# AL Survey Trends Report

## October 2024

*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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# October ALP Survey Update & Rule Review

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Survey activity:

- 27 recertification visits were available for review. 20 of these were insufficiency free. 7 resulted in insufficiencies that averaged 6.9 per program. 1 of these resulted in a fine (or 17%).
- 6 complaint and incident visits were available for review. 2 of these were unsubstantiated with 4 resulting in insufficiencies. The programs with insufficiencies averaged 5.3 with 2 fines (or 50%).
- 127 AL Providers are currently more than 24 months from their last recertification visit.

In addition to the nurse delegation rules included in last month's Assisted Living (AL) rule review, Chapter 67.9 also contains rules regarding sufficient staffing and additional training requirements. While the rules in AL don't provide an overall staffing per tenant ratio, they indicate that the staffing levels must be sufficient and must have training to meet identified tenants' needs. This can be very subjective, however, if during tenant council or town hall meetings you receive complaints about staff response to pendants or a lack of services provided then you likely are not meeting the "sufficient staffing" requirement.

Staff must also be able to implement emergency procedures including accidents and fire safety at all times. In order to meet this requirement, staff must be appropriately trained on what your procedures are. A best practice for this is on hire and periodically thereafter. Each program should identify what periodically means. A good process to identify if your program is including enough training on these emergency procedures is by testing the staff such as drills. Are they following the policies when conducting fire drills? If not, you will want to re-educate them on the what they should be doing.

The last training item included in Chapter 67.9 is dependent adult abuse training. The Assisted Living rules for dependent adult abuse are based on Iowa Code 235B.16. The Iowa Code indicates that staff shall complete two hours of training relating to the identification and reporting of dependent adult abuse within six months of hire and every three years thereafter. In addition, programs may provide supplemental training specific to identification and reporting of dependent adult abuse as its relates to the individuals professional practice. This includes program specific procedures on abuse.

Chapter 67.9(5) is the last rule in this subsection and relates to prohibited practices. A program staff member cannot be designated as a tenant's attorney-in-fact, guardian, conservator, or representative payee unless the program staff member is related to the tenant by blood, marriage, or adoption.

## Congratulations to Terrace AL of Hillcrest Home, Aspen Cottage, Linden Place, Landsmeer Ridge, and Lutheran Home Apts on insufficiency free recertification surveys!

**Insufficiencies Resulting in Fines for the Month of October**

**67.2(3); $3,500.** Tenant #1 received Tenant #2's morning medications including Aspirin, Diltiazem, Iron, Lasix, Levetiracetam, and Potassium. The tenant was sent to the hospital and received a sodium chloride and calcium chloride injection to counteract the medications as well as oxygen due to a low oxygen saturation. During an interview it was identified that the staff pre-popped both tenant's medications and placed them in cups with room numbers written on the cups and they were given incorrectly.

**67.3(9); $2,000.** Tenant #1 had an order for Risperidone liquid 0.5 ml three times per day. Staff and the Health Care Coordinator (HCC) noted the tenant was more lethargic in the afternoon and were attempting to determine a cause as the tenant did not have the same effects in the morning. Staff expressed concerns that Staff A may have been administering a higher dose of Risperidone than ordered. During an interview Staff A admitted this, stating it was to help control the tenants behaviors. The bottle of Risperidone should have lasted 20 days based on the prescribed dose. However, the pharmacy reported that it was refilled on 4/19, 5/3, 5/17, 5/29, 6/11, 6/24, 7/1 and 7/5. The HCC reported the pharmacy called and questioned the frequent refills but the HCC did not investigate it. During investigation, staff reported concerns including witnessing Staff A draw 3 ml of Risperidone into the syringe (6 times the prescribed dose) and when questioned they would put it back in the bottle and ask the staff not to say anything.

**69.32(2); $4,000.** On 8/19/24 at 6:28 p.m. the Activity Director (AD) called the Executive Director to inform them that Tenant #3 was at their house, approximately 1.5 miles away from the program. The ADON went to the AD’s home and assessed the tenant and assisted them in returning to the program. Upon investigation of the incident, it was noted that a family member of another tenant entered the code to open/disarm the alarm on the memory care unit doors and held the door open to allow Tenant #3 to exit as they were unaware they were a tenant. The tenant then left the front doors of the building that were not alarmed. During interviews the ALP-D program reported the front doors to the program did not have an installed door alarm.

**Insufficiencies Without Fining**

**Occupancy Agreement (231C)**

The occupancy agreement did not include all required information regarding involuntary transfer procedures and the internal appeals process.

**Program Policies and Procedures (481-67.2)**

An incident report was not completed when a tenant was missing from the program when they left the building to go for a walk without staff knowledge.

The program did not complete medication error reports according to the policy.

Staff did not follow the program policy on reporting abuse when several staff had concerns that another staff was providing too much liquid antipsychotic medication to a tenant.

The program did not follow the policies on medications and incident reports when a staff member found morning medications locked in medication cabinets that should have been administered for four tenants. Incident reports on the medication errors were not completed. Tenant #1 also had a medication error with their Xarelto that did not have an incident report completed.

The program's policy on medication labeling was not followed as a tenant's insulin pen was not dated when it was opened.

No cleaning checklists were in the kitchen with staff names, initials and dates according to the program policy and procedure. Insulin pens were noted without an open date and one pen had a date on it but was past the 28 days passed the open date and should have been discarded.

**Tenant Rights (481-67.3)**

Unlicensed staff were packing wounds for tenants within the programs which is not allowed according to scope of practice rules.

Tenant #2 had several falls during the month of August and into September. A nursing assessment for an incident report stated that staff will monitor and check on the tenant more often. However, documentation of these checks could not be located and the service plan did not include increased safety checks.

The program did not complete tasks for the tenants including bathing, safety checks, and assistance with toileting. The staff reported that tasks were not completed due to staffing shortages.

**Program Notification to the Department (67.4)**

The program did not report a tenant’s fall that resulted in a hip fracture.

A tenant pushed another tenant causing them to fall which resulted in compression fractures and was not reported to the department.

**Medications (481-67.5)**

Staff did not have insulin pens stored in a locked refrigerator as they were stored in a common area refrigerator where everyone could access them.

Medications were pre-filled and left in unlocked cabinets in the kitchen where everyone (including tenants) could have accessed them.

Physician’s orders were not followed as glucose levels were not monitored appropriately and several medications were not administered.

Did not administer medications according to the physician's orders for five tenants.

Tenant #1 had an order for Lyrica which was increased to 75 mg capsule three times daily. The MAR indicated this dose was administered, however, the control record only indicated 1 tablet was removed from inventory for several days in August. The program also suddenly stopped the medication despite the physician's office calling and saying that it should not have been. The tenant's daughter stated that this caused the tenant to have increased pain, crying, fatigue, sweating and a poor appetite. Tenant #3 did not receive several doses of Tradjenta according to the physician’s order.

Physician’s orders were not followed including monitoring blood glucose levels, changing a Dexcom sensor, application of antiembolism hose, treatments to skin areas, and application of a shrinker.

**Staffing (481-67.9)**

Nurse delegation training and competency evaluation was not completed regarding showering a tenant with a wound vac present.

Staff did not have nurse delegation training on Dexcom blood glucose monitoring devices.

The staff did not follow nurse delegation training for narcotics. While counting narcotics, staff noted the count was incorrect. While investigating the program manager identified that instead of correcting, the staff member wasted a Lorazepam tablet.

**Occupancy Agreements (481-69.21)**

The occupancy agreement did not have the correct phone number listed for the LTC ombudsman, failed to clearly state that dependent adult abuse should be reported to the department, and a statement that the tenant landlord law applied to assisted living programs.

The occupancy agreement was not updated when room charges were changed.

**Evaluation of Tenant (481-69.22)**

Tenant #3 did not have a GDS evaluation completed when the BIMS indicated moderate cognitive impairment.

Several programs were cited for failure to complete evaluations within 30 days of occupancy.

Evaluations were not completed with changes in condition including:

- Increased confusion
- Mental health services initiated
- Blood glucose levels outside of established parameters
- Pain
- Wounds including newly present, treatments ordered, wound vac, and wound clinic services were involved
- Elopement
- Change in ADL assistance, transfers, and mobility
- Behaviors
- Falls
- Tenant-to-tenant incidents
- Refusals of medication
- Hospice services initiated/discontinued
- Hospitalizations
- Refusal of services/cares

**Criteria for Admission and Retention (481-69.23)**

A program retained a tenant that required more assistance than allowed in an AL setting including use of two staff for transfers and mobility.

A tenant was retained who was physically and verbally aggressive towards others.

**Involuntary Transfer from the Program (69.24)**

The program issued an involuntary discharge notice to Tenant C1. The program did not address the letter to the legal representative and include the contact information for the LTC ombudsman. On 6.25.24, the letter was sent to the legal representative, again it did not include information for the LTC ombudsman.

The primary care physician wasn't notified of an involuntary transfer when a tenant exceeded retention criteria.

**Tenant Documents (481-69.25)**

Several programs were cited for a failure to complete nurse's notes by exception including:

- Contacting the primary care physician for new orders
- Low blood glucose levels
- Wound clinic visits
- Surgical debridement and placement of a wound vac
- Return to the program following ER visit, hospitalization, and/or skilled stay
- Newly acquired respiratory illness symptoms
- Antibiotics
- Signs of UTI

The program was unable to find a signed DNR order when a tenant fell and did not have vital signs upon arrival of the ambulance.

Tenant #2 and C1's record did not have copies of power of attorney documentation.

Did not maintain task sheets for one tenant

The program did not maintain communication sheets between the direct care staff and the managing nurse as required.

The program was unable to locate initial evaluations or service plans for Tenant C1.

**Service Plans (481-69.26)**

Several programs were cited for not updating service plans with changes in condition including:

- Frequent low blood glucose levels.
- Staff assistance with monitoring blood glucose levels
- Use of a Dexcom blood glucose monitoring system
- Wounds, including surgical wounds, use of a wound vac, and wound clinic
- Pain
- Changes in ADL assistance including transfers, mobility, and ambulation
- Elopement and wandering
- Safety checks
- Mental health evaluation and treatment
- Suicidal statements
- Hospitalization
- Skilled stay
- Behaviors

- Change in delegation for medication administration
- Pressure ulcer prevention measures
- Falls and interventions
- Hospice
- Medication refusals
- Therapy services
- Infection
- High-risk medications
-

Service plans were not based on completed evaluations as a health evaluation was not completed for Tenant #2.

Several programs were cited for not updating service plans within 30 days of occupancy.

Did not ensure service plans were dated and signed by the tenant or representative and person completing.

Service plans did not include planned and spontaneous activities for two tenants.

**Nurse Review (481-69.27)**

The program did not complete 90-day nurse reviews for four tenants reviewed.

Nurse reviews were not completed at least every 90 days for three tenants.

Nurse reviews were not completed for two tenants including when a tenant had an elevated INR and when a tenant was hospitalized.

**Food Service (481-69.28)**

The program did not have a registered dietitian that provided therapeutic menus and training on thickened liquids and puree processes. During the survey there were concerns about the consistency of thickened liquids and training conducted by the program. The program also did not have the 9th edition of the Simplified Diets Manual available as required.

**Staffing (481-69.29)**

The delegating nurse did not have training in AL rules as required within six months of being appointed.

**Dementia Specific Education for Program Personnel (481-69.30)**

Staff C did not have 8 hours of dementia training within 30 days of hire.

Staff B did not have 8 hours of dementia training annually as required.

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

During observations the door exiting the building to the courtyard was not alarmed.

A patio door did not have an alarm on it as required.

The main entrance and entrance labeled assisted living did not have a functioning alarm system as required.

*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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