AL Survey Trends Report

September 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

September ALP Survey Update & Rule Review

by Kellie Van Ree, Director of Clinical Services

Survey activity:

- 18 recertification visits available for review. 1 program received 3 insufficiencies that did not result in a fine.
- 12 complaint and incident visits were available for review. 5 did not result in insufficiencies cited and 7 resulted in insufficiencies. The programs with insufficiencies averaged 4.4 and 4 of the 7 (57%) received a fine.
- 37 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 involuntary transfers or discharges.

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:

- **Silveridge, an Eventide Community &**
- **Vista Prairie at Fieldcrest**

Insufficiencies Resulting in Fines

67.2(3); $2,500. On 5.10.25 staff recall seeing Tenant #1 sitting approximately 30 feet from the front door in the living room area visiting another tenant. A short time later, the alarm sounded, and Staff A responded to the alarm. Tenant #2 was noted near the door and Staff A also stepped outside but did not see anyone outside the building. They noted that they did not step out of the door far enough to look around a wall that blocked the view to the north and did not have training to check on all tenants in the program. Approximately 6 minutes later, the family of another tenant saw Tenant #1 walking along the street near the program driveway and assisted them back to the building.

67.3(2); $7,500. Tenant #2 returned to the program following a skilled stay from 7.14.25 to 7.21.25. Upon return, the tenant required assistance of one staff person, gait belt and a walker. Staff reported communicating that Tenant #2 had returned to multiple staff as they required assistance with most of their ADLs. During the night, Tenant #2 did not receive assistance from staff because they were noted as still on a “leave of absence” in the computer system. Tenant #2 fell around 3 a.m. and laid on the floor until approximately 5:08 p.m. (13+ hours). Tenant #2 was transferred to the ED and was diagnosed with a right hip dislocation with unsuccessful reduction that later required surgery.

67.3(2); $3,000. Tenant C1 fell on 7.8.25 around 4:00 a.m. The tenant was using the restroom and when they returned, they missed their bed as they attempted to sit down. Staff A reported that they were unable to lift Tenant C1 from the floor due to their weight, so they gave them a pillow and blanket until the day shift staff arrived. When Staff B arrived, the tenant was too weak to transfer due to being on the floor, so they called EMS and the tenant was transferred to the ER for evaluation at 7:15 a.m. Tenant C2 was expected to receive hourly safety checks by staff. On 4.12.25 staff reported seeing the tenant in their room at 7:38 p.m. and then at 8:57 p.m. the tenant knocked on the front door of the program. The tenant removed window block inserts from their second-story window, tied three sheets together and attempted to climb down the sheets. The tenant indicated they fell (but were unsure of the distance) while eloping from the window. During review, the surveyor identified that the hourly checks for 7, 8, and 9 p.m. were all signed at 8:41 p.m. on 4.12.25.

67.3(2); $3,000. Tenant #1 fell on 6.4.25 at 5:30 p.m. when they were walking from the dining room to their apartment. The staff asked if the tenant wanted a wheelchair and then they went to grab the wheelchair the tenant lost their balance and fell. Later in the evening the tenant complained of pain and had difficulty walking so they were transferred to the hospital where they were noted to have a pelvic fracture. During investigation it was noted that the staff failed to use a gait belt according to the service plan with the tenant.

Occupancy Agreement (231C.5)

The program's occupancy agreement did not include that each tenant would be evaluated on a point system including a description of corresponding points and tasks. Additionally, the tenant was charged points for excessive communication, but the occupancy agreement did not define the frequency of routine communication or the points for excessive communication.

The occupancy agreement is to include the internal appeal process for involuntary terminations or discharges and did not. Tenant #1 received a notice of involuntary discharge and cited the nursing home state rules for involuntary discharge along with an appeal process that involved the department which is not the correct process.

Tenant #3 did not have a signed occupancy agreement when they transitioned from the AL to the ALP-D.

Program Policies & Procedures (481-67.2)

The policy on incident reports did not include the requirement that the incident report needed to include statements from individuals who witnessed the incident.

The program did not follow their falls policy which included frequent checks after a tenant fell and hit their head and refused to go the hospital. The program also did not follow their medication administration policy as the indication for use was not included on the MAR for all medications.

The program did not follow the policy related to food safety and sanitation as there were items that were open and not dated, not discarded in a timely manner, and items that were not stored appropriately. Additionally, they did not monitor temperatures of refrigerators and freezers consistently and when monitored, documentation was inconsistent with expected ranges - for example the line for refrigerator/freezer indicated 40 and 42 degrees. There were also omissions in the food temperature logs.

Tenant C4 required hourly checks for safety. In June 2025, staff documented they completed hourly safety checks; however, the tenant was found deceased in their apartment at 7 a.m. and it was determined Staff D did not complete the hourly checks that they documented were complete.

Tenant Rights (481-67.3)

The program did not provide housekeeping services to tenants as indicated in their service plan or the basic services identified in the agreement.

Program Notification to the Department (481-67.4)

The program did not notify DIAL within 24 hours or the next business day of a fall with a major injury.

Medications (481-67.5)

Medications were not administered as ordered as they were charted “not available”. Additionally, an order for Keflex for UTI symptoms was ordered on 7.2.24 but was not started until 7.7.24.

The program did not administer medications as ordered when the cardiologist ordered changes to the medications that were not transcribed as well as other medications that were not available.

Staffing (481-67.9)

Tenants did not receive medications on a particular day/time due to not staffing an individual who was able to administer medications.

Application Content (481-69.4)

The program did not have a policy and procedure for evaluations including identification of all tools used to evaluate the tenant's health, functional, and cognitive status.

Evaluation of Tenant (481-69.22)

The program did not complete evaluations within 30 days of occupancy.

Evaluations were not completed with changes in condition when the tenant had behaviors that required transportation to the ED and the staff calling law enforcement for assistance.

Involuntary Transfer from the Program (481-69.24)

Involuntary discharge notices were issued to Tenant #1 on three separate occasions that cited incorrect administrative rules information, incorrect agency contact information, incorrect appeals information, and the tenant's record lacked notification of the primary care physician.

Tenant Documents (481-69.25)

Nurse's notes were not documented by exception including completion of antibiotics and identifying further signs or symptoms of UTI, skin redness and irritation, and a bruise.

Nurse's notes were not documented by exception including the reason tenant #1 was escorted out of the building by police and ambulance and when they returned from the ED on two occasions or for Tenant #3 when they were transferred from the AL unit to the dementia specific unit.

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

Incident reports were not completed when Tenant #1 had police and EMS escorted them from the building related to behaviors.

Service Plans (481-69.26)

Tenant #2's service plan did not include specific services upon return from a skilled care stay including more assistance with ADLs and mobility. Tenant C1's service plan did not include the use of a wheelchair or that staff would assist with wound treatments.

Tenant #1's service plan did not include interventions to behaviors, reflect that the tenant is receiving 1:1 care, staff administered their medications, or that medications were provided by the VA. Tenant #2's service plan did not include that a thyroid medication was to be administered on an empty stomach. Tenant #3's service plan did not include discontinuation of a Dexcom monitor and that the program would check blood glucose levels 4 times daily. Tenant #4's service plan did not include nitroglycerin as needed for chest pain.

Tenant #3's service plan was not updated within 30 days of occupancy.

Tenant #1 and #2's service plans were not signed by the person completing them or the tenant/representative.

Service plans were not updated with changes including when Tenant #1 wandered into other tenants' apartments, toileted in inappropriate places and had destructive behaviors. Tenant #5's service plan was not updated when they had not gotten out of bed for an extended time or for Tenant C1 when they had an acute change in the color of temperature of their leg and the tenant and responsible party chose comfort measures.

Tenant #1, 2, 3, and 4's service plans did not include planned and spontaneous activities.

Food Service (481-69.28)

Food safety and sanitation training was not provided prior to handling food or annually to 4 of 7 staff.

Staffing (481-69.29)

The staff did not receive training related to brain injuries despite providing care for a tenant with a brain injury.

Dementia Specific Education for Program Personnel (481-69.30)

Staff A, B, C, D, and E did not have 8 hours of dementia specific training completed within 30 days of hire.

Life Safety (481-69.32)

The building had several exit doors that did not have an operating alarm system.

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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