AL Survey Trends Report

February 2025

A LeadingAge Iowa Publication to help Assisted Living Programs track insufficiency data from the Iowa Department of Inspections and Appeals and utilize the information for performance improvement.

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February ALP Survey Update & Rule Review

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Survey activity:

- 26 recertification visits were available for review. 15 of the 26 recertifications resulted in insufficiencies averaging 4.7 per program. 5 of the recertification survey's resulted in a fine (or 33%). 11 assisted living providers had insufficiency free surveys (or 42%).
- 25 complaint and incident visits were available for review. 9 of these were unsubstantiated with 16 resulting in insufficiencies. The programs with insufficiencies averaged 3.3 with 2 fines (or 13%).
- 92 AL Providers are currently more than 24 months from their last recertification visit.

The most recent rule review includes 481-67.21 related to nursing assistant work credit.

You can access previous rule review articles as well as additional assisted living specific resources on our Assisted Living Resource page.

Congratulations to Copper Shores Village AL & MC on an insufficiency free survey!

Insufficiencies Resulting in Fines for the Month of February

67.2(3); $2,000. A staff member did not check a door that alarmed on 1.13.25 at 5:05 a.m. as they believed it was the maintenance door, and the maintenance man generally arrived at that time. At 5:37 a.m. a staff member found Tenant C1 sitting in the parking lot, the tenant had a large laceration on their forehead. The tenant was only wearing a thermal shirt over a t-shirt, sweatpants and slip on shoes. They reported leaving the building but did not know why. The tenant was sent to the ER where they had a low temperature, soft tissue laceration and hematoma without any fractures noted. The tenant did not have a history of elopement attempts and was only rated a 2 on the GDS.

67.2(3); $2,000. The power went out during a thunderstorm which impacted the doors in the program, releasing the locking mechanisms. Staff had all tenants sitting in the dining room during the power outage, however, they were assisting a tenant to the restroom. During this time, they heard a back-up alarm sound on the door and staff went to look in the area but saw nothing and assumed someone entered the building. When they finished providing care to the tenant they noted Tenant #2 was no longer in the dining room. They began searching and the nursing home RN brought Tenant #2 back into the program. Tenant #2 was found in a parking lot approximately 20 feet from the door and was missing for 10 minutes or less. Staff were unaware that the door locks did not function when on backup power. Additionally, staff did not follow program policies and procedures in responding to door alarms including when the surveyor activated door alarms during the on-site survey.

67.3(2); $7,500. Tenant C1’s service plan interventions included 30-minute safety checks after a fall on 8.24.24. On 8.27.24, the tenant was found on the floor in their bathroom with a skin tear and complaints of pain to their hip. The tenant’s hospice nurse evaluated the tenant and consulted with family and decided not to send the tenant to the hospital. The tenant passed away later that morning. Upon review of the incident, the staff reported that they did not complete 30-minute checks as directed and the tenant was last checked approximately 2 hours prior to being found on the floor. Tenant #5's service plan directed staff to provide standby and cueing assistance for transfers and that the tenant was non-ambulatory. On 1.31.25, Tenant #5 was assisted to stand at their bedside, when the staff left them to get their wheelchair. The staff then stood behind the wheelchair as the tenant began to turn and fell backwards, hitting their head. The staff called 911 to transport to the ER and then eventually to the University of Iowa hospital due to the extent of their injuries which included a subdural hemorrhage, subarachnoid hemorrhage, rib fractures, sternum fracture, compression fracture, and a C3/4 fracture.

67.5(2)f(4); $4,000. Staff administered insulin when the resident's blood sugar fell outside of parameters ordered by the physician. Later the tenant was found in their apartment on the floor with low blood sugar. Staff also administered sliding scale insulin for blood sugars that were not within the sliding scale range order.

67.5(2)f(4); $7,500 & Conditional License. Tenant #5's primary physician expressed concerns about the program's management medications, particularly insulin and blood glucose checks. The physician reported that the tenant had higher blood glucose levels, so they increased their insulin only to find out that the program was not consistently monitoring the blood glucose levels and administering insulin. Tenant #4 had orders for warfarin and INR labs. The program was not consistently administering the warfarin or completing the INR. The tenant's primary care physician discovered this when they contacted the pharmacy and requested information on refills. The physician then contacted the daughter and discussed transporting the tenant to the hospital. Tenant #3's primary physician discontinued pantoprazole on several physician visits that were not

followed as the medication remained on their medication list. Additionally, the physician ordered the program to complete thyroid labs which were not completed even with several reminders from the physician. The surveyor observed a staff member administer Tenant #6's oxycodone at 10:55 a.m. upon review the tenant had scheduled oxycodone at 6 a.m. and 6 p.m. and every 6 hours as needed. Through investigation it was determined that the dose observed was the scheduled dose, administered more nearly 5 hours late. Tenant #1 had hospital discharge notes in November for sepsis, acute cystitis, encephalopathy, and e-coli bacteremia. On 11.14.24 the tenant completed their antibiotic without signs of infection. On 12.9.24 the tenant visited their primary physician and reported urinary frequency. A lab was ordered for UA and culture. On 12.24.24, the physician indicated they were still awaiting the culture results, and the program sent the urine to the lab on 12.27.24 for testing.

67.19(3)b; $500. Seven employee files included background checks that didn't include child or dependent adult abuse checks.

69.26(1); $4,500. Tenant C1 eloped from the program on 6/9/24 and was found in the middle of a busy street by individuals driving. The staff reported they were instructed to complete 15-minute checks on the tenant after an incident on 6/7/24 but were not aware of any additional interventions or hourly checks implemented prior to the elopement on 6/9/24. The service plan was last updated on 2.26.24 and did not address the tenant's wandering behaviors, interventions, or history of elopements. Additionally, the program did not revise the service plan to include interventions of repeated episodes of wandering outside the building.

Insufficiencies Without Fining

Occupancy Agreement (231C.5)

The program occupancy agreement did not include whether the program required disclosure of personal financial information for occupancy or continued occupancy, a statement prohibiting retaliation, contact information for the department of health and human services and senior health insurance program. (Cited twice for AL and MC.)

The program did not complete an occupancy agreement for one tenant.

The occupancy agreement did not clearly identify the tenant's cost for services provided.

Program Policies and Procedures (481-67.2)

Incident reports completed for behaviors which resulted in a fall and transfer to the hospital lacked required information and upon investigation some information was inaccurate.

The incident report policy did not include that the reports will be kept for a period of three years following the incident or the policy indicated a duration of less than three years (Cited in 3 programs)

An incident report for Tenant #1 when they had behaviors and required transfer to the ER lacked witness statements from all involved in the incident.

The program did not complete incident reports for (Cited in 4 Programs):

- Falls
- Medication overdose
- Elopements
- Medication errors
- Aggressive behaviors
- Bruises
- Suicidal ideations

The policy indicated that the incident would be documented on a form, however, the incidents were documented in Point Click Care. (Cited in 2 programs)

The policy on retention criteria was not followed when tenants did not receive discharge notices for requiring two staff assistance with transfers or consistent behaviors. (Cited in 2 programs).

The program did not follow their policy on narcotics as a bottle of morphine was found in an unlocked mini refrigerator without a second lock on it. Additionally, staff did not notify the on-call nurse when a tenant fell and received a head laceration.

The policy on staffing stated that the tenant's service plans would include frequency of safety checks, however, the tenant's service plans did not include this information.

The program did not follow the fall policy when the nurse, physician, and responsible party wasn't notified of a fall.

The program did not follow their policy on medication disposal when a nurse used a deceased tenant's medication due to financial concerns for a different tenant that had a dosage change in medication.

Staff did not follow the policy regarding RN communication as Tenant C1 expressed they were not feeling well and were staying in bed more often. The staff did not report the concerns to the RN on the written communication method described in the policy.

Tenant Rights (481-67.3)

During interviews, tenants reported concerns with their call lights being answered in a timely manner. Review of the call light report indicated call light response varied from 15 to 106 minutes.

The program did not ensure that the door was securely shut before they left when visitors left and allowed a tenant to elope from the program.

Staff did not assist tenants with meeting their needs, including assistance to use the bathroom, and that response to emergency pendants were longer than 15 minutes.

Medications (481-67.5)

Did not administer medications and treatments as ordered by the physician. (Cited in 4 programs)

Staff did not store medications in a locked cabinet based on observations of medications left with tenants and liquid oxycodone stored in a dining room refrigerator unsecured.

Staff did not complete narcotic reconciliation with the outgoing staff according to the policy and liquid morphine was missing later.

Staffing (481-67.9)

During interviews staff stated that the program did not follow their staffing plans as they were unable to provide hygiene and care to the tenants directed in their service plans.

Tenants, staff and providers expressed concerns about not having adequate staffing for the tenants in the building.

Staff did not have adequate training and competency evaluations to feed tenants with swallowing difficulties.

The program did not provide service plan requirements for one tenant when a compression stocking and wraps were removed for longer than the physician's order is required.

The program did not maintain a communication book from August to December 2024.

Criminal, Dependent Adult and Child Abuse Register Checks (481-67.19)

Seven employee files included background checks for the employees that did not include child or dependent adult abuse checks.

A background check that had a history of criminal charges was not evaluated by DHS. (Cited in 2 programs)

Occupancy Agreement (481-69.21)

The occupancy agreement did not include the telephone number for the LTC ombudsman, correct contact information for filing a complaint with the department, and a statement that the tenant landlord laws apply to AL programs. (Cited in 2 programs)

The program did not include several elements on the occupancy agreement signed by two newly admitted tenants.

Marketing materials didn’t state that a copy of the occupancy agreement was available upon request.

Evaluation of Tenant (481-69.22)

Pre-occupancy evaluations were not completed. (Cited in 3 programs)

Evaluations were not completed before the tenant signed the occupancy agreement.

Evaluations were not completed within 30 days of occupancy. (Cited in 3 programs)

Significant Change evaluations were not completed for: (Cited in 7 programs)

- Weight loss
- Behaviors
- Change in transfer/mobility
- Hospice services were initiated

- Hospitalization
- SNF stay
- Changes to dietary/nutritional needs.
- Changes to assistance with ADLs
- New/change in medications
- Choking
- Decline in condition
- Wound
- Therapy services initiated/discontinued
- Delegated medication administration to the program
- Wandering/wanderguard
- Fall with injury
- Incontinence
- Inability to take oral medications

Cognitive evaluations were not completed with significant change evaluation.

Criteria for Admission and Retention of Tenants (481-69.23)

A tenant was bed bound for more than 3 months and did not meet criteria for retention. The program did not submit a waiver to the department when they no longer met criteria for retention.

The program retained a tenant who required two-person transfers.

The program retained tenants with exit seeking behaviors, verbal and physical aggression.

Tenant #1 was retained in the program when they continued to act sexual, and with physical and verbal aggression as well as exit seeking behaviors.

Involuntary Transfer or Discharge from the Program (481-69.24)

An involuntary discharge notice was given to a tenant, which was not dated and failed to include contact information for the ombudsman.

The program did not notify the LTC ombudsman of an involuntary discharge.

Tenant Documents (481-69.25)

Incident reports were not completed including behaviors between tenants, behaviors towards staff, choking episodes, and falls.

The program did not document nurse's notes by exception - Tenant #1 and #2 tested positive for COVID-19 and nurse's notes were not completed when the tenant was out of COVID-19 protocols and if symptoms were resolved. Tenant #3 had a UTI and tested positive for COVID-19 and nurse's notes did not include when the tenant completed antibiotics for the UTI or upon discontinuation of COVID-19 protocols and symptom resolution. Tenant #4 was transported to the ER following a seizure and tested positive for COVID-19. Nurse's notes were not completed when the tenant returned from the hospital or when protocols were discontinued and symptom resolution for COVID-19.

A nurse's note was not completed with significant changes including multiple hospitalizations within a short period of time.

The program did not document nurse's notes by exception when a tenant finished a course of eye drops or when a tenant fell and received a hematoma which later turned into cellulitis.

Nurse’s notes were not completed by exception for Tenant C1 when they were on an antibiotic for a UTI.

Staff did not document that service plan tasks were completed for tenants.

Tenant's tasks were not documented when completed by staff including bathing and visual checks.

Tenant records were kept in a shed outside of the program.

Service Plans (481-69.26)

Service plans were not updated with changes including: (Cited in 14 programs)

- Weight loss and physician directed notification on parameters.
- Hospice services
- Staff assistance with applying/removing a medication patch.
- Behaviors
- Wandering/wanderguard
- History of UTIs
- Extent of incontinence
- Pain
- Difficulty swallowing
- A POAs request for the tenant to not leave the program with a particular person.
- Tenant’s representative crossed off services that were provided by them or a caregiver.
- Cueing with meals and speech therapy recommendations
- Assistive devices
- Falls and interventions
- When the program primarily administered medications but the tenant retained control of certain medications.
- Infection/antibiotic use
- Wounds/treatments
- Use of nitroglycerin including storage and administration
- Specialized diets
- Changes in ADL assistance
- Had a SNF stay
- New medications
- Choking
- Hospice
- Refusal of care or services
- Used a bed rail

Service plans were not developed for tenants that the program indicated were independent living tenants but resided in assisted living units.

The service plan was not developed prior to the tenant signing the occupancy agreement or taking occupancy. (Cited in 3 programs)

A service plan was signed but did not have a date that the signature was completed and was an initial service plan completed by an LPN.

Service plans were not updated within 30 days of taking occupancy. (Cited in 4 programs)

Service plans were not updated to include the tenant's nursing home preference. (Cited in 3 programs)

Nurse Review (481-69.27)

Nurse reviews were not completed at least every 90 days for tenants receiving services. (Cited in 6 programs)

A nurse did not document follow up when a tenant had high blood glucose levels, and elevated blood pressure.

A nurse review was not completed when a tenant had a foot wound that required surgery.

Nurse reviews were not completed as necessary for tenants with behaviors and who tested positive for Influenza.

A tenant did not have progress notes or nurse review when they tested positive for COVID-19 and received antiviral treatment.

Nurse reviews were not completed with health status changes for Tenant C1 who was treated with an antibiotic for a UTI and staff reported that the tenant had cold symptoms.

Food Service (481-69.28)

The program did not have a licensed dietitian when they served altered diets.

Foods were not served at appropriate temperatures including cold food was above 41 degrees and hot food was less than 135 degrees.

Staffing (481-69.29)

Staff did not check on a tenant for a period of 12 hours and during that time the tenant fell.

Tenant C1's service plan included an intervention of safety checks related to fall risk but did not identify the frequency of the safety checks.

Dementia – Specific Education for Program Personnel

Dementia specific education was not completed within 30-days of hire as required.

Life Safety – Emergency Policies and Procedures and Structural Safety Requirements (481-69.32)

Door alarms did not sound when the door was opened.

During the onsite survey, the front door opened without difficulty and did not have an alarm when required.

Doors separating the ALP/D and the Independent Living section were not alarmed and were held open with mag locks allowing all tenants to freely travel throughout. Additionally, the front and back entrance/exits weren't alarmed during the daytime (7 a.m. - 7 p.m.)

Structural Requirements (481-69.35)

The program did not maintain a clean environment based on observations of brown substances in a tenant's bathroom and on the carpet in their apartment. Another tenant's carpet had a large wet spot, and the spouse reported the shampoo had not been cleaned in over a year. Food stains were also noted on a recliner and there was an odor noted near the chair that was in a common area of the program.

For comments or questions related to the AL Survey Trends Report, please contact Kellie Van Ree, LAI's Director of Clinical Services.

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Visit our Assisted Living website for additional tools and Resources!