## Compliance Tips from IHCA's Survey Results Committee

## April 2016

The five most frequently cited tags from the 28 annual surveys (2 deficiency free), 35 complaints (6 unsubstantiated), 17 self-reports (10 unsubstantiated), and 2 complaint/self-report (0 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 171 total deficiencies.

The following is a breakdown of severity level:

| | | | | | |
|---|---|---|---|---|---|
| A = | 0% | D = | 63.16% | G = | 7.02% |
| B = | 2.92% | E = | 18.13% | H = | 0.0% |
| C = | 1.17% | F = | 3.51% | I = | 0% |
| | | | | J = | 0.58% |
| | | | | K = | 0% |
| | | | | L= | 0% |

**Total # of Reports: 73**
**Total # of surveys/reports deficiency free or unsubstantiated:** 13
**Avg. # of deficiencies**

- All = 2.34
- Annual = 3.12
- Complaint/Self-Reports= 2.00

**Total state fines for December Report =** $64,500 ($20,500) held in suspension)

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## Top 5 Most Frequently Cited Tags for April 2016 Report

**F 323—Free of Accident Hazards/Supervision/Devices**

- Staff unable to hear bed alarm due to door being shut only one staff member on hall, resident fell and fractured hip (G) **$10,000 fine held in suspension.**
- Facility failed to provide adequate supervision regarding transfer of resident by single staff, care plan called for two-person transfer with gait belt, resident fell to knees during transfer, fractured tibia/fibula. Transfer of another resident was done without use of a gait belt as called for by the care plan (D) **$5,000 fine.**

- Resident did not receive adequate supervision and was not provided call light within reach, resident fell backwards and fractured vertebra (G) **$5,000 fine**.
- Resident with unsteady gait fell and fractures skull and elbow, facility did not have additional approaches placed on the care plan, and additional measures were needed (G) **$5,000 fine**.
- Staff pushed resident in wheelchair without foot pedals; resident spilled hot coffee when left unattended and normally required assistance (G) **$2,000 fine.**
- Facility failed to update care plan for interventions for falls as interviews supported that resident was declining in ambulation, resident fell with fracture (G).
- Unsecured chemicals in soiled laundry and linen room; water temperature 134 degrees (E).
- Medication cart unlocked and unattended (E).
- Front door had Wanderguard alarm only (D).
- Two main floor exits not alarmed, elevators could be accessed (D).
- Facility failed to protect resident from multiple incidents of aggressive verbal and physical behavior (D).
- Mechanical lifts were not in good repair (D).
- Facility failed to ensure adequate supervision care plan called for resident not to be left alone in wheelchair when in room, was, sustained fall without fracture (D).
- Unlocked utility room with unsecured chemicals (D).

**F 281—Professional Standards of Quality**

- Advair dose empty, Mirolax and other medications unavailable (E).
- Staff did not report blood sugars that were out of normal range (E).
- Medications left in resident's room unattended (D).
- Failed to administer medications as ordered, missed two doses of Lasix (D).
- Physician's orders called for derma savers on at all times, MARS showed on at night off during the day (D).
- Nurse administered medications she did not set up, and gave to the wrong resident, resident then hospitalized (D).
- Facility failed to obtain physician's order for wound treatment and failed to follow the wound treatment order, and an angiogram was nor completed per physician's orders (D).
- Facility failed to follow physician's orders for administration of Flonase (did not close opposite nostril), did not place plastic hose per physician's orders, staff could not find order to change gastro tube feeding to four times per day (D).
- Medications ordered were not given due to pharmacy hadn't delivered them, labs not completed as ordered, and fluid restrictions not followed (D).
- Facility failed to follow physician's orders, Lasix was administered daily; order was for every other day, two grams of Amoxicillin ordered, one gram was given (D).
- Facility failed to follow physician's orders, blood pressure not taken, oxygen levels not measures, potassium not given (D).

- Staff did not hold lacrimal sack for one minute as required after eye drop administration, diabetic lab work not completed within six months as ordered (D).
- Facility failed to follow physician's orders, staff didn't notify physician of resident's weight gain (21 lbs.) missed magnesium on lab draw order (D).
- Staff did not hold lacrimal sack for one minute as required after eye drop administration, staff performed one-person transfer when care plan called for two-person transfer (D).
- Facility failed to follow medications administration guidelines by allowing staff to crush extended release tablets (D).

**F 371—Sanitary conditions**

- Undated foods in refrigerator and freezer, no policy in place for dating opened foods (F).
- Hanging spoons had dust on them dishwasher vents had dust on them (F).
- Dust and debris around vents grates of air conditioner, floor around grease trap had black and brown debris, storage room floor had dust buildup (F).
- Facility failed to ensure dietary staff wore hair nets which contained all hair and staff member failed to cover moustache (F).
- Facility failed to maintain a clean, sanitary food area, dirty vents, visible dust (F).
- Dust and dried food on services window in kitchen, wet pans, black substance on can opener, and dust on ceiling exhaust fan (F).
- Spatters from hand wash sink found on utensils hanging nearby, ice machine had black substance inside cooler (F).
- Staff scraped food off plate with thumb (E).
- Facility failed to ensure refrigerated foods items were covered, dated and labelled (E).
- Hair nets not properly worn, baseball caps, facial hair, mucky water (E).
- Baking sheets with black carbon buildup, counter can opener had rusted blade, staff wiped food thermometer with same washcloth used to after putting in different foods (D).
- Low water temperature in dishwasher (D).

**F 329—Unnecessary drugs**

- Facility failed to attempt gradual dose reduction for four resident receiving anti-depressant medications (E).
- Non-pharmacological interventions not done prior to anti-anxiety medication administration (D).
- Failed to show Zyprexa was a necessary drug as care plan failed to show any efforts at interventions to deal with anxiety; didn't follow toileting interventions (D).
- Failed to attempt gradual dose reductions for antipsychotic drugs (D).
- No gradual dose reduction attempt for use of Mirtazapine, family refused gradual dose reduction, facility did not provide education to the family (D).
- Non-pharmacological interventions not done (D).
- Facility failed to attempt gradual dose reduction on antidepressant (D).

- Three instances of facility not attempting non-pharmacological interventions prior to administration of anti-anxiety medications (D).
- No rationale for not completing gradual dose reduction found in record. No non-pharmacological interventions documented before administration of anti-anxiety medications (D).
- No non-pharmacological interventions documented prior to use of prn Ativan or Alprazolam (D).

**F 225—Abuse reporting**

- Facility failed to ensure four residents were free from sexual exploitation from another resident (G).
- Failed to report allegation of abuse. Agency staff put hands down resident's pants and grabbed genitalia, laughing and smirking when resident was incontinent (D) **$500 trebled to $1,500.**
- F—223 (abuse) not reported to DIA (D) **$1,500 fine.**
- Facility failed to report allegation of abuse within 24 hours, resident reported staff hurt their arm, bruising was present (D) **$500 fine.**
- Resident to resident altercation not reported to DIA (D).
- Facility failed to timely report resident on resident altercation (D).
- Facility failed to report to DIA an incident of one resident trying to remove another resident's pants (D).
- Facility failed to report resident on resident altercation (D).
- Facility failed to report allegation of resident abuse because administrator did not feel there was evidence of abuse (D).

**Other notable deficiencies and fines**

**F 241—Dignity**

- Failed to provide explanation for procedure for personal cares before providing hands-on assistance resulting in dignity concerns expressed (D) **$500 fine.**
- Resident complained of one hour response to a call light; only one aide working the entire wing (D) **$500 fine.**

**F 314—Pressure Ulcers**

- Skin assessment not accurate, facility assessed stage two, hospital assessed stage three, areas were not assessed that should have been, care plan not followed for skin care (G) **$9,000 fine.**
- Facility did not properly assess and implement care plan interventions to prevent pressure ulcers (G) **$4,000 fine**.
- Wrong foot boot on, resulted in ulcer (G) **$500 fine.**

**F 333—Medication errors**

- Facility failed to assess resident after change in condition after medication error (Fentanyl patch administered at 125 mg when 12.5 was prescribed. Lack of assessment for urinary infrequency that required hospitalization (J) **$10,000 fine.**

**F 353—Sufficient staffing**

- Facility staff didn't respond within 15 minutes to call lights as verified by log (E) **$1,500 fine.**

**481-58.19 Required services for residents**

- Facility failed to ensure residents were assessed properly with change in condition **$5,000 fine.**

**481-50.9 & 58.11 Background checks**

- Facility failed to have CNA with criminal background evaluated by DHS prior to employment **$500 fine.**

**N 101**

- Failed to report a fall resulting in hospitalization for right hip fracture **$500 fine.**

**C 147**

- After review of incident reports found resident was outside, eloped, should have be reported **$1,500 fine.**