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

# Compliance Tips from IHCA's Survey Results Committee
# April 2021

**Total Number of Survey Reports:** 58

**Survey Composition:**
**Annual:** 12 Surveys 0 Deficiency Free
**Complaints:** 22 Surveys 9 Unsubstantiated
**Self-Reports:** 14 Surveys 6 Unsubstantiated
**Mandatory Reports**: 3 Surveys 0 Unsubstantiated
**COVID-19 Infection Control Survey:** 7 Surveys 0 Deficiency Free
**State Fines:** $18,000
**State Fines in suspension:** $18,000

**Most Commonly Cited Iowa Tags:**
**F880 – Infection Prevention and Control (11)**
**F689 – Free from Accidents and Hazards (7)**
**F812 – Food Procurement, Storage, Preparation, Sanitization (7)**
**F658 – Services Provided Meet Professional Standards (6)**

**Tags Resulting in Actual Harm or Higher Citations and Fines:**
**F689 – Free from Accidents and Hazards 1 G Level Tag, 1 J Level Tag, 1 L Level Tag**
**F692 – Nutrition/Hydration Status Maintenance 1 G 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=15342 | | Total Number of Surveys=23101 |
| F0884 | Reporting - National Health Safety Network | 2,111 | 7.2% | 9.1% |
| F0880 | Infection Prevention & Control | 1,909 | 9.7% | 8.3% |
| F0689 | Free of Accident Hazards/Supervision/Devices | 517 | 2.9% | 2.2% |
| F0684 | Quality of Care | 407 | 2.3% | 1.8% |
| F0686 | Treatment/Svcs to Prevent/Heal Pressure Ulcer | 319 | 1.8% | 1.4% |
| F0580 | Notify of Changes (Injury/Decline/Room, etc.) | 314 | 1.8% | 1.4% |
| F0609 | Reporting of Alleged Violations | 268 | 1.5% | 1.2% |
| F0812 | Food Procurement, Store/Prepare/Serve Sanitary | 259 | 1.5% | 1.1% |
| F0677 | ADL Care Provided for Dependent Residents | 258 | 1.5% | 1.1% |
| F0656 | Develop/Implement Comprehensive Care Plan | 249 | 1.4% | 1.1% |

*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

- Daughter reported she was picking her mother up to transport to a new facility resident's clothing appeared filthy, smelled bad and her hair appeared greasy. The facility provided the resident's clothing to the daughter in three garbage bags and only some of the resident's clothes. D

### F553 – Right to Participate in Planning Care

- The facility failed to include resident in the care planning process. Resident stated she did not receive invitations to care plan meetings. D

### F554 – Resident Self-Admin Meds-Clinically Appropriate

- Facility failed to assure residents were assessed to administer their own medications before allowing them to take them without supervision for 2 of 2 residents. D
- No assessment for resident to self-administer medications at bedside for 3 residents and no physician order to do so. D

### F557 – Respect, Dignity/Right to have Personal Property

- Facility failed to treat each resident with dignity and respect. CNA and CMA verbally abused a resident when administering oral medication. D

### F568 – Accounting and Records of Personal Funds

- Resident trust statements were not provided quarterly. D

### F573 – Right to Access/Purchase Copies of Records

- Facility failed to provide requested medical records in a timely manner for resident. Requested records over a month ago and no records. D

**F578 – Request/Refuse/Discontinue Treatment; Formulate Adv Di**

- Facility failed to provide accurate code status documentation. Review of the admission care plan revealed the resident did not have a code status charted. Electronic health record did not have a code status listed. Review of facility IPOST book revealed no record of resident's code status. Resident's care plan shows resident listed as a DNR. Electronic health record lacked documented code status. Electronic health record scanned in IPOST from 10/10/2019 indicated DNR, Review of IPOST dated 11/13/2020 revealed CPR, on 2/2/21 resident identified she wanted CPR. D
- Advanced directives did not match what was on the binder of the chart. or were lacking all together. MDS had no mention of advanced directives. E

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

- Facility failed to notify an interested family member regarding the initiation of 2 medications. B
- Facility failed to promptly report a resident's change in condition to the resident's family. Resident had fluid filled blisters on lower extremity and family was not notified. D
- Facility failed to notify the physician and the resident's family of a change in condition. A resident who had an order for a "magic cup" to help with calorie intake did not have any documentation of it being initiated. MAR lacked documentation of resident receiving a multivitamin. The facility lacked documentation of physician and family notification of the resident's weight loss between the resident's readmission. The resident's December 2020 documentation survey report lacked documentation staff offered water on multiple shifts. The facility lacked documentation to the provider that the resident was not eating. Resident was admitted to the ER with dry cracked oral mucous membranes and her labs were consistent with acute kidney injury likely secondary to dehydration. D
- No documentation of physician notification of wound status and progress from May 2020 to January 2021for a large area of skin breakdown undergoing treatment. D
- Facility failed to immediately notify the physician of a resident who drank Dakins solution facility did call poison control. Failed to immediately notify the physician of resident who had a bruise injury. Resident stated CNA grabbed upper right arm and bruised him did not follow facility investigation checklist by notifying physician of alleged abuse and bruise. D

**F584 – Safe/Clean/Comfortable/Homelike Environment**

- Failed to maintain facility at acceptable temperature. Temperature was between 64-68. One of four boilers stopped working. Facility had received quote. Staff gave residents multiple blankets and space heater were purchased. Fire marshal gave special approval to place space heater with constant monitoring. Heating and cooling company said boilers at max capacity and facility needed to update

windows, insulation and doors. One boiler needed replacement but system should adequately heat building. Facility failed to report temperature loss to DIA. E

- Failure to provide homelike environment - softball sized area on wall of chipped paint, quarter sized area of wheelchair arm rest missing covering, shower rooms at 70 & 63 degrees & cluttered with wheelchairs, shower chairs and lift equipment. E

**F600 – Free from Abuse and Neglect**

- CNA struck resident on the cheek during cares. Incident not reported or investigated until later date. CNA was allowed to continue working. D

**F607-Develop/implement Abuse/Neglect, etc. Policies**

- Facility failed to assure the development and implementation of written policies and procedures including training as required to prevent financial exploitation. While cleaning the resident's room housekeeper aske the resident if he could borrow $30 the resident had $25 cash and gave that to the staff member. Staff members filed lacked a mandatory adult abuse certificate. A DHS print off showed staff member failed the test with a score of 60% and needed to pass with the post test score of at least 80%.

**F609 – Reporting of Alleged Violations**

- CNA struck resident on the cheek during cares. Incident not reported or investigated until later date. CNA was allowed to continue working. D
- Failure to report an allegation of abuse timely. E

**F610 – Investigate/Prevent/Correct Alleged Violation**

- Facility failed to separate an alleged perpetrator from the victim for 3 residents reviewed and allowed the alleged perpetrator to continue to work and handle narcotic/schedule II medications. D
- The facility investigation report with an incident dated 11/10/2020 revealed a resident reported abuse during care conference on 11/11/2020. Resident reported to IDT team CNA grabbed his arm while attempting to have him lie down on his bed for incontinence care. When asked the resident stated the incident occurred 1-2 days prior to care conference. On 1/28/21 resident stated that the CNA grabbed his upper right arm and bruised him. Review of the facility investigation report for incident on 11/10/20 showed lack of documentation of a head to toe assessment of the resident. The investigation report lacked documentation of a statement from the alleged staff. The investigation lacked documentation as to who reported the incident to the administrator. The investigation report lacked documentation of notification of physician. D

**F623 – Notice Requirements Before Transfer/Discharge**

- Facility failed to notify the Ombudsman of discharges. B

**F624 – Preparation for Safe/Orderly Transfer/ Discharge**

- Failure to provide complete discharge instructions to resident. B

**F641 –Accuracy of Assessments**

- Admission MDS of a resident not marked yes for resident considered level II PASRR process to have serious mental illness. B

**F644 –Coordination of PASARR and Assessments**

- Failure to do a level II PASRR for current resident that was level I with possible serious mental disorder. B

**F655 – Baseline Care Plan**

- Baseline care plan did not list resident's high risk medications and side effects. D
- Facility failed to develop and implement a baseline careplan. D

**F656 – Develop/Implement Comprehensive Care Plan**

- Facility failed to implement a comprehensive person-centered careplan, failed to make sure the resident was wearing heel boots while in bed as stated on the careplan and to make sure the air overlay on the resident's bed was working properly. D

**F657 – Care Plan Timing and Revision**

- Facility did not update care plans for a resident who had a significant weight loss. Facility did not include appropriate non-pharmacological approaches in care plan of resident who received prn Lorazepam for anxiety. D

**F658 – Services Provided Meet Professional Standards**

- Failed to provide professional standard of care for two of four residents. Facility failed to follow physician orders for dressing changes for resident. Failed to obtain physician orders percutaneous endoscopic gastronomy feeding instructions and did not provide adequate monitoring of anticoagulant therapy. No documentation of notifying physician when surgical site had small amount of yellow slough and redness. Lacked documentation of dressing changes. D
- Facility failed to carry out professional standards of practice by not observing the swallowing of medications. During a medication pass, the resident was given Afrin, but there was no order for afrin. Resident had an order for TED hose on in the AM and off in the PM, and the resident was observed as not having them on. D
- Facility initiated investigation after 2 doses of oxycontin were missing. It was determined that medication for resident who received dose was accidentally administered to resident who had orders for prn pain medication. D
- Professional standards not met: lack of nursing intervention resident did not have bowel movement for 7 days and HgbA1c was not done for resident. D
- Resident order for Seroquel was not updated in MAR. D
- Medications left at table dining room table for resident to take without supervision. D

**F677 – ADL Care Provided for Dependent Residents**

- Facility failed to provide appropriate perineal care for bladder incontinence. CNA used the same disposable wipe to clean both the left and right side of the labia. CNA used same wipe the buttocks without changing the cleaning surface. Staff failed to pull the foreskin back to clean the resident's penis. D
- Facility failed to provide repositioning assistance and failed to provide adequate assistance with bathing and failed to provide complete peri care. D
- Facility did not ensure a female resident was shaved of facial hair. D
- Resident requires assistance with hygiene was not cleaned up, documentation did not exist as to why shower was not given. Resident stated he feels like he's forgotten about and doesn't get showers routinely. Staff failed to provide complete peri care. Another resident was found lying in bed with soiled sheets. Staff did not change gloves after peri care and preceded to touch residents chair remote and put nasal cannula on resident. Female resident found with stained shirt and half inch whiskers on her chin. D
- Facility failed to provide resident's baths. D

**F684 – Quality of Care**

- Facility failed to provide the necessary assessments. A comprehensive evaluation should have been completed and documented in the patient's clinical record weekly for all skin issues other than pressure. D

**F685 – Treatment/Devices to Maintain Hearing/Vision**

- Resident wanted an eye appointment and staff forgot to make it. D

**F686 – Trmt/Services to Prevent/Heal Pressure Ulcers**

- Facility failed to assure a resident with a pressure ulcer received necessary treatment and services, consistent with professional standards of practice, promote healing. The resident had an order to turn and reposition every 2 hours for pressure relief, and there was several days and times that this did not occur. D
- Facility failed to notify the physician of a new area of skin impairment and initiate interventions. D
- failure to provide assessments and intervention of pressure. Resident did not have breakdown of heel on readmission and ended up with necrotic tissue present 90% of heel. D

**F689 – Free from Accidents and Hazards**

- Facility failed to provide a safe and secure environment for residents. Resident was given PRN hydroxyzine at 1:01am and documented as effective. Found unresponsive at 7am with CPR initiated. EMS notified and took over CPR efforts. Resident was not able to be resuscitated. Rounds not completed on the night shift due to staff being assigned to provide 1-on-1 supervision with newly admitted resident. D

- Failed to provide receptacle for cigarettes within resident reach, no documented smoking assessment and did not provide a safe place for lighter. Resident kept cigarettes and lighter In his shirt pocket routinely. D
- Failed to ensure each resident received adequate supervision to prevent elopement. Care plan failed to identify the resident at risk for wandering and elopement. Kitchen staff found resident standing outside in the parking lot. D
- Resident being transferred in a mechanical lift (Hoyer) when the strap came loose from the lift machine and resident slipped to the ground and struck her head. Resident found to have a subarachnoid/subdural hemorrhage upon evaluation at the hospital. Returned to the facility and was admitted to hospice. **G $8,000**
- Facility failed to ensure the resident environment remained as free of accidents and hazards. Resident was unsafely transferred when staff used a mechanical lift resulting in a fall and fracture, the left shoulder sling loop detached from the lift. Failed to follow policy and procedures for transfers. Failed to keep residents who smoke safe by holding the resident's lighters and use a smoking apron and failed to ensure the environment was free of hazards drank Dakins solution. G
- Resident with cognitive impairment, exited the facility without staff knowledge. Staff did not know the resident was gone until they received a phone call alerting them the resident was at a local bar and grill establishment. **J $5,000**
- Resident eloped, door alarm did not sound as it was shut off, another alarm sounded but said door 3 not door 4 where resident eloped. Staff member checked door 3 and saw nothing. Did a head count of her area and forgot to tell DON what had happened. Local senior center called to let facility know their resident was there. Resident had stated she would break a window to get out prior. L

**F690 – Bowel/Bladder/Incontinence, Catheter, UTI**

- Facility failed to provide adequate incontinence and catheter cares. CNA failed to pull the foreskin back and cleanse around the meatus or wipe the catheter tubing down. CNA cleansed back to front from the anus to the scrotum. D
- Staff members failed to use clean area of wash cloth when cleansing multiple areas during peri-care. D

**F692 – Nutrition/Hydration Status Maintenance**

- Facility failed to access and evaluate a residents significant weight loss and implement interventions to prevent further weight loss. **G $5,000**

**F697 – Pain Management**

- Failure to manage pain. Resident disheveled looking, soiled sheets, and yelling in pain. Resident was receiving pain medications but nursing did not mark effectiveness of medication always. D

**F698 – Dialysis**

- Failure to provide documentation of assessments of resident fistula pre and post dialysis. D

**F700 – Bedrails**

- Did not obtain consent for use of bed rails until almost a month after they were put on. D
- No assessments done for residents to have bed rails. D

**F725 – Sufficient Nursing Staff**

- Facility failed to assure call lights were answered timely. Failed to have sufficient nursing staff. D

**F732 – Posted Nurse Staffing Information**

- Facility failed to post daily nurse staffing. D

**F755 – Pharmacy Svcs/Procedures/Pharmacist/Records**

- Pharmacy failed to fill admission orders in a timely manner. Nurses progress note revealed and entry on 5 days that medication was not available from pharmacy with no follow up with pharmacy as to why. D

**F758 – Free from Unnec Psychotropic Meds/PRN Use**

- Non-pharmacological interventions were not documented prior to PRN medication given, correct diagnosis not documented, and current physician orders not documented. E

**F759 – Free of Medication Error Rates of 5% or More**

- Facility failed to ensure the medication error rate did not reach 5% or greater. The medication pass observation revealed 3 errors out of 38 opportunities for errors resulting in a medication error rate of 7.89%. D

**F760 – Residents Are Free of Significant Med Errors**

- Medications not given as physician ordered. E

**F761 – Label/Store Drugs & Biologicals**

- Facility failed to store controlled/Schedule II medications in a separately locked and permanently affixed compartment in the medication cart. D

**F800– Provided Diet Meets Needs of Each Resident**

- Facility failed to provide food at palatable temperatures for one resident. Residents complained of cold food and long wait times if sent back. The test tray was well below 140 at 112 and 134. Residents expressed concerns with quality and temperature of foods. E

**F801– Qualified Dietary Staff**

- Dietary manager did not have correct qualifications nor had he enrolled in a class. D

**F803 – Menus Meet Res Needs/Prep in Advance/Followed**

- Failure to follow planned menu for pureed diet as no pureed chicken noodle soup or bread were served and were on the menu. E

**F804 – Nutritive Value/Appear, Palatable/ Prefer Temp**

- Food temperatures were not within limits for room trays. Residents complain food isn't hot. E

**F809 – Frequency of Meals/ Snacks at Bedtime**

- Meals being served late. D

**F812 – Food Procurement, Storage, Preparation, Sanitization**

- Facility failed to show proper hand hygiene for food handling. Marker cap fell on floor put on marker used to mark trays without hand hygiene. Disinfectant bucket was at 0 ppm when should have been at 200 ppm. E
- Facility failed to food temperatures were kept at a safe range throughout serving breakfast. Steam table testing of sausage was 127 degrees and scrambled eggs 142 degrees. No documentation of temperature for several days and missing entries in previous week. E
- Kitchen sanitation issues identified were: Dusty vents over dishwasher, dusty pipes above stove, food splatter noted in drawer containing spatulas, heavy layer of food debris on hinges of multiple cupboards, sticky cupboard surfaces, dirty cupboard shelves, blender top and underside of table holding cooking oil. E
- Kitchen failed to be sanitary - container that had food rinsed less than 30 seconds in sink labeled for sanitizing, used expired milk, placed lids of containers against sanitizer bucket. Resident room refrigerators checked had expired food, build up of ice in freezer, food with no label or date, and no thermometers in refrigerator. E
- Food with no open date, microwave dirty, food expired, ceiling multiple splatters, wearing same gloves touching multiple surfaces, no pan under raw meat in refrigerator. E
- Sink used to clean food service ware did not have disinfectant in the water. E
- Facility failed to store dishes under sanitary conditions. Dishes were stored in the open cupboard face up, dessert bowls near hand sink, mixing bowls, pot and pans, drink pitchers next to sink, and cereal bowls near microwave. Blenders nears steam table were without lids on and face up. Plates under steam table were face up. E

**F868 – QAA Committee**

- Facility did not have documentation of staff attendance for all Quality Improvement committee meetings. D

**F880 – Infection Prevention and Control**

- Facility infection control manual had not been signed by medical director. B
- Facility should conduct annual review of infection control program. Staff member pulled medical mask below chin, blew nose and pulled mask back up provided care for three residents with no hand hygiene. Blew nose several other times without appropriate hand hygiene. Did not wash hands appropriately when performed hand hygiene. Staff wore glasses without protective eyewear in rooms with need for eye protection. Assisted resident with wiping mouth then continued medication administration without hand hygiene. D

- Facility failed to stop urinary drainage bag from contacting the floor. D
- Facility failed to carry out infection control measures. RN took scissors out of pocket and without cleaning them, cut off the residents foot dressing. She subsequently took the Santyl Cream out of the drawer and sat in directly on the floor of the residents room. Nurse picked up medication in her hand with no gloves on. Staff did peri care with gloves and no gown on. D
- Observed nurse dispensing medication from a stock bottle into an ungloved hand. D
- Staff member completed peri-care, removed gloves and then assisted resident with a drink without washing hands. Staff member performing blood sugar failed to remove gloves and wash hands prior to touching multiple surfaces such as cart handle, doors, etc. D
- Facility staff failed to perform hand hygiene and demonstrate proper gloving technique during wound cares with a wound that had drainage. D
- Facility staff failed to change their isolation gowns between resident cares for residents in isolation/quarantine. D
- Staff failed to change gloves and perform hand hygiene before touching other objects and surfaces. D
- Staff touched medication with bare hands before administering, failed to wear gloves while administering insulin, and dropped inhaler cap on floor and did not disinfect it before replacing. Licensed nurse observed dressing multiple wounds for one resident which required several glove changes and the nurse did not perform hand hygiene between any glove changes. Another staff member washed hands for only 10 seconds and then touched the side of sink before drying hands. Facility policy called for washing hands for 20 seconds. E
- Staff had mask pulled down while two residents were sitting within 4 feet. Staff member using nebulizer in nurses station with window open to commons area. Mask pulled down under nose while pushing resident. Staff member used glucometer put back in cloth pouch with gloves on, took gloves off then pulled glucometer back out of pouch and wrapped in sanitizing cloth. Staff entered residents' room without wearing a gown as door stated droplet precautions. Staff donned gloves, removed soiled brief and with same gloves grabbed clean wipes from package. Staff used same wipe twice to clean resident. E

**F909 – Resident Bed**

- Entrapment risk of side rails not assessed. D

**F919 – Resident Call System**

- Resident call lights were not within reach. D

**F943 – Abuse, Neglect, and Exploitation Training**

- 2 staff had not completed adult abuse mandatory reporter. D
- Seven employees did not complete required adult abuse mandatory reporter training within 6 months of hire.

**N102 – Abuse, Neglect, and Exploitation Training**

- Director/directors designee shall be notified by the next business day when damage caused to the facility. E

## Nursing Facility Survey Frequency

As of April 19, 2021: CMS lists 316 Iowa facilities 73.3 (%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 66.1%. National average is 74.2%.

| Provider | City | Survey End Date | Previous Date | Months Between |
|---|---|---|---|---|
| ABCM Rehab of Independence West Campus | Independence | 2/22/2021 | 4/18/2019 | 22.53 |
| Accura Healthcare of Cherokee | Cherokee | 2/18/2021 | 7/18/2019 | 19.37 |
| Bishop Drumm Retirement Center | Johnston | 2/24/2021 | 3/7/2019 | 24.00 |
| Danville Care Center | Danville | 2/10/2021 | 2/20/2019 | 24.03 |
| Elm Crest Retirement Center | Harlan | 2/11/2021 | 3/7/2019 | 23.57 |
| Greene County Medical Center | Jefferson | 1/14/2021 | 10/1/2019 | 15.70 |
| Grundy Care Center | Grundy Center | 2/25/2021 | 5/30/2019 | 21.23 |
| Keosauqua Health Care Center | Keosauqua | 2/8/2021 | 3/21/2019 | 23.00 |
| MercyOne Dyersville | Dyersville | 2/25/2021 | 5/22/2019 | 21.50 |
| Northbrook Manor Care Center | Cedar Rapids | 2/11/2021 | 3/21/2019 | 23.10 |
| Longhouse-Northshire | Spencer | 2/4/2021 | 2/14/2019 | 24.03 |
| | | | **AVERAGE** | **17.78** |