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

Compliance Tips from IHCA's Survey Results Committee
April - May 2020

Total Number of Survey Reports: 28

Survey Composition:

Annual:	**17** Surveys	**2** Deficiency Free
Complaints:	**15** Surveys	**5** Unsubstantiated
Self-Reports:	**4** Surveys	**1** Unsubstantiated
Mandatory Reports:	**0** Surveys	**0** Unsubstantiated

State Fines: $500
State Fines in suspension: $32,250

<u>Most Commonly Cited Iowa Tags:</u>

F 880 – Infection Prevention and Control (30)

F 812 – Food Procurement, Storage, Preparation, Sanitization (18)

F 689 – Free from Accidents and Hazards (18)

F 657 – Care Plan Timing & Revision (14)

F 658 – Services Provided Meet Professional Standards (10)

<u>Tags Resulting in Actual Harm or Higher Citations and Fines:</u>

F 678 – Cardio Pulmonary Resuscitation (CPR)	**1 J Level Tag**
F 686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers	**2 G Level Tags**
F 689 – Free from Accidents and Hazards	**3 G Level Tags and 2 J Level Tags**

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=15456		Total Number of Surveys=24185
F0880	Infection Prevention & Control	1,579	9.2%	6.5%
F0689	Free of Accident Hazards/Supervision/Devices	1,042	6.2%	4.3%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	919	5.7%	3.8%
F0684	Quality of Care	771	4.6%	3.2%
F0656	Develop/Implement Comprehensive Care Plan	739	4.5%	3.1%
F0761	Label/Store Drugs and Biologicals	635	4.0%	2.6%
F0677	ADL Care Provided for Dependent Residents	465	2.8%	1.9%
F0609	Reporting of Alleged Violations	462	2.7%	1.9%
F0657	Care Plan Timing and Revision	459	2.8%	1.9%
F0755	Pharmacy Srvcs/Procedures/Pharmacist/Records	455	2.8%	1.9%

*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
- Employee stood next to resident to assist with eating rather than sitting next to them. D
- Left soiled bed pain in residents' room on floor under sink. D
- Delivered eyedrops in rough manner and yanked on residents legs when assisting with clothing leaving red mark. D

F554- Resident Self Administration Meds Clinically Appropriate
- **No physician order for self administration or notation. D**

F557- Respect, Dignity, Right to Personal Property
- **Posted resident name on social media. D**

F558- Reasonable Accommodations of Needs Preferences
- **Failure to make call light accessible to resident in bed. D**

F568-Accounting and Records of Personal Funds
- **Failed to provide quarterly financial statements to multiple residents. B**

F578 – Request/Refuse/Discontinue Treatment; Formulate Adv Di
- Facility failed to establish code status. D
- Failed to have advance directives updated for two residents. DNR orders not match health record and magnet on door to room. D

F580 – Notify of Changes (Injury/Decline/Room, Etc.)
- Staff failed to notify family members of resident's pain after fall and subsequent x-ray. D
- Failed to notify physician of change in condition of decline in transfer status and significant weight loss (46 lbs over 6 months). D
- Failed to properly assess and carry out interventions in change in condition. D

F582 – Medicaid/Medicare Coverage/Liability Notice
- Failed to provide mandatory denial notice for two residents. D
- Failed to provide resident/resident representative beneficiary notice. B

F584 – Safe/Clean/Comfortable/Homelike Environment

- Multiple residents failed to have soap, paper towels, toilet paper or beds made. E
- Housekeeping staff not completing all cleaning tasks (no beds stripped, linens changed) contrary to policy. E
- Resident had dirty wheelchair not cleaned per cleaning schedule. D

F585 – Grievances

- Facility failed to make information about how to file grievance and who grievance official was. D

F604 –Right to be Free from Physical Restraints

- Resident with soft seat belt restraint did not have documentation of regularly checking restraint. D

F606 – Not Employ/Engage Staff with Adverse Actions

- CNA did not have background check prior to working. D
- Employee did not have record check evaluation by DHS. **D $500 FINE**

F607 – Develop/Implement Abuse/Neglect, etc. Policies

- Fail to ensure licensure of two nurses. D
- Failed to ensure 1 staff member complete dependent adult abuse training in 6 months of hire. D
- Failed to provide dependent adult abuse training to employee. D

F609 – Reporting of Alleged Violations

- Failure to self-report on allegation of neglect, 3 of abuse by nurse. **D $500 FINE**
- Failure to report allegation of abuse. D
- Failed to report altercation between two residents. D

F623 – Notice Requirements Before Transfer/Discharge

- Failure to notify LTC Ombudsman of hospitalization on monthly discharge notification. D
- Fail to notify Ombudsman of residents transfer to hospital for two residents. B
- Facility failed to notify the Ombudsman of residents transfer to the hospital for residents reviewed for hospitalizations. B
- Ombudsman notification of discharge not done for hospital transfers four residents. B

F625 – Notice of Bed Hold Policy Before/Upon Transfer

- Failed to notify resident/resident's representative of bed hold policy for several residents with transfer to hospital. B
- Facility did not provide a bed hold policy. B
- Fail to provide notice to resident/POA of bed hold policy upon transfer to the hospital for residents reviewed for hospitalizations. B
- Bed hold not given at time of hospitalization. D
- Bed hold not given at time of hospitalization. B
- Bed hold not given at time of hospitalization. D
- Failure to provide bed hold policy prior to transfer to hospital. B
- Failed to document review of bed hold policy with resident prior to transfer to hospital. B

F636 – Comprehensive Assessment and Timing

- Failed to accurately code MDS related to PASARR Level II. D
- Failed to complete discharge MDS. B
- Accurate Assessments MDS-hospice not on MDS, another with no physician order, diagnosis D

F637 – Comprehensive Assmt After Significant Change

- Significant change MDS not completed for significant weight loss and change in ADL status. D
- The facility failed to complete a comprehensive assessment after a significant change for 2 of 12 residents when Hospice services were started or discontinued. B

F638 – Quarterly Assessment At Least Every 3 Months

- Failed to complete MDS assessment in required quarterly time frame. B

F641 – Accuracy of Assessments

- MDS lacked documentation of a stage 2 pressure ulcer. D
- Facility failed to accurately complete a Minimum Data Set assessment for one of 18 residents. D
- Failure to identify a medical diagnosis with medications. B
- Assessment didn't reflect dental health concerns. B

F644 – Coordination of PASARR and Assessments

- Failed to incorporate recommendations from the PASRR evaluation into the residents plan of care. Level II PASRR recommended specialized services or support of ongoing psych services and medications. D
- Failed to resubmit for PASRR Screening when a resident remained in the facility beyond a convalescent stay. Staff did not resubmit for Level II when were aware resident would stay beyond 60 day convalescent stay. D
- Failure to submit a new level II PASRR for resident with mental disorder that had change of condition. D
- Resident with a diagnosis of psychotic disorder not included in PASRR. D
- Psychotic disorder not included on PASRR. D
- The facility failed to resubmit a PASRR after a change in diagnosis for 4 of 5 residents reviewed. D
- The facility failed to carry out PASRR requirements and/or list them on the resident's care plan for 6 of 9 resident's reviewed. D
- The facility failed to resubmit a PASRR after a change in diagnosis for 1 of 1 residents reviewed. D
- The facility failed to develop a care plan for 7 of 9 residents reviewed following PASRR Level II recommendations for Specialized Services. C

F655 – Baseline Care Plan

- Failed to develop a baseline care plan with recently admitted resident. Care plan failed to address the urinary catheter, ostomy, fall risk and falls. D

F656 – Develop/Implement Plan of Care

- Failed to review and revise the comprehensive care plan to accurately reflect the resident's condition. D
- Facility failed to develop the comprehensive plan of care. Review of the clinical record revealed the absence of signed consent or assessment for the use of hand assist bars or side rails. D
- The facility failed to develop a comprehensive person-centered care plan for 3 of 20 residents reviewed, including a care plan lacking intervention for adaptive dining equipment, fall prevention interventions, and no mention of monitoring the use of antipsychotic medications for side effects or recommended non-pharmacological interventions. D
- Facility failed to document a comprehensive care plan to address psychotropic and other medications for 2 residents.
- Comprehensive care plan failed to reflect incontinence. B

F657 – Care Plan Timing & Revision

- Failed to update the Comprehensive Care Plans. Lack of documentation on care plan related to antipsychotic use and monitor side effects. D
- Failed to review and revise comprehensive care plans. D
- Care plan had no revisions after resident had been hospitalized. Skin integrity care plan did not include interventions to prevent pressure related skin breakdown. Care plan had wrong diagnosis on it for Xanax. D
- Care plan not updated to show mattress on floor or the most current diet. Care plan also lacked use of anticoagulants, opioids, or diuretics. D
- Care plan not updated to show use of lorazepam or morphine. Care plan lacked risk for dehydration for resident on restricted fluids. D
- Careplans not updated for feeding assistance, open area on buttock, wheelchair modifications, etc. D
- Careplan did not include use of Eliquis (high risk medication). B
- The facility failed to update the comprehensive care plan for 2 of 12 residents reviewed. B
- The facility failed to follow the care plan for a resident who required the use of geri-sleeves. D
- The facility failed to update a care plan for a resident who uses a Broda chair. D
- The facility revealed care plans for residents that lacked interventions regarding the use of supplemental oxygen, out-dated interventions for prophylactic antibiotic use while on antibiotic therapy for active infections, out-dated intervention for antibiotic use for an active infection not resolved on care plan, and lack of care planning for a resident using a hypnotic medication. E
- Facility failed to follow Care Plan by failing to use the adaptive equipment specified. B
- Facility failed to update two of two sampled care plans including failing to reflect resident had RSV and removal of catheter from care plan. B

F658 – Services Provided Meet Professional Standards

- Failed to meet professional standards of care with regard to lab testing related to Coumadin use. Failed to administer medications via PEG tube properly. INR not completed as ordered. Medications administered thru PEG by pushing thru with a syringe. D
- Failed to prime insulin pen. D
- Facility failed to ensure staff followed professional standards observed during a medication administration. D
- Facility failed to ensure physician orders were followed. Patient had order for daily weights to be done and physician to be notified if over 3lbs. Weight gain. Patient gained 4 pounds and the physician was not notified. D
- Medication not on MAR after hospitalization-antibiotic not given for 3 days. D
- Resident not receiving ROM developed a contracture in finger/hand. D
- The facility failed to have a physician's order for the use of an AFO and was not care planned. D
- The facility failed to obtain physician orders for diets for 5 of 18 residents reviewed and failed to follow a physician's order for the use of oxygen. E
- The facility failed to remain with residents and observe medications consumed during medication administration. D
- The facility failed to follow physician orders monthly PTw/INR lab for the use of anticoagulation therapy. D

F676- Activities of Daily Living (ADLs)/ Maintain Abilities

- Failed to shave and trim fingernails after bath and failed to ensure resident was routinely assisted from bed to wheelchair. Care plan instructed staff to assist resident to his wheelchair for a few hours every day. D
- Four residents did not have records of bathing at least twice weekly. E

F677 – ADL Care Provided for Dependent Residents

- Failure to provide appropriate peri care. Did not change washcloth fold from bm then proceeded to do front peri area with same washcloth. Did not clean front to back or the bilateral hips. D
- Resident complained that she was not transferred from bed to chair because of the need for 2 person transfer and that there is often not enough staff to complete the transfers. Peri care often not performed frequently enough to prevent skin redness or breakdown. D
- Four residents did not receive pericare or bathing in accordance with their needs. E
- Did not perform peri-care on an incontinent resident. D
- The facility failed to provide complete incontinent care for 4 of 6 residents reviewed. E

F678- Cardio-Pulmonary Resuscitation (CPR)

- Failure to do CPR on a resident that was a full code when staff witnessed an alert resident go limp. Current care plan was left blank in the DNR section, face sheet had CPR. Resident had actually told ARNP a few days prior he still wanted CPR even though ARNP advised against it. **J $10,000 Fine**
- Facility failed to have a staff member CPR certified on duty 24 hours a day. B

F684 – Quality of Care

- Facility failed to provide accurate assessment and timely interventions for resident after a fall. D
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- Facility failed to provide accurate assessment and timely interventions for resident after a fall. D
- The facility failed to ensure one resident skin treatment was completed as physician ordered. D
- The facility failed to properly assess and carry out interventions for a change of condition for a resident whose nursing notes indicate was declining, appeared more confused, and sustained a skin tear to the toe. No assessment or notification of physician or family was documented. D
- The facility failed to follow physician orders for a daily dressing change. A soiled dressing was observed to be left in place for two days (dated and initialed) during the survey period. D
- The facility failed to follow physician orders for a daily dressing change. A soiled dressing was observed to be left in place for two days (dated and initialed) during the survey period. D
- Failed to provide timely intervention and failed to follow physician order, inappropriately delegated medication administration to unlicensed staff, used dirty gloves to apply cream and clean briefs. D
- Failed to complete ongoing assessment by failing to new medications, failed to assess after change in condition. D

F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers

- Resident was observed sitting in wheelchair for 4 hours without staff checking for the need of incontinence care or toileting. Spouse reported that resident is often up in wheelchair from early am to early evening without anyone providing pericare during that time. Resident did subsequently develop a pressure ulcer. D
- A resident developed an unstageable pressure ulcer on coccyx. Hospice nurse identified it, documented notified nurses and staff continued to document no new skin areas for a month. D
- The facility failed to provide care consistent with professional standards of practice, to prevent a pressure ulcer from developing. **G $7500**
- The facility failed to implement interventions to promote the healing of pressure ulcers for 2 of 3 residents reviewed. **G $10,000**

F688 – Increase/Prevent Decrease in ROM/Mobility

- Failed to provide an adequate amount of range of motion exercises. Restorative logs used to document ROM time as care planned, shows zero days for 2 months, 4 days in 1 month and 7days in another month. Staff report getting pulled to the floor often and was never trained in restorative. Several residents on restorative program with documentation supporting not receive exercises as planned. E
- Failed to complete restorative maintenance programs as recommended by the therapy department. D

- Failed to provide restorative services for multiple residents in relation to mobility and positioning. D

F689 – Free from Accidents and Hazards

- Failed to provide adequate supervision and assistance devices to prevent falls. Staff failed to secure a safety strap around resident in shower chair. Resident fell out and sustained femur fracture. Staff failed to use a foot board on the wheelchair as per care plan. Resident tipped wheelchair and struck head on floor sustaining cervical fracture. G
- Failed to ensure the straps of a sling for a mechanical lift were securely attached to the machine prior to transferring a resident. Sling came unhooked on one corner and resident fell to the floor. Sent to ER with no noted injuries. Appears staff did not ensure sling loop was correctly connected to the lift. D
- Facility failed to thoroughly investigate a residents falls and initiate appropriate interventions to prevent further falls. Resident with 9 falls since admission. Record lacked documentation of an investigation, or care plan update after all 9 of the falls. D
- Failed to prevent a resident from being injured with the use of a mechanical lift. Staff did not open the base of the hoyer lift during transfer, lift tipped and resident head ended up hitting the hoyer lift. D
- Failed to utilize foot pedals when staff pushing residents in wheelchairs**.** D
- Failed to appropriately supervise residents to prevent a fall with injury. No use of gait belt while assisting resident to bathroom, resident lost balance and fell. **G $6,250**
- Facility failed to put pedals on wheelchair when pushing resident. D
- Staff failed to prevent by falls due to not using a gait belt and not using 2 people as directed for assistance. D
- Thermostat was not corrected in a timely manner causing it to be very hot and fire department called. Maintenance had known about it, couldn't fix it and didn't do anything else about it. Administrator nor anyone else was informed of the broken thermostat. The room was very hot, thermostat had sparks coming out of it and smelled hot. **$9,750 J**
- Cognitively impaired resident with limited mobility was found in bed which was pushed up against a radiant heater. The resident suffered burns with blisters to the rith foot. Incident was documented in an incident report but not in the medical records. Resident had unwitnessed fall from wheelchair. Intervention added was to not leave resident unattended in wheelchair. Resident fell out of wheelchair again a few days later when left unattended, suffering facial abrasions and bruising. **$24,750 G**
- Fall interventions not in place for one resident upon surveyor review. 2 residents without foot pedals on upon observation. **D**
- No foot pedals on wheelchair. **D**
- Did not use gait belt as care planned for two residents. **D**
- During a Hoyer lift transfer from bed to chair, once in chair disconnected sling from lift, two staff members grabbed sling to position properly in wheelchair and the brakes were not locked on wheelchair. **D**
- During a hoyer lift transfer from bed to chair, once in chair disconnected sling from lift, two staff members grabbed sling to position properly in wheelchair and the brakes were not locked on wheelchair. **D**
- The facility failed to ensure the wheelchair armrest for one resident was securely in place to prevent accidents. **D**

- Facility failed to ensure one resident had a safe transfer as planned. **D**
- Failed to provide adequate supervisions resulting in elopement, resident was found on roadside fell and bumped head and taken to hospital. **J $7,500 in suspension**
- Facility failed to assure adequate supervision to prevent falls with injury for 1 of 3 residents reviewed and the alarm did not sound. The facility did not know why the alarm did not sound. **$4,712.50 G**

F690 – Bowel, Bladder Incontinence, Catheter Care

- Failed to provide appropriate incontinent care to prevent infections. Washcloths placed in sink with partially filled water. Staff removed washcloths and washed hands in sink, she then refilled the sink with water and put wash cloths and disposable wipes in the sink. Staff rinsed residents glasses from running water in sink while cloths were in the sink. No change gloves during cares, used same side wash cloth. **D**
- Facility failed to provide appropriate handling of an indwelling catheter. Staff failed to cleanse the drainage bag port with an alcohol wipe before or after draining urine from bag. **D**
- Facility failed to ensure staff completed catheter care after a resident had been incontinent of bowels. CNA provided catheter care but failed to cleanse the catheter tubing or around the urinary meatus. **D**
- Did not perform peri-cares completely on one resident and wiped wrong way on another. **D**
- The facility failed to provide complete incontinent care on an uncircumcised male resident to prevent urinary tract infections. **D**

F692 – Nutrition/Hydration Status Maintenance

- No nutritional assessment with weight loss and addition of high calorie pudding being added. **D**
- Resident with a diagnosis of dysphagia was on a liquified diet and received a regular diet for one meal. **D**

F693 – Tube Feeding Management/Restore Eating Skills

- Did not aspirate stomach contents per policy on tube feeding. **D**
- The facility failed to ensure proper technique was utilized when verifying placement of a feeding tube. **D**

F695 – Respiratory/Tracheostomy care and Suctioning

- Facility failed to ensure documentation and maintenance of oxygen equipment measures were maintained. The oxygen tubing nor the humidification bottle were labeled with a date to indicate when they were last replaced. D
- The facility failed to ensure an emergency replacement tracheostomy set was available at the bedside for a resident with a tracheostomy tube. D

F698 – Dialysis

- Facility Failed to consistently complete assessments before and after dialysis. **D**
- Facility did not perform assessments prior to and after dialysis. **D**

F700 – Bedrails

- Failed to assess positioning devices located on both sides of a residents bed as a potential of entrapment. Lack of assessing use of black and grey grab bars on side of bed. Openings measured 13 inches and 9.5 inches. D

- Facility failed to assess and educate residents on the potential for injury or entrapment with the use of hand or siderails. Clinical record revealed the absence of signed consent or assessment for the use of hand assist bars or side rails. D

F725 – Sufficient Nurse Staffing

- Over a period of 6 days, the call light log showed 22 calls not answered within 15 minutes, ranging from 16-48 minutes. D
- Facility failed to ensure adequate staffing numbers to ensure call lights are responded to in a timely manner. Staff reported it took over 15 minutes to have call light answered. D
- Facility failed to provide timely responses for call lights. Resident stated it often took 25-30 minutes for staff to respond and waited longer than an hour for help at times. E
- Call light took 25 minutes to be answered. D
- Failed to answer call lights in timely manner on multiple occasions with times lasting an hour or longer. E

F726- Competent Nursing Staff

- Failed to ensure licensed nurses demonstrated the competencies to accurately acquire and dispense medications. Outdated medications in med cart. Linzess bottles with no manufacturer's label or pharmacy label. Medication had been brought in from home. Both bottles had residents name handwritten on them. D

F729- Nurse Aide Registry Verification, Retraining

- The facility failed to follow up to assure an individual who completed a training and competency evaluation became certified for 1 of 3 CNA's reviewed. D

F730 – Nurse Aide Perform Review – 12Hr/Year In-service

- Failed to ensure certified nursing assistants received at least 12 hours of in-service education per year. D
- Facility failed to ensure all CNA's receive 12 hours of staff education a year. D
- The facility failed to assure CNA's received 12 hours of in-service education per year and/or annual abuse in-service for 2 or 3 staff reviewed. D

F755 – Pharmacy Svcs/Procedures/Pharmacist/Records

- Failed to follow procedures to assure the accurate acquiring, receiving, dispensing and administering of medication. Home bottles of Linzess without proper labels. D
- Failed to perform shift checks of e kits. D

F757 – Drug Regimen is Free From Unnecessary Drugs

- Failed to administer the correct Coumadin dose. Facility adminstered 3mg of Coumadin rather than the ordered 2mg because the pharmacy sent the wrong dosage. A Coumadin dose omitted due to cassette not available after removed due to containing wrong dose. D

F758 – Free from Unnec Psychotropic Meds/PRN Use

- Failed to limit the time frame for as needed (PRN) psychotropic medication that was not an antipsychotic, to 14 days, unless a longer time frame is deemed appropriate by a physician. Xanax ordered every 8 hours as needed (order was from 3/29/19 -2/23/20. Resident had received 48 doses in total. D
- Failed to ensure that as needed orders for psychotropic medications were limited to 14 days. Failed to complete gradual dose reductions for psychotropic medications. (Anti-anxiety, Anti-depressant and Anti-psychotic medication). D

- Failed to assure as needed (PRN) psychotropics were not ordered for more than 14 days without an appropriate rationale and duration to continue that medication for residents reviewed for unnecessary drugs. Record lacked clinical rationale and duration to continue that order after the initial 14 days. D
- Failure to provide non-pharmacological intervention prior to giving PRN psychotropic. PRN Xanax order not reviewed after 14 days. Dose also given closer too close together. D
- Psychotropic med PRN was continued without rationale after 14 days. D

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

- Failed to follow physician's orders. Medications crushed during observation with no physician order to crush medications. 2 medications were extended release. Staff reported resident wouldn't take with them being crushed. DON was notified and addressed. D
- Failed to prime insulin pens as required. D

F760- Residents are Free of Significant Med Errors

- Did not prime the insulin pen. D
- Facility failed to ensure that significant medication orders were avoided. Family asked if resident was receiving medication as ordered to prevent dyskinesia. Documentation showed that medication had not been administered for 28 days for a total of 56 missed doses. **D $500**
- Significant medication error in administration of resident's insulin medication. D

F761- Label/Store Drugs & Biologicals

- Facility failed to store a medication at the appropriate temperature to maintain the stability for usage.
- The facility failed to ensure staff discarded expired medications from the medication carts. Noted x3 expired insulin vials belonging to x3 residents. D
- Facility failed to discard outdated medications for 3 of 43 residents and failed to securely store drugs subject to abuse for 5 of 43 resident. E

F801 – Qualified Dietary Staff

- Failed to employ a qualified person to serve as the Director of Food and Nutrition Services in the absence of a full-time Dietician. Staff in position for one month, not currently certified as dietary service manager. F

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

- Failure to follow planned menu for pureed diets. E
- Failed to serve proper portion for a resident on pureed diet. D
- Failed to give correct amount of pureed food to 4 residents. E
- The facility failed to ensure three residents on a pureed diet received the appropriate serving size. D
- The facility failed to ensure three residents on a pureed diet received the appropriate serving size. D
- Facility failed to ensure all residents on puree textured diets received the proper portion size based on the planned menu for 8 of 8 residents on the pureed diet. E
- Items on always available menu not available, improper serving size of pureed food and failure to measure pureed food. E

- Facility failed to assure residents on a mechanical soft diet received an appropriate portion of meat for 1 meal. E

F804 – Nutritive Value/Appear, Palatable/Prefer Temp

- Failed to serve room trays close to scheduled meal times in order to serve food at safe and palatable food temperatures. Meal times 1120-1230. Rooms trays called to stay they were ready at 1247, staff did not deliver to residents until 1316. Food temp for meat 129 degrees and mashed potatoes at 134 degrees. D
- The facility failed to provide food that was served at a safe, palatable, and appetizing temperature during meal service. D

F805 – Food in Form to Meet Individual Needs

- Facility failed to provide Physician Ordered Therapeutic Diets. D

F808 – Therapeutic Diet Prescribed by Physician

- Failed to ensure all residents on mechanical soft and pureed textured diets received food according to the planned menu during lunch dining service. Mechanical soft diets failed to receive corn or a vegetable substitute. Pureed diets received yogurt in place of chocolate cake. Added bread to the pureed meatloaf, rather than the planned corn bread. E
- Resident with orders for pureed diet received regular diet instead. D

F809 – Frequency of Meals/Snacks at Bedtime

- Facility failed to ensure staff offered residents a snack at bedtime each night. E

F812 – Food Procurement, Storage, Preparation, Sanitization

- Failed to store food under sanitary conditons, maintain the kitchen in a clean and sanitary manner to reduce the risk of contamination to food and food-borne illness. Dirty vents, front of air conditioner visibly soiled vents, buildup of food debris and rime on floor / wall. Outside of 3-door fridge with scattered food debris and grime. Oven & stove burners with heavy dust, food debris and black particles, opened bag of flour. F
- Facility failed to carry out sanitary food handling during meal services observations. 2-3 inches and 4-5 inches of hair unrestrained in hair net. E
- Facility failed to handle and distribute food in a manner that prevented foodborne illnesses to residents. Food delivered to activity room uncovered. Staff with gloves on touched multiple kitchen surfaces and sandwhich buns with same glove. Placed mayo packets on top of food items rather than on top of plate covers. Maintenance in kitchen without beard cover. E
- Failed to store food in sanitary conditions. Cases of bottled water stored on floor in dry storage. Walk-in freezer in basement revealed 4 boxes of frozen food stacked on the floor. Food had been delivered the day before and had not yet been put away. D
- Dietary staff gloving one hand and using it to take buns out, remove steam table lids, scoop food then place top of bun on sandwich. Also served liquids touched residents then did not wash hands. E
- Dietary aide washed hands, grabbed paper towels, turned water faucet off then dried her hands. Gloved hands grabbed bread, then went to refrigerator and grabbed items and then placed items on the bread with same gloves. E
- Hair net did not fully cover head of staff member while serving lunch. E

- Kitchenette not clean - splatters on wall, inside refrigerator door, below sink and spills around microwave. Brown substance in front of ice machine. E
- Facility failed to discard outdated beverages in the main kitchen walk in cooler/freezer in order to reduce the risk of contamination and food-borne illness. E
- Facility failed to prepare, serve and handle food in a sanitary manner during the luch meal service. Staff failed to remove glove and wash hands after serving a resident and returning to kitchenette. D
- Hood vents with grim, touched many items with gloves on, used bare hands to touch ready to eat foods. E
- Two refrigerators had outdated food items in the kitchen. D
- The facility failed to store, prepare, serve, and distribute food in accordance with professional standards for food service safety. This included the sanitizer bucket lacked sanitizer in the bucket, milk and juice stored at 47 degrees F, milk served at 50 degrees F, and meats and hot vegetables served at temperatures lower than the facility policy states. Residents interviewed complained about hot foods received cold on room trays. E
- Failed to provide satisfactory evidence that had identified its own high risk, high volume and problem-prone quality deficiencies and were making a good faith attempt to correct them. Facility had 1 PIP in place dated 5/21/19 with 1st page completed and all other 8 pages of PIP were incomplete. No staff member was assigned to monitor the QAPI program. Staff reported no work had been completed on the PIP. E

F880 – Infection Prevention and Control

- Failed to provide a sanitary environment by not performing hand hygiene while assisting multiple residents with their meals and failed to ensure the dining tables could be cleaned appropriately as they had blue painters tape with the residents name on them. Some of the edges were rolled up & collecting food particles. Facility was using a temporary dining room due to construction in main dining room. Nursing staff wearing gloves while assisting residents with meals, touching multiple surfaces and other residents using same gloves- no washing of hands and/or changing gloves. E
- Failed to utilize infection control techniques. Catheter drain bag and tubing lay under the wheelchair with no dignity bag and on floor. Catheter drain bag lying on fall mat with resident in bed with no dignity bag or barrier. D
- Failed to utilize infection control techniques. Catheter drain bag and tubing lay under the wheelchair with no dignity bag and on floor. Catheter drain bag lying on fall mat with resident in bed with no dignity bag or barrier. D
- Staff did not wash hands after peri care then pulled residents brief up without gloves. Staff did peri cares without gloves, then covered resident up with blanket prior to washing hands. D
- Disinfectant was sprayed on toilet seat then wiped immediately - should have been allowed to sit then wipe. Failure to keep blood glucose monitor surface wet for 2 minutes for infection control. Chem work spray used by housekeeping was to be sprayed then allowed to sit for 10 minutes and they were doing it anywhere from 2-5 minutes. Isolation laundry was not washed separate from regular laundry. Staff did not wear gloves, gowns or goggles when dealing with the isolation laundry. E
- Laundry cart going down the hall that did not have all the clothes covered. Hand hygiene not completed after peri care prior to putting sling on a resident. D

- Catheter bag was directly on the floor and no cover over bag. Bag with soiled linens was placed in resident sink. B
- Facility failed to do two step TB for two staff. D
- CNA performed improper pericare and catheter care on mail patient. After performing these cares, CNA did not change gloves before applying gait belt to resident and assisting them to ambulate. Oxygen tubing was not changed weekly as per facility policy. E
- During catheter care, CNA wiped the catheter toward the insertion site rather than away from the site. D
- Four residents with isolation precautions did not have sign posted at room door. Np documentation that medical direction had conducted an annual review of the facility's infection control plan. E
- Facility failed to properly perform hand hygiene and cross-contaminated items while preforming wound care. Staff did not remove gloves and perform hand hygiene after touching the catheter and before touching other items. Nurse failed to wash or sanitize her hands before leaving the resident's room. D
- Facility failed to maintain infection control practices. Catheter tubing and bag were lying on the floor, and then the CNA held it above the bladder. D
- Facility failed to ensure staff utilized proper infection control techniques. Staff did not complete a PICC line dressing under sterile technique. Patients TAR did not have documentation of oxygen administration tubing changes. D
- Eye drop bottles, inhalers, nasal sprays were set down on table in resident room without barrier and later returned to med storage. Also during peri cares used "dirty" glove for a clean task. During pressure wound dressing change nurse did not change gloves. E
- Failed to wash hands between residents during med pass. D
- Did not follow isolation procedures and did not know what transmission based precautions were. Nurse cleaned trach and used same gloved hands to wash eyes/face. D
- Infection control policies did not address type and duration of isolation. Policies did not include a review by the medical director. D
- Employee held urine soaked brief prior to throwing it away, then put on gloves without washing hands. D
- Insulin items placed on cart with no barrier, an employee touched pills, after touching catheter bag, handled nasal cannula and offered resident a drink of water. E
- After providing incontinent cares and cleaning commode, employee removed gloves without washing hands began to adjust resident's clothing. While working with another resident did not wash hands after removing gloves. D
- The facility failed to demonstrate appropriate infection control practices with respect to wetting disposable wipes touching the bottom of the sink, incontinent care and use of gloves, hand washing, and used gloves and soiled linens thrown on the floor. E
- The facility failed to carry out infection control measures noted when the nurse cleansed a glucometer with an alcohol wipe although the facility policy directs the use of a product containing 1:10 ratio of bleach to water. During the hanging of an intravenous antibiotic bag, the nurse removed the administration tubing set end cap to prime the tubing which fell to the floor. The nurse proceeded to attempt to clean the tubing and use the contaminated set. Noted a resident with a urinary catheter bag uncovered and touching the floor. D
- The facility failed to follow infection control standards. Observation included staff failing to change gloves and complete hand hygiene before placing a clean bed pad, incontinent brief

and pants after providing incontinent care. Observation of nurse performing a clean dressing change without changing gloves and performing hand hygiene. D

- The facility failed to use appropriate hand hygiene practices while providing resident cares. This included failing to change gloves and perform hand hygiene between the soiled and clean steps of cleaning an inner cannula of a tracheostomy tube and no hand hygiene after completing cares for a resident on transmission-based isolation precautions before leaving their room. D
- Facility failed to maintain Infection Control practices during 1 out of 3 wound care observations, 2 out of 6 observations of the residents with catheters, and 3 out 3 dining room observations of meal service. F
- Facility failed to follow proper infection control practices for one resident reviewed with a catheter. D
- Used same gloves from providing incontinence care to fasten clean briefs, staff failed to wash hands after assisting resident with isolation precautions for RSV before returning to folding laundry, failed to wear mask with resident wit RSV precautions. E
- failed to assist resident in washing hands after toileting, placed tape on floor without barrier during wound care, touched faucet with bare hands after washing, washed hands for less than 10 seconds. D
- Facility failed to maintain sanitary environment to help prevent the development and transmission of communicable diseases for 1 of 14 residents reviewed. (medication cup tipped over and one of the Tramadol tabs landed on the surface of the medication cart). D

F883 – Influenza and Pneumococcal Immunizations

- Two residents did not receive pneumococcal vaccine as ordered. D

F909 – Resident Bed

- Facility failed to develop a process for bed maintenance and loggin of bed and mattress measurements to ensure safety with the use of side rails/hand rails. E

F921 – Safe/Functional/Sanitary/Comfortable Environment

- Hot coffee in carafes unattended in the dining room. D

F943 – Abuse, Neglect, and Exploitation Training

- The facility failed to ensure 1 of 5 employee files included certificates of completion for Dependent Adult Abuse training. B

F947 – Required In-Service Training for Nurse Aides

- Facility failed to provide and document 12 hours of inservice training for CNA's.

L1093

- Failed to provide documentation of assessment of eligibility for VA benefits.

Nursing Facility Survey Frequency

As of May 25, 2020: CMS lists 68 Iowa facilities (15.7%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 11.2%. National average is 15%.

Provider	City	Survey End Date	Previous Date	Months Between
Aase Haugen	Decorah	3/12/2020	3/7/2019	12.37
Betterndorf Health Care Center	Bettendorf	3/12/2020	3/7/2019	12.37
Centerville Speciality Care	Centerville	3/5/2020	2/7/2019	13.07
Colonial Manor of Elma	Elma	3/5/2020	2/20/2019	12.63
Good Samaritan Society-Indianola	Indianola	3/12/2020	2/28/2019	12.60
Good Samaritan Society-Ottumwa	Ottumwa	3/12/2020	2/14/2019	13.07
Happy Siesta Nursing Home	Remsen	3/12/2020	3/13/2019	12.17
Hiawatha Care Center	Hiawatha	3/5/2020	3/14/2019	11.90
Iowa Masonic Health Facilities	Bettendorf	3/12/2020	3/28/2019	11.67
North Crest Living Center	Council Bluffs	3/5/2020	2/20/2019	12.63
On With Life at Glenwood	Glenwood	3/12/2020	2/20/2019	12.87
Parkview Manor	Wellman	3/12/2020	2/14/2019	13.07
Patty Elwood Center	Cresco	3/12/2020	2/20/2019	12.87
Ravenwood Specialty Care	Waterloo	3/5/2020	2/14/2019	12.83
Sunrise Terrace Nursing and Rehabilitation Center	Winfield	3/5/2020	2/7/2019	13.07
Valley View Community	Greene	3/5/2020	3/21/2019	11.67
Accura Healthcare of Cresco	Cresco	2/20/2020	2/7/2019	12.60
Algona Manor Care Center	Algona	2/6/2020	1/25/2019	12.57
Bethany Lutheran Home	Council Bluffs	2/13/2020	12/13/2018	14.23
Cedar Manor Nursing Home	Tipton	2/20/2020	1/16/2019	13.33
Cottage Grove Place	Cedar Rapids	2/27/2020	2/19/2019	12.43
Crestridge Care Center	Maquoketa	2/6/2020	1/10/2019	13.07
Deerfield Retirement Community	Urbandale	2/13/2020	1/19/2019	13.00
Donnellson Health Center	Donnellson	2/20/2020	1/24/2019	13.07
Evans Memorial Home	Cresco	2/27/2020	2/7/2019	12.83
Golden Age Care Center	Centerville	2/20/2020	1/31/2019	12.83
Good Samaritan Society-Red Oak	Red Oak	2/27/2020	1/31/2019	13.07
Good Samaritan Society-Holstein	Holstein	2/27/2020	1/31/2019	13.07
Grandview Healthcare Center	Oelwin	2/20/2020	1/31/2019	12.83
Hallmark Care center	Mt. Vernon	2/6/2020	12/19/2018	13.80
Heritage House	Atlantic	2/13/2020	1/10/2019	13.30
Kanawha Community	Kanawaha	2/13/2020	1/10/2019	13.30
Luther Manor Communities	Dubuque	2/20/2020	1/31/2019	12.83
Lyon Specialty	Rock Rapids	2/6/2020	12/20/2018	13.77
Manilla Manor	Manilla	2/27/2020	1/24/2019	13.30
Maple Heights Nursing Home	Mapleton	2/20/2020	1/10/2019	13.53
Marian Home	Ft. Dodge	2/20/2020	10/25/2017	28.27
Mechanicsville Specialty Care	Mechanicsville	2/22/2020	11/16/2017	27.60
Mississippi Valley Healthcare and Rehabilitation Center	Keokuk	2/10/2020	12/31/2018	13.53

Nora Springs CC	Nora Springs	2/6/2020	1/16/2019	12.87
Oakland Manor	Oakland	2/6/2020	8/30/2017	29.67
Pearl Valley Rehabilitation and Nursing at Gowrie	Gowrie	2/27/2020	1/29/2019	13.13
Pearl Valley Rehabilitation and Nursing at Washington	Washington	2/3/2020	12/3/2018	14.23
Pearl Valley Rehabilitation and Healthcare center of Muscatine	Muscatine	2/13/2020	1/10/2019	13.30
Regency Care Center	Norwalk	2/6/2020	1/3/2019	13.30
Ruthven Community Care Center	Ruthven	2/13/2020	1/16/2019	13.10
Scottish Rite Park Health Care Center	Des Moines	2/20/2020	2/22/2019	12.10
St. Luke Lutheran Nursing Home	Spencer	2/27/2020	2/7/2019	12.83
Sunny view Care Center	Ankeny	2/6/2020	1/16/2019	12.87
The Gardens of Cedar Rapids	Cedar Rapids	2/13/2020	1/3/2019	13.53
valley view village	Des Moines	2/13/2020	1/10/2019	13.30
Wheatland Manor	Wheatland	2/27/2020	1/24/2019	13.30
Woodland Terrace	Waverly	2/13/2020	1/16/2019	13.10