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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October ALP Survey Update & Rule Review

by Kellie Van Ree, Director of Clinical Services

Survey activity:

- 34 recertification visits available for review. 5 programs received insufficiencies averaging 3.8 per program without any fines issued.
- 21 complaint and incident visits were available for review. 15 did not result in insufficiencies cited and 6 resulted in insufficiencies. The programs with insufficiencies averaged 3 per program and 2 of the 6 (33%) received a fine.
- 24 AL Providers are currently more than 24 months from their last recertification visit. During the recent Assisted Living Bootcamp, Catie Campbell reported that the Assisted Living unit has a plan to catch up with recertification visits by the end of the year.

The latest AL Rule Review includes information on 481-69.24 – Involuntary Transfer from the Program Based on Department Findings.

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: Grace Estates by Lakeside Lutheran Home and Vista Prairie at Fieldcrest Memory Care

Insufficiencies Resulting in Fines

67.2(3); $5,000. Tenant #1 triggered the entrance door alarm on 8.27.25 at 4:55 p.m. and the marquee reported the tenant's information as the person triggering the alarm. The staff did not immediately respond to the door as their policy directed them to. According to the timeline established through investigation, staff did not respond to the door until approximately 10 minutes after the door alarmed and 7 minutes after the tenant exited the door. The program alerted the police who assisted with the search and the tenant was eventually found at 11:54 p.m. near the railroad tracks more than a mile away from the program.

67.3(2); $4,500. The program did not have a nurse assess a tenant in a timely manner when the tenant complained of pain after a fall. The tenant was later transferred to the ER and diagnosed with multiple rib fractures. Additionally, the program did not provide services for incontinent care and administer medications as ordered.

Insufficiencies without fines

Occupancy Agreement (231C.5)

Tenant #1's daughter reported during an interview that they received a bill for nearly $80,000 in charges that they did not authorize. The tenant's occupancy agreement did not include a description of fees charged for 1:1 care provided by agency staff that the tenant received a bill for.

Program Policies & Procedures (481-67.2)

An incident report was not completed for a tenant's fall.

The incident report policy did not include information on obtaining witness statements.

The program did not follow the medication administration policy and procedures when medications were not transcribed on the MAR, they did not have a MAR developed for a long time and they did not administer medications as ordered.

Tenant Rights (481-67.3)

The staff were unaware of how to reapply a Wanderguard device. According to interviews, the device was removed when the tenant went on an outing and staff did not know how to reapply the device. This resulted in the tenant leaving the building without staff assistance.

Program staff did not communicate health concerns with home health staff that were providing care for the tenant. Additionally, tenants did not receive care and services which resulted in them missing meals and receiving incontinent care.

Medications (481-67.5)

Medications were not administered as ordered as they were unavailable.

The program did not administer medications as ordered due to not having supply available from the pharmacy including several tenants and different prescriptions.

Staffing (481-67.9)

A new program registered nurse did not review the staff competencies within 60 days of hire. (Cited twice)

Evaluation of Tenant (481-69.22)

The program did not complete cognitive evaluations prior to occupancy for several tenants. Tenant #4's health and functional evaluation indicated they were independent with eating, transfers, and ambulation but the staff reported the tenant was unable to stand or transfer on their own and was observed needing assistance with eating due to a visual impairment.

Tenant evaluations were not completed within 30 days of occupancy.

Tenant evaluations did not include health, cognitive, functional or a combination of these on several tenants.

Did not complete a significant change evaluation when a tenant was placed on hospice (cited twice).

Cognitive evaluations were not completed with significant change evaluations. Also, Tenant #2's assessments and service plan did not include that they received hospice care. Tenant #3 did not have significant change evaluations with initiation of OT services. Tenant C1's evaluations were not completed upon significant change when they went to the hospital and returned with hospice services due to a terminal condition.

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

Tenant #5 was primarily bed bound and was retained by the program.

During a staff interview they reported that Tenant #1 needed two-person assistance for transfers more than half the time and routinely needed two-person assistance to get out of bed. The program did not discharge or transfer the tenant when they exceeded retention criteria.

Tenant #4 required assistance with eating due to visual impairment, was unable to bear weight and needed two-person assistance for transfers. The staff reported that the tenant required this level of assistance since they moved into the program and the program allowed the tenant to move in and remain in the program.

Involuntary Transfer from the Program (481-69.24)

The program did not notify the tenant's primary physician of involuntary transfer or discharge from the program.

Tenant Documents (481-69.25)

The program did not maintain tenant records including have medication cart audit reports, medication error reports, or individualized tenant task sheets.

Service Plans (481-69.26)

The following items were not identified on service plans, which was cited in ___ surveys:

- Falls
- Wandering
- Need for crushed medications
- Behaviors
- The tenant's preference to use alcohol and the physician's recommendation to taper use.
- Staff dispensed medications but the tenant stored them in their apartment.
- The provider of mental health services.
- Home health company that provided services to the tenant.

Tenant's service plans were not updated when they were admitted to hospice care (cited twice).

Tenant #4's service plan indicated they were independent with eating, transfers, and ambulation. During staff interview they reported Tenant #4 always required assistance with eating and two staff to help transfer.

The program did not complete a service plan prior to occupancy.

The service plan was not updated within 30 days of occupancy (cited twice).

Service plans were not updated upon significant change in condition including hospice services, OT services, hospital transfer and return with terminal condition/hospice referral.

Nurse Review (481-69.27)

The program did not complete a nurse review every 90 days.

Nurse reviews were not completed at least every 90 days and with significant changes for 3 tenants reviewed.

Nurse reviews were not completed to ensure that wound care orders were followed and were current on the MAR.

Nurse reviews did not include wounds, use of a wound care specialist, and review of the orders. A discharged tenant's nurse reviews did not include that they were diagnosed with a terminal illness or that hospice services were initiated.

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

Access current resources on the LeadingAge Iowa Assisted Living Resources page!