IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319-0083
(515) 281-4115 Phone
(515) 242-5022 Fax

TERRY E. BRANSTAD
GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #:
55873-I

December 11, 2015

Ms. Stephanie Johnson, Director
Heritage at Northern Hills
4002 Teton Trace
Sioux City, IA 51104

RE: Final Complaint/Incident Investigation Report, Heritage at 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 **November 30 - December 7, 2015.** Based on staff interviews, and review of tenant files, discharged files, incident reports, program policies, the following was found:

Allegation: Service Plans
Comments: Cognitive, functional, and health evaluations were conducted prior to and upon admission. Evaluations were conducted as needed with change of condition and service plans developed and updated as conditions and results of evaluations changed.
Findings: unsubstantiated

The Report notes a Regulatory Insufficiency in the area(s) of: Policies and procedures.

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.

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 12/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE AT 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 000	481-67 Initial Comments Assisted Living Programs are defined by the type of population served. The census numbers were provided by the Program at the time of the on-site. Dementia-Specific Program by Definition Number of tenants without cognitive disorder: 51 Number of tenants with cognitive disorder: 10 Total Population of Program at time of on-site: 61 TOTAL census of Assisted Living Program: 61 Incident investigation #55873-I was conducted at the Program on 11/30/15 - 12/7/15. The following insufficiency was cited during the incident investigation to determine compliance with certification for an Assisted Living Program:	A 000		
A 003	481-67.2 Program policies and procedures 481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program ' s policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse. This REQUIREMENT is not met as evidenced by: Based on interviews and record review Program staff failed to follow policies and procedures regarding incident reports. This affected 1 of 1	A 003		

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A 003	Continued From page 1 tenant identified in investigation #55873-I. Findings follow: Review on 11/30/15 of the Program's Incident/Accident Report dated 9/27/15 at 7:30 p.m., described Certified Nurse Aide (CNA) A assisted Tenant #1 off the toilet to a standing position using a gait belt. During the transfer, the tenant said he/she "need(ed) to move (his/her) foot". The tenant then pushed against grab bars near the toilet, causing both Tenant #1 and CNA A to lose their balance. CNA A lowered Tenant #1 to the floor in a seated position on the bathroom floor. CNA B was called and assisted CNA A to get Tenant #1 off the floor and into a wheelchair. The report also stated on 9/28/15, Tenant #1 went to the physicians' office due to right ankle pain and was diagnosed with a non-displaced ankle fracture. When interviewed on 11/30/15 at 1:15 p.m., the Director of Health Services confirmed CNA A assisted Tenant #1 off the toilet when they lost their balance and he lowered the tenant to the floor. She reported even though the incident report was dated 9/27/15, CNA A actually completed the incident report on 9/29/15, two days after the incident. The Executive Director (ED) said incident reports should be completed on the shift the incident occurs. The Director of Health Services reported all staff had been retrained on incident reports and the definition of a fall. When interviewed on 12/2/15 at 3:30 p.m., CNA A confirmed he assisted Tenant #1 to a standing position from the toilet and the tenant wanted to move his/her foot and pushed against CNA A and the grab bars near the toilet. They both lost their balance, CNA A regained his balance and	A 003		

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A 003	Continued From page 2 lowered Tenant #1 to the floor to a sitting position. According to CNA A, Tenant #1 denied complaints of pain at that time, but complained of pain in his/her right foot/ankle later in the evening. CNA A said he didn't complete an incident report the evening of the incident because he didn't think lowering a tenant to the floor constituted a fall or required an incident report. He reported he had worked at the facility for approximately one month and had not been trained on incident reports yet. Review of staff training sheets titled, "A "fall" includes: ....5. Staff member, family member or another tenant lowering a tenant to the floor (kneeling or seated position)." Review of the Program's policy on Falls, revised 5/17/11 stated under Guidelines for Falls: "...Document in communication log and complete incident report..." Review of the Program's Incident/Accident Report policy & procedure, revised 7/11/11 revealed on page 3, the incident report should be forwarded to the supervisor within 24 hours of the incident.	A 003		

A 003 481-67.2 Program policies and procedures

481-67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.

Plan of Correction for violation:

A. To ensure proper training is met regarding reporting incidents, training regarding our Incident/Accident Policy and Procedure took place on 12/17/15, documentation attached. Training regarding incident reports is also provided at orientation with their Orientation Record. Completion of training will be monitored upon hire by the Office Director. Training for staff has taken place regarding what a "fall" includes and documentation for that is attached. Regulatory compliance was established on 12/17/15. The Executive Director will review and revise the Plan of Correction if necessary.
B. The Executive Director, or designee, will review 10% of files quarterly to ensure any fall will have had an incident report turned in to comply with the Incident/Accident policy.