January 2020
ICAL Survey Committee Report
ICAL Regulatory Insufficiencies

(Includes October, November and December 2019 data)

Total Surveys Conducted: 104
No Deficiencies: 37
Total Deficiencies Cited (tags): 103
Average Number of Insufficiencies Cited per Facility: 2.2
Total Fines: $21,000

# of Certification surveys: 8 (4 deficiency free)
# of Recertification surveys: 50 (33 deficiency free)
# of Complaint/Incident Investigation surveys: 47 (21 deficiency free)

Program Policies and Procedures – A003

- Program failed to consistently implement its policy and procedure regarding the completion of incident reports
- Facility failed to follow their policy regarding the identification, investigation and reporting of dependent adult abuse after a report of allegations by one tenant
- Program failed to complete an incident report as directed by the Program's policy. Tenant exhibited sexual behavior toward staff and no incident report was filled out. Tenant defecated in the dining room, had stool on a spoon and placed it in a bowl. No incident report completed.
- Program did not notify guardian of tenant fall which necessitated a hospital and finally a nursing facility admission
- Program failed to follow its policy on bedside positioning bars leading to the death of a tenant. Nurse providing care was not aware of the program's policy to advise the family of risks, obtain physician's order for use and other policy specifics

Program Policies and Procedures – A008

- Program failed to immediately record incidents. Program had a report dated 7/1/19 for an incident that happened on 3/22/19. Report dated 7/1/19m for an incident on 3/26/19. Report dated 7/1/19 for incident that happened on 4/13/19.
- Program failed to complete an incident report for 1 of 3 residents reviewed on two separate medication errors. Methadone ordered for tenant was filled by pharmacy in double the dose form. The pill should have been cut in half for administration and was not. Tenant was given double dose with each administration.

- Program and Procedures - Program did not complete an incident report for tenant who attempt to rectally insert a hanger to relieve constipation. Incident was charted but no incident report was completed.

Tenants' Rights - A013

- Tenant's care plan stated that he has disabled an alarm at last facility and that tenant was a high risk of elopement. Safety alarms were to be installed on all windows in the dementia unit. Staff noted tenant was not in main area and started looking for him and found a window open in the kitchen. Tenant was found and returned uninjured. **$2000 Fine**
- Tenant could not be found so police were notified. Tenant found near was found outside of facility and was returned. Tenant had abrasions on right palm, the back of his right shoulder and knees **$4000 Fine**
- Program failed to provide services that were adequate and appropriate for tenants. Tenants care plan stated they would be bathed twice a week, family had concerns this was not getting done. Tenants chart revealed they had not been assisted with a shower from 8/16-8/30.
- Tenants service plan indicated to use a gait belt with transfers. The aide who assisted the tenant with a shower did not use a gait belt and tenant verbalized feeling rushed and abused
- Tenant did not receive safety checks or toileting assistance as directed on her service plan
- Program failed to consistently ensure tenants received care, treatment and services there were adequate or appropriate. Tenant was found on floor with bleeding from his wrist. Staff asked I he could get up and tenant said "no". Staff stated program policy did not allow them to help tenant up, but they could call 911 for assistance. Tenant refused 911 call, so staff left tenant on floor and called son who did not answer. Staff did not notify nurse as policy required.
- Tenant on hospice care with DNR order wasn't feeling well. A call was placed to emergency services because the program staff was not aware of DNR order. A family member delivered a tenant medication to program staff and later the program stated they did not have knowledge that it had been delivered. The program revealed they had no process when receiving and documenting medications delivered by a family member or outside pharmacy.
- Due to communication issues with a contract on-call nurse, a cognitively impaired tenant, while unharmed, remained on the floor after an unwitnessed fall and refused to be helped up for a period of 20 hours. The family was aware and refused EMS assistance. The tenant was fed, provided appropriate peri care and comfort while on the floor. The tenant was lifted from the floor by use of a mechanical lift when the manager was notified of the situation.
- Tenant, who had U-shaped positioning bar on bed, was found deceased with feet entangled in the sheets and her neck resting on the bar attached to the bed. Autopsy revealed that the tenant died of positional asphyxiation since the decedent was in a position where significant weight and pressure was placed on the neck due to the placement of the bedrail. **$10,000 Fine**

Program Notification to the Department - A025

- Program failed to notify the Department of an elopement

Structural/Life Safety - A029

- Program failed to notify the department of remodeling projects including extensive remodeling of apartments and community areas that required plumbing and electrical modifications

Occupancy Agreement – A032

- Program failed to ensure the Occupancy Agreement included all the required information within the agreement or in supporting documents/attachments. Occupancy Agreement did not include all criteria for admission/retention of tenants

Evaluation of Tenant – A036

- Eight tenants admitted from other programs did not have evaluations completed prior to occupancy

Evaluation of Tenant – A037

- Program failed to complete evaluations within 30 days of taking occupancy and as needed with significant change in condition.
- Program failed to ensure functional, cognitive and health evaluations were completed within 30 days of occupancy.
- Program did not complete evaluations of tenants with significant changes that included post-surgical care requiring increased level of personal cares and medication changes.
- Program did not complete evaluations of tenants within 30 days of occupancy or with significant changes. Tenant was admitted on respite care and then transferred to memory care. An evaluation was completed upon the transfer, but not prior to 30 days in the new memory care occupancy as required.
- Program did not complete evaluations of all tenants within 30 days of occupancy or with significant changes in condition.
- Eight tenants did not have evaluations completed within 30 days of admission to the program.
- Cognitive evaluations were not completed on 2 tenants with significant changes in condition.

Medications – A038

- Program failed to ensure all medications administered were documented on the medication administration record. MAR contained blanks for several med administrations.

Criteria for Admission and Retention – A039

- Program failed to consistently discharge tenants who exceeded criteria for admission and retention. Program has 2 tenants requiring a 2 person lift and one in wheelchair bound tenant who could not propel self.

Criteria for Admission and Retention – A040

- Program failed to discharge tenant who exceeded level of care. Tenant was physically aggressive to staff.

Involuntary Discharge – A050

- Program did not provide written notice to tenant of involuntary discharge following hospitalization for a fractured hip and subsequent transfer to a SNF. Tenant continued to pay for her AL unit while in the SNF. When tenant was ready to transfer back to the AL program, AL staff advised POA that tenant exceeded level of care and that return was not possible without providing a 30-day notice.

Staffing – A055

- Program failed to provide a sufficient number of staff to meet the needs of the tenants in a dementia unit. Nurse was instructed to notify maintenance of the incident of tenant leaving and need for the kitchen window to be alarmed. When the maintenance employee did not alarm window before shift's end at 2 pm, the nurse locked the kitchen door.
- Program's pendant call policy stated that calls would be answered within 15 minutes. Call logs for response times indicated that 14.3% - 16.7% of calls were beyond the 15-minute response time during a previous two-week period.
- Program failed to respond to emergency pendant calls in a timely manner, with some response times exceeding 2-3 hours.

Staffing – A056

Program staff failed to implement fire safety procedures. Furniture was placed in front of the fire door in the memory care unit.

Staffing – A058

- Program's RN failed to complete a review to ensure staff were sufficiently trained and competent to provide services within 60 days of beginning employment.
- Program failed to ensure staff were competent in all tasks assigned or delegated. Nurse delegations were not completed within 60 days of the DON's employment. Staff were competencies were not observed, but were documented as complete.
- Two staff members were not sufficiently trained within 60 days of hire.
- Three staff members had not been observed demonstrating competency with all skills within 60 days of hire

Staffing – A059

- Nurse delegations were not completed for all staff within 30 days of employment (2)

Staffing – A060

- Staff training for one employee did not include education on assisting with ADL's and IADL's.

Staffing – A061

- Staff were not properly instructed regarding care for a tenant who needed assistance with toileting and changing her brief. As a result, tenant often went 12 or more hours with a wet brief or wet clothing.

Staffing – A063

- Observation of non-licensed staff member performing med pass revealed the following: staff member signed off meds prior to administration, removed medication from the wrong slot for administration, picked up a medication with a glove, not a gloved hand, and put in med cup.

Tenant Documents – A069

- Program failed to ensure a signed authorization to receive emergency medical care was in tenant files.

Service Plans – A080

- Service plan for tenant with history of weakness and falls failed to have interventions that included number of staff needed for transfers and use of bed alarms

Service Plans – A083

- Program failed to update service plans as needed and failed to ensure service plans reflected the service needs of tenants. Tenant who fell and fractured hip and returned to the program did not have service plan updated to show he was a max assist of 2 for transfers. Service plan not updated reflecting tenant needed help with TED socks. Tenant who had suicidal ideations and aggressive behaviors with other male tenants did not have service plan interventions updated.
- Service Plans - Service plan did not reflect new self-administered medications or physical therapy services ordered.

Service Plans – A084

- Preliminary service plans were not developed for 8 tenants prior to occupancy

Service Plans – A085

- Program failed to update a service plan with a significant change in condition. Tenant was having increased behaviors, striking out at staff and wandering into other tenant rooms. Service plan was not updated to address those needs.
- Program failed to ensure service plans were updated within 30 days of occupancy.
- Service plan was not updated within 30 days of admission to a memory care unit after transferring from a respite care status. Service Plans - Service plan did not reflect new self-administered medications or physical therapy services orders

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- Program failed to ensure service plans were updated within 30 days of occupancy.
- Service plan was not updated within 30 days of admission to a memory care unit after transferring from a respite care status.
- Program failed to update the service plans of 3 tenants within 30 days of occupancy

Service Plans – A086

- Program failed to have service plans signed by all parties when a significant change occurred.

Service Plans - A087

- Program failed to add all discretionary changes to the service plan as needed. Tenant was noted to have a behavior of biting on several occasions and the service plan failed to include any information regarding the behavior. Tenant who was on hospice and receiving a bath from the hospice aide did not have service plan indicating those services.

Service Plans – A089

- Tenants service plan failed to include his exit seeking behavior.
- Tenants service plan was not updated to reflect bathing order after surgery or physician's order to self-administer over the counter medications.
- The service plan did not contain interventions to address the tenant's verbal and physical behavior towards staff.
- Service plan did not reflect the tenant's history of traumatic injury to the toes or the treatment of the injury. Care plan did not reflect the tenant was taking a sponge bath due to placement of a port.
- Service plan did not reflect new orders to crush meds and administer with yogurt or increased need for toileting.
- Tenant with multiple falls did not have interventions on service plan
- Therapy orders and treatment were not on service plan
- Tenant with a managed risk agreement to improve issues with incontinence did not have the interventions documented on the service plan
- The service plan for a cognitively impaired resident did not reflect the need for assistance with meals and pocketing of food, assistance with ambulation, needed nighttime checks and assistance with toileting or discontinuation of hospice services.
- Program did not have service plan interventions documented for the following: use of medicated shampoo twice weekly, new diagnosis of cellulitis, use of a bed rail, assistance with bathing, or use of a whirlpool bath
- Service plan did not include tenant use of a wheelchair that tenant used when fatigued. Another service plan did not include the removal of all hangers from a tenant's room after he attempted to use one to alleviate constipation by rectally inserting such a device.
- Tenant service plan did not include such items as: use of anticoagulant medication, change from weekly to monthly weights, frequent shower refusals; history of UTI's and treatment when needed, and use of outside therapy providers

Nurse Review – A094

- Program failed to consistently ensure nurse reviews were completed at least every 90 days for tenants.

Nurse Review – A096

- Nurse failed to subsequently monitor the condition of a resident and the appropriateness of agreed interventions in a managed risk agreement aimed at improving episodes of incontinence.
- Nurse review failed to include documentation regarding recent falls and effectiveness of current interventions, status of shoulder pain and results of a recent UA.

Food Service – A104

- Program failed to ensure staff responsible for serving food had an orientation on sanitization and safe food handling prior to handling food.

Staffing – A115

- The program did not provide a 24 hour on-call response system for 4 units which were converted from independent living to assisted living occupancy.

Record Checks – A118

- Program failed to perform a criminal background checks prior to employment.
- Program failed to complete child and dependent adult abuse record checks for 2 staff reviewed. **$500 Fine**
- Record Checks - Program failed to complete a criminal background and abuse check prior to employing 1 staff member.
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- Program did not complete background and abuse checks prior to employee hire.
- Record checks - 1 employee began employment prior to completion of the background check process.

Records Checks – A121

- Program failed to request an evaluation with the Department of Human Services to determine whether an employee's crime warrants prohibited the person's employment. **$500 Fine**
- Record Checks - Program failed to obtain an evaluation of a criminal history record prior to employment.

Dementia Training – A123

- Program failed to ensure staff received eight hours of dementia-specific education within 30 days of beginning employment or the beginning date of the contract. (5) **One program was fined $500.**

Dementia Training – A125

- Program failed to include hands on dementia training.

Life Safety – A136

- Dementia specific program did not have an alarm on every exit door.

Life Safety – A138

- Tenant exited out the north door and staff could not find tenant, and police called to say they had the tenant and were in route to return them, no injuries noted. Staff did not hear the alarm announce the north door opened. **$2000 Fine**
- Tenant exited the building on 11/14/19. Program was aware that the door alarm had not been functioning since 10/30/19. As a corrective measure, the program assigned a security guard to monitor the doors. The security guard let staff know he was leaving his post to deliver newspapers and staff acknowledged his absence. While he was absent, the staff heard a door open but assumed it was the security guard coming back. When staff did a head count however, a tenant was missing.

Medications – A147

- Program failed to ensure the medications were administered as ordered by the physician. Methadone was ordered was to be cut in half for the proper dosage, but staff administered the whole pill and doubled the dose.
- Program staff administered medication to the wrong tenant resulting in need for emergency care for drop in blood pressure and unresponsiveness. **$1000 fine**

Abuse Training – A149

- Program failed to provide training related to the identification and reporting of dependent adult abuse as required by Iowa Code,
- DAA abuse training was not completed within 6 months of hire for all staff.
- 3 staff members had not completed DAA training within 6 months of hire.

Structural Requirements – A154

- The program failed to provide a safe environment related to the use of assistive bed positioning bars.
- Kitchen ceiling had missing drywall and one light that had pulled loose leaving another hole.

Structural Requirements – A155

- Program failed to install single action lockable entrance doors on dwelling unit entrance doors. One apartment had a keypad for the deadbolt lock, the deadbolt could be unlocked with either the key code or the master key.

Life Safety – A230

- Program staff failed to consistently respond appropriately to the door alarm. Nurse received a call from the police inquiring if the program had a missing tenant. The officer escorted the tenant back to the program. The tenant did wear a wanderguard. Staff was in the bathroom when alarm sounded. When staff responded they did not see anyone by the door or outside. 40 minutes elapsed from when the tenant exited, and the police returned them to the program. **$500 Fine**