Compliance Tips from IHCA's Survey Results Committee

August 2016

The five most frequently cited tags from the 22 annual surveys (4 deficiency free), 34 complaints (8 unsubstantiated), 35 self-reports (8 unsubstantiated), 12 complaint/self-report (3 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 159 total deficiencies.

The following is a breakdown of severity level:

A =	0.00%	D =	56.00%	G =	6.30%
B =	1.90%	E =	31.00%	H =	0.00%
C =	0.63%	F =	0.63%	I =	0.00%
				J =	1.90%
				K =	0.00%
				L=	0.00%

Total # of Reports: 71
Total # of surveys/reports deficiency free or unsubstantiated: 23
Avg. # of deficiencies

- All = 2.24
- Annual = 4.72
- Complaint/Self-Reports= 1.20

Total state fines for December Report = $18,500 ($27,000 held in suspension)

Top 5 Most Frequently Cited Tags for August 2016 Report

F 323—Free of Accident Hazards/Supervision/Devices

- Resident eloped through a window, was found three blocks away, care plan called for 15 minute checks, was not done by staff (J) **$5,000 fine**.
- Facility's dementia unit had a resident elope by climbing a fence in a fenced area; door back to facility was locked, resident was seen walking outside of the facility but still on the facility's grounds, resident was unattended in fenced area (J) **$5,000 fine**.
- Care plan not followed; resident fell and broke hip (G) **$5,000 fine.**

- Unwitnessed resident fall from a recliner and call light switch not within reach (G) **$5,000 fine (in suspension).**
- Resident with a BIMS score of 3 eloped out of the facility's front door alarm or lock; during survey many other unalarmed exit doors were found; resident with body alarm slid out of chair and no documentation the alarm sounded (J) **$5,000 fine (in suspension).**
- Resident fell and broke pinky finger, was left unattended in therapy room, staff did not provide close supervision (G) **$500 fine**.
- Resident with a high fall risk, care plan called for uncluttered floor, gripper shoes, etc.; resident fell and was injured, did not have walker nearby, floor was cluttered, and no gripper socks (G).
- Resident with cognitive impairment were left outside on patio without supervision and resident to resident to altercation occurred (E).
- Oxygen tanks behind unlocked doors (E).
- Staff left bleach wipes on top of medications cart unattended (E).
- Multiple episodes of resident to resident physical aggression (E).
- Door alarms did not sound, loose railing, open garbage containers with discarded medication cups with crushed medications and spoons, delayed egress door did not work, staff left resident medications in cups unattended with residents (E).
- All facility exit doors were not alarmed, door between nursing facility and hospital in hospital-based NF was Wanderguard alarmed only; fan plugged into metal surge protector (E).
- Shower room entrance door sticking; sharp edges on heat register (D).
- Staff transferred resident from toilet with assist of one staff instead of two, resident fell and hit head and sprained fingers (D).
- Resident fell, no alarm was attached per care plan, family found resident on floor (D).
- Staff transferred a resident using EZ stand lift, failed to secure trunk strap or calf strap, resident fell suffering a contusion on the back of head, one staff had walked away when the fall occurred 9D).
- Alarm did not sound when resident fell (D)
- Staff left medications cart unattended, scissors and box of Symbiacort left on top (D).
- 11 prefilled insulin pens/syringes left unattended on top of medications cart (D).
- No chair alarm in place as per care plan, when observed by surveyor (D).

F 225—Abuse Reporting, Background Checks

- Housekeeper spoke harshly to resident and resident said she was scared, facility didn't report to DIA (D) **$1,500 fine (3 x $500)**.
- Facility failed to report abuse to DIA within 24 hours, resident was agitated and hit and kicked staff, who then escorted him/her from the dining area, staff reported bruise on resident at 10 a.m., bath staff reported bruise on resident's forearm on July 16, was not reported to DIA until July 20, staff failed to report injury of unknown cause to administrator (E) $**1,500 fine**.
- Facility failed to DIA an allegation of abuse by a staff member (D) **$500 fine**.

- Facility failed to properly investigate and report suspicious injuries of unknown origin (D) **$500 fine**.
- Resident missing $40 and facility didn't report to DIA (D).
- Facility failed to report immediately a resident to resident abuse incident/altercation resident punched another resident in face with closed fist, then that resident punched the other resident in the face (D).
- Facility failed to report an allegation of abuse until 48 hours later, dementia resident accused staff of beating her up (D).
- Director of Nursing said she was alerted by CNA that resident had scratches around groin after family member took him/her to the park, DON didn't report abuse but Hospice worker did (D).
- Facility failed to report resident to resident abuse for five days, there was no injury 9D).
- Facility failed to report resident to resident abuse within 24 hours (D).
- Facility failed to report to DIA resident grabbing another resident (D).
- Facility failed to report abuse, administrator grabbed a resident's arm, and incident was not reported because administrator thought the CNA would report it (D).

F 281—Professional Standards of Quality

- Medications discontinued without physician's order--Clavinet (E).
- Medications set up ahead of time in medication cups (E).
- Staff failed to apply pressure to lacrimal ducts following eye drop administration (D).
- Facility failed to obtain physician's order for oxygen D).
- Facility failed to follow physician's orders for oxygen, was ordered at night, surveyor observed resident using 02 during the day (D).
- Tylenol dose administered exceeded maximum dose limit set by resident's physicians, two different medications were administered (D).
- Staff failed to follow physician's orders for wound care, didn't look under brace/boot to assess worsening wound, resulted in amputation (D).
- Staff failed to hold lacrimal duct pressure when administering eye drops (D).
- Facility failed to follow physician's orders: 1) resident missed at least 17 doses of Symbiacort; staff did not apply CPM treatment 12 times (D).
- Physician upgraded resident's diet, facility failed to serve upgraded diet, was not following physician's orders (D).

F 441—Infection Control

- Staff made resident's bed over bottom wet sheet and family member sat on beds and their pants became wet (B).
- Staff failed to put barrier on floor when emptying catheter bag (E).
- Staff failed to properly sanitize glucometer and whirlpool tub by not leaving sanitizer on proper length of time per manufacturer's recommendations (E).
- Scissors kept in nurse's pocket was used for wound treatment; when staff emptied catheter, urine was spilled on the floor, the floor was not sanitized; when

an isolation room was being cleaned, housekeeper did not wear an isolation gown, did not change gloves and did place soiled mops back on housekeeping cart, physical therapist did not wear gown when entering room (E).
- Facility staff failed to disinfect blood glucose monitor (D).
- Staff picked up dirty towel from the floor and placed it on the tray table, picked up clothes from the floor and placed in resident's chair (D).
- Facility staff failed to disinfect blood glucose monitor per manufacturer's recommendation (D).
- Staff placed graduate on floor without a barrier to empty urine (D).
- Staff's soiled gloved hand touched bed controller, closet doors, drawers and clean clothes (D).
- Improper medications administration, staff donned gloves and touched other surfaces before touching pills (D).

F 312—Quality of Care Prevention of Decline

- Facility failed to document residents received two baths per week (E) **$1,500 fine ($500 x 3)**.
- Incomplete pericare, staff didn't fold cloth correctly, and scrubbed (D).
- Incomplete pericare, staff did not cleanse hips and outer thighs and failed to follow policy (D).
- Staff failed to perform oral care on two residents (D).
- CNA performing pericare used the same area of the washcloth, washed in upper motion and failed to cleanse all areas of the buttocks, and staff failed to provide pericare for resident in the morning despite dirty incontinence pad on bed (D).
- CNA did not retract penis foreskin when providing pericare (D).
- Incomplete incontinence care (D).
- Staff failed to completely cleanse hips and buttocks during pericare (D).
- All soiled areas on resident not cleansed during incontinent care, poor glove use, soiled washcloth used all over resident's body (D).

Other notable deficiencies and fines

F-157

- Facility failed to notify family of the resident's deteriorating wound and other changes (D**.**

F-223

- A resident with inappropriate sexual behaviors caused a resident to resident confrontation, multiple instances (G).

F-224

- A resident with inappropriate sexual behaviors caused a resident to resident confrontation, multiple instances (G-related to F-223 above no fine).

F-241

- Resident expressed concerns staff were on cell phones instead of providing care (E) **$500 fine**.
- Facility failed to treat a dementia resident in a dignified manner when the administrator grabbed the resident by the arm in a wheelchair (administrator was trying to retrieve dinner plate from the resident (D) **$500 fine.**

F 309

- Staff failed to follow physician's orders for wound care, didn't look under brace/boot to assess worsening wound, and resulted in amputation (J) **$5,000 fine.**
- Staff failed to complete ongoing physical assessment with intervention, did not complete skilled assessments for two days; which included resident refusal of morning cares, morning meal weights, and vital signs; resident sent to the ER with a diagnosis of sepsis (G) **$2,000 fine.**
- Skin areas found by CNA not reported to nurse (D) **$500 fine.**

F-314

- See F-157 citation above--a heel wound continued to worsen—Braden scale—resident at risk for developing ulcers, wound became infected, approaches not followed, poor glove changing procedures; another resident had no wound dressings in place, when observed, anti-pressure boots not in place as per care plan (G) **$4,500 fine.**
- Resident at high risk for pressure ulcers, resident's feet pressed against foot board, resulting in toe wounds, no skin assessment sheet present, lacked revised approach for non-healing wound (G) **$2,000 fine.**
- Heel wound worsened with no treatment change for 60 days; resident observed without pressure relief boots as per care plan (G) **$500 fine.**

F-318

- Staff failed to complete restorative nursing interventions for six residents (E) **$500 fine.**

F-353

- Resident with a fractured clavicle required assistance with transfer and ambulation, resident did not want to be incontinent because she would have to wait longer than 15 minutes for a call light response so she would transfer herself, staff told her it was OK because staff had seen her do it in the past ; resident requiring two-person transfer had to wait too long for call light response due to understaffing, resident would go out into the hallway to find staff, staff would answer call light, turn off light and say they would be back (E) **$500 fine.**

(MORE)

Annual Survey Frequency
August Survey Results Meeting

Facility	City	Last Year	This Year	Frequency
Algona Manor Care center	Algona	8/20/15	7/7/16	46 Weeks
Anamosa Care Center	Anamosa	8/6/15	6/30/16	47 Weeks
Bethany Life	Story City	8/27/15	7/14/16	46 Weeks
Blair House	Burlington	8/13/15	6/16/16	44 Weeks
Cedar Health	Charles City	8/27/15	6/30/16	44 Weeks
Crest Haven Care Centre	Creston	8/20/15	7/21/16	48 Weeks
Crestview Acres	Marion	8/20/15	6/30/16	45 Weeks
Ennoble Skilled N &R	Dubuque	9/3/15	6/30/16	43 Weeks
Franklin General Hospital	Hampton	8/6/15	6/23/16	46 Weeks
Glen Haven Home	Glenwood	7/9/15	7/21/16	53 Weeks
Good Shepherd Health Center	Mason City	9/3/15	7/21/16	46 Weeks
IOOF Home &Community Center	Mason City	9/3/15	7/21/16	46 Weeks
Jefferson Place	Pella	6/4/15	7/8/16	56 Weeks
Maple Heights Nursing Home	Mapleton	9/3/15	7/21/16	46 Weeks
Maquoketa Care Center	Maquoketa	9/17/15	7/21/16	44 Weeks
Montezuma Specialty Care	Montezuma	9/10/15	7/21/16	45 Weeks
Rehabilitation Center of Belmond	Belmond	8/13/15	7/14/16	48 Weeks
Sanford Senior Care	Sheldon	5/14/15	6/23/16	57 Weeks
Shady Rest Care Center	Cascade	8/27/15	7/14/16	46 Weeks
Stacyville Community N. H.	Stacyville	9/10/15	7/14/16	45 Weeks
*The Abbey of LeMars	LeMars	1/28/16	7/28/16	----------
Valley View Specialty Care	Eldora	8/20/15	7/7/16	46 Weeks

Of the 21 Tabulated Annual Surveys Reviewed in August:

3 Annual Surveys were later than last year:

Sanford Senior Care	Sheldon	5/14/15	6/23/16	57 Weeks
Jefferson Place	Pella	6//4/15	7/8/16	56 Weeks

18 Annual Surveys were earlier than last year:

Earliest Surveys:

Ennoble Skilled N & R	Dubuque	8/13/15	6/2/16	43 Weeks

Average Survey Frequency:

August Survey Meeting	**47 Weeks (5 Weeks Early)**
July Survey Meeting	**45.12 Weeks (6.88 Weeks Early)**
June Survey Meeting	**45.31 Weeks**
May Survey Meeting	**46.60 Weeks**
April Survey Meeting	**48.50 Weeks**

*Special Focus Facility