Compliance Tips from IHCA's Survey Results Committee

April 2018

Survey composition: 32 annual surveys (7 deficiency free), 31 complaints (14 unsubstantiated), 5 self-reports (1 unsubstantiated), 8 complaint/self-report (4 unsubstantiated) and 6 mandatory reports (1 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 159 total deficiencies.

The following is a breakdown of severity level:

A =	0.00%	D =	64.78%	G =	5.03%
B =	1.26%	E =	20.75%	H =	0.00%
C =	1.89%	F =	2.52%	I =	0.00%
				J =	3.14%
				K =	0.63%
				L=	0.00%

Total # of Reports: 71
Total # of surveys/reports deficiency free or unsubstantiated: 27
Avg. # of deficiencies

- All = 3.61
- Annual = 3.33
- Complaints = 4.38
- Self-reports = 1.66
- Complaint/Self-Reports= 4.60
- Special Focus = 0.00
- Mandatory = 1.00

Total state fines = $14,250 ($90,750 held in suspension)

<u>Deficiencies and Fines</u> (sorted ascending by f-tag number)

F 550—Resident Rights/Exercise of Rights

- Failed to knock before entering room, resident state they don't over 50% of the time, called resident "sweety" and they don't like that (E)
- Resident rights: staff threw ice at resident (D)

- Surveyor observed administrator and other staff member arguing with cognitively impaired resident regarding receiving a shower creating a resident dignity issue (D)
- Facility failed to ensure staff maintained privacy during personal cares. Staff provided personal care to resident without the privacy door closed (D)
- Facility failed to always treat resident with dignity and respect when providing activities of daily living. Staff who was transferring a resident who had dementia and behaviors was terminated for verbal abuse. Resident became agitated and tried to bite staff's arm and staff said, "if you bite me, I'll knock your teeth out" (D)

F 557—Respect, Dignity/Right to Have Personal Property

- Staff drug/lifted resident backwards into his room when staff found him in the hallway (D)

F 558—Reasonable Accommodations of Needs/Preferences

- Failed to ensure planned transportation to scheduled appointments (D)
- Facility failed to ensure two of four residents observed had the call lights within reach in order for the resident to summon assistance (D)

F 561—Self determination

- Resident wanted to go to church activity, but staff didn't have time to get them up (D)
- Resident told surveyor that staff made her have a shower when she had refused because she was in too much pain. Staff told her she did not have a choice (D)

F 574—Required notices and contact information

- Failure to post phone numbers and information on how to contact the Department of Inspections and Appeals (C)

F 578—Refusal of treatment/advance directive

- Medical records did not show code status (E)
- Care plan on one resident said, "Full Code", but code status had changed to a DNR per signed sheet in chart - care plan was not updated with code status change (D)

F 580—Notification of Changes Injury/Decline/Room)

- Notification of changes decline/injury: improper catheter was inserted (too big) resulting in injury and decline of the resident which was not reported to physician or family (D)

F 582—Medicaid/Medicare Coverage

- Facility failed to comply with all applicable Federal Regulations regarding Medicare requirements governing billing practices for tenants. Facility provided the notice of Medicare provider non-coverage form but did not provide the required 48 hours' notice and the selection of "yes" or "no" was not checked (D)

- No mandatory skilled denial notices provided to 3 residents when skilled care services ended (D)

F 584—Safe/Clean/Comfortable Homelike Environment

- Water temps only 80 (E)

F 600—Free from Abuse and Neglect

- Resident threw milk at meal, so staff held down arm, so resident wouldn't do this again (D)
- Resident was missing topical Fentanyl patch on 2/9/18 and 3/11/18 and no investigation of the missing patches was conducted, no incident report was completed, or allegation of potential abuse was reported to administration or to DIA (D)

F 602—Free from Misappropriation/Exploitation

- Missing 28 MS Contin (D)
- Hospice nurse, present when facility nurse was administering oral medication to cognitively impaired resident, struck resident on arm and yelled "Please stop" after resident spit medication on her and another staff member (D)

F 607—Develop/Implement Abuse and Neglect Policies

- The facility policy had no reference to requiring a completed investigation of allegations of abuse be reported to the administrator and subsequently to DIA within 5 working days of the alleged incident (F)
- CNAs drug/lifted resident backwards into his room from hallway, was considered abuse but not reported with 2 hours per elder justice act (D)
- Did not report missing MS Contin immediately to DIA (D)

F 609—Reporting of Alleged Violations

- Resident to resident altercation and not reported to DIA for 8 days, 3 situations of resident hitting another resident, one skin tear occurred (E)
- Facility failed to report to DIA an allegation of abuse due to multiple missing Fentanyl patches for one resident (D)

F 610—Investigate/prevent/correct alleged violation

- No investigation was completed with potential theft of resident Fentanyl patches (D)
- Facility failed to investigate an allegation of abuse and separate the accused staff members from the resident after the allegation (D)

F 623—Notice Requirements Before Transfer/Discharge

- Resident was sent to hospital and not re-admitted without proper involuntary DC letter (D)

F 625—Notice of Bed Hold Policy Before/Upon Transfer

- Facility failed to give bed hold policy prior to a resident going to the hospital. Resident was hospitalized for 10 days (D)
- No bed-hold notification occurred with resident sent to hospital (D)
- Facility failed to notify the resident/resident representative of the bed hold policy prior to transfer (D)

F 635—Admission physician orders for immediate care

- No medication reconciliation performed at time of admission to facility. Resident was diabetic and hospitalized for hypoglycemia as per hospital history and physical and subsequent hospital records. Facility failed to obtain orders for known diabetic condition including meds or lab work. One week after admission, resident was readmitted to hospital with septic shock, pneumonia, acidosis and blood sugar reading of 607. Resident subsequently placed on comfort care and transferred to a hospice facility (J) **$7,250 fine in suspension**

F 636—Comprehensive assessments and timing

- Facility failed to develop a care plan to address tow residents' interests and interactions. One resident kissed another resident on the lips in the resident's room and both agreed this relationship was consensual. Neither one of the residents' care plan had areas of focus or interventions addressing the residents' relationship (D)
- Facility failed to complete a timely admission assessment (B)

F 644—Coordination of PASRR and Assessments

- Facility did not follow PASRR recommendations for one resident. Resident had schizoaffective disorder. The PASRR recommended ongoing psych services to evaluate psychotropic medications. The care plan did not address the psychiatric services or follow up (D)
- Facility failed to follow all PASRR level2 recommendations. Facility did not arrange for a neurological evaluation or obtain past archived mental health records (D)

F 645—PASARR screening

- Facility failed to renew a 60-day PASRR (D)

F 655—Baseline care plan

- Failed to develop baseline care plan within 48 hours for 1 of 2 closed records (D)

F 656—Develop/Implement Plan of Care

- No care plan interventions to monitor for the side effects of psychotropic drugs for 3 residents. MDS did not have complete oral and dental assessment for resident who required ground meat (E)
- Failed to update the care plans to reflect current care needs for 2 residents; one care plan lacked staff instruction for risk of seizures associated with ingesting excessive amounts of water with resulting hyponatremia and the other care plan

lacked any mention of a catheter or any direction to staff regarding care of the catheter (D)

- Care plan interventions for smoking and physical therapy not addressed on care plans (D)
- Care plan interventions for smoking not followed for one resident, change in resident status requiring use of Hoyer lift not documented on care plan, improper use of Hoyer lift by staff caused femur fracture. No notation on care plan prior to incident about how to transfer or after incident to modify transfers due to fracture (D)
- Facility failed to develop the comprehensive care plan. Residents care plan lacked any identification of psychotropic drug use (D)
- Failed to update care plan on change in pressure reduction mattress, and care plan not updated to include interventions for MRSA, VRE, and C-diff (D)
- Failure to develop a care plan for a resident with PASRR recommendations. Resident was on Seroquel and had a dose increase (the Seroquel was not addressed at all in the care plan). Also, a resident with a fall and lumbar FX did not have a new transfer method or new pain medication addressed in care plan (D)
- Failed to ensure that interventions were implemented as planned for one resident; staff did not apply a brace correctly during a transfer (D)
- Care plans did not reflect 15-minute checks for 3 residents, one with suicidal ideations and 2 with inappropriate sexual behavior, nor did care plan reflect wander guard placement or suicidal ideations on resident who threatened to go outside and freeze to death (suicide threat) for which she was hospitalized (D)

F 658—Services Provided Meet Professional Standards

- Failure to follow physician's order for oxygen which was to be on at all times (may have off when out of room). There was no order for the liter flow. Staff provided cares and left resident in bed with no oxygen on (D)
- Failed to assure res medications available for the next scheduled dose on day of admission and follow physician orders as written; staff documented "meds not available" for multiple medications (D)
- Failed to do INR checks, failed to report low blood sugars, and IV meds given 1-2 hours late (D)
- Facility failed to follow physician's orders as written. There were no vital signs taken before giving Coreg. Order for Oxygen saturation to be checked every shift did not get transcribed so didn’t get done (D)
- Facility failed to follow physician orders as directed. Patient had an order for Fentanyl Patches to be applied every 72 hours and resident did not have patch applied as ordered (D)
- Failed to follow physician order for weights and to report changes due to CHF (D)
- Failed to follow diet orders for 2 residents; One resident had orders for a lactose free diet and the nurse fed the resident a small carton of 2% milk; One resident had an order for nectar thick liquids and observed having a clear liquid pitcher at bedside and resident reported to surveyor that he gets thickened liquids off and on (D)

- Facility failed to obtain orders for indwelling urinary catheters and leg bags. Orders for client lacked orders for the leg bag and catheter with size and bulb included (D)
- Facility failed to ensure staff visualized tow residents taking their scheduled medications as ordered by physician. Residents medication cup with 7-9 pills on breakfast try with no staff present (D)
- Wound treatment being performed without TAR documentation (D)
- Professional standards: incorrect oxygen flow set by RN for resident (D)

F 660—Discharge planning process

- Lack of discharge plan for resident who transferred to another facility (D)

F 675—Quality of life

- Resident fell with finger fx., not assessment or pain medication given until return from Dr. visit for other reason and hand in cast and never returned for recheck with physician; Another resident given PRN Morphine and no vital signs or assessment done and resident continue to decline; resident had back surgery, SOB treatment ordered and no long assessments or vitals, found dead in bed; another resident had heart failure, no weight or assessment, ended up hospitalized; and resident returned from hospital with sepsis, wound vac not plugged in or directions on care of PICC line (K) **$30,000 fine in suspension**
- Resident did not eat for 2 days and had 300cc of fluid intake those days. Was transferred to the hospital on 3rd day with hypernatremia and dehydration. Resident's weight went from 112# to 90#. There were no nurses' notes documented on the resident during the time that she was not eating. Upon return from hospital, facility did not implement any changes to attempt to increase food and fluid intake. (There were no nurses' notes from 11/1/17 to 11/29/17 when she was transferred to the hospital) (D)

F 677—ADL Care Provided for Dependent Residents

- Failed to assure all resident's bathed according to their preference and failed to provide complete incontinence care. 1 res received 4 baths in Sept.and staff failed to clean the front perineal area and buttocks; 1 res 5 baths in Sept and staff failed to clean front perineal area; 1 res received 6 baths in Sept, and 1 res went 12 days without a bath (E)
- Staff changed incontinency pad on a resident that was wet and put a dry pad on with no incontinency care, then transferred resident to bed. Staff then removed brief and wiped buttocks using the same side of the wash cloth several times (D)
- Staff used dry instead of wet wipes for pericare, did not fold the wipes between swipes, and failed to cleanse left buttock (D)
- Resident was incontinent when being transferred to toilet, but CNA only wiped with toilet paper rather than provide complete incontinent cares (D)
- Facility failed to provide the necessary services to maintain adequate grooming and personal hygiene. Staff failed to offer or provide oral care (D)
- Facility failed to assure staff bathed all residents according to their preference and maintained residents' personal grooming. Bath schedules of 2/Week were

not followed- residents went 4-17 days without a bath and ordered nail care with each bath did not happen. Nails were long with debris under them (D)

F 684—Quality of care

- Facility failed to assess and intervene for 2 residents who had significant changes in status. Resident had several days of declining mental status, refusing meds and food. Resident admitted to hospital after 4 days with severe dehydration, acute kidney failure, fecal impaction and areas of skin breakdown. Resident subsequently died in hospital. Family felt they were not advised of the resident's declining condition. Resident experiencing fall and subsequent large upper thigh hematoma which required hospitalization and blood transfusion had no assessment documented after return to facility from hospitalization (J) **$10,000 fine in suspension**
- Facility failed to assure necessary treatment to maintain resident bowel function was followed. Resident went 4 days with no PRN constipation medication given (E)
- Resident observed by surveyor to have arm bruising for 3 days without facility having any documentation (D)
- Facility failed to ensure resident reviewed had an assessment of a skin issue completed and treatment was started to prevent further skin impairment (D)
- Incomplete nurses' documentation of heel pressure ulcer for a period of 6 weeks - no weekly wound measurements documented (D)
- No neurological assessment completed for resident who suffered a head injury with skin abrasion (D)
- Facility failed to measure oxygen saturation levels to assess the resident's response to oxygen. Order was for 2L of oxygen but was set at 1L (D)
- Lack of assessment and documentation for skin rashes and bruises (D)
- Resident showed scabs on arm to surveyor, and no skin assessment, treatment or documentation (D)
- Facility failed to ensure residents received treatment and care in accordance to professional standards of practice. Resident with an abdominal wound did not have a skin sheet initiated (D)

F 685—Treatment/Devices to Maintain Hearing and Vision

- Resident lost glasses and not replaced for many months (D)

F 686—Treatment to Prevent Pressure Ulcers

- Resident did not have tx done for PICC, do not notify physician of open area on foot, open area not documented for several days after opened (G) **$10,000 fine in suspension**
- 2 residents with pressure ulcers did not have assessments of the wounds done. Dietitian noted "no skin concerns" when there was a pressure ulcer noted in the care plan. There was no assessment, no measurements, no stage, or no characteristics of the wounds documented on 2 residents with pressure ulcers (D)

- 1. Resident with an open area not documented and was sitting in a recliner with no cushion. 2. Pressure ulcer grew in size without physician being notified of worsening (D)

F 688—Prevent Decrease in Range of Motion

- Failure to follow PT and OT recommendations for a restorative program on one resident. Resident only received Restorative Program one time during January and 4 times from 2/1 to 2/19 (D)
- Failed to provide ROM per recommendations (D)
- Staff pushed three residents without wheelchair pedals in place (D)

F 689—Free from Accidents and Hazards

- Staff using a Hoyer lift to transfer a resident from shower chair to bed pushed on resident's inflexible legs to move resident toward bed and caused a fracture of the femur (G) **$15,000 fine in suspension**
- Failed to provide adequate nursing supervision as planned by the use of personal safety alarms which resulted in further falls and one which resulted in a right hip fracture. Staff documented that a bed alarm would be implemented after a fall and the resident had 2 more falls that day and the bed alarm was not implemented but sat on a bedside dresser all day (G) **$5,500 fine**
- Accidents/hazards: resident at risk for falls, interventions called for pad alarm, low bed height and floor mats in front of bed, staff found resident on floor in closet, pad alarms malfunctioned (G) **$5,250 fine**
- Hot water in women's rest room, failed to implement interventions after incidents of fx, head injury (J) **$2,000 fine in suspension**
- Resident fell on 2/17/18 at 11:30 AM. Surveyor checked the chart at 1:11 and there was no IR, no care plan update, or no interventions put in place to prevent another fall. On 2/20 surveyor asked DON about it - DON stated it was an agency nurse working and she (the DON) was filling out paper work for the fall (D)
- CNA observed pulling a resident backwards out of a room and then down the hall without wheelchair pedals in place and feet dragging (D)
- Facility failed to ensure resident transfer was transferred in safe and comfortable manner. Resident unable to grip handles of EZ Way Smart Stand and knees were well bent, shoulders and arms pulling upward (D)
- Facility failed to assure each resident received adequate supervision to prevent accidents, investigate falls to identify interventions, and assure interventions were in place at the time of the fall. Client had a fall and alarm did not sound and staff could not say why that happened (D)
- During surveyor observation, staff did not use gait belt per care plan for transfer (D)
- Facility failed to ensure one resident medication was securely stored. Nurse left the albuterol for the nebulizer treatment in client's room and the client did not do the treatment (D)

F 690—Bowel, Bladder Incontinence, Catheter Care

- Facility failed to always provide assessment and intervention for a resident with low urine output and dark urine with urinary catheters. Resident with Foley had declining output and darkened urine which nurse stated wasn't reported. Client eventually ended up in ER with blood in urine and kidney infection (G) **$5,000 fine**
- Staff used improper techniques when inserting catheter, catheter was too big (G) **$500 fine**
- Staff used same wipe from BM to cleanse catheter tubing (D)
- Resident sent to Dr. for evaluation for removal of Foley catheter and still on in return, no paperwork or staff sent with resident (D)

F 695—Respiratory/Tracheostomy Care and Suctioning

- Facility failed to ensure safe and accurate delivery of oxygen. Clients oxygen tubing was kinked in 2 places and humidifier canister was empty and the tubing was 2 weeks overdue from needing changed (D)

F 697—Pain management

- Dr order for Oxycodone and not ordered by facility for almost a month, and out of pain meds for 3 days for SNF resident (G) **$3,250 fine in suspension**
- Resident with shingles had no interventions on her care plan to manage pain. Resident was in so much pain that food and fluids were refused. Had subsequent hospitalization with UTI, mental status changes, and dehydration (G) **$500 fine**

F 700—Bedrails

- Facility failed to assess bed rails for risk of entrapment and failed to ensure the space between the rail and mattress did not have a gap in which the resident could become entrapped for 1 of 60 residents. The opening or gap measured 4 inches on one side of the bed, and 8 inches on the other side of the bed (J) **$5,250 fine**

F 712—Physician visits frequency

- Two residents were not seen every 30 days after admission for 90 days and then every 60 days thereafter (E)

F 725—Sufficient Nurse Staffing

- Call lights not asnwered timely, pressure sore tx not completed, and waited 50 minutes for pain med (E) **$500 fine in suspension**
- Residents reported call lights not answered timely and often over an hour wait (E)
- Facility failed to answer resident call lights in a timely manner in order to meet resident's needs (E)
- Family said resident didn't get 2 showers a week, and residents said call lights often on 1-2 hours (E)
- Facility failed to ensure staff answered call lights in a timely manner in order to meet resident's needs, some resident waited up to 27 minutes (E)

F 726—Competent nursing staff

- CNA removed a Fentanyl patch from a resident after Roxanol was initiated because she felt the resident was receiving too much pain med and was too sedated (D)

F 729—Nurse aide registry verification

- Failed to check NA registry prior to hire X 3 (D)

F 755—Pharmacy Services/Procedures

- Missing 28 morphine tablets, and narcotic records missing for other residents (D)

F 756—Drug Regimen Review, Report Irregularities

- Dr. did not agree to one-year reduction of Risperdal (antipsychotic) and did not document "adequate rationale" for continuing same dose - he simply documented "resident stable" (D)

F 757—Drug Regimen/Freedom from Unnecessary Drugs

- Facility failed to administer the correct dose of narcotic pain medication which resulted in overdose and subsequent hospitalization of resident. Ordered medication was 5 mg of oral morphine tid. Pharmacy sent different concentration of liquid morphine and actual dose delivered was 50 mg tid (J) **$7,000 fine in suspension**
- Antipsychotic medication decreased, then increased higher than the previous dose based on staff stating increased agitation, however the chart lacked documentation as such (D)

F 758—Free from Unnecessary Psychotropic Medications

- 3 Residents receiving Lorazepam (anti-anxiety drug) were given the drug greater than 14 days without reassessment by the physician or documented rational as to why continued use was necessary (D)
- PRN Lorazepam, no non-pharmacological interventions attempted prior to PRN use (D)
- Resident taking Seroquel for management of hallucinations, behaviors and increased agitation. Inadequate documentation from physician regarding why gradual dose reduction was not attempted (D)
- Facility failed to provide non-pharmacological interventions consistently prior to an anti-anxiety medication, and an anti-depressant medication administered (D)

F 759—Free of medication error rates of 5%

- Facility failed to ensure staff administered resident medications as directed resulting in four medication errors after observation of 38 opportunities that equaled a 10.5 % error rate. Staff did no prime the Flexpen needle with 2 units of insulin prior to administration. Nurse held a medication without an order. Staff administered eye drops and did not apply pressure to the inner canthus (E)

- Nurse administered a single component medication from a stock bottle instead of the dual component medication as ordered, nurse drew up and was going to administer the wrong form of insulin and surveyor intervened prior to administration (D)

F 761—Label/Storage of Drugs and Biologicals

- 2 expired medications in Med room (8 months and 3 months expired (E)
- Staff taped a Lorazepam back into the medication card after it was accidently punched out during med pass (D)

F 790—Dental services in SNFs

- Resident without teeth not offered dentures until survey (D)

F 791—Dental services in NFs

- Facility failed to arrange dental services for three residents who were without teeth or dentures (D)

F 801—Qualified dietary staff

- Facility failed to employ an individual to manage the dietary department with the required qualifications, in the absence of a full-time dietician (C)

F 803—Menus Meet Residents' Needs/Preparation in Advance/Followed

- Facility failed to provide a meal to one resident; The resident was in bed during the meal and there was nobody present, and no tray offered. Staff reported that they didn't bring the resident a tray unless family was there because she wouldn't eat for anybody else (D)
- Facility failed to follow the planned menu. Menus called for Hard Boiled eggs which was not served, and/or a substitute was not offered (D)

F 808—Therapeutic diet prescribed by physician

- Staff served 2 2/3 oz instead of 3 oz of pureed meet to 4 residents (E)

F 809—Frequency of Meals/Snacks at Bedtime

- HS snacks not offered to all residents - no documentation to indicate snacks were offered or if they were consumed (E)
- Resident said no bedtime snacks offered (E)

F 812—Food Procurement, Storage, Preparation, Sanitization

- Facility failed to store food/beverages and handle clean dishes/equipment under sanitary conditions in order to reduce the risk of contamination and food-borne illness. Beverages stored in the refrigerator had expired but had not been thrown away (F)
- Dish machine below the recommended 120 degrees (F)
- Dietary staff failed to wash hands before gloving on several occasions, also touched buns with bare hands, and touched utensils, counter, pot holders, clip board, frig handle, etc. with hand - then touched food (E)

- Food safety: dirty area around dishwasher, missing floor tiles, dirty refrigerator (E)
- No labels or dating on leftovers stored in refrigerator; improper glove use when serving bread (E)
- Facility failed to follow proper sanitation and food handling practices during the meal service observed. Dietary staff donned gloves and touched multiple surfaces and with same gloves served food and thumb touched top of plates (E)
- Facility staff failed to store food/beverages under sanitary conditions in order to reduce the risk of contamination and food-borne illness. Shakes in the refrigerator did not have dates on them (E)
- Facility failed to always ensure staff prepared and served food under sanitary conditions. Microwave with a heavy coating of dried yellow debris on the carousel and interior walls. Drip tray on the juice dispenser had an orange and yellow curdled liquid which emitted a sour order. Afternoon snack tray brought back to the kitchen with dirty shelves and 2 pitchers of liquid sideways and floating in liquid in cooler. Review of the Cook 2-day chore list revealed no chores completed on multiple days. Chemical strip for dishwasher was not registering and dietary could not figure out why so used paper plates for supper meal (E)
- Improper hand washing/gloving for dietary workers, picked up utensils, opened refrigerator door with gloved hands then served food, touching bread (E)
- Sour cream not kept cold per label of 33-40 degrees and measured 68.5 degrees but was still served to 23 residents (why didn't the surveyor intervene before 23? (E)
- Dried food on the mixer, wooden shelves in food storage area with chipped paint, uncovered beard on Food Service Supervisor, rust on ice machine (E)

F 835—Administration

- Administration failed to provide oversight, involvement and direction to staff to assess beds for risk of entrapment when put into use and failed to ensure beds are assessed for risk of entrapment on a regular basis. (D)

F 842—Resident Records—Identifiable Information

- No documentation of bathing and nurses signed for treatments they didn't have time to do (D)

F 868—QAA Committee

- Medical director did not attend QA (E)
- No documentation of QA meetings (C)

F 880—Infection Prevention and Control

- Facility failed to ensure staff followed infection control practices. Staff did not clean their hands after removing gloves and put a dirty dressing on floor with no barrier and then did not sanitize floor where dirty dressing had been placed after throwing it out. Oxygen tubing was over 2 weeks old and had not been changed (E)

- Not all staff attended annual infection control in service; nurse performing wound care did not wash hands between glove changes (E)
- Lack of hand washing during cares (E)
- Improper glove use-failed to remove when dirty, improper folding of washcloth during pericare (E)
- Wheeling resident out of room and pulling up resident pants without removing gloves after performing cares (D)
- Facility failed to ensure staff utilized proper infection control technique after one resident had an incontinent episode. Staff failed to cleansed cushion in wheelchair once it was soiled before putting the resident back in the wheelchair (D)
- No dressing change barrier, did not wash hands after removing gloves (D)

F 881—Antibiotics Stewardship Program

- Facility did not have an antibiotic stewardship program in place (F)

F 883—Influenza and Pneumococcal Immunizations

- Facility failed to document if one resident had the influenza vaccine - she had no record as to whether it was given, although she had signed the consent form (D)

F 909—Resident bed

- Facility failed to conduct inspections of all bed frames, mattresses and bed rails as part of a regular maintenance program to identify areas of possible entrapment. (D)

F 921—Safe/functional/sanitary environment

- Facility failed to maintain a clean and sanitary resident environment. Buildup of dust and debris on floor and along the baseboards (E)
- Facility failed to maintain resident furniture and equipment in good repair. Chairs on 3rd floor had legs worn of finish and vinyl peeling on chairs. Floor tile was soiled and had dark blackened worn/missing vinyl (E)

F 947—Required in-service training for new aides

- Three certified nurse aides did not have 12 hours of annual in service training documented (B)

F 948—Training for feeding assistants

- Facility failed to ensure staff was properly trained to assist one resident. Staff who was receptionist was help resident with hand over hand technique to eat and had no training of being a paid Nutritional Assistant. (D)

L 1093—Notification of VA benefits

- Facility failed to report a resident's admission to the Iowa Department of Veteran Affairs

L 190—TB testing

- Not all employees had records of physical exams and TB testing as required

Survey Frequency April 2018

Name of Facility	City	Date	Previous Date	Time Frame Months
ACCURA HEALTHCARE OF MARSHALLTOWN	MARSHALLTOWN	**03/15/2018**	**1/12/2017**	14.2
CEDAR FALLS HEALTH CARE CENTER	CEDAR FALLS	**3/22/2018**	**1/12/2017**	14.5
CHAUTAUQUA GUEST HOME #3	CHARLES CITY	**3/1/2018**	**12/22/2016**	15.2
CLEARVIEW HOME	MOUNT AYR	**03/08/2018**	**12/15/2016**	14.9
COLONIAL MANOR OF AMANA	AMANA	**03/08/2018**	**12/29/2016**	15.1
CORNING SPECIALTY CARE	CORNING	**03/15/2018**	**1/19/2017**	14.0
CRESTVIEW NURSING AND REHAB	WEBSTER CITY	**2/22/2018**	**12/15/2016**	14.5
DUMONT WELLNESS CENTER	DUMONT	**3/29/2018**	**2/16/2017**	13.2
FRIENDSHIP HOME ASSOCIATION	AUDUBON	**3/8/2018**	**1/5/2017**	14.1
GOOD SAMARIATAN - NEWELL	NEWELL	**03/08/2018**	**1/5/2017**	14.2
GOOD SAMARIATAN - POSTVILLE	POSTVILLE	**03/22/2018**	**1/5/2017**	14.7
GOOD SAMARIATAN - ST. ANSGAR	SAINT ANSGAR	**3/8/2018**	**12/22/2016**	14.7
GRUNDY CARE CENTER	GRUNDY CENTER	**03/01/2018**	**1/5/2017**	14.0
HAWKEYE CARE CENTER	DUBUQUE	**3/15/2018**	**1/5/2017**	14.5
LINN HAVEN REHAB AND HEALTHCARE	NEW HAMPTON	**03/22/2018**	**1/19/2017**	14.2
LUTHER RETIREMENT HOME	NORTHWOOD	**03/19/2018**	**1/19/2017**	14.1
MANORCARE HEALTH SERVICES - DUBUQUE	DUBUQUE	**03/01/2018**	**12/22/2016**	14.5
NEW HAMPTON NURSING AND REHAB	NEW HAMPTON	**03/08/2018**	**1/26/2017**	13.5
NORTHERN MAHASKA SPECIALTY CARE	OSKALOOSA	**3/15/2018**	**1/5/2017**	14.5
REHABILITATION CENTER OF ALLISON	ALLISON	**3/29/2018**	**1/19/2017**	14.5
REHABILITATION CENTER OF DES MOINES	DES MOINES	**03/05/2018**	**12/15/2016**	14.8
ROLLING GREEN VILLAGE CARE CENTER	NEVADA	**3/29/2018**	**1/5/2017**	14.9
SUNSET KNOLL CARE AND REHAB CENTER	AURELIA	**3/15/2018**	**1/17/2017**	14.1
TABOR MANOR CARE CENTER	TABOR	**3/1/2018**	**12/22/2016**	14.5