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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April ALP Survey Update & Rule Review

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Survey activity:

- 10 initial and recertification visits were available for review. 7 of the 10 (70%) received insufficiencies with an average of 4.7. 2 (29%) fines were issued based on recertifications. 3 (30%) were insufficiency free.
- 16 complaint and incident visits were available for review. 5 (31%) didn't result in insufficiencies cited and 11 resulted in insufficiencies. The programs with insufficiencies averaged 3 per program with 5 (45%) resulting in fines.
- 50 AL Providers are currently more than 24 months from their last recertification visit with the longest being 36 months since their last recertification. This number increased over the last couple months with fewer recertification visits being conducted.

The latest AL Rule Review includes information on 481-69.27 - Nurse Review.

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); 3,000. Tenant #1 eloped from the program on 3.17.26 after exiting the memory care door at 4:19 a.m. Approximately 11 minutes later, the tenant was noted shaking the doors attempting to gain entry to the building. During interviews, the staff reported that the alarms sounded but the staff member in the memory care unit was afraid that it was someone attempting to gain access to the building. They contacted another staff member to have them check out the door alarm with them. When they approached the door, they noted that Tenant #1 was shaking the doors, attempting to get back in.

67.3(2); $8,000. Tenant C1 was transferred to the ER on 9.19.25 when they were found non-responsive, could not get a blood pressure and their oxygen saturation was 80%. The service plan indicated the tenant required total assistance with dressing, toileting, was incontinent of both bowel and bladder, and had a history of UTIs. The pre-hospital report indicated that staff were unable to report what the tenant's baseline was, and the last time the tenant was well. They also noted that the tenant had visible pus in their depends, brown and purulent color urine, had severe encephalopathy, presumed severe sepsis and was admitted for end-of-life care. Additionally, the hospital noted the tenant was severely dehydrated, their urine specimen was very abnormal, and their weight was 87 pounds. According to staff interviews they noted that the tenant was not well but were unsure if the nurse was aware. There were no nurses' notes completed outside of the tenant receiving their influenza vaccine 3 days before being found unresponsive. There weren't any communication sheets for the tenant. On 9.14.25 at 7:47 a.m. Tenant C2 was noted to have a fever. The family requested the tenant be sent to the ER and they returned soon after with a diagnosis of a virus. Later that day (1:30 p.m.) the staff called the triage nurse and reported the tenant fell while trying to pick up their tray and complained of left hip pain at 10/10. A staff member reported the tenant got off the floor and the staff failed to notify the triage nurse promptly. The tenant was sent to the ER where they were diagnosed with a hip fracture and had surgery the following day. The hospital also noted that the tenant tested positive for COVID-19 prior to surgery. The tenant passed away on 9.19.25 due to acute hypoxic respiratory failure, dementia, hip fracture, and COVID-19 related pneumonia.

67.3(2); $4,000. On 11.18.25 at 6 a.m. Tenant C1 was found outside along the road. The tenant told staff they were dreaming of a lost baby and were trying to keep the baby from running into the road. The tenant was muddy with a rapid pulse and complained of pain. They also reported hitting their head. At the ED, the tenant was noted to have scrapes on their leg, an abrasion and hematoma on their head. Their electrocardiogram, CT scan, and chest x-ray were normal. The tenant's service plan included 30-minute checks and the 5:30 a.m. check was documented at 5:02 a.m. and the 6 and 6:30 a.m. were documented more than 6 hours late. According to an interview, staff admitted they didn't check on the tenant at 5:30 a.m.

67.3(2); $3,000. Tenant C1 and #4 were found in Tenant C1's apartment on the bed. A newer staff member completed hourly rounds and Tenant C1 told the staff member that it was his wife, so they told them good night and completed the rest of the rounds. When they told other staff about it the staff indicated Tenant #4 was not his wife and when they went to get her, she had tears in her eyes and appeared scared. Both tenants were without pants on.

67.3(2); $4,000. On 1.5.26, Tenant C1 was found on the floor in their apartment. The tenant reported that the door hit them when they were trying to walk in and it pushed them to the ground. The staff took the tenants vital signs and notified the nurse. They attempted to get the tenant to stand but the pain was significant in their right leg, so they called EMS who took them to the hospital. The tenants' service plan included that they required stand by assist but staff allowed them to walk independently since moving to the memory care unit.

67.9(1); $2,000. There were three staff assigned to the memory care unit and two of the staff left the unit to assist with an activity on the main unit. Shortly after, Tenant #2 left the floor and the only staff remaining didn't feel as though they could leave the floor to search for the tenant. They called for assistance and reported the tenant exited through the stairwell. Tenant #2 was returned to the unit and assessed without injuries.

67.9(4); $4,000. Tenant C1's service plan directed staff to assist the tenant with 1 person along with a two-wheeled walker, and a gait belt. During assistance with toileting, staff used the wheelchair to get the tenant to the toilet and then went to get the walker to assist off the toilet. When moving the wheelchair out of the way, the tenant fell backwards into the sink vanity and then to the floor. The tenant complained of pain in their left upper leg. The incident report included that staff were not using a gait belt as directed in the service plan at the time of the fall. The tenant was transported to the hospital and admitted for pain control after being diagnosed with a sacrum and pelvic fracture.

69.26(4); $3,000. Tenant #1's service plan didn't include individualized information when the tenant had several falls related to the use of a lift chair.

69.32(2); $1,500. The main door alarm was not turned on and Tenant #1 eloped from the program. The staff were able to get the tenant back in the building within a couple minutes.

Insufficiencies Without Fines

Program Policies & Procedures (481-67.2)

Incident reports weren't completed when: (cited in 2 programs)

- When a tenant flooded their bathroom with the shower
- A tenant was found in their apartment following a major stroke
- They attempted to elope
- A tenant reported an unwitnessed fall

Staff failed to follow the program policy regarding elopement and wandering as a tenant reported needing to leave the building and staff failed to implement 15-minute checks as directed in the policy.

Staff failed to document bathing on the monthly care sheets and when tenants complained about food temperatures, the surveyor noted that food temperatures were not consistently documented for all items outside of the entrée and soup.

The policies and procedures weren't followed when a door was not properly alarmed, an incident report didn't include all required elements when two tenants were found following a sexual incident, and staff failed to document tasks.

A post incident observation note was completed by medication aides and not by licensed nurses in accordance with the policy. (Cited in 2 programs)

Incident reports didn't include witness statements as required.

Tenant Rights (481-67.3)

Tenants reported they weren't receiving services they were paying for such as housekeeping.

Tenants expressed concerns about a significant increase in rent that they attempted to talk to the program about their concerns but were unable to talk to anyone about it. Another tenant reported they met with the ED and they only listened to their concerns then walked away without providing any response.

Dietary staff cleared a door alarm which allowed a tenant to leave the memory care unit and enter the elevator into a separately licensed area.

Staff didn't provide care to the tenants that they needed including when a staff refused to take a tenant to the bathroom when they were having bladder spasms and didn’t empty their catheter drainage bag causing it to leak.

Medications (481-67.5)

Medications were administered early based on camera footage review but were not signed out until later.

The MAR wasn't updated to discontinue or initiate new medications timely, which resulted in medications being administered after the physician discontinued the order.

Blood glucose monitoring was not completed as ordered by the physician for one tenant.

The medication wasn't cut in half as it was supposed to be indicating medication dose was double what it should have been.

The wound care treatments weren't followed as ordered for Tenant #2.

Staffing (481-67.9)

Staff failed to communicate in writing occurrences that differed from the tenant's normal health, functional, and cognitive status.

Delegation training for perineal care wasn't completed until after they were allowed to perform perineal care on the tenants.

Staff were not trained in providing catheter care for the tenants.

Staff didn't receive competency training within 30 days of hire.

Criminal, Dependent Adult Abuse, and Child Abuse Background Checks (481-67.19)

When checking the staff members’ background, the adult and child abuse registry section indicated there was an error and to check back later which was not completed before hiring.

Evaluations weren't completed on criminal history for Staff A, B, and C.

An evaluation was not completed on a child abuse registry hit when completing the SING report. When completed after hire, DHS determined the staff member could not work for the program and was terminated.

Evaluation of Tenant (481-69.22)

Significant change evaluations weren't completed when: (Cited in 6 programs)

- A tenant had increased confusion and agitation noted.
- Had increased signs of confusion and was self-injured.
- Swallowing changes, low urine output and converting oral pills to liquid.
- Lost significant weight
- Functional status declined when on hospice
- Moved to the memory care unit

An evaluation wasn't completed within 30 days of occupancy (cited in 2 programs).

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

A waiver for retention of a tenant on hospice was not completed in a timely manner when the tenant was noted to have a change in condition on 11.19 and the waiver wasn't submitted until 12.9.

Tenant Documents (481-69.25)

Nurse's notes weren't completed by exception when a tenant had a change of condition including increased confusion and agitation.

Nurse's notes weren't completed by exception including when tenants were self-injured, transferred to a behavioral unit and then another provider or when a tenant was discharged.

An incident report wasn't completed when they eloped from the program.

The communication logs were not available for review when asked for.

A task was not documented as complete when a tenant had an angiogram that required post-op monitoring.

Service Plans (481-69.26)

Service plans weren't updated with significant changes including: (cited in 8 programs)

- Skin abnormalities
- Moved to memory care
- No longer lived with their spouse
- Changes to visual/safety checks
- Needed soft foods, began pocketing foods, and discontinued oral medications
- Use of a splint/cast
- Increased need for assistance from staff
- Use of personal alarms
- Infection
- Increased confusion
- Elopement

- Refusal of care and services
- Weight loss
- Use of a private caregiver
- Sexual incident between two tenants

Service plans failed to include tenant specific information including: (cited in 6 programs)

- Individualized fall interventions
- Identify specific therapy provider
- Identify palliative care company
- Managed risk agreements
- Medication management
- Non-compliance with care and services
- Frequency of incontinence with staff assistance
- Fluid volume overload and interventions such as daily weights
- Use of pressure-reducing devices
- Wounds
- When a wheelchair seatbelt would or wouldn't be used.

A service plan wasn't updated within 30 days of occupancy for Tenant #4 and upon significant change in condition for Tenant #2.

Service plans weren't signed or dated by the program nurse, the tenant and/or their legal representative upon significant change in condition for two tenants.

Nurse Review (481-69.27)

Discharge instructions from the hospital weren't noted in a timely manner and a nurse review was not completed as needed when there was a hand fracture with a split use.

The program didn't complete nurse reviews at least every 90 days for those receiving health services (cited in 2 programs).

Structural Requirements (481-69.35)

There was dust/debris built up in vents, fire damper connections in HVAC of closet, stained ceiling tiles, peeling/bubbled paint throughout the building.

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.

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