AL Survey Trends Report

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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.

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March ALP Survey Update & Rule Review

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Survey activity:

- 6 initial and recertification visits were available for review. 4 of the 6 (67%) received insufficiencies with an average of 3.5. 1 (25%) fine was issued based on a recertification visit.
- 38 complaint and incident visits were available for review. 16 didn't result in insufficiencies cited and 22 resulted in insufficiencies. The programs with insufficiencies averaged 3.7 per program with 3 (14%) resulting in fines.
- 39 AL Providers are currently more than 24 months from their last recertification visit with the longest being 35 months since their last recertification. This number increased over the last couple months with fewer recertification visits being conducted.

The latest AL Rule Review includes additional information on 481-69.26(4) - Individualized Service Plans.

Note in the report under 481-69.24 that a program was cited for not sending the involuntary discharge notice to the ombudsman via certified mail. With the changes to the administrative rules which were effective mid-March, this is no longer required. Programs will be compliant if they *"immediately provide to the office of the long-term care ombudsman, by mail or email, a copy of the notification…"*

Congratulations to the Assisted Living at Northcrest Community on an insufficiency free survey!

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

Insufficiencies with Fines

67.2(3); $6,000. Tenant C1's service plan indicated they needed reassurance checks. During an interview the assistant director of health services indicated that reassurance checks included checking on tenants every two hours, but his was a general expectation and not included in individualized service plans. An incident involving Tenant C1 occurred on 12.5.25 at approximately 2 a.m. when staff responded to their room for the motion sensor being triggered. They turned off the alarm and exited the room while the tenant used the bathroom as the tenant was independently ambulatory. The following morning, the staff were called to the tenant's unit due to the tenant still being on the toilet and couldn't stand due to pain which later led to an ER visit. The tenant's family reported they checked the doorbell camera footage and identified that staff failed to check on the tenant for more than 6 hours while they sat on the toilet. Staff also reported that tenants in the memory care didn't use pendants and there weren't call lights in the bathrooms to summon help.

67.2(3); $3,000. Tenant C1's progress notes included an incident on 6.1.25 at 8:40 p.m. when staff reported a fall. The staff left the resident's unit to summon the Wellness Director and the tenant got themselves off the floor. At the time the tenant denied pain and their vital signs were normal. A couple days later the tenant reported pain and had difficulty standing. The nurse completed an assessment which noted range of motion was completed without difficulty, but the tenant reported pain which staff administered Tylenol for. The following day (6.5.25), the tenant had increasing difficulty standing and the ARNP directed staff to send them to the ER. The incident report for the fall wasn't completed until 6.5 (4 days after the incident). During review of camera footage from the incident, it was noted that the tenant became aggressive when the staff member attempted to give another resident medication and the staff member pushed Tenant C1 causing them to fall. No incident report of the staff member pushing the resident was located. The program failed to complete an incident report when the fall occurred and failed to complete additional investigation within three business days as outlined in their policy. Additionally, the tenant’s legal representative or family weren't notified of the fall.

67.3(2); $6,000. Tenant #1 was admitted to the hospital on 2.23.26 because they had a fall and possibly laid on the floor since the day prior. During assessment and diagnostic testing, it was noted the tenant had rhabdomyolysis and a pressure wound to the left hip. Staff reported that the tenant didn't receive any services and was very independent. They frequently went out of the program so if the tenant didn't show up to meals it wasn't abnormal. The program implemented a system that they will now check on tenants who don't come to meals.

69.32(2); $3,000. Tenant #1 left the building through a door on the north side of the building that failed to properly magnetically lock after a staff member entered the building. The tenant was noted outside and escorted back into the building without injuries 12 minutes later.

Insufficiencies Without Fines

Program Policies & Procedures (481-67.2)

The program failed to follow their abuse policy by reporting possible allegations of abuse immediately.

Incident reports weren't completed when tenants were noted to have open sores on their buttocks and arm.

The program failed to follow their internal abuse reporting policies when Tenant #2 reported a concern with a staff member being rough while assisting them with care. The program specifically didn't notify DIAL of the tenant's concern.

Staff had a snapchat group where they sent pictures of tenants back and forth including one of a tenant going to the bathroom. The policy for abuse was not followed as numerous staff had knowledge of the incident and failed to report it. During investigation it was also noted that another staff member was making degrading comments towards tenants including statements about their weight and odor. Additionally, staff failed to follow the menu substitution policy when staff didn’t complete substitution logs. During observations refrigerators were also dirty, the temperatures exceeded 40 degrees, and freezer temperatures weren’t monitored.

An incident report wasn't completed for a tenant who fell and fractured their right wrist and pelvis.

The program didn't follow their abuse policy when a tenant's family reported that there were charges on their credit card. The program identified a suspected staff member and didn't update the report to the department. The program also failed to report other tenants’ missing items that were identified during the investigation. An incident report wasn't completed when a tenant's spouse pushed and pulled on their spouse and grabbed staff.

The program’s policy for incident reports failed to include collection of witness statements.

The program’s occurrence policy failed to identify that reports would be maintained onsite for three years.

Staff didn't follow the program policy on narrative charting by including sufficient details in the charting such as failing to include which ER the tenant was sent to, date, time or reason the tenant went to the ER.

The program failed to follow the incident report policy as an incident report wasn't completed until 3 days after a fall occurred and the family wasn’t notified for more than an hour after the incident.

The staff failed to follow medication administration policies when they borrowed a bottle of Morphine from another tenant. Additionally, staff failed to notify a tenant's family when the tenant was transferred from the program to the emergency room.

Tenant Rights (481-67.3)

Staff took a tenant's cell phone away from them at night due to repeatedly calling their daughter overnight.

Staff said degrading comments to tenants including comments about their weight and odor.

Tenants were not treated with respect and dignity, including when a staff used profanity and was rude to the tenants. Staff also forced tenants to take showers which elicited behaviors.

Medications weren't administered to the tenant due to the family electing to use a different pharmacy and the staff weren’t aware the medications were in the apartment.

The program failed to address ongoing concerns expressed by tenants when another tenant at the program had their TV volume excessively loud.

According to interviews the program requested an order for hospice to evaluate without consulting with the tenant's family/responsible party first.

A family member expressed concerns about the tenant's clothing being returned to them after laundering.

Staff weren't present in the dining room as the program required, which led to incidents between several tenants including a tenant choking another tenant and the other tenant attempting to fight while other tenants intervened. Another tenant reported being left in the shower for an extended time. During investigation it was determined the tenant's bathroom pull cord was activated for 27 minutes.

Program Notification to the Department (481-67.4)

There were several incidents of flooding in the building that caused damage to multiple areas that weren't reported to the department.

Medications (481-67.5)

Medications for one tenant weren't administered in a timely manner and according to physician orders.

Individuals who were not certified medication managers handed tenants medications prepared by other staff.

Tenant #4 went to the ER following a tenant-to-tenant incident and was diagnosed with a broken rib and given pain medication as needed and use of an incentive spirometer. The incentive spirometer was not transcribed onto the MAR. Additionally, Tenant #4 had an order for Entyvio and there was a note that the program was discussing with the family and awaiting insurance approval. There wasn't an order or documentation that the medication was discontinued.

Medications weren't administered according to physician's orders when a tenant failed to have Jardiance.

Staff failed to administer cranberry tablets to the tenant as ordered by the physician.

Medications weren't administered according to physician's orders when they weren't available.

Waiver of Criteria for Retention (481-67.7)

The program didn't submit a request for waiver when a hospice patient exceeded residency criteria.

A waiver for retention criteria wasn't submitted to DIAL for Tenant C1 who exceeded residency criteria.

Staffing (481-67.9)

Staff didn't observe the tenants fully administer medications before walking away from them, which was not in accordance with their competency training.

Staff failed to have a communication form for the memory care unit to express changes or concerns with tenants to the program staff.

Communication notes weren't completed when changes were identified including increase in agitation and verbal aggression, an incident between spouses where the spouse became physical with the other, increased confusion, and behaviors.

Staff didn't complete Dependent Adult Abuse training within six months of hire.

During observation the staff failed to follow established competency training by completing hand hygiene prior to medication administration.

Staff failed to administer insulin in accordance with competency training as they didn’t complete hand hygiene prior to donning gloves and didn't cleanse the site before administering. Additionally, another staff provided a tenant's family member with a syringe of morphine for them to administer.

Sufficient staffing wasn't provided to prevent tenants from fighting as evidenced by reviewing camera footage where a fight occurred between two tenants.

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

The criminal background check was not completed until 2 days after one staff began employment. (Cited 2 times)

A criminal background check indicated staff had a criminal history. The background wasn't submitted to HHS for evaluation. (Cited 2 times)

A staff member's maiden name was not submitted during a background check.

An evaluation of a criminal history was not requested from HHS for one staff member.

Evaluation of Tenant (481-69.22)

Evaluations weren't completed upon significant change in condition including the following examples: (Cited 4 times)

- Stopped getting out of bed
- Pocketing food
- Frequent weight monitoring
- Weight loss
- Decreased urinary output
- Improvement in condition including discontinuation of an immobilizer and upgraded weight bearing status
- Overnight restlessness
- Falls
- Edema
- Therapy services initiated and/or discontinued
- Hospitalization

Evaluations upon a significant change in condition failed to include cognitive and functional evaluations.

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

A tenant was retained by the program that exceeded criteria including dependence on two staff for transfers and ADLs along with evacuation.

Tenants were retained in the program when they were physically aggressive and displayed unmanageable aggression.

Tenant C1 exceeded criteria including being mostly bed bound and required assistance with repositioning in bed.

The program retained two tenants with physical and verbal aggression.

Involuntary Transfer from the Program (481-69.24)

The program failed to provide an involuntary discharge/transfer notice to the tenant or their family including the reason why they were being asked to leave.

The long-term care ombudsman wasn't notified of an involuntary transfer/discharge via certified mail as required. *See notes at the beginning of this report.

Tenant Documents (481-69.25)

An incident report wasn't completed when Tenant #6 was found walking outside of the building.

Nurses' notes weren't documented by exception including the following examples: (Cited 4 times)

- A tenant was hospitalized and returned due to jaw swelling and starting an antibiotic until the tenant passed away the following day
- Allegations of abuse and investigation
- Incidents
- Laboratory specimen collection & follow up

- Confusion

Progress notes weren’t available for specific tenants as the program indicated the previous management company didn't turn them over.

Incident reports weren't completed for all incidents involving Tenant #2 and #3.

Staff failed to document tasks they assisted the tenants based on their service plans.

The program was unable to locate records for tenants when requested by surveyors.

Service Plans (481-69.26)

Service plans weren’t updated to include (cited 11 times)

- Changes to assistance with ADLs
- Changes to continence
- Urinary catheter & the need for assistance with care
- Hospice
- Behaviors & interventions
- Infections
- Pocketing food
- Weight loss & interventions
- Decreased urinary output
- Improved condition
- Pain medication
- Bed bound
- Fall
- Fracture
- Therapy

The tenant's services plans failed to include a list of planned and spontaneous activities for tenants with dementia. (Cited 3 times)

Service plans weren't based on evaluations for three tenants. (Cited 2 times)

Service plans weren't signed by all parties who participated in developing them. (Cited 3 times)

Tenant #1's service plan wasn't reviewed and signed at least annually.

Nurse Review (481-69.27)

Nurse reviews were not completed as needed including an incident for Tenant #4.

Dementia Specific Education for Program Personnel (481-69.30)

Staff failed to complete at least 8 hours of dementia specific training within 30 days of hire (Cited 2 times)

Staff failed to complete at least 8 hours of dementia training annually. (Cited 2 times)

Life Safety – Emergency Policies & Procedures and Structural Safety

Tenant #1 was attempting to exit the building and staff thought they had the door latched but went to get a walkie talkie and upon return the tenant was not present but their walker was. The staff member reported the alarm didn't sound but the tenant was found outside.

There wasn't a policy or procedures addressing the staff's response when a tenant exhibited wandering behavior or when they were at risk for elopement.

Structural Requirements (481-69.35)

The building was not maintained appropriately including broken handicap buttons that left doors ajar, discolored countertops, water marks that were not repaired or replaced, mold in two apartments,

Written Occupancy Agreement (231C.5)

The occupancy agreement failed to identify emergency response procedures.

Medication Setup- Administration and Storage of Medications (231C.16)

Staff who were not administering medications to tenants had access to keys and locked medications.

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

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