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 _____	11/16/2017

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	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: 56 Number of tenants with cognitive disorder: 10 Total Population of Program at time of on-site: 66 TOTAL census of Assisted Living Program: 66 The following regulatory insufficiencies were cited during the recertification visit conducted to determine compliance with certification for an Assisted Living Program.	A 000	See attached POC 12/31/17	
A 121	481-67.19(3)c Record Checks 481-67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks. 67.19(3)c If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program. This REQUIREMENT is not met as evidenced by:	A 121		

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

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A 121	Continued From page 1 Based on interview and record review the Program failed to obtain evaluation from the Department of Human Services prior to employment of an individual with a crime on his/her record. This pertained to 1 out of 1 staff reviewed that required an evaluation of their criminal history (Staff A). Finding follows: Review of Staff A's file revealed a Single Contact License and Background Check, completed on 2-1-17, noted further research required for the criminal history. Continued record review failed to produce DHS evaluation of the criminal history for approval to work in the Program. Interview with the Executive Director on 11-15-17 at 3:07 p.m. confirmed this finding. She stated the previous Administrator failed to complete the appropriate follow up.	A 121		
A 045	481-69.23(1)g Criteria for Admission/Retention of Tenants 481-69.23(231C) Criteria for admission and retention of tenants. 69.23(1) Persons who may not be admitted or retained. A program shall not knowingly admit or retain a tenant who: g. Has unmanageable incontinence on a routine basis despite an individualized toileting program This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to discharge a tenant who exceeded criteria for admission and retention in an assisted living program. This pertained to 1 out of 1 tenants with unmanageable incontinence	A 045		

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A 045	Continued From page 2 (Tenant #1). Findings follow: Review of Assisted Living Monitoring Entrance Form dated 11-15-17 it was revealed that Tenant #1 had a Managed Risk Agreement in place for urinating in cups and other items in his/her room and, at times, in common areas. Review of his/her Shared Risk Agreement, dated 3-23-17, revealed he/she had not been using incontinence products and urinated in cups in his/her room. He/she agreed to begin a toileting schedule, have the recliner replaced, have the carpets shampooed, and wear proper fitting incontinence briefs at all times. The Shared Risk Agreement was signed by him/her, the Executive Director, and the Registered Nurse. Tenant #1 continued to have unmanageable incontinence despite interventions by the Program. Review of his/her Resident Service Level-Assisted Living dated 10-19-17 revealed he/she needed staff assistance with toileting and use of incontinent products. Staff were to empty the trash and notify nursing if there were no incontinence products in the garbage. Housekeeping staff should wash the cover for his/her recliner weekly, or as often allowed, to help decrease urine odor. Housekeeping should notify nursing if a strong urine odor was noticeable. Staff were expected to add/change wax to Scentsy pot as needed for odors. Review of Quick Notes revealed the following: a. On 10-19-17, the Registered Nurse documented a Nurse Review: 90 day assessment. The assessment noted Tenant #1 continued to have issues with incontinence and not using depends at times. The assessment further noted Tenant #1's room still had a strong	A 045		

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A 045	Continued From page 3 odor of urine. Tenant #1 scored a one on the Global Deterioration Scale (GDS). b. On 11-3-17, Staff B documented staff reported a bottle of urine sitting on his/her side table along with two washcloths soaked in urine. The room had "an awful aroma of urine." c. On 11-9-17, Staff B documented on 11-8-17 staff notified nurses of two dirty pads next to Tenant #1 on a shelf and an Ensure bottle with urine in it. Review of Admission Agreement dated and signed by Tenant #1 on 8-9-03 revealed the Transfer and Discharge Policy included inability to manage incontinence. When interviewed on 11-16-17 at 12:21 p.m. the RN stated Tenant #1 had periods of managing incontinence, then would have issues with urinating in cups. The RN explained she believed he/she would just stand up by his/her recliner and urinate instead of going to the restroom. She agreed the urine odor in the apartment was noticeable, but had been much worse when she began working at the Program and the carpet had been replaced about two months ago. She stated Tenant #1 was informed he/she could be discharged for unmanageable incontinence when the Managed Risk Agreement was put into place.	A 045		
A 123	481-69.30(3)a Dementia Specific Education for Personnel 481-69.30(231C) Dementia-specific education for program personnel. 69.30(3)a Except as otherwise provided in this subrule, all personnel employed by or contracting with a dementia-specific program shall receive a minimum of two hours of	A 123		

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A 123	Continued From page 4 dementia-specific continuing education annually. Direct-contact personnel shall receive a minimum of eight hours of dementia-specific continuing education annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review the Program failed to ensure all staff with direct contact with tenants completed at least eight hours of dementia training annually. This pertained to 3 of 3 staff employed more than one year (Staff B, Staff C, and Staff D.) Findings follow: Record review revealed the following: a. Staff B, hired 6-8-16, completed 8 hours of dementia training by 6-24-16. Further review revealed as of 6-24-17, Staff B completed only four hours of dementia training. b. Staff C, hired 8-24-16, completed eight hours of dementia training by 8-26-16. Further record review revealed no subsequent dementia training completed. c. Staff D, hired 9-26-16, completed eight hours of dementia training by 9-30-16. Further record review revealed no additional dementia training completed. Interview with Executive Director on 11-15-17 at 3:07 p.m. confirmed this finding. She stated that her understanding was that she had all of 2017 to complete dementia training to meet the annual requirement.	A 123		

Record Checks - Tag ID A121

Elements detailing how the Program will correct this regulatory insufficiency:

- Staff A was terminated from her position on 11/16/2017
- Audit of all other current employee background checks completed by ED on 11/15/17
- All department managers will be educated on the background check process by 12/22/17

What measures will be taken to ensure the problem does not recur:

- The community's Office Director or designee will continue to run all required background checks on all potential employees
- The community's Office Director or designee will give all background checks to the Executive Director or designee for review
- The Executive Director or designee will then verify that the background check is complete and compliant with all DIA, DHS, and company policies before giving the department manager approval to move forward with the hiring process
- The Executive Director or designee approval will be verified by a notation made on the background check which will include the signature and the date of approval

How the Program plans to monitor performance to ensure compliance:

- The Regional Director of Operations or designee will audit this process quarterly until 100% compliant for 12 consecutive months.

The date by which the regulatory insufficiency will be corrected:

- The process to ensure that the problem does not recur was fully implemented on 11/17/17
- Quarterly audits until 12 consecutive months are 100% compliance

Criteria for admission and retention of tenants – Tag ID A045

Elements detailing how the Program will correct each regulatory insufficiency:

- Tenant 1 was discharged from our community on 11/27/2017
- All other Shared Risk Agreements were reviewed against criteria for retention of tenants

What measures will be taken to ensure the problem does not recur:

- The RN and Executive Director or their designees will review any active Shared Risk Agreements on a quarterly basis as per company policy
- The RN will document this review in the tenant's record by utilizing the "Quick Notes" section of the Vitals program
- If it is found that a tenant is not managing their Shared Risk Agreement, the Executive Director and RN or their designees will modify the Shared Risk Agreement with the tenant or designee. If modification is inappropriate, the discharge process will begin

How the Program plans to monitor performance to ensure compliance:

- Tenants with Shared Risk Agreements will be reviewed by the Regional Director of Health Services or designee quarterly with chart audits
- Tenants of concern, as evidenced by interviews with community staff and nurses, will be reviewed by the Regional Director of Health Services or designee quarterly and reviewed with the Community RN and Executive Director

The date by which the regulatory insufficiency will be corrected:

- Tenant 1 was discharged on11/27/2017
- The new process to ensure compliance was implemented on 11/16/17
- Audits will be ongoing

Dementia Specific Education for Personnel – Tag ID A123

- The identified staff members that were out of compliance with their annual dementia training were assigned training modules and will be compliant by 12/22/17
- Dementia training records for all staff will be audited for compliance by the Office Director or designee by 12/30/17

What measures will be taken to ensure the problem does not recur:

- The community's Office Director or designee will send out a monthly email to all department managers with anniversary dates for their employees
- Department manager's will review training records and remind staff of any remaining dementia training required
- The staff member will then be required to complete dementia training
- The staff member will have to prove completion of all required training by presenting a certificate of completion and/or proof of attendance at a live session to their supervisor to receive their annual evaluation
- Staff will be taken off the schedule until required dementia training has been completed
- The community's Office Director or designee will send out a monthly training compliance report to the department managers for ongoing monitoring

How the Program plans to monitor performance to ensure compliance:

- The community's Office Director or designee will send out a monthly compliance report to the appropriate department managers to ensure staff are remaining compliant with their dementia training
- Regional Director of Operations or designee will audit 10% of employee files on a quarterly basis to ensure compliance is achieved at 100% for 12 consecutive months

The date by which the regulatory insufficiency will be corrected:

- This regulatory insufficiency will be corrected by 12/31/2017.