AL Survey Trends Report

September 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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September ALP Survey Update & Rule Review

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Survey activity:

- 24 recertification visits were available for review. 9 of these were insufficiency free. 15 resulted in insufficiencies that averaged 2.5 per program. 3 of these resulted in a fine (or 20%).
- 19 complaint and incident visits were available for review. 8 of these were unsubstantiated with 11 resulting in insufficiencies. The programs with insufficiencies averaged 2.8 with 3 fines (or 27%).

The next rule to review in the AL Rule Review series is 481-67.9 which relates to staffing. This month we will focus on nurse delegation procedures. Each program must staff a registered nurse (RN) that must ensure each staff member employed in the program is competent to perform expected duties. At a minimum, nurse delegation has to include:

- A newly hired RN must document a review to ensure that all staff are properly trained and competent to perform duties within their assignments within 60 days of hire.
- All staff must receive training and competency evaluation within 30 days of being hired by the program.
- Training for non-certified staff must include the provision of activities of daily living (ADLs) and instrumental activities of daily living (iADLs). Again, this will be within their assigned tasks. For example, if a person is assigned dietary tasks and activities, they will not be required to receive training/evaluation on ADLs.
- Both certified and non-certified staff must receive training regarding service plan tasks in accordance with medical or nursing directives and the acuity of the tenants in the program. This takes into account the individual tenant needs in your program. For example, you may have a tenant that has a colostomy which would require that each staff member be trained and competent with colostomy cares. However, if that tenant leaves and no others have a colostomy, then it would no longer be required to teach and evaluate competencies for staff.
- The RN must provide direct or indirect supervision of all staff (certified and non-certified) as necessary in their professional judgement and in accordance with the needs of tenants and staff. As stated, supervision is based on the necessity of each person and in accordance with the RNs comfort level. For example, the RN may routinely review task records to ensure that all items are being completed and documented. However, if there are concerns identified that an individual may be signing tasks that are not actually completed, they may directly supervise the person to ensure the task is being completed as it should be according to the training including accurate documentation.
- Services must be provided in accordance with the training. This rule is important as your competency training and evaluation checklists may require specific details to your program, such as electronic charting vs. paper. The expectation is that the staff provide care exactly to the training they received. For example, if your program has a policy that the aide will notify the program RN when a blood sugar is less than 70, the surveyor is going to expect that task is occurring when reviewing the tenant's records.
- The program must have a system in place for communicating concerns on tenant's health, functional and cognitive status. This must be retained for a minimum of three years and

must be provided to the surveyor upon request. Insufficiencies are occasionally written on this when programs discard the communication after all staff have read it.

- In the absence of the program RN due to vacation or other temporary circumstances, the nurse assuming the duties of the program's RN shall have access to staff training in relation to tenant needs.

While we are discussing nurse delegation it is also important to review 481-69.29(6) which requires new delegating nurses that are hired after January 1, 2010 must receive an assisted living manager course or assisted living nursing class whose curriculum includes at least six hours of training specifically related to Iowa rules and laws on assisted living. A minimum of one delegating nurse from each program must complete the training. If there are multiple delegating nurse and only one attends the training, they must train the other delegating nurses on the rules and laws.

Congratulations to Calvin Community on an insufficiency free survey in both AL & Memory Care!

Insufficiencies Resulting in Fines for the Month of September

67.2(3); $500. Staff did not immediately report an incident of abuse when it was witnessed on the evening of 3/27/24 and the staff member who was the alleged perpetrator continued to work until the morning of 3/28/24.

67.3(2); $3,000. A tenant had behaviors of going into other apartments and collecting other tenants' items. On 7/6/24 the tenant was in another tenant's apartment and attempted to take some papers when the other tenant went to protect their property. The tenant pushed them down which resulted in a fractured hip. During record review, Tenant #1's record showed that several medications including anti-anxiety, cognitive enhancing, and antipsychotics were not administered as ordered.

67.5(2)f(4); $7,000. On 8/21/24 the program nurse determined that Tenant C1 received more Warfarin than prescribed from 8/4/24 to 8/20/24. It was discovered that staff administered medications to the Tenant from a med planner which included a dose of Warfarin in the morning and the pharmacy provided Warfarin punch cards for the afternoon. The tenant received duplicate doses of Warfarin since medications were administered from both sources. Tenant C1 had a fall on 8/22/24 and 8/23/24 in which there were no apparent injuries. On the afternoon of 8/23/24 the tenant was found lying on the floor of their room and were noted bleeding from their nose and had an injury to their forehead. They were sent to the local ER via ambulance and returned to the program approximately 3 hours later with a diagnosis of pneumonia, enterovirus infection, and a forehead contusion. Approximately 45 minutes later the staff noticed the tenant was increasingly confused and became less responsive when the staff sent them back to the ER. The CT scan identified a large acute subdural hematoma, and the tenant passed away the following day.

67.5(2)f(4); $2,000. The program failed to administer medications according to the physician's orders for 4 of the 5 tenants reviewed. This included medications that had precaution statements such as stopping medications abruptly can cause adverse effects.

67.19(3); $500. Staff A was hired on 3/26/24 with a national criminal history check completed but the program did not complete a SING report or abuse checks. Staff B was hired on 12/27/23 and a SING report was not completed until 12/29/23.

67.19(3); $500. Staff A and Staff D did not have background checks completed.

69.32(2); $2,000. Tenant #1 eloped from the building, and during investigation staff identified that a door was ajar when the tenant eloped. The door was supposed to alarm pagers that alerted the staff; however, it was identified that the sensor did not recognize when the door was open. The surveyor observed the door ajar for 20 minutes without alerting the pagers. In addition, the magnetic lock on the door failed the day of the elopement. Staff reported adjusting the door and then it functioned properly.

Insufficiencies Without Fining

Program Policies and Procedures (481-67.2)

The program did not complete incident reports on all unusual occurrences such as physical abuse between two tenants.

Witness statements were not obtained when a tenant eloped from the building.

Staff did not follow the door alarm policy as they cleared a sounding alarm without checking the door.

Staff did not complete safety checks on Tenant C1 according to the policy and procedure.

The program did not follow their policy on medication administration. Staff administered medications from a planner that they did not ensure was correct according to the rights of administration. This resulted in the tenant receiving duplicate doses of Warfarin.

The policy on falls was not followed as staff did not complete a falls assessment form with interventions implemented.

The program did not follow the policy on falls by completing a falls assessment form with interventions implemented and the staff notified the tenant's guardian but not their family when the tenant fell.

Staff did not follow the policy for medication storage as they identified a bubble pack with Hydrocodone tablets was altered and did not report it immediately to the resident care coordinator.

Staff A sent a snapchat of a tenant lying on the floor face down to other staff members of the assisted living program who reported it to the supervisors. The program policy included that cell phones were not to be carried or used by staff except when on break and were not allowed at any time in a tenant's apartment. The social media policy also indicated staff were not allowed to reference or post pictures of tenants. In addition, the policy on confidentiality stated staff should not share any confidential information with co-workers except as part of their job duties.

The program did not complete medication errors according to the program policy.

The program did not follow their policy on Wanderguard devices for Tenant #2 who did not have a consent obtained.

The staff did not notify the tenant's family of a fall according to the policy.

Tenant Rights (481-67.3)

The program did not provide care with respect and dignity based on tenant interviews regarding the clinical manager. Tenants reported that the clinical manager did not assess them after a fall and spoke to them in an uncaring manner. The clinical manager also yelled at Tenant #5 for needing assistance with clothing and was described by Tenant #7 as lacking bedside manner and had poor communication skills.

The program did not provide adequate care and service to Tenant #2 who went to the ER five times from May 11 to August 6 for UTIs and problems with their catheter.

Tenant C1 got their hand stuck between the wall and the sink in their bathroom. Staff had to call 911 for assistance and the first responders had to break the sink to get the tenant's hand free. The sink remained broken until the tenant went to the ER five months later and did not return to the program.

Medications (481-67.5)

Staff attempted to administer two tablets of Tramadol to a tenant on two occasions. The tenant recognized the extra dose and did not take the medication.

Staff C and D did not complete a medication manager course.

Staff did not administer pain medications according to the physician's order. The MAR indicated the medication was not available.

Staff did not administer the correct dosage of medication during observation. The tenant had an order for Magnesium Glycinate 120 mg - two tablets daily and staff administered 200 mg - two tablets.

Staff did not correctly reconcile a tenant's medications upon discharge from the hospital.

Tenant C1 had several medications that were stopped, restarted, and stopped again without physician's orders for discontinuing or restarting medications.

Staffing (481-67.9)

The program shredded communication logs instead of maintaining them for three years as required.

Staff did not complete supervision according to nurse delegation training for safety checks.

Criminal Background Checks (481-67.19)

Staff A was hired on 3/26/24 with a national criminal history check completed but did not check the SING report or abuse checks. Staff B was hired on 12/27/23 and a SING report was not completed until 12/29/23.

Staff B was hired on 11/16/23 and a background check was not completed until 12/29/23.

The program did not complete a background check on an employee until the day after they were hired.

Evaluation of Tenant (481-69.22)

The program did not complete a cognitive evaluation prior to occupancy and within 30 days for Tenant #2.

Evaluations were not completed when a tenant developed a pressure ulcer.

Significant change evaluations were not completed when a tenant had a fall that resulted in a left humerus fracture and subdural hematoma which resulted in orders for new medications including Keppra and Lorazepam.

Tenant #2 did not have evaluations completed when a wound was identified on their foot.

Tenant #4 returned from a psychiatric hospitalization to the program and the service plan was updated. However, evaluations were not completed until the RN returned from a vacation as the Executive Director was an LPN and could not complete the significant change evaluations.

Tenant #1 did not have a significant change evaluations completed when they had a pelvic fracture and required increased assistance with ADLs.

Significant change evaluations were not completed when Tenant #2 had frequent UTIs and began using a Wanderguard device.

Tenant C1 did not have significant change evaluations when they exhibited behavior changes.

Criteria for Admission and Retention (481-69.23)

The program retained a tenant who was aggressive towards other tenants and staff.

Tenant Documents (481-69.25)

Tenant #2's record did not contain documentation of their legal representative.

Service Plans (481-69.26)

Tenant #1's service plan did not include staff crushed medications and placed in applesauce or pudding, nutritional supplement, PT services, and refusals of bathing. Tenant #2's service plan was not updated to include a wound and treatments. Tenant #3's service plan did not include fall interventions, history of MRSA and interventions or precautions necessary. Tenant #4's service plan did not include fall interventions, or therapy services being discontinued.

The service plan was not updated when Tenant #1 had concerns about bed bugs in their apartment and had skin irritation. Tenant #2's service plan did not include information on refusal of care, hygiene, and housekeeping concerns with their apartment being unkempt and odorous. Tenant #3's service plan did not indicate services provided by hospice, diet instructions following a hospitalization, and that they refused to remove their dirty laundry. Tenant #4 had significant macular degeneration and needed assistance with ambulation. However, the service plan did not include they went on frequent walks including outside of the building. Tenant #5's service plan was not updated when their spouse was not providing care identified in the service plan, fall interventions, or skin concerns. Tenant #6's service plan did not include concerns about bed bugs, bites or skin irritations, or if staff/visitors needed precautions when entering. Tenant #7's service plan did not include their history of major depressive disorder and comments to the provider about loneliness.

The service plan was not based on evaluations as the evaluations were not completed.

Service plans were not based on evaluations as a cognitive evaluation was not completed.

The service plan for Tenant C1 was not updated to reflect changes in their cognition and Tenant #5's service plan did not include preferences for assistance with dressing.

The tenant did not sign a preliminary service plan prior to signing the occupancy agreement.

Tenant #2's service plan was not updated within 30 days of occupancy.

Tenant #1's service plan was not updated within 30 days of occupancy.

Tenant #2 had a fracture with a cast on the right wrist and lower forearm. The service plan was updated to include the fracture and cast but did not identify increased needs with dining and ADLs. The service plan was also not signed by the tenant, representative or DON.

A service plan was not signed when a significant change occurred.

Service plans were not updated for Tenant #2 with frequent UTI's and use of a Wanderguard device.

Did not obtain signatures on 30-day service plan updates.

Tenant #1 and #2's service plans were signed but were not dated.

Tenant C2's service plan was not updated to address pressure ulcer and wound care needs. Tenant #1's service plan was not updated as the tenant would yell out when staff provided showers. The staff provided bed baths to the tenant to reduce behaviors.

Tenant C1's service plan did not indicate the tenant and family preferred being notified about medication changes for the tenant.

Nurse Review (481-69.27)

Tenant #3 did not have a nurse review completed following hospitalizations.

A nurse review was not completed following behavioral changes for Tenant C1 including hallucinations and accusations against staff.

The program did not complete a nurse review for one 90 day period for one tenant reviewed.

Nurse reviews were not completed for significant changes in condition.

Staffing (481-69.29)

The emergency alert system was supposed to alert a tablet for staff but it went to a computer that was located in an office area near the front of the building. Due to the location staff were unable to hear the system alert when they were not in the area including while in another tenant's apartment. The lack of functional equipment led to delayed response times to the emergency pendants.

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

Doors with alarms were turned off and propped open.

There was no policy and procedure on staff response if a tenant was missing from the program.

The program did not have a policy on staff response to door alarms or when tenants have elopement/wandering behaviors.

Structural Requirements (481-69.35)

A panel of fence was missing, and an orange safety fencing was in place. A previous insufficiency was cited on this, and a plan of correction submitted that the fence would be replaced by March 2024. This was not completed as indicated.

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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