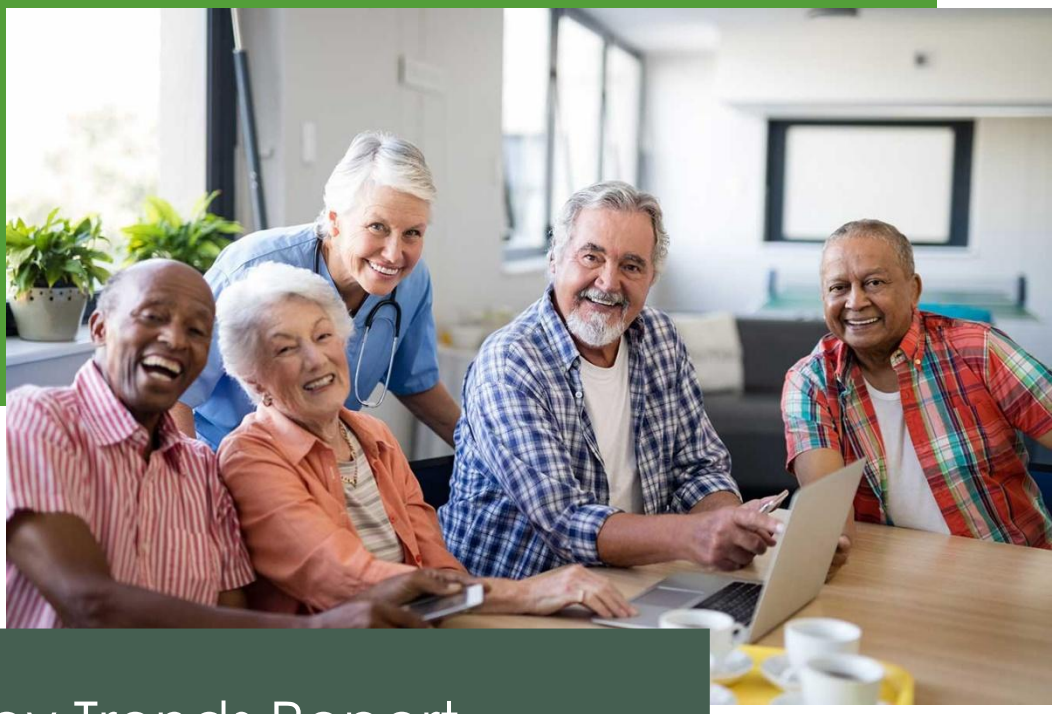

AL Survey Trends Report

November 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.

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November ALP Survey Update & Rule Review

by Kellie Van Ree, Director of Clinical Services

Survey activity:

- 5 recertification visits available for review. All 5 received insufficiencies with an average of 2.6 per program. However, no fines were issued on recertification visits.
- 22 complaint and incident visits were available for review. 12 did not result in insufficiencies cited and 10 resulted in insufficiencies. The programs with insufficiencies averaged 2.4 per program and 4 of the 10 (40%) received a fine.
- 26 AL Providers are currently more than 24 months from their last recertification visit. However, 5 of the 26, DIAL reported as having recent recertification visits but the reports have not been posted at this time.

DIAL continues to report that they are close to being caught up with Assisted Living recertification visits. The survey reports are taking a while to be posted to the entity website which is when they are also released to the providers. At this time, most of September's surveys are posted with very few posted from October or November.

The latest AL Rule Review includes information on 481-69.25 – Tenant Documents.

You can access previous rule review articles as well as additional assisted living specific resources on our Assisted Living Resource page.

Insufficiencies Resulting in Fines

67.2(3); $3,000. The procedure for checking door alarms was not followed when Tenant #1 exited through an egress door and a secondary alarm attached by magnet failed to alert. The initial alarm was sent to the staff members' phone, but the staff could not hear the alarm as they were vacuuming, and another staff member attempted to contact Staff A but did not check the door. A short time later, Staff A was unable to find Tenant #1, so they began a search inside and outside and notified law enforcement who found the tenant approximately 1/10 of a mile away but the tenant had to cross a busy highway with a 55-mph speed limit to reach the location.

67.3(2); $6,000. Tenant C1's file included an incident report dated 6.24.25 at 9:23 p.m. when the staff heard profanity coming from the tenant's apartment and when they entered the apartment, the tenant was noted on the floor. The tenant reported they were going to the bathroom at the time of the fall. Staff assisted them off the floor and the tenant reported pain to their right hip and leg, but staff assisted them to the bathroom and then to bed anyway. The tenant had changes to their transfer and weight bearing ability, which prompted the program to seek a physical therapy evaluation. During the PT session, the tenant couldn't bear weight on their right leg so the therapist suggested obtaining x-rays to rule out injury. The tenant was sent to the ER where they were noted to have a pelvic fracture. During investigation, the tenant's vital signs were elevated at the time of the fall including the blood pressure at 144/119. Staff interview included the tenant cried in pain and limped when staff assisted them with walking. The tenant was not sent to the hospital until the following day, despite complaints of pain. According to the hospital records the tenant was sent to the hospital in a wheelchair after being dropped off by a bus without a report called to the ED.

67.3(2); $1,000. Tenant #1 exited the front door after staff members walked in. During investigation of the incident, the staff used a key fob to swipe in and out of the building which would automatically open the door for 12-13 seconds and then close and lock again. The staff did not notice the tenant exit behind them. Tenant #2 also was noted to exit the building when the receptionist pushed the release button for the door which opened it.

69.32(2); $5,000. Tenant C1 was noted outside the front door of the program when a staff member arrived at the building. When the staff member got the tenant back to the memory care unit safely, they checked all the doors and noted that an emergency exit door was not alarmed. They notified other staff who then reset the alarms. During interview, the ED indicated that the door was not originally wired into the system, so they had a separate alarm that was quiet and would not alert to staff phones. Since the alarm was quiet, they placed another louder alarm on the door. While they are unable to identify, they suspect that staff did not reset the quieter alarm appropriately as it required a key and the other alarm was stuck between on and off which may have caused it to not alarm.

Insufficiencies without fines

Program Policies & Procedures (481-67.2)

The program did not follow their policy on sexual relationships as they did not include interventions for inappropriate sexual behaviors in the service plan or identify if the tenant had the capacity to consent to sexual activity.

Staff did not complete an incident report at the time of a fall. Additionally, vital signs were not documented, and it wasn't reported to a nurse until the following day to notify the physician and family.

During observations, staff touched food with gloved hands after they touched multiple as well as touching a hamburger patty with their bare hand to place it on the bun.

The program did not follow their policy on narcotic reconciliation and responding appropriately when discrepancies were identified.

The program did not follow their sexual relationship policy by determining if two confused tenants had the capacity to consent to a sexual relationship.

Medications (481-67.5)

The physician's orders were not followed when staff didn't administer acetaminophen and morphine correctly.

Staffing (481-67.9)

A new program RN did not review nurse delegations within 60 days of hire.

Staff left gait belts on the tenants when in the dining room, which was not in accordance with delegation training.

Evaluation of Tenant (481-69.22)

Evaluations were not completed upon significant change including when a tenant fell with a fracture and was admitted to hospice.

Evaluations were not completed upon significant change when a resident expressed suicidal thoughts without a plan.

Tenant #3's evaluations were not accurate to identify health and functional status for the tenant based on staff and family interviews.

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

The program maintained a tenant's residency despite ongoing behaviors with physical aggression towards other tenants and staff.

During review, two tenants required assistance of two staff for transfers and were retained by the program.

Involuntary Transfer from the Program (481-69.24)

An involuntary discharge notice included the incorrect LTC ombudsman's phone number and address.

The tenant's physician was not notified of the program issuing an involuntary discharge notice to the tenant.

Service Plans (481-69.26)

Tenant #2's service plan was not based on evaluations due to evaluations not being completed and did not indicate the service needs.

The program did not update service plans including:

- Individualized fall interventions
- Sores in the tenant's mouth
- Pocketing of food and fluids
- All hospice services provided
- Interventions based on the tenant's suicidal thoughts
- Assistance of 2 staff members for transfers
- Behaviors
- Increased visual checks and supervision
- Change in cognition
- Infections
- New services such as application of ted hose
- Initiation of therapy services

Service plans did not address all of the tenants identified needs including:

- Wandering
- Aggression
- Hallucinations
- Yelling
- Therapy services
- Refusal of care
- Level of staff assistance for ADLs
- The service plan had blank areas where staff were to fill in individualized information

Tenant C2's service plan did not have a signature by the person updating the service plan or the tenant.

Nurse Review (481-69.27)

Tenant #1 had several falls, on of which resulted in a fractured hip. The program failed to document notification of the primary physician of ongoing pain. Additionally, the program did not complete documentation of nursing assessments.

The nurse reviews did not include medication management services and an accurate medication reconciliation.

Tenant #1's record did not include documentation when the program notified the physician that the tenant began refusing their medications. Tenant #3 did not have a MAR that included dressing change orders that the wife reported the program completed.

Dementia Specific Education for Program Personnel (481-69.30)

Staff did not complete 8 hours of dementia specific training within 30 days of hire.

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

The program did not include the alarm systems in the policy for elopement and wandering or have a separate policy on alarm systems.

For comments or questions related to the AL Survey Trends Report, please contact Kellie Van Ree, LAI's Director of Clinical Services.

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