Compliance Tips from IHCA's Survey Results Committee

April 2017

The five most frequently cited tags from the 30 annual surveys (11 deficiency free), 54 complaints (32 unsubstantiated), 45 self-reports (24 unsubstantiated), 17 complaint/self-report (10 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 205 total deficiencies.

The following is a breakdown of severity level:

A =	0.00%	D =	58.00%	G =	11.70%
B =	2.44%	E =	17.56%	H =	0.50%
C =	1.95%	F =	3.90%	I =	0.00%
				J =	2.93%
				K =	1.46%
				L=	0.00%

Total # of Reports: 133
Total # of surveys/reports deficiency free or unsubstantiated: 88
Avg. # of deficiencies

- All = 1.54
- Annual = 3.97
- Complaints = 2.31
- Self-reports = 2.06
- Complaint/Self-Reports= 1.82
- Mandatory = 6.14
- Special Focus = 1.8

Total state fines for February Report = $57,000 ($81,000 held in suspension)

Be sure to read the Annual Survey Frequency April Survey Results on the last page!

Cited Tags for April 2017 Report

F 323–Free of Accident Hazards/Supervision/Devices

- Improper use of EZ life and severe eye injury $**15,000 fine** K

- Facility failed to ensure 1 of 4 residents received adequate supervision to prevent accidents; resident found on floor with the walker backwards; second resident walked to dining room and there was no pad alarm in dining room chair; CNA left to get pad alarm and resident stood back up and fell and fractured hip **$15,000 fine** G
- Facility failed to ensure, the resident environment remained free from accident hazards, that each resident received adequate nursing supervision. Staff did not follow care plan and take resident to the bathroom and staff could not hear alarm down the other hallway. Facility failed to conduct adequate investigations after falls and failed to implement new/revised interventions after falls occurred. Staff did not follow fall policy of the building to do assessment and neuro checks on residents as they should have **$10,000 fine** (in suspension) F
- Resident with repeat falls fell by nurses' station, sustained subdural hematoma and was admitted to hospital **$9,000 fine** (in suspension) G
- Facility failed to provide adequate nursing supervision to protect residents against hazards from themselves, others, or the physical environment. Resident go up by themselves to go to bathroom and fell and fractured hip **$7,000 fine** G
- Facility failed to ensure that each resident received adequate supervision and assist devices to prevent accidents for 1 of 5 residents reviewed with falls. An alarm failed to sound and fall with skin tear; an alarm failed to sound and fall with left scapula fracture; staff transferred resident with pants around ankles **$6,000 fine** G
- Facility failed to provide adequate supervision to protect residents at risk of elopement. Wanderguard bracelet did not activate or sound. Bracelet did not consistently activate when tested **$5,000 fine** (in suspension) J
- The facility failed to ensure a resident's environment remained as free from accident hazards as possible and have assistance devices to prevent accidents; failed to ensure wheel chair pedals were attached to the wheel chair before transporting resident resulting in a fractured right tibia fracture during an escort when the resident put foot down during transfer and the foot caught in the wheel chair without pedals **$4,000 fine** G
- Failed to assess side rails, mattress, resident rolled onto baseboard heater with 2nd degree burns to leg **$4,000 fine** (in suspension) J
- Facility failed to provide adequate supervision and use appropriate assistive devices when transferring a resident with a mechanical lift; transferred resident x 2 with sit to stand lift without a buttock strap and resident had arm fracture and collar bone displacement **$4,000 fine** G
- Resident got up from chair to answer door, unattended, and fell to floor causing a major injury. Resident's alarm did not function. A second resident did not have a motion alarm in place as per care plan **$3,000 fine** (in suspension) G
- Side, bed rails and mattress not assessed, resident rolled out of bed and onto baseboard heater, alarm notified staff, transfer to ER with 1st and 2nd degree burns to both extremities and left side of bed **$4,000 fine** (in suspension) J
- An unattended resident seated in a chair got up from chair to answer the door and fell causing a major injury. Alarms, as per care plan, did not function.

Therapist did not set alarms at their visit. A second resident's alarm did not function during an observation **$3,000 fine** (in suspension) G

- Incorrect sling size used for a resident who has lost a lot of weight. Sling size was too large, causing a resident to fall from sling **$3,000 fine** G
- Fell from lift chair during power outage and had fx, chair in up position due to power, and staff placed resident there **$2,000 fine** G
- Facility failed to provide adequate supervision and perform a proper transfer with a gait belt in order to protect the resident. A staff member released a gait belt when a resident stood by the recliner, resident lost balance and fell, hit back on a shelf which caused further vertebrae fractures and pain **$2,000 fine** G
- Facility failed to ensure resident received kind and considerate care at all times and free from mental abuse; resident was on the toilet and staff made a video recording of resident's bowel incontinence accident that was on the floor and the resident's leg was visible in the video; the staff posted the video recording on a social media site Snapchat sharing with 2 other staff members **$2,000 fine** G
- Facility failed to ensure that the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Staff failed to adequately assess resident after a fall. X-ray showed- left radial fracture, ulnar fracture, proximal left humerus fracture, left femur fracture; resident ended up dying at the hospital G
- Staff forcefully held resident's arms behind back to do cares, left bruises on hand and forearm. The DON thought it was "no big deal" G
- Therapy Room was unlocked/open with stove knobs functioning (not in "lock-out" mode) E
- Front door alarms were not activated at the time that the doors were unsupervised when receptionist was off duty E
- Free of Accident Hazards/ Supervision devices-Resident had multiple falls without adequate investigation and adequate interventions being put into place. Resident had 13 fall in three months. Incident reports were not being done for all incidents including witnessed ones. Staff did not toilet the resident before and after meals on multiple observations by surveyor per the care plan D
- No audible alarm on front door and cognitively impaired residents E
- Resident had 5 falls from Sept. to Feb. In Feb resident fell and broke hip. Resident had a therapy recommendation for assistance but staff was allowing resident to be independent D
- Disinfectant wipes, cleaners in unlocked shower room D
- Facility failed to always follow interventions to ensure appropriate nursing interventions to prevent falls. Resident did not have gripper socks on as a fall prevention D
- Facility failed to ensure safety devices were in place and failed to utilize appropriate electrical equipment in a resident area. Resident was pushed in a wheel chair with no pedals present and left foot dragging. Large plastic surge protector in an office area of the activity room D
- Facility failed to ensure 1 of 4 residents with history of falls had interventions in place that prevented additional falls. Resident was to be lifted by mechanical

sling and had been dropped twice, once the sling ripped and once the loop came off. There were not enough slings for all the resident who required one D

- The residents slapped at each other facility failed to prevent resident to resident altercations/abuse; a care plan intervention was not updated when an electric recliner was replaced with a manual recliner D
- Same info as 241-resident staff argument D
- Resident fell out of Hoyer during transfer, only injury was soreness D
- Staff did not separate 2 residents when aggressive D

F 281—Professional Standards of Quality

- Facility failed to treat and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life recognizing each resident's individuality; resident put on call light to go to the bathroom and had to wait an hour and by that time they had soiled themselves. They said they were left on the toilet sometimes for more than an hour **$8,000 fine** (in suspension) G
- Failure to hold Metoprolol when pulse was below 55 (per physician order), failure to hold pressure on the lacrimal sac for 1 minute after administering eye drops (per manufacturers' recommendations, staff placed nebulizer in her pocket (failure to follow 5 rights of med administration) E
- Physician ordered BP and heart rate measurements to determine heart medicine medications administration. MAR showed BP recorded but not pulse, and other instances or neither being measured during noon and evening changes D
- TED hose not on per physician's order D
- Staff left meds with residents without watching them swallow - asked aides to watch to make sure they took them. Also, found a resident's meds still in the cassettes from the night before. The resident's family said the resident stated he/she had gotten someone else's meds the night before D
- Resident had orthotic shoes that had a breaking schedule to follow with notification required if redness o or any other issues presented themselves, resident had shoes withheld from resident due to a reddened area noted with no notification to the clinic or in the nurses notes D
- Failed to do lab draws D
- Resident not given pain med prior to cath changes D
- Failed to report blood sugars over 350 D
- Facility failed to follow physician orders; resident had order for blood draw that was not done resident had a catheter replaced but it was the wrong size D
- Weekly weights were not documented as ordered by the physician B

F 371—Store, prepare and serve food under sanitary conditions

- Milk was too warm and food too cool in CCDI E
- Facility failed to ensure staff stored food in a manner to reduce the chances of food-borne illness and failed to ensure clean and sanitary conditions in the kitchen; kitchen had sweet potatoes and a green pepper with white spots on them in the refrigerator with temps greater than 41 degrees; dietary staff placed a

serving utensil on the counter without a barrier between the utensil and the counter top F

- Facility failed to ensure the kitchen environment an equipment was clean and functional. Pots with black substance, dried food on mixing bowl, cupboard and drawers with sticky substance, walk in cooler with dried food F
- Soiled floor by oven. Dishwasher did not reach required temp of 120 degrees F
- Milk served in CCDI to warm, food served below temp E
- Failure to properly sanitize an air mattress that was soiled with urine E
- Facility failed to maintain an ice machine in a clean and sanitary manner; ice machine had a visible brownish substance on the upper inner surface directly over the ice and there was a whitish build-up on the outer surface near the cover E
- Failure to wash hands (Kitchen staff) prior to putting on gloves E
- Failed to label, date and cover food items E
- Facility failed to utilize sanitary techniques while handling food during breakfast services; employee touched paper and pen and hair net 4 times and then cut an onion E
- Failed to promote sanitary conditions in the food preparation area in the kitchen; dietary staff returned several times from dining room to kitchen without washing hands or using hand sanitizer E

F 441—Infection Control

- Laundry sorted isolation laundry in same bin as regular E
- Lack of follow-up the resident with swab for Influenza E
- Peri care provided using "back and forth" motion, staff did peri care and did not change gloves or wash hands before wiping a resident's mouth E
- A catheter bag was placed directly on the floor during cares. The same cotton tipped applicator was use to apply ointment to 3 separate wounds on the same resident D
- Improper glove use in pericare, didn't change gloves during process D
- Improper cleansing of oxygen tubing and emptying cath bag D
- Failure to properly sanitize an air mattress that was soiled with urine D
- An oxygen tube and nasal canula dragged on the floor during a transport, then handed canula to resident to apply to nose D
- The facility staff failed to provide services to minimize the spread of infection for a resident; staff nurse placed the g-tube syringe on the serving cart without a barrier and then used the plunger to mix the Miralax and water D
- C.N.A.s did not change dirty turn sheet under resident after doing peri-care. Also touched clean brief and pants without changing gloves after touching soiled wash cloth D

Other notable deficiencies and fines

F-314

- Ulcer worsen and interventions not being implemented G

F-223

- Facility failed to ensure one of three residents were free from resident to resident abuse. Resident #1 inappropriately touched resident #2 Physician not notified of resident behavior (G)
- An agitated/combative resident struck at, threw candy wrappers, threatened to strike other residents, staff, etc; resident was ultimately struck another resident causing a bloodied nose; resident to resident abuse. G
- A staff member threatened to hit a demented& combative resident. Stated " She's full of (expletive). Also threw her "Baby Doll" (which she carried) across the room G

F-225

- Failure to separate the alleged perpetrator from the resident following an allegation of abuse (2 residents). One incident involved 2 staff holding residents behind back to do cares, the other involved a C.N.A. hitting a combative resident (different resident). Employees were not suspended immediately and no separation was provided to protect the residents. Also, staff that witnessed the slap did not report immediately to their supervisor K

F-241

- Dignity and Respect of Individuality- Staff failed to treat and care for each resident in a manner and in an environment of that promoted quality of life. Residents complained of staff demeanor and treatment of residents. Resident was given meds during a period of time resident sleeping. Staff member noted eating a roll of a resident. Reports made to Administrator with no follow up on resident concerns of staff talking to them demeaning and talking on their phones when they were supposed to be helping residents. Multiple incidents of a CNA staff member with several residents with no disciplinary action noted or taken upon review of employee personnel file **$5,000 fine** (in suspension) H

F-250

- Facility failed to prevent resident on resident abuse **$15,000 fine** G

F-309

- Facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Facility failed to ensure that pain management was provided to residents who required them. Staff did not assess a resident after a fall, who was later found to have 3 fractures, and remained at the facility for 8 hours before receiving medical attention for pain control **$10,000** (in suspension) J
- Resident had a condition change, poor appetite, not drinking, difficulty swallowing. No assessment in chart. Resident admitted with sepsis R/T UTI and was dehydrated. Also a resident that returned from the hospital. No assessments in the chart. Resident declined and required re-hospitalization. Resident had returned skilled from hospital on 12/22 and was c/o pain. Assessed on 12/27, then no further assessment until 1/5/17. RE-admitted with urine retention (850cc), coughing up blood, and shortness of breath **$5,000 fine** (in suspension) G

- A resident showed indicators of having a CVA/TIA, no adequate report was made to the physician on a timely basis. Should not fax physician with any acute condition change, must telephone **$5,000 fine** (in suspension) J
- A resident showed indicators of having a CVA/TIA, no adequate report was made to the physician on a timely basis. Should not fax physician with any acute condition change, must telephone **$5,000 fine** (in suspension) J
- Provide Care/Services for Highest Well-being- Foley catheter pulled to do a UA instead of taking it out of the bag per Physician order causing the resident to go to Urologist to reinsert. Resident sent to an appointment without Oxygen, who had been on oxygen since admission and resident O@ level dropped to 82% which required clinic staff to find oxygen for them. Resident given medication on multiple days without a dr. order Same resident above never had a Doctor order for O2 although staff were using at the facility **$5,000 fine** (in suspension) G

F-333

- Resident free of significant med errors-Residents with Coumadin orders, 6 out of 9) were not following orders and also not doing INR (blood clotting checks) as required. Resident was also sent to hospital for Lethargy and it was found that Staff had failed to remove Exelon patches. Immediate jeopardy was noted at that time to the resident **$9,000 fine** (in suspension) K

F-325

- Maintain Nutritional status unless unavoidable. Resident was not be given a breakfast tray and facility did not have a system in place to provide a resident a tray upon waking. Resident had excessive weight loss **$4,000 fine** (in suspension) G

F-226

- Failed to do background check **$500 fine**

F-499

- Failed to verify nursing license **$500 fine**

F-517

- No detailed plan and procedure in event of power outage **$500 fine**

N-101

- Failure to notify state of a fall with major injury (subdural hematoma) **$500 fine**

L-189

- Facility failed to do required TB and physicals of employees

Annual Survey Frequency
April Survey Results Meeting

Facility	City	Last Year	This Year	Frequency
Bedford Specialty Care	Bedford	3/10/16	3/9/17	52 Weeks
Bloomfield Care Center	Bloomfield	3/22/16	3/30/17	53 Weeks
Faith Lutheran Home	Osage	1/28/26	1/12/17	50 Weeks
Fort Dodge Health & Rehab	Fort Dodge	2/17/16	3/16/17	55 Weeks
Genesis Senior Living	Des Moines	3/3/16	3/2/17	52 Weeks
Good Samaritan Society	Davenport	3/3/16	3/9/17	53 Weeks
Good Samaritan Society	Fontanelle	2/29/16	3/2/17	52 Weeks
Good Samaritan Society	West Union	3/10/16	3/16/17	53 Weeks
Green Hills Healthcare Center	Ames	3/31/16	3/30/17	52 Weeks
Griswold Rehab & Health Center	Griswold	3/2/16	3/2/17	52 Weeks
Heartland Care Center	Marcus	3/3/16	3/9/17	53 Weeks
Heritage Care Center	Iowa Falls	3/17/16	3/23/17	53 Weeks
Hubbard Care Center	Hubbard	3/10/16	3/9/17	52 Weeks
Humboldt Memorial	Humboldt	3/3/16	3/9/17	53 Weeks
Lake Mills Care Center	Lake Mills	3/31/16	3/30/17	52 Weeks
Lamoni Specialty Care	Lamoni	3/17/16	3/9/17	51 Weeks
Lenox Care Center	Lenox	3/10/16	3/16/17	53 Weeks
Monticello Nursing & Rehab	Monticello	2/25/16	3/2/17	53 Weeks
Oaknoll Retirement Residence	Iowa City	3/10/16	3/16/17	53 Weeks
Pleasantview Home	Kalona	2/4/16	3/2/17	56 Weeks
Premeire Estates	Muscatine	1/28/16	3/23/17	58 Weeks
*Regency Care Center	Norwalk	--------	3/27/17	----------
**Rehab of Lisbon	Lisbon	--------	3/2/17	----------
Riverview Manor	Pleasant Valley	3/10/16	3/23/17	54 Weeks
Rockwell Community	Rockwell	2/4/16	1/26/17	51 Weeks
Stonehill Care Center	Dubuque	3/31/16	3/30/17	52 Weeks
Sunnycrest	Dysart	3/3/16	3/15/17	54 Weeks
Thornton Manor	Lansing	2/25/16	3/2/17	53 Weeks
Touchtone Healthcare Community	Sioux City	1/28/16	1/26/17	52 Weeks
Tripoli Nursing & Rehab	Tripoli	3/3/16	3/9/17	53 Weeks
Union Park	Des Moines	3/24/16	3/20/17	52 Weeks
Willow Dale Wellness	Battle Creek	3/31/16	3/30/17	52 Weeks
Winslow House	Marion	3/10/16	3/23/17	54 Weeks

Of the (31) Tabulated Annual Surveys Reviewed in April:

13 of the Annual Surveys were earlier than or the same as last year &
18 of the Annual Surveys were later than last year.

Earliest Surveys:

Faith Lutheran Home	Osage	1/28/26	1/12/17	50 Weeks

Latest Surveys:

Premeire Estates	Muscatine	1/28/16	3/23/17	58 Weeks
Pleasantview Home	Kalona	2/4/16	3/2/17	56 Wee

Note: 13 of the 33 (39%) of the Annual Surveys were deficiency free!!!

Average Survey Frequency:	**2017**		
	April Survey Meeting	**52.84 Weeks**	**(0.84 Weeks Late)**

March Survey Meeting	**51.21 Weeks**	**(0.79 Weeks Early)**
February Survey Meeting	**50.88 Weeks**	**(1.12 Weeks Early)**
January Survey Meeting	**49.69Weeks**	**(2.30 Weeks Early)**
2016		
December Survey Meeting	**48.52 Weeks**	**(3.48 Weeks Early)**
November Survey Meeting	**48.03 Weeks**	**(3.97 Weeks Early)**
October Survey Meeting	**47.04 Weeks**	**(4.96 Weeks Early**
September Survey Meeting	**46.72 Weeks**	**(5.28 Weeks Early)**
August Survey Meeting	**47 Weeks**	**(5 Weeks Early)**
July Survey Meeting	**45.12 Weeks**	**(6.88 Weeks Early)**
June Survey Meeting	**45.31 Weeks**	**(6.69 Weeks Early)**
May Survey Meeting	**46.60 Weeks**	**(5.40 Weeks Early)**
April Survey Meeting	**48.50 Weeks**	**(3.50 Weeks Early**

*** Special Focus Facility**
**** First Survey of Facility**