29-14 documented Tenant #2 had been experiencing changes in bowel continence and diarrhea. The changes in bowel condition was related to the use of prune juice and the antibiotic, and the documentation indicated was expected to resolve when the antibiotic was completed.. A nurse review was not completed when the antibiotic was finished to follow-up on Tenant #2's bowel condition. A nurse review was not completed monitoring of the progress of the bowel condition and the antibiotic.

3. Tenant #3, an 81 year-old, was admitted on

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A 096	Continued From page 16 5-14-14 and had diagnoses of: atrial fibrillation, congestive heart failure, dementia, and hypothyroidism. Tenant #3 was staged at three on the Global Deterioration Scale which indicated mild cognitive decline. A discharge summary dated 7-21-14 documented Tenant #3 had been hospitalized in a behavioral unit on 7-15-14 for crying spells, diminished interest, and decreased activity level with fatigue. The discharge summary indicated Tenant #3 also displayed verbal aggression and had a history of depression. Tenant #3 had been admitted to the behavioral unit as Tenant #3 was considered a danger to self and others, had failed outpatient medication management and non-medication interventions. The summary documented Tenant #3 required a safe and secure environment which led to the admission to behavioral health. Tenant #3 was discharged from behavioral health on 7-21-14 and returned to the program. A nurse review was not completed post-hospitalization for a change of condition. 4. Tenant #4, an 81 year-old, was admitted on 5-14-14 and had diagnoses of: Alzheimer's Disease, hypertension, diabetes type II with neuropathy, and congestive heart failure. Tenant #4 was staged at four on the Global Deterioration Scale which indicated moderate cognitive decline. A hospital report dated 8-18-14 documented Tenant #4 had been admitted to the hospital on 8-16-14 for dizziness and inability to ambulate. It was reported Tenant #4 had episodes of vomiting and near falls. Tenant #4 was discharged on 8-18-14 and Tenant #4 was to be encouraged to change position slowly, use fall precautions and up with assistance. A nurse review was not	A 096		

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A 096	Continued From page 17 completed upon return to the program to assess and document Tenant #4's health status following a change of condition.	A 096		

Northern Hills
Retirement Community

December 15, 2014

Department of Inspections and Appeals
Attn: Rose Boccella
Lucas State Office Building
321 East 12th Street
Des Moines, Iowa 50319

Dear Ms. Boccella:

On behalf of Northern Hills Assisted Living, I respectfully submit our Plan of Correction for your approval. Our response is specific to the Complaint/Incident Investigation Report #48413-C, 48205-C, and 48206-I for your onsite visit on December 1 and 2, 2014. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Iowa law.

Alleged Regulatory Insufficiency – Evaluation of Tenant

1. Elements detailing how the program will correct each regulatory insufficiency.
    - The RN will complete a baseline assessment for Tenants #1, #3, and #5. The RN will use Heritage Nurse Evaluation Form #F-437 (see Attachment A) to assess function. Health and cognition assessments are part of the web based software (see Attachment B). The assessments will review status of issues identified within the regulatory report.

2. What measures will be taken to ensure the problem will not recur.
    - Northern Hills has developed a functional assessment to be used to assess a tenant prior to move-in, within 30 days of move-in, annually, and with a significant change in condition (see Attachment A).
    - The RN will be re-educated on regulatory requirements and Northern Hills' Policy for completing an assessment, including a review of the assessment tools, identifying when to complete an assessment for a significant change in condition, and signing/dating assessment tools.

Northern Hills
Retirement Community

3. How the program plans to monitor performance to ensure compliance.
    - The Corporate Director of Healthcare, Corporate Director of Community Support or Designee will audit tenant charts quarterly for the next 12 months and the Executive Director, RN, or Designee will audit tenant charts at least annually thereafter to ensure a health, functional, cognitive assessment is completed as required by regulation.

4. The date by which the regulatory insufficiency will be corrected.
    - The regulatory insufficiency will be corrected by January 9, 2015.

Alleged Regulatory Insufficiency – Service Plan

1. Elements detailing how the program will correct each regulatory insufficiency.
    - The RN will complete a baseline service plan update for Tenants #1, #3, and #4, which will be based on a health, functional, and cognitive assessment. The service plan will identify tenant needs and requests for assistance.

2. What measures will be taken to ensure the problem will not recur.
    - The RN will be re-educated on regulatory requirements and Northern Hills' Policy for service plan development.

3. How the program plans to monitor performance to ensure compliance.
    - The Corporate Director of Healthcare or designee will review service plans quarterly when completing the 90-day nurse review to ensure the service plan is accurate and identifies the tenant's needs and requests for assistance.

4. The date by which the regulatory insufficiency will be corrected.
    - The regulatory insufficiency will be corrected by January 9, 2015.

Alleged Regulatory Insufficiency – Nurse Review

1. Elements detailing how the program will correct each regulatory insufficiency.
    - The RN will complete a baseline 90-day nurse review for Tenants #1, #2, #3, and #4.

2. What measures will be taken to ensure the problem will not recur.
    - The RN will be re-educated on regulatory requirements and Northern Hills' Policy for completing 90-day nurse review.
    - The RN will be re-educated on regulatory requirements and Northern Hills' Policy for completing a nurse review with a significant change in condition.

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Retirement Community

3. How the program plans to monitor performance to ensure compliance.
    - The Corporate Director of Healthcare, Executive Director, RN, or designee will audit tenant charts at least annually to completion of 90-day nurse reviews as required by regulation.
    - The Corporate Director of Healthcare, RN or designee will audit tenant charts when completing a 90-day nurse review to ensure any potential issues, concerns, or changes in condition were addressed as required by regulation.

4. The date by which the regulatory insufficiency will be corrected.
    - The regulatory insufficiency will be corrected by January 9, 2015.

Please feel free to contact me at 712-239-9402 with any questions.

Sincerely,

Stephanie Johnson
Executive Director