Iowa Health Care Association
Iowa Center for Assisted Living
Iowa Center for Home Care

RCF Survey Committee Report
RCF Regulatory Insufficiencies
4th Quarter 2019

(Includes July, August and September data)

Total Surveys Reviewed: 32
Insufficiency Free Surveys: 15
Total Insufficiencies Cited: 66
Average Number of Insufficiencies Cited per Facility: 3.8
Total Fines: $5,250
# of Recertification surveys: 1 (0 insufficiency free)
# of Complaints/Incident Investigation surveys: 25 (14 insufficiency free)

C 203: Background Checks
- Failure to conduct a background check for staff prior to employment.
- Facility failed to complete background checks as required prior to employment for employees. Could not locate checks completed through Iowa department of public safety and Iowa DHS.

C 210: Background Checks
- Failure to complete a dependent adult abuse/child abuse background check after SING showed a finding of possible criminal history requiring additional research**. $500 FINE**

R 294: Administrator
- Failure to have a person in charge, duly approved by the dept or acting in a provisional capacity.

R 304: Administrator
- Facility failed to conduct in-service educational programming on resident activities.

R 358: Personnel
- Failure to ensure staff received Dependent Adult Abuse Training for multiple staff.
- Facility failed to comply with requirements related to employee background record checks. Failed to complete criminal record checks, child abuse checks and dependent adult abuse checks

R 372: Personnel
- Fail to ensure a physical exam was completed prior to employment for staff hired in past eight months.

- Fail to ensure administrative staff had physical examinations updated every four years after hire.

R 373: Personnel

- Facility failed to consistently implement orders. Resident had an order to change a dressing daily and there were several dates on the MAR indicating the dressing was not changed.

R 390: General Policies Facility Operation

- Medication policy did not contain information for all types of medication and administration.
- Facility failed to ensure the medication management policy was followed for residents receiving eye drops. Staff failed to follow policy of washing hands before putting gloves on and washing again after taking them off.

R 412: General Policies

- Failure to follow policies for resident supervision. Resident eloped, was returned by an ambulance driver who found resident on highway. Staff did not increase supervision per internal protocol.

R 456: Admission, Transfer, and Discharge

- Failure to ensure written level of care orders were received on residents after this deficient practice was identified in earlier surve**y. $500 FINE**

R 458: Admission, Transfer, and Discharge

- Facility admitted resident with greater needs of services than the RCF could provide.

R 470: Admission Transfer, Discharge

- Failure to document notification of primary care providers prior to discharge for several residents.
- Facility failed to notify primary care providers of discharges.
- Discharge or Transfer, Notification not made to the legal representative, primary care provider, and sponsoring agency, if any, prior to the transfer or discharge of any resident.

R 478: Admission Transfer, Discharge

- Failure to obtain written orders from PCP to send unused meds with multiple residents upon discharge.
- Resident's PCP didn't sign off on order for resident to take Rx home upon discharge, but resident did.
- Facility failed to receive a written order prior to sending prescriptions with a discharged resident.
- Failure to obtain written orders from primary care providers to send unused medications with discharged residents.

R 574: Medical Examinations

- No physical exam of resident prior to admission.

R 580: Medical Examinations

- No TB test of resident prior to admission.

- Facility failed to comply with requirements related to tuberculosis testing. Facility failed to complete TB screenings as required for multiple residents.

R 608: Records
- Failure to keep PCP's ordered in record for all residents reviewed.
- Facility failed to obtain level of care orders on a quarterly basis.
- Primary care medical provider orders were not obtained and signed for residents.

R 616: Records
- Failure to note condition upon admission for multiple residents.
- Facility failed to note condition upon discharge for residents.
- Facility failed to note condition at admission and discharge.

R 622: Records
- Failure to note disposition of personal property for multiple discharged residents.
- Facility failed to document resident's personal belongings or meds upon discharge.
- Facility failed to note the disposition of personal property and medications for residents.
- Facility failed to document the disposition of personal property for several discharged residents.

R 642: Records
- Incident reports not completed for all resident incidents and accidents.

R 678: Drugs
- Facility failed to ensure the drug storage was kept locked when not in use, potentially affecting all residents of the facility.

R 690: Drugs
- Failure to ensure pharmacy inspections were completed on a quarterly basis.
- Facility failed to ensure the pharmacy inspections were completed on a quarterly basis.

R 742: Drug Administration
- Facility failed to ensure staff administering medication watched the pills being swallowed for residents.
- Staff member administering medication filled out MAR early in day prior to administering medications.

R 756: Drugs
- Facility failed to obtain a written order certifying the level of self-administration of medications and treatments.

R 780: Dietary
- Failure to ensure multiple new staff responsible for food prep/service had orientation on sanitation and safe food handling and received animal in-service training.
- Facility failed to ensure new staff responsible for food preparation and service had orientation on sanitation and safe food handling and received annual in-service training on food protection.

R 782: Dietary
- Failure to follow PCP's nutritional needs for multiple residents.

R 826: Orientation and Service Plan

- Service plans for residents were not completed within 48-hours of admission.

R 828: Orientation and Service Plan

- Facility failed to develop a service plan within 30-days for resident.
- Integrated, comprehensive service plans were not developed for residents within 30 days of admission.

R 830: Orientation and Service Plan

- Facility failed to ensure service plans included measurable goals and objectives, specific services provided, initiation dates and anticipated duration of service multiple residents.

R 834: Orientation and Service Plan

- Service plan did not contain updates about multiple attempts at elopement from ID/DD facility.
- Failure to modify a service plan as needed for residents. Behavior of a resident diagnosed with Schizophrenia began escalating; resident began roaming hallways, going into other residents' rooms at night, threatening staff, making sexual remarks and inappropriate actions towards others. A second resident began making sexual advances towards other residents and using inappropriate language and sexual behaviors. This happened to multiple residents over a prolonged time period. Residents' service plans were not updated to reflect and address these behavioral changes. **$4,250 FINE**
- Service plan did not contain updates about resident's changes in behavior and health.

R 836: Orientation and Service Plan

- Facility failed to review service plans on a quarterly basis for multiple residents.

R 838: Resident Activities Program

- Facility failed to offer two organized evening group activities each week.
- No activities were provided for residents on weekends.

R 842: Resident Activities Program

- Facility failed to include activity goals in the service plan for residents.
- No measurable activity goals were provided for several residents.

R 922: Dignity Preserved

- Facility failed to ensure privacy of resident. The resident was transferred to a new room in the facility as part of a remodeling project. The door to the resident's room would not close at the time resulting in a 3-4-inch gap between the door and the frame at all times.

R 1024: Safety

- The facility failed to adequately supervise several current and former residents in order to keep all resident's safe. Resident noted to be in/out of other consumer's rooms often during the night, agitated, threatening. A second resident reported waking up one night about a week earlier to find resident touching his penis. Resident did not report this to staff, but staff reported to surveyor that she heard this occurred. Multiple other occasions of inappropriate sexual behavior between residents that were not reciprocated by other consumers.

R 1026: Safety

- Facility failed to keep cleaning agents and poisonous materials locked up.

R 1036: Housekeeping

- Facility failed to clean resident rooms on a routine schedule. Resident had a toilet seat riser with dried BM and urine stuck to the sides of the toilet seat riser, outside of the toilet and bathroom floor. The resident stated it had been months since the bathroom was cleaned.

R 1058: Maintenance

- Facility failed to ensure the building was maintained and in good repair. Bedroom door did not close, toilet did not flush unless someone lifted the lid.
- Facility failed to maintain the outside facility grounds in a clean and orderly condition.

R 1072: Maintenance

- Facility failed to keep the building free of insects. Resident's couch had bed bugs and the cushion was being carried in a black bag thru the hall.

V 235: Baseline TB Screening Procedures for Resident

- RCF failed to conduct TB testing for multiple residents upon admission in last 6 months.