AL Survey Trends Report

July 2025

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

Website:

www.LeadingAgeIowa.org

Tel: (515) 440-4630

11001 Aurora Avenue

Urbandale IA, 50322

LeadingAge Iowa

July ALP Survey Update & Rule Review

by Kellie Van Ree, Director of Clinical Services

Survey activity:

- 23 recertification visits were available for review. 4 programs received insufficiencies averaging 1 per program. None of these insufficiencies resulted in a fine.
- 21 complaint and incident visits were available for review. 11 did not result in insufficiencies cited and 10 resulted in insufficiencies. The programs with insufficiencies averaged 2.7 with 4 of the 10 receiving a fine.
- 33 AL Providers are currently more than 24 months from their last recertification visit, with the longest time period being 33 months. The latest AL Rule Review includes information on ongoing tenant evaluations.

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

Congratulations to LeadingAge Iowa members on insufficiency free recertification surveys:

- AASE Haugen Assisted Living,
- Assisted Living at Deerfield,
- Kahl Home Assisted Living,
- Leland R. Smith AL Residences (Wilton Retirement Community),
- Martina Place (Bishop Drumm), &
- Wesley on Grand Central Assisted Living (WesleyLife)
- Heritage House Assisted Living (WesleyLife)

Insufficiencies with Fines

67.2(3); $7,000. Tenant #1 eloped from the program on 7.5.25. Tenant #1's last known location was by the beauty salon door at 1:50 p.m. The staff reported they did not receive a door alarm alert and didn't notice the tenant missing until approximately 4:00 p.m. The police were notified, and the local fire department directed search efforts. At 9:00 p.m. the police received a call saying that the tenant was located near the middle school, which was approximately a half mile away, they were transported to the ER and admitted for acute kidney injury, dehydration, and elevated creatinine levels. Investigation revealed that earlier in the day there were problems with the fire panel, and the mag lock did not reengage on the beauty salon door as well as a secondary alarm should have been in place, but when checked the batteries were removed from the alarm. The program had checked function of the alarms weekly, but the maintenance director indicated that they only completed the primary alarm and did not check the function of the secondary alarm.

67.2(3); $5,000. Tenant #1 was noted to frequently stand by exit doors and attempt to follow others out when the door was open. According to staff reports on 6.1.25 a door alarm sounded between 7:30 and 7:45 p.m. but both staff were in the middle of tasks and did not immediately respond. When they were able to respond, they did not see anyone near the door. Later they realized that Tenant #1 was missing. During investigation it was determined that staff members did not respond to the alarm for approximately 9 minutes (the report identified the alarm sounded at 8:00 p.m. and ended at 8:09 p.m.). Another staff member was off duty and drove past a person who resembled Tenant #1 when they drove to the program to see if the tenant was missing. The tenant was then found about 0.9 miles from the building, sitting in an ambulance before returning to the program.

67.3(2); $10,000. Tenant C1's service plan directed staff to provide standby assistance with a weekly shower and that the tenant was at risk for falls. On 7.8.25 at 6:30 p.m. Tenant C1 was in the shower when they slipped and fell on the wet floor. The tenant was noted to have a hematoma on their head and abrasion to their right arm. They were assisted off the floor, dried off and dressed before staff called for transportation to the ER. In the ER, the tenant was diagnosed with subdural and subarachnoid hemorrhages and their condition declined quickly including a need to intubate. The tenant was placed on comfort cares and admitted to the hospital, later passing away. During investigation it was noted that a non-slip mat, which is standard in all showers in the program, was not in place. Additionally, the staff reported not being educated on what stand-by assistance meant and that they needed to remain at the tenant's side during the shower. During review of training records, the staff member that assisted the tenant with the shower was hired on 6.625 and the sections that included training on bathing/shower were blank/incomplete. The ED indicated that staff follow a staff trainer and once the trainer felt the new employee was confident in completing tasks they signed off the form. The ED was unaware that the training was incomplete.

67.5(2)f(4); $5,000. A staff member prepared two tenants’ medications at the same time resulting in Tenant #1 receiving another tenant's medications including a hypoglycemic medication. Later the tenant was unresponsive, and staff called EMS who administered nasopharyngeal glucose and then D50 when the tenant finally began responding.

Program Policies & Procedures (481-67.2)

An incident report completed when a tenant eloped from the program lacked required information.

An incident report was not completed when a tenant eloped from the program.

The staff did not follow the medication policy by notifying the program manager when they had suspicion of altered medication packaging.

The program did not follow their policy on medication errors by documenting the medication error and notifying the primary physician.

The allegation of abuse policy was not followed when the program investigated the incident and terminated the employee for exploitation but did not report the incident to DIAL.

Program Notification to the Department (481-67.4)

The program did not notify the department when a tenant pushed another tenant down causing fractures.

Medications (481-67.5)

Tenant #1 did not receive their medications as ordered as the medications were on hold during a hospitalization and were not resumed timely upon the return of the tenant.

Staffing (481-67.9)

Three staff did not receive training by the programs registered nurse within 30 days of hire.

Evaluation of Tenant (481-69.22)

Change in condition evaluations were not completed when:

- Hospice services were initiated.
- Increased behaviors were identified.
- The tenant had increased swelling.
- Had a change in assistance required for ADLs.
- Falls
- Hospitalization.
- Had a skilled care stay.

Only cognitive evaluations were completed without completing health and functional evaluations.

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

Tenant #4 remained in the program despite routinely requiring two-person transfer assistance.

Tenant Documents (481-69.25)

The program did not document nurses notes by exception including when a tenant had a urinalysis, what led to the test, results and further actions based on results.

Tenant #3 and C4's service plans could not be located prior to 2024.

Service Plans (481-69.26)

Service plans were not updated as needed with examples including:

- Hospice services
- Diet changes
- Fall risk and interventions
- Actual falls
- Offers to use PT services
- Skin breakdown, treatments, and when the areas were healed.
- Use of gait belt
- Discontinuation of therapy services
- Toileting assistance
- Use of incontinent products and directions of assisting the tenant with changing.
- Fractures of the hand and hip/pelvis which led to changes in ADL assistance.
- Hospitalization
- Skilled nursing stay
- Changes to medications

The service plans did not accurately reflect the tenant's ADL abilities when staff were interviewed about how tenants actually performed.

Tenant #1's service plan was not updated until approximately two months after a change in condition occurred.

Staffing (481-69.29)

The program staff did not ensure that staff were adequately trained to provide care to the tenants of the program based on a staff member not having signed orientation/training forms.

The program manager/delegating nurse did not complete a new program manager or nurse delegation course within 6 months of hire.

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

The program did not have a policy on staff response when a service plan identified a risk of elopement or wandering.

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

Visit our Assisted Living website for additional tools and Resources!