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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July ALP Survey Update & Rule Review

by Kellie Van Ree, Vice President of Clinical Services & Education Strategy

Survey activity:

- 8 initial and recertification visits were available for review. 2 of the 8 (25%) received insufficiencies. The averages are skewed for the 2 as the one provider received 17 insufficiencies while the other only received 1. Both programs received a fine as a result of the survey. 6 (75%) were insufficiency free.
- 8 complaint and incident visits were available for review. 6 (75%) didn't result in insufficiencies cited and 2 resulted in 1 insufficiency cited and both programs received a fine.
- 75 AL Providers are currently more than 24 months from their last recertification visit with the longest being 39 months since their last recertification.

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(2); $2,000. Tenant C1 eloped from the building when staff assisted other tenants from the memory care unit to the main assisted living building for an activity. The staff member indicated they propped the doors open to assist the tenants out of the unit and wasn't sure that the door closed, which allowed Tenant C1 to elope. Tenant C1 was found outside the main assisted living building lying on their back. No injuries were noted from the fall and the elopement. Tenant #1 left the memory care unit into the independent living building when a door was left unlocked due to staff not properly ensuring the doors were locked at the start of their shift.

67.2(2); $7,500. The program failed to follow their policy and procedures for incident reports when Tenant #2 was missing from the program and staff failed to alert the on-call staff that the tenant was unable to be located. Additionally, staff failed to notify the executive director and the family when an allegation of abuse was made and didn't assess the tenant following the allegation. Staff also failed to notify the on-call staff when Tenant #2 experienced a significant change in condition which included reports of increased pain and a decline in ADLs.

67.3(2); $8,000. Tenant C3's service plan included hourly safety checks. On 1.1.26 at 7:05 a.m. staff entered the tenant's apartment and found them face down on the floor. The tenant had blood around their head, was without a pulse, their skin was cold and body was stiff. During interviews, the overnight staff admitted that they didn't check on the tenant due to multiple high need tenants and that the program needed more than one staff in the memory care unit. Additionally, Tenant C3 went to the ER and the family visited 4-5 days later and the tenant was lying in bed and wouldn't leave their apartment. The family member noted that the resident was so swollen and had still had electrodes on them from the ER. The family then installed a motion activated camera in the tenant's apartment where they identified that staff were not providing the care and service they should have been. The family member also had videos of the staff yelling at the tenant. Tenant C7 was noted with extreme edema and weeping from their legs. The wound clinic ordered lower extremity dressing changes every other day. A staff member reported that the trained staff were not available to complete the treatments and untrained staff attempted to do it but would run out of supplies including gloves, bandages, or chux pads to complete their care. During an interview a staff member reported that they entered the memory care unit one day when Tenant #7 could be heard upon entering yelling out. When they got closer to the tenant, they noted they were sweating and pale. The tenant reported having chest pains and was dizzy. The staff member reported that another staff member was sitting very close to the tenant watching their tablet and ignoring the tenant who was in distress. Tenant #3's POA directed the program that the tenant's daughter was not allowed to visit the tenant anymore however the tenant expressed concern and wished they could see the daughter again. According to a memo from the LTCO office the POA does not have the authority to restrict visitation as they only had authority to make healthcare decisions indicating the right of visitation remained with the tenant.

67.5(2); $6,000. Tenant #1 was admitted to the program under a respite stay and the daughter reported prior to admission that the tenant required two different insulins. Upon admission, the daughter handed the insulin vials to the program nurse who indicated they could not administer insulin from a vial and required insulin pens which they could obtain from the program pharmacy. The daughter reported they received phone calls from the program that the tenant slid out of bed on 5.28.26, had a fall on 5.30.26, and was vomiting and seemed delirious on 6.1.26 with a blood sugar in excess of 600. According to the program nurse the pharmacy attempted to clarify the Novolog insulin and then asked about starting the order as it was initially written and the program nurse failed to respond to the email and didn't include the Novolog on the MAR which resulted in staff not administering the medication and the tenant being hospitalized for diabetic ketoacidosis.

Insufficiencies

Program Policies & Procedures (481-67.2)

The program didn't ensure allegations of possible abuse were reported to leadership immediately, didn't thoroughly investigate allegations of abuse, didn't ensure protections for tenants from further abuse and report to the state agency as outlined in their abuse policy. Additionally, the program didn't complete incident reports, notify appropriate parties, and ensure documentation in the tenant record.

Medications (481-67.5)

A tenant's daughter asked to administer medication to the tenant due to the high number of medication errors the program made and was told it would be looked into but never responded to. Tenant #13 recalled a time when they had a terrible headache and finally a medication tech offered the tenant Tylenol to which the tenant asked if they could keep the Tylenol in their apartment and were told that they could not.

Medications weren't administered as prescribed for 7 of 7 tenants reviewed.

Staffing (481-67.9)

The program didn't ensure there were enough staff available that were properly trained to ensure the safety of the tenants including 5 of 10 current tenants and 3 of 7 discharged tenants.

The program nurse failed to ensure 3 of 4 staff were competent with tasks within 60 days of hire.

The program didn't provide wound training to Tenants' C7 wound care needs or Tenant #4's colostomy bag.

The communication and documentation form copies weren't maintained by the program.

Criminal, Dependent Adult Abuse, and Child Abuse Record Checks (481-67.18)

Staff K didn't have a child abuse record check prior to beginning employment with the program.

Evaluation of Tenant (481-69.22)

The program nurse used the SLUMS test during a change in condition evaluation instead of the GDS.

Tenant Documents (481-69.25)

Nurse's notes and wound care notes weren't retained by the program including physician orders for the treatments noted in the assessment, emergency room visit notes, wound clinic visits, hospitalization or discharge notes.

Medication errors weren't documented for 7 tenants reviewed.

Staff failed to accurately document tasks on the task sheets including hourly checks that weren't completed.

Nursing notes, tasks sheets, and MARS were not available for 2 discharged tenants.

Service Plans (481-69.26)

Service plans weren't signed by the tenant or their representative for 1 discharged tenant and 4 current tenants.

Food Service 481-69.28

Food temperatures weren't maintained at 135 degrees or warmer.

Staffing 481-69.29

Safety checks weren't completed as required for 2 of 3 tenants in the memory care unit.

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.