



# AL Survey Trends Report

May 2026

*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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Iowa

## May ALP Survey Update & Rule Review

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Survey activity:

- 4 initial and recertification visits were available for review. 3 of the 4 (75%) received insufficiencies with an average of 5.3 (this is skewed due to a large number of insufficiencies in one program. No fines were issued based on recertifications. 1 (25%) were insufficiency free.
- 15 complaint and incident visits were available for review. 2 (13%) didn't result in insufficiencies cited and 13 resulted in insufficiencies. The programs with insufficiencies averaged 2.8 per program with 5 (33%) resulting in fines.
- 61 AL Providers are currently more than 24 months from their last recertification visit with the longest being 37 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 481-69.28 - Food Service - Meals & Nutritional Requirements.

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) \$5,000.** Tenant C2 went to the physician on 11.6.25 and received new orders including Torsemide 20 mg daily which was not transcribed or given and subsequently resulted in the tenant being hospitalized due to fluid retention. Additionally on 10.22.25, Tenant C2's 70/30 insulin was increased to 30 units in the morning and 28 in the evening. Following this increase, the tenant had low blood sugars (49 and 56) which staff failed to report to the on-call nurse

**67.2(3) \$4,000.** The staff failed to notify the on-call RN when a tenant refused to eat breakfast and was sleepier than baseline which later resulted in the tenant falling and being transported to the ER. Following hospitalization, the tenant was admitted to the nursing home with hospice services. Incident reports weren't completed when Tenant #2 was noted with odd behaviors including eating spoonfuls of coffee grounds, telling the staff to "F"-off when they couldn't play games at that moment.

**67.3(2) \$3,000.** Tenant C2's service plan directed staff to complete incontinence checks at midnight and 4 a.m. with hourly safety checks. The tenant lacked documentation of the incontinence checks and hourly safety checks. At 5 a.m. on 4.1.26, Tenant C2 was found on the floor by staff. According to a screenshot of a camera in the tenant's room they fell at 2:13 a.m. and were not found until 5 a.m.

**67.5(2)e(3) \$5,000.** The program failed to transcribe several orders from the wound care clinic onto the tenant's MAR including two in October, three in November, two in December and one in February. Additionally, an order was included in the MAR to change the dressing daily, when the wound clinic notes included three times per week. The tenant was hospitalized in December 2025 and diagnosed with osteomyelitis with recommended amputation, but the tenant refused and was discharged with new orders for both open areas on the left foot. These orders weren't transcribed. The tenant also had a wound on the right foot which was treated by the wound care clinic and orders weren't transcribed. In January 2026, the tenant underwent toe amputations for two of their toes on the left foot. Upon discharge, there were orders for the left and right foot. The orders were implemented for the left foot; 2nd toe but not the 5th toe or the right foot. Medications were also discontinued in the hospital which were not followed through on at the assisted living program.

**67.9(4) \$5,000.** Tenant #1 received their medications and then Staff A set up medications for Tenant #2 but stopped in Tenant #1's apartment to assist them with a transfer before administering Tenant #2's medications. Staff A placed Tenant #2's medications on Tenant #1's counter, assisted with the transfer, and then left the apartment returning shortly after and the medications were gone. Tenant #2's medications included Oxycodone 10 mg and Morphine 30 mg ER tablet. The staff immediately called for the ambulance and the tenant was transported to the hospital. During an interview the staff reported that the RN delegated tasks to them and they were trained to administer medications based on the rights of medication administration and to not leave medication unattended.

# **Insufficiencies Without Fines**

## **Occupancy Agreement (231C.5)**

The occupancy agreement failed to include a description of additional services received by the tenant and their fees.

## **Program Policies & Procedures (481-67.2)**

The program failed to follow their policy on incident reports when the physician wasn't notified of a black eye, and the representative wasn't notified immediately as indicated.

Staff didn't follow the incident policy and procedure by notifying a nurse of an incident where a male tenant was in a female tenant's apartment and was undressed.

Staff failed to follow the narcotic policy when a medication fell on the floor and staff threw it away instead of destroying it accordingly and didn't notify the nurse. Additionally, staff failed to follow the incident report policy when tenant C2 was found in another tenant's apartment on the floor. The incident report lacked the time of the incident and a different staff member completed the report then found the tenant on the floor.

The program had several policies related to incidents but didn't have an overall incident report policy that included who completes the incident report, that all accidents and unusual occurrences will be documented on an incident report, and that the reports will be retained for at least three years.

The program didn't have a staffing policy that included all required elements outlined in the rules.

The policy wasn't followed for discarding outdated food as tenants were served juice for meals that was dated more than 3 days before when it was served.

The program failed to follow their policy on medication disposal when a nurse put water in with pre-filled morphine syringes and then wasted them without documenting disposal.

## **Tenant Rights (481-67.3)**

Staff failed to complete tasks as identified on the tenant's service plan for two tenants including bathing, dressing, toileting, and laundry. Additionally housekeeping services weren't included in the service plan or task list.

Tasks weren't documented as completed according to the tenant's service plan.

Staff failed to ensure that Tenant #1's apartment door was locked according to the families' wishes. Additionally, the resident's record and service plan failed to include this information.

## **Medications (481-67.5)**

The program staff failed to reorder medication according to the tenant's service plan in a timely manner to ensure the medication was available for administration.

The MAR lacked identification that the tenant refused to have wound care performed, but when interviewed staff reported that they refused most of the time.

Program staff administered medications without completing a department approved medication manager course.

Medication administration records lacked signing medications to indicate they were administered on multiple occasions.

Sliding scale insulin was not signed off the MAR when administered to Tenant #6

Medications including Eszopiclone and Belsomra were not administered according to the physician's order when one was discontinued and the other started but remained on the same medication without a physician's order to do so.

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

Evaluations weren't completed following a return to the program from the hospital when they received another tenant's medications.

Evaluations weren't completed when a tenant returned to the program following hospitalization for osteomyelitis.

Tenant #1 didn't have an evaluation completed prior to occupancy.

Tenant #1, #5 and C1 didn't have evaluations completed within 30 days of occupancy.

Evaluations weren't completed with significant change including wounds and reddened areas being noted, increased assistance with transfers, increased behaviors, and use of home health agency services.

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

Two tenants were retained when they exceeded retention criteria including behaviors of physical aggression which placed others at risk of harm.

Tenant C1 wasn't discharged from the program in a timely manner when the tenant's behaviors were not manageable.

### **Tenant Documents (481-69.25)**

Nurse's notes weren't documented by exception when a tenant was sent to the ER for chest pain and returned to the program on two different occasions.

Nurse's notes weren't completed by exception when a tenant went to the ED, with completion of antibiotics, return to the program following hospitalization, when a second antibiotic was started and finished and respiratory signs/symptoms for antibiotic use.

An incident report wasn't completed for tenants when they had injuries of unknown origin including skin tears and bruises to their arm.

Staff failed to document the safety checks for two tenants.

An incident report wasn't completed for tenants when they reported falling and with behaviors.

### **Service Plans (481-69.26)**

The program didn't update the service plan within 30 days of occupancy.

The service plan wasn't updated with various treatments recommended by the wound clinic.

Service plans weren't updated with significant changes or annually. Additionally, the service plans updated on an annual basis were not updated in a timely manner.

Staff failed to include a camera was in use in the tenant's service plan which violated their policy.

Service plans didn't include tenant specific needs including a mechanically altered diet texture, comments about self-harm, use of a Broda chair, hospital bed, fluid intake decreases and repositioning needs, and when a tenant was unable to put the leg rest down on their recliner. Service plans weren't based on evaluations when the evaluations weren't completed.

The service plans weren't developed and signed prior to occupancy.

Service plans weren't updated within 30 days of occupancy and signed by those participating in development.

### **Nurse Review (481-69.27)**

During nurse reviews, the nurse failed to ensure that medications administered by the program were correct and in accordance with the physician orders for two tenants.

### **Food Service (481-69.28)**

A licensed dietitian didn't review procedures for food preparation and service when a tenant had a mechanically altered diet.

### **Structural Requirements (481-69.35)**

Staff placed a deadbolt on the outside of tenant #1's door to ensure that it could be locked. The door is required to be a single-action lockable door.

### **Respite Care Services (481-69.39)**

Two tenants were coming to the program during the day and weren't admitted.

*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.*

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