IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

HEALTH FACILITIES DIVISION
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TERRY E. BRANSTAD
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RODNEY A. ROBERTS, DIRECTOR

Complaint/Incident Intake #: 58759-I

March 30, 2016

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, IA

Dear Ms. Johnson:

Enclosed is the **Final Complaint/Incident Investigation Report** from the on-site monitoring visit of March 21 - 23, 2016, 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.

Based on observations, staff interviews, and review of tenant files, incident reports, and program policies, the following was found:

1. Allegation: Service Plans
   Comments: The Program had assessed the tenant identified in the investigation and developed and implemented a service plan to meet her needs. The tenant had no history of wandering or elopement behavior prior to this elopement incident. The tenant was diagnosed with a urinary tract infection the day following the incident. The Program re-assessed the tenant and developed a new service plan to include history of wandering/elopement and implemented hourly checks on the tenant as part of the plan.
   Findings: unsubstantiated

No Regulatory Insufficiencies were identified.

If you have any questions regarding 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 03/23/2016

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. General Population Program Number of tenants without cognitive disorder: 49 Number of tenants with cognitive disorder: 10 Total Population of Program at time of on-site: 59 TOTAL census of Assisted Living Program: 59 At the time of investigation #58759-I no insufficiencies were written.	A 000		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE