Compliance Tips from IHCA's Survey Results Committee

August 2017

The five most frequently cited tags from the 26 annual surveys (4 deficiency free), 22 complaints (9 unsubstantiated), 13 self-reports (3 unsubstantiated), 7 complaint/self-report (0 unsubstantiated) and 2 mandatory reports (0 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 148 total deficiencies.

Be sure to see the survey frequency data at the end of this report.

The following is a breakdown of severity level:

A =	0.00%	D =	62.90%	G =	11.32%
B =	1.26%	E =	18.90%	H =	0.00%
C =	1.26%	F =	1.89%	I =	0.00%
				J =	1.76%
				K =	2.52%
				L=	0.00%

Total # of Reports: 56
Total # of surveys/reports deficiency free or unsubstantiated: 16
Avg. # of deficiencies

- All = 2.61
- Annual = 3.32
- Complaints = 3.38
- Self-reports = 2.31
- Complaint/Self-Reports= 2.57
- Mandatory = 1.00
- Special Focus = 0.0

Total state fines for August Report = $24,000 ($104,500 held in suspension)

Five Most Cited Tags for August 2017 Report

F 323—Free of Accident Hazards/Supervision/Devices

- Resident rolled off of a van wheelchair lift when wheelchair brakes were unlocked, hit the ground, knocked unconscious. Head pain and blurry vision. Van driver was untrained (K) **$5,000** fine in suspension
- Facility failed to ensure that the resident environment remained as free from accident hazards as possible and failed to provide adequate supervision and assistance devices to prevent accidents. Facility failed to care plan the resident for toileting needs and high risk of falls, even after seeing the resident attempt to self-transfer without activating the call light. Facility failed to implement interventions knowing of the self-transfer attempt, the resident fell and had a right hip fracture (G) **$18,500** fine in suspension
- Failed to provide a safe transfer r/t resident refused to use a gait belt, no other interventions attempted, transfer without a gait belt and resident fell and sustained a Fx tib/fib (G) **$15,000 fine** in suspension
- A resident had multiple falls and ultimately fractured a trochanter. Facility did not put additional fall interventions in place to prevent future falls (G) **$12,000 fine** in suspension ($4,000 trebled)
- A resident had multiple falls and ultimately fractured a hip. Facility did not have additional fall prevention protocols in place (G) **$15,000 fine** in suspension ($5,000 trebled)
- Staff lowered resident to floor when knee gave out, hit head, lose consciousness, sent to ER, returned same day on Hospice, and died 2 days later (G) **$8,000 fine**
- A resident had multiple falls and ultimately fractured a hip. Facility did not have additional fall prevention protocols in place. Resident requiring assistance with ambulation and toileting fell fracturing femur after CNA turned off bed and floor alarms to set up breakfast tray. CNA left room and did not return to check on resident for 2 hours. Resident fell while trying to toilet self (G) **$5,000 fine**
- Failed to provide adequate supervision and appropriate interventions to ensure against hazards from self and failed to ensure the maintenance of safe hot water temperature to prevent potential injury to residents; one resident had multiple falls resulting in 3 different subdural hematomas (G) **$5,000 fine in suspension**
- Resident fell 3 times in 2 hrs. with no interventions. Staff observed walking a resident with a brief at their knees to the bathroom. Staff transferred the resident with a gait belt that was not big enough to fit around the resident (G) **$2,000 fine**
- C.N.A. placed gait belt on resident, stood resident, walked away from resident to get gloves, resident fell and got 2 rib fractures (G)
- Water temps too hot in several areas - 127 - 128 degrees (E)
- Medication cart was unlocked and no staff in the area (E)
- Failed to ensure the entrance pavement is free of accidents/hazards, had uneven surfaces/crevices (E)
- Failed to lock med cart when unattended and left needles and lancets unattended on cart (E)

- Two uneven and cracked sidewalks outside of 2 exit doors (E)
- Unlocked disinfectant, razors, and clippers in the unlocked shower room, jagged door edges, metal surge protector with 2 desk fans plugged into it (E)
- Failed to ensure that a resident received adequate supervision to prevent an elopement for a resident with an alert bracelet. Facility did not report the incident due to the resident having a BIMS score of 15 and notified staff prior to leaving. A wanderguard was placed at the time of admission due to intermittent confusion. The resident cut off wanderguard with fingernail clipper, called a cab and went to the bank. Facility dietician picked the resident up who did not have his walker and had money with him. Facility contacted family to tell them that the resident went to the bank and they locked up the money, not that he went unsupervised and did not sign out and cut his alert bracelet off (J lowered to D)
- Code locked door observed propped open that lead to stairwell (D)
- Facility failed to implement new interventions for falls on one resident (D)
- Care plan lacked fall interventions after 4 falls (D)
- Resident fell without alarm attached as care planned (D)
- Facility van had tires in bad repair and on two separate trips over at least a month with residents in van, had 2 blown tires. Service station had advised facility that van needed new tires for safety reasons after first incident (D)
- Facility failed to remove dangerous items from room after suicidal ideation and attempts (D)
- Care plan stated not to leave resident unattended in wheelchair in room and observed by surveyor in room in wheelchair unattended (D)

F 309—Highest Practicable Well-Being

- Resident with GI vomiting, not assessed until several episodes, sent to ER with severe sepsis, resident with non-healing surgical wound and physician orders for treatment, not completed, additional residents with no wound care per orders (G) **$3,000 fine** in suspension
- A resident had a significant change in condition over the week-end. Confusion, inability to stand, loss of appetite, complaints of pain, etc. a proper assessment was not conducted by facility staff. Family insisted the resident be sent to ER by ambulance (G) **$500 fine**.
- Nurse failed to assess resident who reported a fall during the previous night after the resident asked for pain medication for hip pain (D)
- Failed to implement and change interventions for a non-pressure area on the feet (D)
- Licensed nurse did not assess/document a resident condition change r/t unusual behaviors, swearing, resident admitted to acute care with dehydration and hypotension (D)
- Failed to provide a timely assessment of a resident with a condition change r/t respiratory assessment after a fall and rib fxs with hemothorax and lung collapse (D)
- Facility failed to ensure that each resident received and the facility provided the necessary care and services to attain or maintain the highest practicable

physical, mental and psychosocial well-being consistent with the resident's comprehensive assessment and plan of care. Orders to change g-tube dressing when drainage and staff applied new dressing over the saturated dressing and client was admitted to the hospital with left upper quadrant cellulitis (D)

- Resident with behavioral changes, verbal and nonverbal indications of pain, and elevated temp after a fall did not receive adequate assessment or timely interventions, timely notification of physician. Resident had broken femur that was not diagnosed until 14 hours after fall (D)
- Fall with head laceration and physician not notified for 2 hrs. after the fall by Fax and physician responded another 2 hrs. later to send to ER so resident not sent to ER for 4 1/2 hrs. after the fall (D)
- No skin sheet assessments for areas that had been treated by the dermatologist for basal and squamous cell skin CA (D)
- Failure to assess a resident with URI symptoms - did not apply O2 when sats dropped to 87% (D)
- Failed to administer MOM as ordered for constipation (D)
- Failed to timely assess residents with pain and significant weight variances (D)

F 314—Pressure Ulcers

- Facility failed to ensure that a resident to ensure that a resident received care, consistent with professional standards of practice. To prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable. Resident did not have a weekly skin assessment and physician/wound orders were not always followed. Resident had low albumin level and stage 4 pressure injury sore. The resident refused supplements so they were discontinued with nothing else offered. Resident with a stage 4 pressure ulcer did not have a pressure reduction bed. Skin sheet upon admission failed to identify an assessment for abdominal incision, left ischial and right gluteal fold open areas (G) **$12,000** fine in suspension
- Five of five residents with skin ulcers didn't have assessment and interventions to prevent further wound problems. Wound increased in size from 6cm X 5cm to 23 cm to 14 cm in less than one month, lack of weekly skin assessments, improper glove use during wound care, many bed linens on top of a pressure reduction mattress, failed to follow Infection Control Policy for wound care, many residents did not get skin treatments per physician order, resident not taken to dr. appointment for ulcer (K) **$8,000 fine** in suspension
- Care plan did not identify pressure ulcer risk when the assessment showed high risk and the resident developed heel ulcers. Care plan did not identify risk for pressure ulcer due to use of oxygen and tubing (G) **$2,500 fine**
- Resident developed "avoidable" pressure ulcers (G) $**2,000 fine**
- facility failed to put interventions I place for a resident with a change in condition to prevent them from developing a pressure ulcer (G) **$2,000 fine**
- Facility failed to properly identify risk factors for pressure ulcers upon admission survey and failed to implement adequate interventions to prevent the development of an avoidable heel ulcer. Nurse staged wound as unstageable with granulating tissue (G) **$2,000 fine** in suspension

- Failed to prevent development of a pressure ulcer to right, care plan interventions were not followed to elevate legs when in chair or wheelchair and did not float heels (G) **$2,000 fine** in suspension
- Facility failed to properly identify risk factors for pressure ulcers upon admission survey and failed to implement adequate interventions to prevent the development of an avoidable heel ulcer. Nurse staged wound as unstageable with granulating tissue (G) **$2,000 fine** in suspension
- Resident developed a pressure sore, surveyor saw heels not suspended off bed (D)
- Failed to implement interventions written on the care plan to prevent development of avoidable pressure ulcer on heels (D)
- Care plan stated to float heels and use heel protectors but resident observed without those in place (D)

F 279—Comprehensive Care Plans

- MDS identified care plan requirements, but care plans weren't included such as wounds, behaviors, and wandering (E)
- Failed to implement Care Plan interventions to prevent heal ulcer (D)
- One resident threw a knife at another resident in the dining. CP instructed staff to provide plastic utensils only and surveyor observed metal utensils (D)
- Failure to update care plan with interventions after resident to resident altercation and fall (D)
- Failed to update the care plan timely for new catheter care (D)
- Failed to ensure staff added psychotropic medications and adverse effects for high risk medications on the care plan, (Sertraline and Ativan) (D)
- Care plan did not identify the use of oxygen (D)
- Facility failed to provide a comprehensive care plan to monitor for side effects of psychotropic mediations. Resident had a mood problem as exacerbated and care plan lacked focus and intervention for psychotropic medication use and side effects to monitor for (D)
- failed to develop a comprehensive care plan post hospital discharge for rib Fxs (D)

F 371—Food Preparation-Sanitary Conditions

- Dirty dishwasher housing, dirty mixer, moldy cheese in frig, dirty ceiling vents, staff touching plates with bare hands (F)
- Open packages of food not dated when opened. Kitchen staff failed to wash hands or change gloves between tasks of dirty and clean in the dining room. Frost build-up in freezer (F)
- Failure to test dish machines in the "households" utilizing the appropriate sanitation strips (using the wrong test papers) (E)
- Facility failed to store left over foods in the walk-in cooler, dry storage area and refrigerator within the required timeframes (E)
- Failed to maintain the kitchen stove/grill and convection oven in sanitary condition (E)

- Facility failed to make sure staff prepared and served food in a manner that minimizes the chance of food-borne illness. Staff did not wash hands after hugging a resident and went back to serving food (E)
- Frig temp in kitchenette was 48 degrees and freezer 20 degrees (E)
- Failed to handle and serve food under sanitary conditions; dietary aide cleared soiled dishes and failed to wash hands prior to returning to serving other residents; staff applied gloves on 3 different occasions and failed to wash hands before and after applying gloves. Staff touched multiple areas and failed to apply gloves (D)

Other Notable Deficiencies and Fines (sorted ascending by f-tag number)

F 156—Notice of Eligibility

- Failed to comply with all Medicare requirements governing billing practices for 1 resident reviewed for liability and appeal notices (D)
- Resident was not properly notified of their right to request a demand billing for skilled services (D)
- 48 hour notice not provided to a patient who was ending skilled services (D)

F 157—Notice of Changes to Family, Physician

- Failed to notify physician of held insulin r/t insulin outdated and did not have another for replacement (D) **$2,000 fine** in suspension
- Failed to notify the physician in a timely manner of a severe weight loss (D)
- Failure to notify the Dr. of a blood sugar of 57 (parameter was to notify if below 60) (D)
- Resident stated severe pain in ankle, sent to ER, no fx, family and responsible party not notified of ER visit or condition change (D)

F 167—Examination of Survey Results

- The resident identifier list from a previous survey was posted with the survey results in the facility (D)
- Most recent annual survey not posted (C)
- LSC Inspection was not available in the facility for public review (B)

F 223—Freedom from Abuse

- "Humiliating" snap chat photos of 2 residents sent. Resident was demented. Staff admitted sending the photos (G) **$2,500 fine**
- A staff member pushed a resident from a doorway to prevent them from entering another resident's room. The resident stumbled backward, but did not fall. Facility did not prevent abuse to that resident (D) **$500 fine**
- Facility failed to ensure a resident free from verbal abuse during cares when a staff member made derogatory remarks to a resident (D) **$500 fine**

- Resident fell 2 times after being led out of another resident's room by the resident. Resident found in another resident's room with their hands on the resident's penis (D)
- Only 1 page of 4 of 2567 posted UNABLE TO EVALUATE THE SURVEY (D)

F 225—Reporting to the Department

- Failed to investigate allegations of abuse, failed to report for 2 residents r/t staff statement to resident "I'm going to hang you by your neck" when resident c/o leg pain, and another staff member to a different resident stated, " better sit down because I do not want to pick up your sorry ass off the floor if you fall." (K)
- Resident had a fractured toe with no known source of injury and the facility did not investigate possible causes (D)

F 226—Staff Treatment of Residents

- Facility failed to implement their abuse policy, failed to investigate allegations of abuse, failed to report for 2 residents r/t staff statement to resident "I'm going to hang you by your neck" when resident c/o leg pain, and another staff member to a different resident stated, " better sit down because I do not want to pick up your sorry ass off the floor if you fall."
- Facility hired RN prior to receiving final Abuse Registry approval. Resident had no abuse training after 9 months of employment (D) **$500 fine**
- Failed to complete criminal and abuse background checks prior to hire for 1 employee (D) **$500 fine**
- Failed to ensure that a new employee did not receive the mandatory 2 hour dependent adult abuse training within 6 months of their hire date (D)
- Facility failed to assess a resident after an allegation of abuse and failed to ensure staff completed an approved dependent adult abuse training course within 6 months of hire (D)
- A staff member had completed a combined 2 hour child/adult abuse program, not 2 hours for adult abuse only within the 1st six months of employment (D)
- Facility failed to complete the required two hour dependent adult abuse education 6 months after hire (D)

F 241--Dignity and Respect of Individuality

- Facility failed to treat and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life recognizing each resident's individuality. Staff did not follow care plan when resident resisted care, which resulted in a large bruise. Staff did not answer call light within 15 minutes, which then the resident soiled self which caused emotional distress (G)
- A resident became combative after his alarm sounded; Nurse gave resident a bear hug to keep the resident from falling as the resident ran from the staff. Dignity issue (D)
- Staff got resident out of bed for a meal even though the resident did not want to get up and informed the staff (D)

- Resident stated severe pain in ankle, sent to ER, no fx, family and responsible party not notified of ER visit or condition change (D)

F 242--Dignity

- Failed comply with resident wishes by giving meds at 5 am (D)

F 246--Accommodation of Needs

- Resident, being treated for vascular issues, had appointment for angiography cancelled due to facility van being broken down. Resident required longer facility stay due to this incident. Another resident was rescheduled for gastro endoscopy for transportation issues. Other residents had multiple appointments rescheduled due to lack of appropriate transportation (D)
- Resident had ulcers, no interventions on care plan and Dr. visit not scheduled, resident's bed not working so unable to reposition resident per care plan (D)

F 250—Social Services

- Failed to complete social services assessments on 9 residents for over a year (E)
- Failed to provide assistance to obtain power of attorney (E)

F 252—Safe, Clean, Homelike Environment

- Failed to maintain homelike environment r/t dining room floor with blackened areas (D)

F 253-- Housekeeping and Maintenance Services

- Failed to maintain homelike environment r/t cracked tiles and caulking, peeling paint, red sticky splatters, black grime, brown drips, cobwebs, dust and debris (E)

F 273--Assessment Frequency

- Admission MDS had most of the sections not completed, short staffed so corporate staff assisting (D)

F 274-- Significant Change Assessment

- Significant change MDS not completed after change of conditions (D)

F 276--Quarterly Review Assessment

- An MDS assessment was not completed quarterly as required (D)
- Quarterly MDS not completed (D)

F 281—Professional Standards of Quality

- Medication sheets did not state time to give meds, sliding scale insulin not given per order after BS check, meds often not given, residents state they don't always get meds, failed to watch resident's actually take their meds (F)
- Nurse failed to properly observe residents consume oral medications by turning her back to them after handing them their medications (E)

- Staff not using protective heel devices as specifically designated on resident care plan (D)
- Failed to provide insulin as ordered when vial was out dated (D)
- Facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the residents rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment. No care plan developed for a resident with high risk of falls who fell and fractured hip. Resident who was ordered non weight bearing was not transferred by Hoyer (D)
- Failure to draw an A1C every 3 months as ordered by Dr. (D)
- Failure to assess the bruit and thrill of the fistula to the left arm of a dialysis patient (D)

F282—Services Provided per Written Plan of Care

- Resident with two pound weight loss was care planned to receive extra egg at breakfast and did not receive during meal observation; resident did not have heels "floated" while in bed as listed on care plan (D)
- Facility failed to follow interventions on the resident care plan. Care plan instructed staff to place non-slip strips by the residents bed and recliner to maximize safety and no non-slip strips are present (D)

F 312—Quality of Care; Activities of Daily Living

- Care plan did not address personal care, bathing, unkempt hair, facial hair not trimmed, fingernail and toenails long and dirty (E)
- Residents did not receive at least 2 baths a week and one went over 8 days without a bath (E)
- Failed to provide complete incontinent cares r/t didn't cleanse all areas (E)
- Facility failed to ensure that a resident who is unable to carry out activities of daily living received the necessary services to maintain grooming, and personal hygiene by failing to provide twice weekly baths (D)

F 315--Incontinence Care

- Catheter bag and tubing laying on the floor (D)
- Improper glove use and handwashing during suprapubic catheter care (D)

F 318—Range of Motion to Prevent Decline

- Facility failed to provide restorative nursing as recommended and care planned (E)

F 322—Gastrotube Feeding

- Failed to administer feeding formula for feeding tubes per physician order, used different formula from orders (D)

F 353—Sufficient Nurse Staffing

- Resident complained in resident council about waiting longer than 1/2 hour for call light to be answered. Resident had a BIMS score of 15 (D)
- Call lights greater than 15 minutes (E)

F 363—Menus, Nutritional Adequacy

- Failure to follow menu - meat balls were 2.5 oz. instead of 3, failed to offer pasta to residents as a choice (was on the menu), residents complained of "small portions" due to staff running out of food (E)
- Pureed and mechanical Soft diet residents did not get broccoli and rice per the menu. Failed to serve a cookie per the menu (E)
- Facility failed to serve 6 of 6 residents on a pureed diet the proper serving size for one meal observed (E)
- Quality of Life interview with all residents c/o poor call light response time (E)
- Three residents did not receive pureed corn as written on the menu and approved by the dietitian (D)

F 364—Food-Proper Temperature

- Food temp problems with ground pork (137), ground chicken (122.9), and lettuce (59.4) (E)

F 425--Pharmacy Services

- A narcotic pill count was conducted and 2 Narco tablets were missing. A CMA admitted to removing the meds accidently and disposing then into a sharps container (D)

F 428—Drug Regimen Review by Pharmacist

- No documentation for continued use of psychotropic meds, Melatonin and Seroquel (E)

F 431—Labelling of Drugs and Biologicals

- Failed to label insulin bottles with name and dosage (D)

F 441—Infection Control

- Failure to follow proper infection control techniques when changing a dressing on a resident with MDRO. Did not clean scissors before cutting off dressing, did not wash hands and re-glove after removing dirty dressing (before applying clean dressing), touched a capsule with bare hands (D)
- Dirty linens put on the floor in 2 resident rooms and failure to wash resident hands after they did their own peri care (D)
- A blood stained remained on the carpet after a resident had fallen approximately 5 weeks after the fall (E)
- Facility failed to adequately perform hand hygiene between clean and dirty tasks during a dressing change (E)
- Failed to change resident's equipment in a timely manner, r/t did not leave disinfectant on surface for appropriate hang time, G-tube graduate and syringe with no date off when put in use (E)

F 465—Safe, Sanitary Environment

- Failed to provide sanitary condition in kitchen r/t entire ceiling discolored, back wall stained yellow, many dirty white smears/streaks in multiple areas (E)

F 496—Registry Verification

- Failed to document registry verification for Certified Nurse's Aides prior to the initiation of employment for 3 aides (D)
- Facility did not assure that all hired CNA were not verified on the CNA Registry prior to employment (D)
- Failure to check nurse aide registry on one C.N.A. prior to employment (D)
- Facility hired 2 CNAs without checking the CNA registry (D)

F 498--Proficiency of Nurse Aides

- Failed to provide minimum 12 hours of annual inservice training for certified nursing aides (E)

F 499—Staff Qualifications

- Facility Failed to verify Iowa Nurse licensure after verifying another state licensure that had expired (D)

F 514—Clinical Records

- Facility failed to maintain medical records in accordance with acceptable professional standards that were complete, accurately documented, readily accessible and systematically organized. Residents records did not contain physician progress note, physician discharge summary, discharge plan and orders (D)
- Medical record lacked evidence of interventions attempted prior to admin of PRN Seroquel (D)

F 520—Quality Assessment and Assurance

- Facility failed to have the required staff members attend quality assurance meetings quarterly (C)
- Medical Director did not attend quarterly QA meetings (B)

L1093 & 441-58.12(1)

- Veteran residents were not listed on the "VA Resident Eligibility" list
- Facility failed to submit info to VA for a resident who's spouse was a veteran

Annual Survey Frequency
August Survey Results Meeting

Facility	City	Last Year	This Year	Frequency
Anamosa Care Center	Anamosa	6/30/16	7/20/17	54 Weeks
Arbor Springs	W. Des Moines	6/23/16	7/20/17	55 Weeks
Blair House	Burlington	6/16/16	7/20/17	56 Weeks
Cedar Health	Charles City	6/30/16	7/20/17	54 Weeks
Chariton Specialty Care	Chariton	6/23/16	7/27/17	56 Weeks
Corydon Specialty Care	Corydon	6/16/16	7/20/17	56 Weeks
Crestview Acres	Marion	6/30/16	7/27/17	55 Weeks
Denison Care Center	Denison	6/2/16	7/18/17	58 Weeks
Exira Care Center	Exira	5/24/16	7/13/17	58 Weeks
Friendship Village	Waterloo	6/9/16	7/13/17	56 Weeks
Genesis Medical Center	DeWitt	6/16/16	7/20/17	56 Weeks
*Grand Meadows	Asbury	----------	7/6/17	----------
Grandview Health Care Center	Dayton	5/26/16	7/13/17	58 Weeks
Great River-Klein Unit	West Burlington	4/30/16	6/15/17	58 Weeks
Laurens Care Center	Laurens	6/30/16	7/27/17	55 Weeks
Madrid Home for the Aged	Madrid	6/16/16	7/13/17	55 Weeks
Parkview Home	Wayland	6/2/16	7/13/17	57 Weeks
Royale Meadows Care Center	Sioux Center	6/16/16	7/20/17	56 Weeks
Salem Lutheran Home	Elk Horn	6/16/16	7/27/17	57 Weeks
Scenic Manor	Iowa Falls	6/23/16	7/20/17	55 Weeks
Simpson Memorial Home	West Liberty	6/9/16	7/27/17	58 Weeks
The New Homestead	Guthrie Center	6/9/16	7/20/17	57 Weeks
Vinton Lutheran Home	Vinton	6/23/16	7/13/17	54 Weeks
Westridge Care Center	Cedar Rapids	5/5/16	5/11/17	53 Weeks
Westridge Quality Care & Rehab	Clarinda	4/7/16	5/11/17	56 Weeks
Willow Gardens Care Center	Marion	6/16/16	7/13/17	55 Weeks

***1st Annual Survey**

4 Facilities were "Deficiency Free" (15.4%)

Of the (25) Tabulated Annual Surveys Reviewed in August:

None of the Annual Surveys were earlier than last year
All of the Annual Surveys were later than last year

Earliest Survey:				
Westridge Care Center	Cedar Rapids	5/5/16	5/11/17	53 Weeks
Latest Surveys:				
Five (5) Facilities				58 Weeks
Average Survey Frequency:	**2017**			
	August Survey Meeting		**55.92 Weeks**	**(3.92 Weeks Late)**
	July Survey Meeting		**56.54 Weeks**	**(4.54 Weeks Late)**

June Survey Meeting	**54.90 Weeks**	**(2.10 Weeks Late)**
May Survey Meeting	**54.90 Weeks**	**(2.10 Weeks Late)**
April Survey Meeting	**52.84 Weeks**	**(0.84 Weeks Late)**
March Survey Meeting	**51.21 Weeks**	**(0.79 Weeks Early)**
February Survey Meeting	**50.88 Weeks**	**(1.12 Weeks Early)**
January Survey Meeting	**49.69Weeks**	**(2.30 Weeks Early)**
2016		
December Survey Meeting	**48.52 Weeks**	**(3.48 Weeks Early)**
November Survey Meeting	**48.03 Weeks**	**(3.97 Weeks Early)**
October Survey Meeting	**47.04 Weeks**	**(4.96 Weeks Early**
September Survey Meeting	**46.72 Weeks**	**(5.28 Weeks Early)**
August Survey Meeting	**47 Weeks**	**(5 Weeks Early)**
July Survey Meeting	**45.12 Weeks**	**(6.88 Weeks Early)**
June Survey Meeting	**45.31 Weeks**	**(6.69 Weeks Early)**
May Survey Meeting	**46.60 Weeks**	**(5.40 Weeks Early)**
April Survey Meeting	**48.50 Weeks**	**(3.50 Weeks Early**