Iowa Center for Assisted Living

October 2019
ICAL Survey Committee Report
ICAL Regulatory Insufficiencies

(Includes July, August and September 2019 data)

Total Surveys Conducted: 94
No Deficiencies: 59
Total Deficiencies Cited (tags): 78
Average Number of Insufficiencies Cited per Facility: 2.2
Total Fines: $18,000

# of Certification surveys: 4 (2 deficiency free)
# of Recertification surveys: 46 (29 deficiency free)
# of Complaint/Incident Investigation surveys: 56 (30 deficiency free)

A003: Program Policies and Procedures

- ALP failed to report an allegation of suspected dependent adult abuse immediately. Assistant DON said the ALP failed to report as required because staff didn't report immediately. **$500 FINE**
- ALP failed to follow policy regarding medication for multiple tenants. Unmarked medication in unlocked med cart. Staff was not attending to the cart and it could have been accessed by others. Medication errors for multiple tenants on multiple occasions- orders stated tenants should receive med at various times daily, but meds were not available to administer as ordered for several tenants. **$4,000 FINE**
- Program did not follow its policy on medication administration; MAR did not match current physician medication orders.
- Program did not consistently follow their procedures for narcotic counting at each shift.

A012: Tenants' Rights

- Fail to ensure healthcare documents were signed by tenant/legal representative for healthcare.

A013: Tenants' Rights

- Dementia tenant eloped from a courtyard gate; Tenant left the building and the AL was contacted by a school employee to notify of the elopement. AL Staff didn't hear courtyard gate alarm. **$1,000 FINE**
- Failure to ensure tenants maintain rights to receive care, treatment, and services which are adequate and appropriate. Specifically, services identified in service plan. Tenant with a GD score of five eloped through courtyard, staff responded to alarm and returned resident to building right away.
- Safety/visual checks not completed on multiple residents.

- Tenant with history of cellulitis; physician ordered wound treatments that were not completed as ordered.
- Tenant did not receive prompt and adequate care following an injury; wandered into another tenant unit and was bleeding from the mouth, had a missing tooth. Injury was not witnessed. Neither tenant's family nor hospice provider were notified of the injury at the time. No licensed nurse assessment at the time of the injury.
- When administering medications, staff did not stay with tenant until medication was taken. Significant gaps in MAR documentation of a narcotic were found. Staff did not administer Lidocaine patch as ordered.
- Tenant was to have 30 min checks completed. Multiple gaps in documentation on checks. Tenant was heard yelling and found on the floor by her sink with abrasion on elbow. Tenant with multiple falls, safety checks every 30 minutes initiated but were not documented by staff, tenant had multiple other falls after safety checks were put into place, no documentation on safety checks. **$2,500 FINE**

A033: Occupancy Agreement

- Program failed to ensure the Occupancy Agreement and/or supporting documents did not include all required criteria for admission and retention of tenants. The program failed to update tenant was when program rules changed to include additional admission/retention criteria.
- Program did not obtain a signed occupancy agreement prior to the resident taking occupancy.

A037: Evaluation of Tenant

- Resident with persistent wandering behaviors continued to attempt to elope and successfully did so on multiple occasions. ALP failed to fully evaluate the tenant's needs.
- ALP failed to complete evaluation as needed with significant change in condition for several tenants (wound treatment, assistance with transfers, bathing, dressing oral cares, etc.)
- Program failed to complete evaluations within 30 days of occupancy and as needed with significant change.
- Failed to evaluated tenant's functional, cognitive, health status as needed with significant change for tenants. This included the tenant requesting assistance with medications from program, and tenant returning from hospital with a foley catheter, required assistance with catheter cares.
- Program failed to evaluate tenants as needed for reviews with a significant change.

A039: Criteria for admission and retention of tenants

- ALP retained a tenant who required two-person transfer; This goes against 481-69.23(1)b-Criteria for admission and retention of tenants.

A055: **Staffing**

- ALP failed to provide adequate staffing. Staff failed to document safety checks on tenants that required them. Staff stated usually only one staff member on weekends; were unable to keep up on safety checks along with tenants needing assist of one with ambulation. Other staff reported they were too overloaded with other responsibilities that one person "could not do it all"

A058: Staffing

- Failure to ensure training on all nurse delegated tasks within 60 days of a new nurse's employment.

- Program failed to document a review to ensure staff were sufficiently trained and competent within 60 days of the newly hired nurse.
- Program RN failed to delegate staff within 60 days of hire for RN.

A059: Staffing

- Failure to ensure training on all nurse delegated tasks within 30 days of hire, including training on supervision of self-administered insulin.
- Failure to ensure training on all nurse delegated tasks within 30 days of hire. The former healthcare administrator was employed as the delegating nurse.
- Program failed to provide training on tasks within 30 days of employment. Training completed did not include catheter care and anti-embolism hose. Staff had a medication pass competency checklist, however, did not have delegations for medications, eye drops, nasal sprays, nebulizers, inhalers, blood sugars and insulin.

A061: Staffing

- Program did not delegate insulin administration training for unlicensed workers assigned this task.
- Unlicensed staff members were assigned administration of nasal medications but were not trained.

A063: Staffing

- Program RN failed to delegate staff within 60 days of hire for RN. Program staff administered medication without delegation training regarding medication errors.
- Program failed to provide services to tenant in accordance with training provided. Staff administered eye drops to tenant, failed to wear gloves. Nurse delegation showed she was trained to don gloves.
- Staff failed to meet individual needs in accordance with training provided. Resident did not feel well and had several bouts of vomiting and loose stools, nurse on call was not notified, vitals were not taken. Resident was sent to ER and later died of obstructed bowel. **$2,000 FINE**

A071: Tenant Documents

- Failure to document nurses' notes by exception for multiple residents.
- Failure to document nurses' notes by exception for multiple residents. Hospice physician's orders indicated new orders regarding multiple meds but was not documented by exception.

A077: Tenant Documents

- Program failed to complete medication error report for tenant.

A079: Tenant Documents

- Failure to ensure task sheets for routine personal or health-related care were completed for tenants on memory care unit. Tasks sheets included peri-care two times a day for tenant with GDS of 6, toileting for GDS tenant of five.

A083: Service Plans

- ALP failed to update tenants' service plans when changed were needed; failed to reflect the needs of the tenant.
- Service plan not updated at least annually and whenever changes are needed.
- Program failed to ensure service plans reflected the identified needs of tenants. Resident's service plan was not updated and did not reflect to hold morning insulin if resident did not eat

breakfast. The service plan was not updated as needed and did not reflect the change from leg wraps to compression hose. Plan did not reflect diagnosis of gout with dietary recommendation, new orders and treatments, treatment for lesions on face, refusals of cares.

- Resident with history of alcohol use and frequent falls had no service plan interventions for either; tenant who had received therapy services had no notation on service plan when therapy was discontinued; tenant service plan did not indicate orders for therapy or how staff should approach tenant who had significant aggressive behaviors related to cognitive impairment; Fall precautions and new physician's orders not listed on the tenant service plan.
- Program failed to develop service plans based on evaluations as required. Comprehensive assessments were not completed as required for a significant change in condition regarding medication administration. Cognitive assessments were not completed as required for a significant change in condition regarding bathing.

A086: Service Plans

- Failure to reflect toe amputation, current treatment of the area and history indicated on the orders.
- Failed to ensure tenants' service plans updated with significant changes had all signatures signed and dated as needed.

A089: Service Plans

- Failure to develop an individualized service plan according to tenant's identified needs. Staff failed to update tenant's service plan after a first elopement to reflect exit seeking behavior.
- Service plan did not identify tenant need of specific fall interventions; use of assistive devices, hospice services, administration of anti-coagulant, use of a private caregiver, OT & PT services, and weights to be completed weekly; did not include history of cellulitis/current treatment, need for use of walker, nebulizer treatments, treatment of open buttock wound, administration of Nitroglycerin.
- Service plan did not indicate self-administrator of Flonase, back pain issues and interventions, or independent blood glucose checks and insulin administration; service plan did not include meds that were tenant administered, use of oxygen and CPap, initiation or dc of therapy services or interventions for chronic pain.
- Program failed to ensure service plans addressed identified needs for tenants. Service plan not updated for multiple falls in a timely manner. Tenant was also refusing medications, and POA informed nurse that tenant had a history of refusing medications prior to admission. Service plan failed to indicate interventions for staff related to tenant refusing medications. Tenants service plan not updated after 90-minute family meeting where family expressed concern that tenant not being bathed appropriately, poor clothing choices by tenant. They requested tenant not just sit in dining room following meal. Also requested tenant's food being cut up due to weight loss. Requested escorts to meals, yet plan was not updated to reflect these requests/changes. Plan was not updated to reflect falls, assistance with transfers and escorts or the therapies she received. Interventions was not updated to provide interventions related to falls.
- Program failed to develop service plans that reflected the identified needs of tenants. Tenant had orders for Triamcinolone cream to keep at bedside and it was not identified on the SP. Another treatment of lymphedema wrap was not indicated on the SP. Tubigrips on the tenant legs were not indicated on SP. CPAP machine was not indicated on the SP. Program failed to have SP signed for tenants within 30 days of occupancy

- Service Plans not reflecting identified needs for tenants. A tenant and his smoking interventions and assistance. Floating heels and treatment to bottom were not identified on SP.

A094: Nurse Review
- Facility failed to fully implement POC required from a previous regulatory insufficiency. **$3,500 FINE**

A095: Nurse Review
- ALP failed to ensure HC professional's orders were current for tenants.

A096: Nurse Review
- Program failed to complete nurse reviews every 90 days

A104: Food Service
- Program failed to provide an orientation on sanitation and safe food handling prior to handling food. Orientation regarding sanitization and safe food handling prior to handling food could not be found.
- Staff was not provided training on safe food handling prior to being assigned that task.

A109: Food Service
- Program failed to follow requirements for storage of food/drinks without obtaining a food establishment license. Did not have a food establishment license for kitchen in program.

A118: Record Checks
- Failure to ensure staff received Dependent Adult Abuse Training within six months.
- SING was not completed prior to employment for one staff member.
- No record check completed prior to hire for one employee.
- Failed to complete criminal history dependent adult abuse/child abuse checks prior to employment.
- Program failed to request background checks for staff prior to hire. Background check for employee was completed more than 30 days prior to hire. **$500 FINE**
- Program failed to complete a background check prior to hire for staff.
- Program failed to complete background check prior to hire for an employee.

A121: Dementia- Specific Education for Personnel
- Program failed to ensure staff received dementia specific training within 30 days of employment.

A124: Record Checks
- Program failed to ensure background checks were not completed within 30 days of hire.

A125: Dementia- Specific Education for Personnel
- Failed to complete dementia-specific education that included hands-on training. Documentation revealed staff had 8 hours of dementia training online but lacked hands-on training as required.

A138: Life Safety

- Program failed to ensure there was an operating alarm system connect to each exit door, potentially affecting all tenants of the program. Alarm to front door of dementia specific program was turned off during the hours of 7AM-4PM and staff were not monitoring the front door.
- Program failed to have an operating alarm system connected to each door connected to each exit door in a dementia-specific program as required.
- Failed to ensure door alarms were installed on all exit doors of the program. Resident exited out a door and found in parking lot and walked back into the building. **$500 FINE**

A147: Medications

- Failure to administer medication as ordered for multiple tenants. Meds were given to tenant on multiple occasions after it was ordered to be stopped. Meds were unavailable although order required, therefore, meds not given to resident as ordered.
- Program failed to consistently administer medications as prescribed. Resident did not receive liquid medication as it had run out and was not ordered when it was low because staff couldn't tell how low the liquid medication was. Labs drawn showed the blood level was very low. **$2,500 FINE**
- Program failed to consistently administer medications and physician ordered treatments as prescribed. Residents' MARs indicated insulin and blood glucose assistance was not documented as completed per orders. Residents sliding scale units of insulin administered was not consistently documented. Oral medications that were given were not documented.
- Facility failed to ensure pharmacy delivered insulin pens for tenant use for one week.

A149: Staffing

- Failure to ensure staff received Dependent Adult Abuse Training within six months for multiple staff.

A154: Structural requirements

- Failure to maintain building in a well-maintained, clean and sanitary condition. ALP had broken washing machine, gunk on floor of laundry room.
- Program failed to maintain a well-maintained, clean and sanitary building. Tenants voiced concerns with lack of cleanliness in common areas and lack of garbage pickup in the apartments.
- Program failed to maintain the building in good repair. Lights on keypad were not working, main driveway and sidewalk had several areas of concrete that had cracked and loosened resulting in large holes in areas, especially where transport bus loaded and dropped off tenants. During exit interview, bus driver notified staff that a tenant had fallen on the sidewalk while going to the bus. Memory care courtyard fence had missing panels due to wind damage. They were replaced with chain link fencing. Wind also damaged the locking mechanism to the fence, it was replaced with a chain and padlock, staff working at the time did not have the key to the padlocks and did not know where they were in case of emergency. **$1,000 FINE**

A224: Service Plans

- Program failed to update the service plans within 30 days of taking occupancy.