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

Compliance Tips from IHCA's Survey Results Committee
April 2019

Total Number of Survey Reports: 56

Survey Composition:

Annual:	45 Surveys	13 Deficiency Free
Complaints:	20 Surveys	8 Unsubstantiated
Self-Reports:	17 Surveys	8 Unsubstantiated
Mandatory Reports:	2 Surveys	0 Unsubstantiated

State Fines:	$10,500
State Fines in suspension:	$22,750
Trebled Fines:	$12,000

Most Commonly Cited Iowa Tags:

F 644 – Coordination of PASARR and Assessment (13)

F 880 – Infection Prevention and Control (12)

F 625 – Notice of Bed Hold Policy Before/Upon Transfer (11)

F 658 – Services Provided Meet Professional Standards (10)

F 684 – Quality of Care (8)

F 689 – Free from Accidents and Hazards (8)

Tags Resulting in Actual Harm or Higher Citations and Fines:

F 689 – Free from Accidents and Hazards: 1 G Level Tag, 1 J Level Tag

F 600 – Free from Abuse and Neglect: 1 K Level Tag

F 692 – Nutrition/Hydration Status Maintenance 1 G Level Tag

F 684 – Quality of Care 2 G Level Tag

F 606 – *Not Employ/Engage Staff with Adverse Actions 1 E Level Tag

F 609 – *Reporting of Alleged Violations 1 D Level Tag

Top 10 National F-Tags*

Citation Frequency Report

National Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Active Providers=15575		Total Number of Surveys=9651
F0880	Infection Prevention & Control	693	4.3%	7.2%
F0689	Free of Accident Hazards/Supervision/Devices	623	3.8%	6.5%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	594	3.7%	6.2%
F0656	Develop/Implement Comprehensive Care Plan	544	3.4%	5.6%
F0684	Quality of Care	466	2.8%	4.8%
F0761	Label/Store Drugs and Biologicals	419	2.6%	4.3%
F0657	Care Plan Timing and Revision	350	2.2%	3.6%
F0758	Free from Unnec Psychotropic Meds/PRN Use	345	2.1%	3.6%
F0677	ADL Care Provided for Dependent Residents	308	1.9%	3.2%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	272	1.7%	2.8%

*Additional detailed national, regional, state and facility-specific CMS regulatory data can be found S&C's Quality, Certification, and Oversight Reports (QCOR).

Deficiencies and Fines (sorted ascending by F-tag number)

F550 – Resident Rights/Exercise of Rights

- Failure to treat residents in a dignified manner. No privacy bag on catheter, resident had an accident while waiting for call light to be answered, CNA told resident she stinks and is gross, surveyor observed CNA telling a resident rudely they had to wait for help, resident reported CNA told her facility is filthy and people go there when they have nowhere else to go and was only providing care to them out of the kindness of her heart. CNA acted rude, had a bad attitude towards resident, agency CNAs were sarcastic towards resident saying they couldn't go to bed as it was only 7pm. Resident asked LPN for nebulizer- surveyor observed LPN stating in a short tone of voice, "I can't, I already gave it to you." This resident had shortness of breath/cough. Resident reported staff acted mean, didn't listen, didn't believe resident. During interview LPN reported resident's lungs were coarse with wheezes, hard to tell if sick as she thought resident had history of making up symptoms. Several hours later resident was admitted to the ICU with pneumonia. E

F554 – Resident Self-Administers Meds-Clinically Appropriate

- Failed to provide ongoing assessment, care planning, current physician orders for a resident to self-administer medications. Resident's record lacked any type of assessment or evaluation of resident's ability for safe administration of medications and

for keeping medications at bedside; care plan lacked documentation that resident self-administered medications. D

F558 – Reasonable Accommodations of Needs/Preferences

- Resident, who is very kyphotic, sat with head almost touching knees, when CNA was attempting to feed resident. Facility had not sought OT positioning eval. D

F561 – *Self-Determination

- Failure to ensure resident given right to self-determination and choice with preferences for where to eat meals. D

F578 – Request/Refuse/Discontinue Treatment; Formulate Advance Directive

- Failure to ensure information regarding advanced directives was readily available for staff to be able to carry out measures according to resident's choice of whether or not to provide CPR; failed to review and update code status. D
- Failure to maintain consistent records of a resident's CPR wishes. D

F580 – Notify of Changes (Injury/Decline/Room, Etc.)

- Failure to notify resident's physician following knowledge the resident drank alcohol, yelled out and talked to people who were not there. D
- Failure to promptly notify resident representative of a physical change of condition until the resident was hospitalized. D
- Failure to notify physician of change of condition for residents related to significant weight loss. D
- Failure to notify resident's representative of a significant weight loss. D
- Failure to notify the physician of change in condition for resident. D

F582 – Medicaid/Medicare Coverage/Liability Notice

- Failure to provide appropriate notices of Medicare coverage coming to an end for multiple residents. D
- Medicare notice of noncoverage form CMS-10055 and appeal rights not given to residents. D

F583 – Personal Privacy/Confidentiality of Records

- Failure to assure personal privacy during care, CNA left resident uncovered from abdomen to genital area while washing hands; other CNA started to put on pants, then shoes with resident exposed. D
- Failure to ensure staff-maintained resident's privacy. D
- During suprapubic cares, window curtains were left open. D

F584 – Safe/Clean/Comfortable/Homelike Environment

- Failure to provide residents a home-like and well-maintained shower room. E

- Resident's room- odor due to not allowing briefs thrown away; Vents overheating, unit broken/missing pieces. Care plan did include resident preferences for room. D

F600 – Free from Abuse and Neglect

- Staff failed to prevent highly agitated/aggressive CCDI resident from being physical and psychological threat to other residents and staff over a period of several weeks. During that time the resident damaged facility property, knocked down or hit other residents, threatened other residents physically and verbally. **K $8,500 FINE**

F604 – Right to be Free from Physical Restraints

- Failure to obtain quarterly physician orders and complete residents' assessments for the continued use of a physical restraint. D

F606- *Not Employ/Engage Staff with Adverse Actions

- Failed to conduct a criminal or dependent adult abuse background check for all staff prior to hire. **E $500 FINE**

F609 - Reporting of Alleged Violations

- Facility failed to report two separate allegations of abuse to DIA. D
- Failure to report abuse allegation to DIA; resident felt intimidated/bullied by staff; Incident report- staff would prevent resident from being allowed to utilize bathroom in her room on a daily basis. **D $500 FINE**
- Failed to report a resident to resident altercation to DIA. D
- Staff failed to report abuse immediately to Administrator/DON as per policy. CNAs attempted to transfer resident who refused. Reported to LPN who began to yell at resident. Resident held onto Hoyer lift pad stating they did not want to get up. LPN began "tug of war" over the pad, eventually pried resident's fingers off the pad and staff completed transfer. One CNA told a nurse who stated CNA was a tattletale and wouldn't help her find administrator's phone number. CNA did find the number and reported it. Second nurse stated she did receive the report and did not forward it onto the DON or administrator because it was one person's word against another. Incident reported late. Administrator reported they called DHS abuse hotline instead of DIA number. Surveyor contacted DHS finding report was made to DHS. On interview resident reported feeling mistreated. D

F610 – Investigate, Prevent, Correct Alleged Violation

- Facility failed to investigate two separate allegations of abuse and failed to ensure that residents were protected against further incidents of abuse. E
- Failure to complete/document thorough investigation of possible abuse, was not reported to DIA. D

F622 – Transfer and Discharge Requirements

- Facility did not provide adequate transfer information to the hospital regarding the nature of the resident's condition at the time of transfer. D

F623 – Notice Requirements Before Transfer/Discharge

- Facility did not notify LTCO of hospital transfers for residents. B
- Failed to notify the long-term care ombudsman who transferred to the hospital. B
- Failure to notify LTC Ombudsman of hospital transfer for residents with hospital stays. B
- Facility failed to notify the ombudsman of a transfer to the hospital. B
- Failure to notify State Ombudsman of transfer to hospital. B
- Failure to notify the state ombudsman of a resident transfer to the hospital. C
- Fail to send copy of Transfer Notice to SLTC Ombudsman after hospital transfer. C

F625 – Notice of Bed Hold Policy Before/Upon Transfer

- Bed hold policy- not reviewed with resident/family prior to transfer to the hospital. B
- Bed hold policy not reviewed with resident or family prior to transfer to the hospital. B
- Failure to provide bed hold notices to residents who were transferred to the hospital. E
- Failure to provide notice to resident and/or representative of facility bed-hold prior to/upon transfer to the hospital. D
- Failure to provide notice to resident and/or their representative of facility bed-hold prior to and upon transfer to the hospital. D
- Failure to provide written information to resident/rep of facility's bed hold policy. C
- Failure to provide notice to resident and/or representative of facility's bed-hold policy prior to and upon transfer to the hospital for residents reviewed. D
- Fail to provide notice to resident/rep of bed-hold prior to/upon transfer to hospital. B
- Failure to provide written notice to resident or resident representative in regard to information explaining bed hold policy when resident was transferred to hospital. B
- Failure to provide bed hold policy notice to resident/family representative when transferring to hospital for residents. B
- Failure to notify resident/rep of bed hold policy nor reserve bed payment for residents. D
- Failure to notify resident or representative of bed hold policy with transfer to hospital or within 24 hours of admission to hospital. C

F637 – Comprehensive Assessment After Significant Changes

- Comprehensive assessment of significant change MDS was not completed after a resident was discharged from hospice care. D

F640 – Encoding/Transmitting Resident Assessment

- Fail to complete a discharge MDS when resident was transferred to the hospital. D

F641 – Accuracy of Assessments

- Failure to identify resident with 12.5% weight loss in 6 months, implement interventions; another resident had no nutritional assessment completed on admission. D
- MDS coded as resident having invasive mechanical ventilator when in fact it is a BIPAP machine. D
- Accuracy of MDS assessments. Resident who was hospitalized for UTI received antibiotics & antipsychotics in hospital and was not included on MDS. Another resident's MDS did not include dx of PTSD, depression/anxiety as indicated in behavioral note. MDS coordinator stated had heard resident had PTSD but never researched it further. D

F644 – Coordination of PASARR and Assessments

- Failure to request Level II screening for residents with new mental health diagnosis and new antipsychotic medications. D
- Residents who had negative Level I PASRR's and subsequently had changes in meds and conditions were not screened for Level II PASRR status. E
- Failure to submit PASRR for residents after new diagnosis of bipolar disorder revealed with admission. D
- Failure to refer residents with negative level 1 for the preadmission screening and resident review who were later identified with newly evident/possible serious mental disorder, intellectual disability, or other related condition to appropriate state designated authority for level 2 PASRR evaluation and determination. D
- Failure to ensure submission for updated level 1 screening related to new diagnosis of mental disorder. D
- Failure to complete a Level II PASRR to ensure residents with a mental disorder and a change in condition received services appropriate for their needs. D
- Failure to submit PASRR for a resident started on a new psychotropic medication. D
- Failure to refer resident for Level II screening due to changes in diagnoses of depression and psychotic disorder. D
- Failure to care plan specialized services documented in PASSAR Level 2 approval for multiple residents. B
- Resident newly placed on antipsychotic medication with mental health diagnosis and no new PASSAR completed. D
- Failure to resubmit level 1 PASSAR when additional mental health diagnosis were added for multiple residents. D
- Level I did not include dx of PTSD, depression, anxiety as indicated in behavioral note. A new PASARR was not initiated to capture these diagnoses. MDS coordinator stated they had heard resident had PTSD but never researched it further. D
- Failure to follow PASRR recommendations for residents. All records lacked archived psychiatric records as required by Level II. E

F645 – PASARR Screening for MD & ID

- Failure to report a diagnosed major mental illness and/or mental disorder on a level 1 preadmission screening and resident review upon admission to the facility. D
- Failure to resubmit proper paperwork for PASSAR review after resident's short-term NF approval expired. D

F655 – Baseline Care Plan

- Failure to provide resident/representative with a summary of baseline care plan. D
- Failure to review baseline care plan with resident or resident representative within 48 hours after admission to facility. D
- Failure to develop/review a baseline care plan within first 48 hours of admission. D
- Failed to complete baseline care plans within 48 hours after admission. C

F656 – Develop/Implement Plan of Care

- Failure to develop a comprehensive care plan to ensure that residents could attain their highest practicable level of well-being care plan lacked any relevant information and interventions related to alcohol and drug dependency issues. D
- Failure to develop a comprehensive care plan; residents not reviewed for use of siderails. E
- Failed to develop a comprehensive care plan related to potential side effects of antipsychotic medications; identification of resident with diabetes or interventions regarding signs/symptoms of hypo/hyperglycemia; mood indicators or interventions to address the residents' needs; nutritional interventions; anti-anxiety/anti-depressant medications or what staff should monitor for with those medications. E
- Failure to care plan use of antipsychotic medication or monitor for SE's. D
- Care plan did not address the antipsychotic medication or include measurable goals and interventions for psychotropic drug use. D

F657 – Care Plan Timing & Revision

- Failure to follow care plan which called for two-person transfers for resident with leg amputation. D
- No changes to care plan noted when resident had changes in respiratory care. D
- Failure to revise care plan to reflect accurate transfer needs, pain interventions and behavioral symptom interventions. D
- Failure to update care plans when indicated for residents related to Hospice intervention. D
- Failure to update care plans timely for new concerns, resident's change in status/treatments: skin injuries, cares of treatment, edema, use of wound vac, impaired skin integrity d/t cancer, d/c isolation precautions. Resident was not invited to Care Conferences. D

- Care plan revision not completed after dx of PTSD, depression/anxiety were given in the behavioral note. MDS coordinator stated they had heard resident had PTSD but never researched it further. D

F658 – Services Provided Meet Professional Standards

- Nursing staff did not address addition of new psych diagnosis or medications on care plan. D
- Failure to assure medications were transcribed as written to avoid med errors. D
- Failure to monitor weight fluctuations for resident with order for daily weights and MD was not notified. D
- Failure to follow up on lab results for PT w/INR, did not clarify MD orders for Coumadin and repeat labs and did not have MD signed orders for Coumadin or PT w/INR's. D
- Failure to prepare/administer medications per nursing standards. Failure to prime insulin flex pen, failure to assess BP prior to administering antihypertensive medication per the MD orders. D
- Failure to ensure blood pressure and pulse checks were done prior to administering medication that physician's ordered parameters- for Betapace and Metoprolol. D
- Failure to identify an expired med for resident receiving medication. D
- Failure to follow physician's orders as directed for resident, failure to ensure correct dose was verified on the medication administration record for resident. D
- Services provided did not meet professional standards. Xanax QID ordered on admission, but incorrectly transcribed. Resident received increased dose 77 times. D
- Failed to follow physician orders. Did not hold Metoprolol with pulses below 60 per order parameters. Daily pulses and blood pressures were not on MAR. D

F677 – ADL Care Provided for Dependent Residents

- Survey staff noted that a resident who was resting in bed was incontinent of urine and stool over a period of 3 hours, but incomplete care was provided when sheets soaked with urine and having feces stains were not changed during peri-care leaving a strong odor in the room. D
- Pericare provided to resident who was incontinent of stool included a wet wash cloth without soap and cleansing motions that were not front to back only. D
- Failed to provide complete incontinence care for 2 of 2 residents; failed to cleanse all areas exposed to urine. D
- Failed to provide complete and proper pericare. And failed to assist residents with oral care on a regular basis. Staff cleansed resident from back to front during pericare. Resident reported staff not assisting with brushing teeth. Staff verified they did not assist resident with brushing teeth. D
- Failure to complete position changes and carry out interventions to prevent skin breakdown for a dependent resident. D

F679 – Activities Meet Interest/Needs of Each Resident

- Failure to provide enough 1:1 activities for resident that did not like to participate in large group activities. D
- Failure to ensure ongoing activity program of choice. Resident not noted in Bingo- staff reported on bedpan when they invited him. D

F684 – Quality of Care

- Staff members did not follow care plan for transferring resident which called for 2-3 staff members, resident to use walker while wearing appropriate footwear. Surveyor observed transfer by two staff members where gait belt was loosely applied, no walker was used and resident was wearing a heel lift boot, not gripper socks. Resident was unable to bear weight and had to be lifted with assist of another staff member from bed to chair. D
- Failure to assure adequate positioning, facility skin/wound policy stated bedfast, chair fast, and who had problems with mobility included turning/repositioning at residents every 2 hours or more frequently. D
- Failure to immediately notify physician in order to obtain prompt treatment for physical change of condition that resulted in blood infection (urosepsis) for resident. Physician notified of changing condition by fax only after office hours. **G $12,000 FINE-TREBLED**
- Failure to notify physician in a timely manner in order to obtain orders for a change in condition. **G $7,250 FINE**
- Failure to ensure wound care was completed as directed for multiple residents with skin issues. D
- Failure to ensure assessment of possible injury completed. Following abuse allegation of LPN "yanking" Hoyer sling from resident/prying hands of resident off of sling, resident received bruise. Policy indicated to not document bruises smaller than 3 cm. Nurse consultant stated it's an old policy. After allegation of abuse/subsequent bruising, resident was not assessed as per center's abuse policy. D
- Failure to timely/fully notify physician of resident's change in condition; failed to intervene for complaints of shortness of breath. Failure to thoroughly document assessments for a resident subsequently admitted to ICU with pneumonia. Resident asked LPN for a nebulizer. Surveyor observed LPN stating in a short tone of voice, "I can't, I already gave it to you." Resident had shortness of breath/cough. Resident reported staff had acted mean, didn't listen stating they did not believe him. LPN reported resident's lungs were coarse with wheezes and "it's hard to tell if sick as she thought resident had history of making up symptoms". Several hours later resident was admitted to the ICU with pneumonia. During survey chart review it was noted another incident of low blood sugar and other respiratory issues charted by same nurse within same week of this incident. No physician notifications documented of these incidents. D

F686 – Treatment to Prevent Pressure Ulcers

- Failure to prevent pressure ulcers, provide complete documentation of assessment of new pressure ulcers; Failure to update resident's care plan with pressure ulcers; no pressure relief in wheelchair or recliner; no Prafo boots or air mattress on bed for resident with heel ulcer. G
- Failure to assure resident at risk for skin breakdown receive care to prevent development of pressure ulcer, intervention put into place after pressure ulcer formation, lack of documentation of reposition. D
- Failure to complete wound dressings as ordered for resident with pressure sores. D
- Failure to provide interventions to prevent the development of pressure ulcers. D

F 688 – Increase/Prevent Decrease in ROM/Mobility

- Failure to assist resident to walk as planned; Failure to initiate restorative nursing program as recommended by OT. D

F 689 – Free from Accidents and Hazards

- Staff used peri wash solution sprayed on washcloth to cleanse resident's face around eyes. D
- Failure to increase nursing supervision when multiple episodes of resident to resident contact resulted in physical harm (fall with a fracture). K
- Failure to ensure an intoxicated resident did not leave the facility without supervision and to an unknown destination, resident with a BIMS score of 15/15 signed herself out to go to "church" which actually meant going to the liquor store rather than church; resident returned to the building; later found empty vodka bottle but did not know the size of bottle, later that evening the resident left with a heavyset woman after CNA opened the door for them, resident left without signing out, this was not the first time resident had done this. **J $7,500 FINE**
- Failure to ensure proper supervision to prevent elopement; Failed to supervise a hot pack after application resulting in a stage 1 burn. D
- Failure to adequately supervise residents reviewed for falls; resident slid out of wheelchair because staff had not put the resident's seat belt on. D
- Resident fell from EZ-lift sling during transfer. Fell backward from sling, hitting head on floor due to sling placement too low to support upper body. D
- Failure to follow safe smoking procedures to ensure resident received adequate supervision to prevent injury from unsafe smoking. D
- Failure to provide adequate supervision to prevent accidents. Resident was able to shut off personal alarm. This was not communicated to all staff. Resulted in a resident elopement and fall. **G $6,750 FINE**

F 690 – Bowel, Bladder Incontinence, Catheter Care

- Failure to provide appropriate catheter care, staff pulled disposable wipes from the package when still wearing gloves she had on when handling resident's shoes, other

staff cleaned the b.m. from the anal area and buttocks, attempted to turn the wipes but touching clean areas, at times wiping several times without turning, after wiping the buttocks area several times, wiped the genital area from the back with the same cloth. staff changed gloves with no hand hygiene, and applied barrier cream. D

- Failure to provide incontinence care in a manner to reduce risk of developing UTIs, staff wiped resident's buttocks with visible loose feces present in moderate amount, used several wipes to cleanse the buttocks area, with the same contaminated gloves the staff wiped the resident's front groin region. without changing the gloves. D
- Failure to appropriate perineal care after incontinence episode, or cleanse right hip or buttock. D
- Failure to provide appropriate catheter care: contaminated gloves, touched catheter tubing, cleaned catheter tubing near urethral opening with alcohol wipe and disposable wipe, cleansing toward the urethral opening. Rinsed catheter tubing/bag with plain water, did not follow policy for use of vinegar and water solution. D
- Failure to change gloves during incontinent care when starting anal/buttock area before cleansing peri area, groin, labia. Didn't assist resident to commode for evacuating bowel. D
- During catheter cares, CNA wiped from body towards meatus, then placed soiled wipe between resident's legs inside soiled brief. After rolling resident over, wiped buttocks wrong way, removed soiled brief. Package of wipes dropped on floor, CNA picked it up disposed of top wipe and placed package back in resident's drawer. D

F 692 – Nutrition/Hydration Status Maintenance

- Failure to implement physician's order for nutritional supplement for four days after order was received. D
- Failure to provide dietary interventions to maintain acceptable nutritional status related to significant weight loss. D
- Failure to initiate dietician recommendation for supplement for residents with weight loss of greater than 9% in one month, clinical record lacked documentation that staff provided resident house supplement 90mls TID. **G $2,250 FINE**

F 693 – Tube Feeding Management/Restore Eating Skills

- Facility failed to identify a weight loss. D

F 698 – Dialysis

- No pre and post dialysis assessments documented. D
- Failure to complete nursing assessments before and after dialysis. E
- Failure to assess and monitor residents before and after dialysis treatments. D
- Resident not assessed pre and post dialysis treatments. D

F 700 – Bedrails

- Failure to obtain informed consent for use of side rails. E

- Failure to assess for use of bed rails; to review risks/benefits of bed rails with resident or resident representative and obtain informed consent prior to installation date. E
- Failure to assess each resident for use of bed rails, review risk vs benefit with resident/representative or obtain consent for use of side rails. D
- Failure to assess/obtain informed consent for use of bed rails, specifically guard rails, for multiple residents. E
- Failure to adequately assess each resident for use of bed/side rails; Review risks benefits with resident/rep or obtain informed consent for use of side rails. D
- Failure to obtain informed consent prior to installation of bedrails residents. E

F 725 – Sufficient Nurse Staffing

- Facility did not provide sufficient staffing in dementia unit to meet behavioral needs of residents residing there, thus placing other residents at risk. E
- Failure to respond to call lights within 15 minutes for multiple residents. Residents reported call lights taking too long. Call light monitor report for each resident indicated times ranging from: 20-268 min, 17-129 min, 18-235min, 16-17 min, 17-89 min, 17-67 min, 21-42 min, 21-89 min, 24-25 min, 17-54 min, 18-502 min. This was also addressed at resident council. E

F 727 – RN 8 Hours/7 days/Week, Full Time DON

- Failed to provide 8 consecutive hours of RN coverage seven days per week. E

F 729 – Nurse Aide Registry Verification, Retraining

- Facility failed to verify CNA eligibility. D
- Failure to ensure all nurse aide assistants were on the Nurse Aide Registry. E

F 730 – Nurse Aide Perform Review – 12 Hours /Year In-service

- Several CNA's did not have 12 hours of annual in-service training. D

F755 – Pharmacy Services/Procedures/Pharmacist/ Records

- Failure to ensure staff counted narcotics as facility policy directed for oncoming and off-going staff in order to prevent drug diversion. D
- Failure to document accurately, track controlled substance medication for discharged resident. Nurse could not locate narcotic destruction log. B

F756 – Drug Regimen Review

- Consultant pharmacist failed to complete monthly medication regiment reviews. D
- Failure to have a resident's primary physician individually address psychotropic meds individually during a medication regimen review. D

F757 – Drug Regimen- Free from Unnecessary Drugs

- No documentation to support faculty attempt to analyze cause of resident's behaviors, implement non-pharmacologic interventions prior to administering psychoactive drugs. D
- No proper diagnosis for use of antipsychotic medication. D

F758 – Free from Unnecessary Psychotropic Meds/PRN Use

- Failed to address each psychotropic medication individually during a GDR. B
- Failed to implement non-pharmacological interventions prior to administering antianxiety meds for 1 resident. D
- Inappropriate use of an antipsychotic to treat insomnia which it isn't indicated for. D
- Failure to attempt GDR of antipsychotic medication. D
- Failure to ensure residents use of an as-needed (PRN) med showed an approved rationale for use. D
- Center did not have primary physician review use of psychotropic med within 14 days of start date; failed to obtain GDR for residents. PRN Xanax did not have an order/review to continue PRN medication after 14 days. Another resident had an order for Seroquel initiated, the resident continued to receive same dose for 8 months without GDR and no clinical rationale documented to continue it without GDR. Another resident received Lorazepam same dose for 10 months without GDR/documentation of rationale to continue without GDR. D

F759 – Free of Medication Error Rate of 5% or More

- Failure to remain free of a medication administration error rate of 5%or greater, during observation of 27 medications administrated, six errors occurred resulting in an error rate of 22.2%. D

F761 – Label/Store Drugs & Biologicals

- Facility staff did not properly keep Schedule II drugs secured under double lock and 60-doses of Hydrocodone went missing when resident was discharged. D
- Fail to ensure expired blood draw equipment was not available for resident use. D

F800 – Provided Diet Meets Needs of Each Resident

- Failure to serve appropriate serving of ground meat to residents on main floor, did not serve full scoops of ground meat. D
- Failure to provide diet prescribed for multiple residents with altered consistency diets. E

F801 – Qualified Dietary Staff

- Facility did not have certified dietary manager in lieu of a full-time dietitian. E
- Facility did not have a certified dietary manager in absence of a full-time dietitian. E
- Failure to ensure information regarding advanced directives was readily available for staff to be able to carry out measures according to resident's choice of whether or not to provide CPR; Failure to review/update code status that dietary supervisor had required qualification, facility document for dietary department, defined qualifications and responsibilities of FSS that included completion of certified dietary manager certification program within 1 year of hire if not certified prior to hire date. E
- Dietary manager not a CDM. E

F803 – Menus Meet Resident Needs/Prep in Advance /Followed

- Dietary staff did not puree biscuits as a part of the pureed diet for that meal. B
- Failure to follow menu for residents on pureed diets, did not receive bread/margarine. E

F804 – Nutritive Value/Appearance/Palatability/Temp

- Failure to provide hot and cold foods at appropriate temperatures. E
- Staff did not follow policy, ensure food served at appropriate temperature during meal service. Many days over 30-day period there were no temps logged. Didn't obtain temperature of soup after removing from cooler and heating in microwave. E

F805 – Food in Form to Meet Individual Needs

- Failed to follow therapeutic menu on a mechanical soft diet. D

F808 – Therapeutic Diet Prescribed by Physician

- Failure to follow the therapeutic menu, residents on pureed diet did not get margarine. E
- Failure to provide therapeutic diets for residents on pureed and mechanical soft diets. E

F 812 – Food Procurement, Storage, Preparation, Sanitization

- Pieces of pie uncovered, undated in dementia unit refrigerator. Staff picked up item from floor then without washing hands went to refrigerator to remove milk, touched chair, removed clean dishes from cupboard, and went on to serve meals. D
- Facility failed to dispose of outdated food items in refrigerator. E
- Failure to assure hair covers were worn during meal, food was reheated to the required temperature and proper dishwashing temperatures. F
- Failure to serve food in accordance with professional standards for food safety. E
- Failure to serve pureed foods at correct temperature for hot foods; maintain dishwasher temperature at 120˚F or higher. E
- During meal service staff members placed butter packets on the plate touching buns/ready to eat foods for 25 times. E

F 838 – Facility Assessment

- Facility did not develop a comprehensive facility assessment that included CCDI unit that addressed acuity of residents, staffing needs and staff training requirements. F
- Failure to update facility assessment to include change in management company that occurred about 7 weeks before survey. D

F 880 – Infection Prevention and Control

- During wound care, nurse removed scissors from pocket but did not cleanse them prior to placing them on clean barrier. D
- CNA provided pericare to resident and did not wash hands before assisting the resident to dress for the day. D
- Nurse failed to cleanse a glucometer before and after testing and also failed to provide a barrier when supplies were placed in a resident's room. D
- Failure to practice proper hand hygiene during lunch meal service, dietary aide rubbed hands together for less than 5 seconds, shut off water with clean hands. Did this 5 times during the lunch meal service. D
- Failure to ensure staff performed infection control measures during incontinence, medication administration and respiratory treatments. Not removing gloves, sanitizing hands or washing hands at appropriate times. E
- Failure to follow infection control precautions. Dropped lancet on floor, picked up lancet with gloves on, proceeded to administer residents' meds in plastic cup, touched call light/bed control with same gloves. No barrier in place during glucometer check. D
- Failure to ensure staff changed gloves in accordance with proper infection control techniques when contaminated to protect against cross contamination/potential infection. D
- Failure to change gloves between cleaning wound and applying new dressing. Failure to perform hand hygiene between glove changes. D
- Failure to establish/maintain infection prevention and control program designed to provide safe, sanitary, comfortable environment and help prevent development and transmission of communicable diseases and infections. D
- While preparing for dressing change, LPN placed supplies in bin then placed bottle of hand sanitizer in bin without barrier. During dressing change LPN placed bin of supplies on tile floor (without a barrier) next to resident's recliner. Facility could not provide a copy of the wound care policy. D
- Infection control: cath bag touched floor, no dignity bag for resident. Second resident receiving cath cares- CNA provided cares away from catheter side correctly, then used dry towel to dry area by drying towards catheter site incorrectly. Another CNA encouraged her to changed gloves which she did not. CNA touched privacy curtain with dirty gloves. Infection control plan had not been revised/reviewed since 2016 and no date listed on the antibiotic stewardship program. E

- Failure to utilize proper infection control techniques during resident care: did not perform hand hygiene between glove changes, no hand hygiene after resident care prior to exiting room. E

F881 – Antibiotic Stewardship Program

- Failure to create comprehensive antibiotic stewardship program that included antibiotic use protocols and system to monitor antibiotic use. D
- Failure to create comprehensive antibiotic stewardship program that included antibiotic use protocols, and system for monitoring use of antibiotics; failed to document and reassess the need for long-term antibiotic for a resident on a long-term antibiotic. D

F908 – Essential Equipment, Safe Operating Condition

- Failure to maintain mechanicals in safe and operating condition. During kitchen rounds surveyor found a cardboard box with plastic spoons and drinking glasses in right side of oven with the burner on. Burned, built-up substances on door and around door openings. Foam-like, tan/beige colored substance near door attachment. Staff reports they don't use the oven but it is functional. E

F923 – Ventilation

- Strong urine and stool smell noted at various times down the hall coming from a resident room without proper ventilation. E

Nursing Facility Survey Frequency

As of April 23, 2019, CMS lists 86 Iowa facilities (19.7%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 10.1%. National average is 8.0%

Provider	City	Survey End Date	Previous Date	Months Between
Aase Haugen Home	Decorah	03/07/2019	12/18/2017	14.80
Accura Healthcare of Cresco	Cresco	02/07/2019	10/19/2017	15.87
Accura Healthcare of Pomeroy	Pomeroy	03/07/2019	11/27/2017	15.50
Bettendorf Health Care Center	Bettendorf	03/07/2019	11/28/2017	15.47
Carlisle Center for Wellness and Rehab	Carlisle	03/07/2019	10/26/2017	16.57
Danville Care Center	Danville	02/20/2019	11/16/2017	15.37
Eastern Star Masonic Home	Boone	2/28/2019	11/9/2017	15.87
Elm Crest Retirement Community	Harlan	03/07/2019	11/2/2017	16.33
Evans Memorial Home	Cresco	02/07/2019	10/19/2017	15.87
Good Samaritan Society - Holstein	Holstein	01/31/2019	10/12/2017	15.87
Good Samaritan Society - Indianola	Indianola	02/28/2019	11/2/2017	16.10
Good Samaritan Society - Manson	Manson	02/14/2019	11/2/2017	15.63
Good Samaritan Society - Red Oak	Red Oak	01/31/2019	10/12/2017	15.87
Grandview Healthcare Center	Oelwein	01/31/2019	10/12/2017	15.87
Happy Siesta Nursing Home	Remsen	03/13/2019	11/10/2017	16.27
Iowa Veterans Home	Marshalltown	02/28/2019	11/9/2017	15.87
Karen Acres Care Center	Urbandale	01/03/2019	12/15/2016	24.97
Keosauqua Health Care Center	Keosauqua	03/21/2019	11/28/2017	15.93
Longhouse Northshire	Spencer	02/14/2019	11/2/2017	15.63
Luther Manor Communities	Dubuque	01/31/2019	10/19/2017	15.63
North Crest Living Center	Council Bluffs	02/20/2019	10/19/2017	16.30
On With Life	Glenwood	02/20/2019	10/19/2017	16.30
Patty Elwood Center	Cresco	02/20/2019	11/2/2017	15.83
Pearl Valley Rehabilitation and Nursing – Gowrie	Gowrie	01/29/2019	10/19/2017	15.57
Pearl Valley Rehabilitation and Nursing – Muscatine	Muscatine	01/10/2019	9/14/2017	16.10
Ravenwood Specialty Care	Waterloo	2/14/2019	10/26/2017	15.87
Rehabilitation Center of Hampton	Hampton	02/19/2019	10/26/2017	16.03
Sigourney Health Care Center	Sigourney	02/20/2019	11/9/2017	15.60
St. Luke Lutheran Nursing Home	Spencer	02/07/2019	10/19/2017	15.87
Thomas Rest Haven	Coon Rapids	02/14/2019	10/26/2017	15.87
Touchstone Healthcare Community	Sioux City	03/21/2019	9/26/2018	5.87
			Average=	**15.17**