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

Compliance Tips from IHCA's Survey Results Committee
August 2019

Total Number of Survey Reports: 77

Survey Composition:

Annual:	**49** Surveys	**2** Deficiency Free
Complaints:	**34** Surveys	**6** Unsubstantiated
Self-Reports:	**19** Surveys	**3** Unsubstantiated
Mandatory Reports:	**6** Surveys	**0** Unsubstantiated

State Fines: $30,000
State Fines in suspension: $45,000

Most Commonly Cited Iowa Tags:

F 812 – Food Procurement, Storage, Preparation, Sanitization (17)

F 880 – Infection Prevention and Control (17)

F 689 – Free from Accidents and Hazards (15)

F 644 – Coordination of PASRR and Assessments (15)

F 625 – Notice of Bed Hold Policy Before/Upon Transfer (14)

F 623 – Notice Requirements Before Transfer/Discharge (12)

F 758 – Free from Unnecessary Psychotropic Meds/PRN Use (11)

F 657 – Care Plan Timing & Revision (10)

F 690 – Bowel, Bladder Incontinence, Catheter Care (10)

Tags Resulting in Actual Harm or Higher Citations and Fines:

F 684 – Quality of Care **1 G Level Tags**

F 686 – Treatment to Prevent Pressure Ulcers **1 G Level Tags**

F 689 – Free from Accidents and Hazards **4 G Level Tags, 2 J Level Tags**

F 700 – Bedrails **1 J Level Tag, 1 K Level Tag**

F 760 – Residents Are Free of Significant Med Errors **1 J 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=15592		Total Number of Surveys=39533
F0880	Infection Prevention & Control	3,678	21.9%	9.3%
F0689	Free of Accident Hazards/Supervision/Devices	3,430	18.1%	8.7%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	3,019	18.4%	7.6%
F0656	Develop/Implement Comprehensive Care Plan	2,742	16.0%	6.9%
F0684	Quality of Care	2,484	13.6%	6.3%
F0761	Label/Store Drugs and Biologicals	2,123	13.0%	5.4%
F0657	Care Plan Timing and Revision	1,740	10.4%	4.4%
F0758	Free from Unnec Psychotropic Meds/PRN Use	1,594	9.8%	4.0%
F0677	ADL Care Provided for Dependent Residents	1,572	8.6%	4.0%
F0550	Resident Rights/Exercise of Rights	1,491	8.7%	3.8%

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

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

F550 – Resident Rights/Exercise of Rights

- Several residents were transported in wheeled bath chairs without being completely covered. Another resident complained of being taken to the dining room for breakfast in her pajamas. A resident, with intact cognition, complained of an evening nurse who had a condescending tone to her voice. E
- Resident's catheter bag did not have the dignity cover in place. D
- Facility failed to care for each resident in a manner and in an environment that promotes maintenance or enhancement of quality of life. Staff informed a resident they needed to wait until another staff could be found to help take resident to the bathroom, both staff passed resident several times assisting other residents, surveyor approached the resident and he stated he no longer has to use the bathroom because he had an incontinent episode in his pants. Resident had waited 1 hour and 21 minutes for assistance to the bathroom. D

- Facility failed to treat resident in a dignified manner. Resident acted very agitated and threw a notebook and water at staff, staff told resident that if he/she were a child, she would take resident over the knee; then staff got up and walked away. D
- Failed to knock and wait for permission to enter a resident's room. Resident reported it happens all the time and it bothers him. D
- Facility failed to ensure the resident had a right to a dignified existence, self-determination, and communication and access to persons, services inside and outside the facility. Resident was combative during morning cares, staff continued to attempt to dress her and resident hit self while putting on sleeve causing her nose to bleed. Did not stop and reproach later as per care plan. D

F567 – Protection/Management of Personal Funds
- Residents did not have access to personal funds on weekends. B

F576 – Right to Forms of Communication with Privacy
- Failure to deliver resident mail on Saturdays. B

F578 – Request/Refuse/Discontinue Treatment; Formulate Advance Directive
- CPR status of residents was not consistently posted or identified so that all staff members could locate status as needed. D
- Fail to ensure advanced directives for health care were clearly documented. IPOST reported full code, care plans and condition alerts file reported DNR status. No code status on Face Sheet. D

F582 – Medicaid/Medicare Coverage/Liability Notice
- Didn't provide skilled beneficiary notice to resident with Medicare Part A services. B
- Fail to provide required form for Medicare Liability Notices and Beneficiary Appeals when skilled services were exhausted, or services no longer covered. B
- Fail to provide residents required forms for Medicare Liability Notices/Beneficiary Appeals when skilled services have been exhausted or no longer covered. D

F584 – Safe/Clean/Comfortable/Homelike Environment
- Failed to ensure residents had a safe, clean, comfortable and homelike environment related to wheelchair neck rest cover with holes and exposed foam. D
- Housekeeping staff did not clean toilet smeared with BM. Facility failed, per policy, to sanitize all mattresses and ensure day bed linens were changed each week. F

F600 – Free from Abuse and Neglect
- Failure to prevent resident to resident physical abuse by failing to implement recommendations and thoroughly investigate and report an instance of resident to resident physical altercation for a resident who later engaged in another resident to resident physical altercation. D

- Facility failed to provide goods and services to a resident that were necessary to avoid mental anguish or emotional distress. Rude verbal and physical behavior to resident from staff due to language barrier. D

F602 – Free from Misappropriation/Exploitation

- Failed to assure residents are free from misappropriation of personal funds. SSD had access to resident's credit/debit card without administrator knowledge. It was discovered SSD used the card to purchase items SSD's own use. D

F606 – Not Employ/Engage Staff with Adverse Actions

- Staff with criminal records were employed by facility before DHS evaluation was completed. One employee, with an extensive criminal record, was denied employment by DHS. D
- Failed to ensure staff has approval letter to work from DHS. D

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

- Failure to complete a background check for an employee before hire. D

F609- Reporting of Alleged Violations

- Staff transferred resident without gait belt and resident hit right ankle on bed frame, staff did not report it. Resident reported next day that ankle was hurting. D

F610 – Investigate, Prevent, Correct Alleged Violation

- Facility reported allegation of rough treatment of resident, according to facility's abuse prevention policy that any allegation of abuse, neglect or misappropriation or exploitation must result in immediate suspension to protect the resident, employee worked the whole shift. D
- Failed to investigate/report allegation of dependent adult abuse. Administrator didn't know facility had to report alleged abuse to DIA and separate identified staff from resident; DIA made the determination whether or not it was abuse, not the facility. F
- Failed to adequately investigate/report allegations of abuse. Resident reported allegation of abuse by staff to administrator and investigation was not completed and/or reported to DIA. D
- Failed to notify DIA following and allegation of abuse; failed to separate alleged perpetrator from the victims. Staff transferred resident per self (care planned as two assist) resident received a laceration to leg requiring ER visit. Resident report staff member yelled at me and was aggressive. F

F622 – Transfer and Discharge Requirements

- Facility failed to provide discharge and medical information to the receiving health care institution at time of discharge for a resident who transferred to the hospital. D
- Failed to send transfer form when residents transferred to the hospital. D
- Fail to send transfer form to hospital on transfer to hospital for a blood transfusion. B

- Facility failed to provide discharge and medical information to the receiving health care institution at time of discharge. Record lacked documentation of information sent with resident to hospital. D
- Failed to provide discharge and medical information to the receiving health care institution at the time of transfer to the hospital. D
- Facility failed to initiate an emergency discharge and re-evaluate a resident's condition for re-admission. Resident was emergently discharged to hospital due to agitated behaviors, stating suicide, threatening staff, putting other residents at risk. Hospital ER attempted to return resident; facility declined due to behaviors. Hospital reported facility was dumping resident. Facility failed to justify need for involuntary discharge and provide physician documentation for rationale of involuntary discharge; failed to ensure disability rights Iowa received proper notification of the involuntary discharge. D

F623 – Notice Requirements Before Transfer/Discharge

- Facility failed to send notice of hospital transfer to the LTCO for a resident. D
- No notice provided to LTCO of residents transferred/discharged from the facility. B
- No notification of LTCO of resident transfer or discharge. B
- No notice provided to LTCO of residents transferred or discharged from facility. C
- Facility did not notify LTCO prior to transfer or discharge from facility. B
- Resident had pneumonia and was transferred to the hospital. Another resident had a head injury and was sent to hospital. Clinical record lacked information that the LTC Ombudsman had been notified of any of these residents' hospitalization. C
- Failed to send a copy of Notice to Transfer to the Ombudsman office. D
- Failed to send a copy of Notice to Transfer to the Ombudsman office. D
- Fail to send copy of notice of transfer to the office of the State LTC ombudsman. B
- Failed to notify state's Ombudsman's Office of resident's transferred to hospital. B
- Failed to send a copy of Notice to Transfer to State Long Term Care Ombudsman with transfer/admission to Hospital. D
- Failed to notify the Long-Term Care Ombudsman who transferred to the hospital. D

F625 – Notice of Bed Hold Policy Before/Upon Transfer

- Several residents were not provided information regarding facility bed hold policies prior to or within 24-hours of transfer. B
- Bed hold notice not provided to resident prior to hospital transfer. B
- Facility did not provide resident with bed hold notice prior to transfer from facility. B
- Failed to notify resident or rep of bed hold policy prior to or shortly after transfer. B
- Failure to provide resident and/or family with bed hold policy when the resident transferred to the hospital. C
- Failure to provide residents and/or family with bed hold policy when multiple residents transferred to the hospital. D
- Failure to provide bed hold notice to residents/families sent to ER/hospital. B
- Failed to notify the resident or their representative of the bed hold option. D
- Failed to notify the resident or their representative of the bed hold policy. B
- Failed to notify resident/representative of bed hold when transferred to hospital. B

- Failure to provide multiple residents with bed hold policies. D
- Failed to provide notice to resident or representative of bed hold policy prior to and upon transfer to the hospital. C
- Failure to provide resident/family with bed hold policy when transferred to hospital. D
- Facility failed to provide notice to the resident and/or representative of the facility's bed hold policy upon transfer to the hospital. D

F636 – Comprehensive Assessments &Timing

- Facility failed to complete a comprehensive and accurate assessment using RAI Manual for a resident on hospice services. MDS lacked documentation in Section J that resident had life expectancy of less than six months; lacked documentation in Section O that resident had not received hospice services. Inaccurate coding. D
- Facility failed to update care plans when changes occurred, care plan directed staff to monitor the resident for signs of dysphagia refusing to eat and concerns during meals, but also directed staff that resident was NPO and received nutrition through a G-tube. Resident was on a diuretic and not on the care plan. D

F637 – Comprehensive Assmt After Significant Change

- Failure to submit a significant change in MDS assessment for resident receiving hospice services. D

F640 – Encoding/Transmitting Resident Assessment

- Failed to complete and transmit an MDS within the required timeframe. D

F641 – Accuracy of Assessments

- Failure to accurately assess resident's status. D
- Facility failed to ensure an accurate assessment of a resident was completed. D
- MDS Coordinator failed to complete a resident's discharge assessment. D
- Failed to accurately complete an MDS assessment. Lack of documentation on MDS of current tobacco use. D

F642 – Coordination/Certification of Assessment

- Failed to complete an accurate MDS related to coding anticoagulants when an antiplatelet (Plavix) was given. D

F644 – Coordination of PASRR and Assessments

- Resident with Level II PASRR determination and recommendations did not have those included in the individualized plan of care. D
- Nursing staff failed to continually measure and document appearance of a persistent Stage 4 chronic pressure area after ARNP deemed it essentially healed; staff did not notify physician of resident's blood glucose reading of 465. D
- Facility failed to provide PASRR specified services for psychiatric visits. D
- Facility failed to care plan specialized services required by Level II PASRR. B

- Facility failed to submit a PASRR for review a resident with a qualifying mental health diagnosis. New diagnosis of delusional disorder, recurrent depressive disorder and unspecified psychosis with no new PASRR submitted for review. D
- Failure to document and care plan psychiatric visits. (NONE)
- Failed to update PASARR when a new possible serious mental disorder was identified. D
- Failed to reassess for PASARR after a diagnosis of mental illness received. D
- Failed to update PASARR when a new possible serious mental disorder was identified, and medication use was changed. (NONE)
- Failure to identify a possible mental health disorder and refer resident to appropriate state for PASRR and evaluation. D
- Failed to update PASARR when resident had a significant change in mental status and treatment. D
- Facility failed to refer residents reviewed with a qualifying mental illness diagnoses for a level 2 Pre-admission screening and resident review. E
- Failure to implement PASRR recommendations for multiple residents with PASRR level II recommendation. D
- Resident wasn't referred to a Level II PASRR evaluation and determination with a new diagnosis of psychotic disorder. D
- Facility failed to incorporate PASRR findings into the care plan. D

F645 – PASARR Screening for MD & ID

- No Level I PASRR completed by facility for resident with diagnosis of Major Depressive Disorder and Dementia who also was taking antipsychotic and anti-depressant prior to admission to the facility. D
- Facility failed to resubmit the PASRR on a resident with a Level II 6-month waiver. D
- Failure to do PASRR Level II assessment for resident with diagnosis of depression taking anti-depressant medication. D
- New PASARR not completed when previous PASARR expired. (NONE)

F655 – Baseline Care Plan

- No written summary of baseline care plan provided to six residents as required. E
- Failed to provide a written summary of the baseline care plan to the resident or resident representative. Chart lacked documentation the facility reviewed the baseline care plan with the resident or resident representative. D
- Fail to provide resident and representative with a summary of baseline care plan. B
- Facility failed to provide resident and rep with a summary of baseline care plan. B
- Failed to develop/implement baseline care plan within 48-hrs for several residents. D

F656 – Develop/Implement Plan of Care

- Nursing staff failed to follow care plan for resident at risk for falls which required use of non-skid socks or shoes at all times. Resident was noted during survey to have regular socks and no shoes during two transfers. D
- Care plan- missing interventions for indwelling catheter and continuous oxygen. D

- Failed to develop and implement comprehensive and person-centered care plans focusing on Hospice and Dialysis. D
- Failure to implement care plan interventions to address signs and symptoms related to Diabetes Mellitus. D
- Facility failed to develop a comprehensive care plan for the use of psychotropic medication and monitoring for adverse effects. D
- Failed to develop a comprehensive person-centered care plan; did not include use of antidepressant and anti-anxiety meds or potential side effects of the medication. D
- Failed to develop a comprehensive care plan for use of an anticoagulant, use of an antidepressant and monitoring of side effects. D
- Failed to address specific interventions on care plan regarding a resident with COPD and use of oxygen. D

F657 – Care Plan Timing & Revision

- Failure to develop a comprehensive care plan for multiple residents reviewed for anticoagulant. Lack of documentation of signs and symptoms to monitor for. E
- Accuracy of Assessments- Failure to update care plan with specific signs and/or symptoms related to antipsychotic drugs. (NONE)
- Failure to revise care plan to reflect resident's use of insulin related to diabetes mellitus diagnosis. D
- Failure to revise the Plan of Care for multiple residents. D
- Facility failed to update the comprehensive care plan. Lack of update related to recent surgical procedure and JP drains. Lack of care plan update to reflect change in transfer status from Hoyer to EZ stand lift. D
- Failed to update and revise care plans for several residents. D
- Failure to revise care plan to reflect accurate diet order on residents. D
- Failure to review and revise comprehensive care plans for residents. D
- Failed to revise a care plan to include the presence of a pressure sore with measurable goals and interventions. D
- Facility failed to ensure the resident or representative participate in the care plan. D

F658 – Services Provided Meet Professional Standards

- Nurse did not properly check for G tube placement (failed to check for residual contents of stomach as per facility policy) prior to cocktail administration of medications through the G tube. No physician order for the mixed administration of crushed medications. D
- Insulin pens were not primed according to manufacturer's instructions before administration of insulin. D
- Failure to follow physician's order for eye drop administration for a resident. D
- Failed to follow physician orders as directed, lacked TAR documentation that a treatment was completed. D
- Fail to follow physician orders for resident with feeding tube. Staff flushed tube with 60cc of water before/after meds while medication review report said to flush with 30cc. Policy stated flush ordered amount of water before and after medications. D

- Facility failed to properly document administration of controlled medications. Staff administer narcotic medication without removing the narcotic book from the drawer prior to administration of the medication. Further review showed staff had not signed out any of the narcotics in narcotic book for any resident staff had administered a narcotic for that morning. Staff stated this is a bad habit of mine, I know it's wrong. D
- Failed to follow physician orders for fluid restriction. Full pitcher of water noted on resident's bed side table, used freely per self. Dietary card did not reference fluid restriction. D
- Fail to follow physicians' orders. Medications noted in medication cards and initialed as given on the MAR. E
- Facility failed to ensure professional standards of medication administration. Lack of direction from nurse to resident to rinse mouth and spit after inhaler use. D

F661 – Discharge Summary

- Facility failed to complete a recapitulation of the resident's stay. D

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

- Failure to make sure ADLs are performed for multiple residents. Restorative program had not been started for a resident as needed. D

F677 – ADL Care Provided for Dependent Residents

- Residents not receiving baths two times weekly. E
- Facility failed to provide ADLs for residents who are dependent on staff for assistance with incontinence care, toileting assistance and bathing. Staff informed a resident that he/she needed to wait until another staff was found to help take the resident to the bathroom, both staff passed the resident several times assisting other residents; surveyor approached the resident and resident stated he/she no longer has to use the bathroom because he/she had an incontinent episode in his/her pants. Staff failed to check resident for incontinence or assist to bathroom, several residents not receiving their baths. E
- Failed to provide proper and complete incontinence care; resident had a moderate amount of bowel incontinence. Staff had soiled gloves and continued to provide cares, staff failed to retract resident foreskin, and cleanse the tip of the penis. D
- Facility failed to assist dependent residents with repositioning when residents demonstrated a need to reposition. D
- Facility failed to provide at least two baths for multiple residents. D
- Failed to provide repositioning incontinence care and provide repositioning and incontinence cares for 10.75 hours resulting in two stage 1 pressure sores. D
- Facility failed to reposition residents in a timely manner, resident was not repositioned from 0750 am to 1114. D
- Toileting dependent resident, who is frequently incontinent was not toileted or checked for incontinence for three hours; a similar resident was not toileted for four hours after being incontinent of stool; another resident complained staff did not toilet frequently enough to prevent incontinence and wet clothing and felt embarrassed. E

F678 – Cardio-Pulmonary Resuscitation (CPR)

- Facility failed to provide basic life support on each shift. E

F679 – Activities Meet Interest/Needs of Each Resident

- Several residents did not have documentation of preferred activities and there was no quarterly documentation of activity progress notes for those residents. D
- Failure to assess residents' interest to provide an ongoing activities program. D

F684 – Quality of Care

- Facility failed to properly assess resident's respiratory status and report to the primary care provider in a timely manner. Upon arrival at hospital resident was in respiratory failure due to acute pulmonary edema and pneumonia. Temp was 102. O2 saturation was only 80% and patient required 15 L of oxygen to bring sat to low 90%. Facility had been notified by outpatient ERSD center that resident tested positive for URI six days earlier. D
- Failed to appropriately assess and provide interventions when a resident had a change of condition related to a fall resulting in a fracture. D
- Staff did not follow resident's care plan and reposition at least every two hours. D
- Failed to provide accurate assessment and timely intervention for all residents who have an onset of adverse symptoms which represent a change in condition in regard to C-diff. Loose stools for two weeks. Failed to communicate symptoms to NP timely, failed to consistently assess the resident regarding loose, odorous stools and failed to submit stool specimen until ten days after initially reported symptoms. Lab reports sent to facility d/t unable to run specimen with request for facility to call lab, but no one called the lab. Resident presented with elevated temp and confusion above baseline and transferred to the hospital and passed away from septic shock. **G $10,000 FINE**
- Failed to meet professional standards of practice to ensure residents blood glucose levels are monitored/recorded as ordered and insulin administered per physician's orders. Transcription error on MAR for insulin pen orders causing dramatic swings in blood sugar results. D

F686 – Treatment to Prevent Pressure Ulcers

- Failed to prevent development of stage III pressure ulcer for a resident. Didn't demonstrate the development of pressure sore was unavoidable due to failure to provide adequate pressure reduction after resident was previously bedfast for a stroke. **G $3,000 FINE IN SUSPENSION**
- Failure to complete weekly pressure ulcer assessments. D

F 688 – Increase/Prevent Decrease in ROM/Mobility

- No documentation of restorative therapy provided as care planned/recommended for residents. D
- Failed to ensure a resident with limited range of motion received appropriate treatment to increase ROM and/or prevent further decrease. ROM therapy was stopped when

resident was admitted to hospice. Resident voiced concern and did not understand why exercises stopped. D

- Clinical record lacked documentation that a resident needed a restorative program. Program was not provided to resident. D
- Facility failed to follow therapy recommendations for restorative services. D
- Restorative maintenance program was not completed for residents. D

F 689 – Free from Accidents and Hazards

- Failed to store drugs per currently accepted professional standards. Medication cart left unlocked and unattended. E
- Failed to secure cigarettes and lighters for smoking residents. Cigarettes/lighters noted sitting at nurses' station unsecured. Resident reported they keep my cigarettes at the nurses' station so I can smoke whenever I want. E
- Failed to ensure residents received adequate supervision to protect against accidents. Resident noted in recliner without having call light or phone within reach. Also, noted in room a sign that states "Please Call, don't fall" . D
- Inadequate supervision of a resident in the community resulting in an elopement; staff left a resident with a diagnosis which included Non-Alzheimer's dementia who resides in a locked RCF and is court committed to the facility in the van while staff went into the physician's office to get orders signed; staff returned to the van and resident was not there, staff looked down the alley and didn't see anyone so staff returned the physician's office to ask if the resident may have come in; staff returned to van and her supervisor called asking if she had found the resident. The physician's office had called and reported seeing resident walking in the alley, staff stated she saw a gas station, thought resident may have gone there to get cigarettes. Staff pulled into parking lot and resident was walking out of gas station. **J $4,000 FINE IN SUSPENSION**
- Failed to maintain a safe environment, free from hazards r/t unlocked cabinets containing chemicals noted left unattended thru out the day in kitchenettes. Key was left in the cabinet door unlocked. E
- Failed to follow intervention to prevent a fall, fall intervention instructed staff not to put footrest up on recliner, resident's room also had a sign on the wall that read "Please do not put my feet up when in recliner" and had a picture of a recliner, resident got feet tangled in footrest of the recliner causing fall. **G $6,750 FINE**
- Failed to ensure staff transferred residents according to their assessed needs and care plan; CNA transferred resident that was a two-person transfer by herself and had to lower the resident to the floor. For a resident that was a sit-to-stand transfer, a CNA pivot transferred the resident without a gait belt, dropping resident. D
- Failure to supervise a resident as directed by the care plan. Resident needed toileting help and had to wait to receive. D
- Failed to ensure safety devices in place at all times and ensure safe transfer techniques; Failed to put pull tab alarm in place as per care plan; did not use lifts as required. **G $6,250 FINE**
- Failed to lock brakes on a resident's wheelchair which resulted in an unwitnessed fall. Also failed to use pedals when staff assisted resident down the hall. D

- Failure to implement care plan interventions designed to prevent falls. Personal alarm was not attached to resident as listed in care plan. D
- Resident with BIMS Score of four exited the facility and set off alarms. Staff on duty did not respond to alarms but did see resident outside in facility parking lot, approx. 40 feet from a four-lane street with heavy traffic. Resident was not injured. **J Tag; IHCA has requested the fine amount from DIA but has not received.**
- Facility failed to ensure staff appropriately and safely transferred a resident. Staff lifted back of wheelchair, so wheels were off the floor in attempt to position resident further back in wheelchair during an EZ stand transfer. D
- Facility failed to ensure the resident environment remained as free from accident hazards as possible. Failed to ensure bed frame protective end caps were in place which resulted in the sharp edge of the bed frame coming in contact with resident during transfer causing injuries. Lack of following care plan related to assist of one rather than two. Failed to have system in place to ensure that protective end caps were in place for multiple beds placing residents at further risk. **G TAG; IHCA has requested the fine amount from DIA but has not received.**
- Resident sustained a fractured femur when a staff member transferred the resident independently with a mechanical lift. Roommate stated the resident called out in pain during the transfer. Second resident had multiple falls from wheelchair without care plan interventions being put in place to prevent further falls. A subsequent fall caused a fractured jaw and broken teeth. **G $7,000 FINE**

F 690 – Bowel, Bladder Incontinence, Catheter Care

- Catheter bag was hung beneath wheelchair and touched floor as did tubing. Dignity bag was present but not in use. D
- Failed to document a complete assessment of the resident's bowel/bladder patterns upon admission to the facility and upon return to the facility after hospitalization. E
- Failure to offer toileting assistance to a resident who needs assistance. D
- Facility failed to maintain adequate infection control measures, resident sitting with catheter drainage bag had direct contact with the floor. E
- Failed to provide adequate incontinence care, observation revealed resident to be incontinent of urine through the resident's pants. Staff provided perineal care but did not provide it to areas outside of middle perineal region of resident. D
- Failed to provide incontinent care for multiple residents. Resulted in UIs and bladder infections. D
- Failed to complete bowel and bladder assessments for an incontinent resident in an effort to maintain or reduce incontinence; failed to provide correct incontinence care to minimize the risk of infection. D
- Failed to ensure incontinence care was completed in a manner to prevent infection, odor, skin breakdown. Used scrubbing motion without turning wipe to clean area. Wiped back to front on buttocks crease. Placed clean brief in place prior to changing dirty gloves. D

- Failed to change gloves and complete incontinent care. Staff applied gloves and proceeded to adjust clothing, touch items prior to using same gloves to wipe resident. Did not offer to provide incontinence care (residents brief had been wet prior to toileting). D
- Failed to complete peri care. Supplies not gathered prior to toileting. Resident left on toilet unattended to get needed supplies. Did not dry skin after peri care. D

F 692 – Nutrition/Hydration Status Maintenance
- Resident with significant weight loss and orders to receive nutritional supplements had none been receiving supplements for three months. D
- Failed to provide sufficient fluid intake to maintain proper hydration; resident on thickened liquids that are not available unless dietary staff are there to mix them. D
- Failed to ensure fluids readily accessible to residents when in bed. Water jugs no within reach. D

F 693 – *Tube Feeding Management/Restore Eating Skills
- Resident laid in bed with feeding tube running and head flat on bed when head of bed should have been elevated 30-45 degrees. D
- Prior to medication administration for a resident with a G-tube, staff failed to check for tube placement and check for residual. D

F 695 – *Respiratory/Tracheostomy care and Suctioning
- Facility did not have tracheostomy care policy/procedure and properly trained nursing staff to provide care for a trach that required cleaning/changing due to accumulating secretions. Improper insertion of trach tube by an untrained nurse caused resident discomfort and subsequent cough, bloody secretions. Resident requiring BiPap with oxygen at HS had no physician orders listed on MAR for this treatment. D
- Failure to provide infection control measures for oxygen services for multiple residents. Nebulizer mask hanging off back of bedside stand touching the floor and oxygen tubing attached to the portable oxygen of the wheelchair was draped over the wheelchair with nasal cannula piece touching the floor. D
- Failed to assess resident's blood oxygen saturation levels and ensure humidification water bottle for oxygen use contained water, failed to label/date oxygen equipment to ensure clean. Care plan lacked documentation to support oxygen use. D

F697 – *Pain Management
- Facility failed to provide prompt pain relief. D

F 698 – Dialysis
- Facility failed to complete pre and post dialysis assessments on three residents. D
- Facility did not complete pre and post dialysis assessments. D
- Failure to complete nursing assessments and monitoring before and after outpatient dialysis for multiple residents. D
- Failed to consistently complete nursing assessments and monitoring of vital signs before and after dialysis treatments. D

- Failed to consistently complete nursing assessments and monitoring of vital signs before and after dialysis treatments. (NONE)
- Failed to complete nursing assessments and monitoring of a resident when they returned from outpatient dialysis. D
- Failure to complete nursing assessments and monitoring before and after outpatient dialysis for multiple residents. D

F 700 – Bedrails

- Two residents with siderails had no documentation of informed consent, nursing assessment of need for rails, or maintenance assessment of rails. D
- Failed to assess each resident for use of side rails, review risks and benefits with the resident or representative and obtain informed consent. D
- Failed to review risks vs benefits with resident and/or representative for use of grab bars; no signed consent for use. E
- Failure to assure side rails are in compliance with safety guidelines to reduce risk of entrapment which resulted in immediate jeopardy to resident's safety. Lack of alternative interventions attempted, review of risks and benefits with resident reps, or informed consent. **J $7,250 FINE in suspension**
- Failure to assess each resident for risk of entrapment of bed side rails. Lack of alternative interventions attempted, review of risks and benefits with resident reps, or informed consent. D
- Failure to carry out side-rail assessments for majority of residents in facility. Lack of documentation of use of siderails. E
- Failed to assess bed rails for risk of entrapment and obtain consent for use of side rails for residents. Several beds noted to have measurements for entrapment greater than recommended 4 3/4 inches. Lack of bed rail assessments/consents throughout facility. **Abated IJ K $23,250 FINE IN SUSPENSION**

F 725 – Sufficient Nurse Staffing

- Facility failed to ensure resident call lights and needs were answered/met in a timely manner (no longer than 15 min). E

F727 – RN 8 Hrs/7days/Wk, Full-time DON

- Facility did not have RN coverage for at least eight contiguous hours each day. DON thought hours reported ran from 6 am one day to 6 am the next, rather than midnight to midnight as required. D
- Failure to ensure an RN was on duty eight hours daily seven days per week. D
- Failed to have eight hours of RN coverage for one day during a 30-day period. B

F728 – Facility Hiring and Use of Nurse

- Failure to verify a CNA certification for newly hired CNA prior to working in facility. D

F729 – Nurse Aide Registry Verification, Retraining

- Failed to verify eligibility with the C.N.A registry prior to employment. (NONE)

- Facility failed to verify certification for the nurse aide form the direct care worker. D

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

- No documentation of prior year's CNA in-services was provided. D
- Fail to ensure CNAs received minimum12-hours of in-service education per year. D
- Failure to ensure nurse aides completed 12 hrs. of in-service training on an annual basis for multiple CNAs employed by the facility for more than a year. B
- Facility failed to assure all CNAs received 12 hours of yearly education in-services and to complete the annual performance evaluations. D

F 732 – Posted Nurse Staffing Information

- Facility failed to post complete staff posting during the survey, lacked total number of hours worked for LPNs, RNs, CNAs, CMAs, and lacked the facility census. B

F745 – Provision of Medically Related Social Services

- Failure to obtain a social history and provide social services for resident. D

F756 – Drug Regimen Review

- Failure to act on pharmacy recommendations for gradual does reduction for a resident. D
- Failed to document appropriate diagnosis for psychotropic medication; medication regimen review lacked documentation the pharmacist reported the irregularities for duplicate antipsychotic therapy to the physician. D
- Fail to address each psychotropic medication on drug regimen review. Pharmacist report listed all psychotropic medication on one sheet. Physician made no changes. Physician failed to address each medication individually. D

F757 – Drug Regimen- Free from Unnecessary Drugs

- Failure to assure use of non-pharmacological approaches prior to administration of Lorazepam; failed to document rationale for usage beyond 14 days for a resident. D
- Facility failed to adequately monitor for a resident receiving warfarin, clinical record revealed no documentation of an INR being completed. D

F758 – Free from Unnecessary Psychotropic Meds/PRN Use

- No physician documentation provided for failing to attempt a gradual dose reduction for resident on psychotropic med. D
- No documentation of physician response to consultant pharmacist's recommendation for gradual dose reduction. D
- Facility failed to ensure interventions were attempted to reduce behaviors before administration of prn anti-anxiety agent. D
- Facility failed to limit the timeframe for PRN psychotropic medication that was not an antipsychotic to 14 days unless a longer timeframe is deemed appropriate by a physician. D

- Facility failed to renew an order for an antianxiety medication ordered to be given as needed after 14 days. No stop date on a PRN Ativan order. D
- Failure to ensure residents are free from unnecessary Psychotropic Meds/PRN Use. NONE
- Fail to assure GDR's were attempted for psychotropic medications such as antianxiety, antipsychotic, PRN psychotropic use (Ativan) not reviewed after 14 days. D
- Failed to ensure residents were free of unnecessary psychotropic as needed, antianxiety medication was ordered without a stop date. D
- Failure to appropriately gradually reduce dose of antipsychotic for a resident. D
- Failed to assure appropriate rationale of gradual dose reduction attempts. GDR form lacked rationale from physician regarding why no attempt was to be made to reduce the antidepressant. D
- Failure to document non-pharmacological interventions prior to administering an anti-anxiety medication for several residents. D

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

- Failed to administer medications per physician's orders; gave one spray of Flonase instead of the ordered two sprays and waited only 30 seconds between Spiriva and Advair administration. D

F760 – *Residents Are Free of Significant Med Errors

- Failed to ensure resident didn't experience a significant medication error. Resident's physician ordered staff to administer a diuretic and staff failed to implement the order until four days later resulting in significant decline in resident's condition and hospitalization. **J $8,000 FINE IN SUSPENSION**
- Failure to prime an insulin Flexpen prior to administering insulin to ensure the proper amount was administered. D

F761 – Label/Store Drugs & Biologicals

- Multiple vials of insulin were stored unsecured in a locked shower room and accessible to all staff members. D
- Failure to properly label medicines for a resident. D

F770 – Laboratory Services

- Failed to provide laboratory services to meet the needs of the resident with C-diff. Failed to communicate with lab dept to complete labs in a timely manner. D

F801 – Qualified Dietary Staff

- Failed to ensure the Dietary Service Manager had the required qualifications in the absence of a fulltime dietician; had not taken CDM examination. E
- Failure to ensure dietary service manager had required qualifications. DM was not certified for DM. C

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

- Facility failed to serve the proper portion of ground meat for a resident, failed to have a policy on therapeutic diets. D
- Failure to ensure menus Meet Res Needs/Prep in Advance/Followed- Failed to properly follow serving procedures for pureed meals. (NONE)
- Failure to ensure residents on a mechanical soft or pureed texture diet received proper portion sizes as planned. E
- Failed to ensure correct portion size used for mechanical soft and pureed diets. (NONE)
- Failed to ensure residents on pureed diet received the correct serving portion as planned during observation of the lunch meal service. D
- Failed to serve the proper amount of pureed chicken. E

F812 – Food Procurement, Storage, Preparation, Sanitization

- Several dietary staff members failed to have all hair covered; dozen spilled foods noted in freezer. E
- Dietary staff members did not have all hair covered; staff member who had been using sanitizer to clean in kitchen did not wash hands prior to scooping vegetables into blender; improper use of gloves when making sandwiches; dust found kitchen, dead fly stuck to range hood. E
- Dietary staff did not have all hair covered; dusty surfaces in kitchen. E
- Cookie sheets with carbon, cupboard and drawer handles in dining room with sticky substance. E
- Facility failed to handle food in a sanitary manner, dry storage room revealed an open undated bag of croutons, unsealed box of uncooked potato casserole, box containing open blue bag filled with uncooked rice, two shelved silver cart holding mixing bowls/measuring cups showed multiple dried white food particles on cart shelves, kitchenette revealed refrigerator contained fruit box with no date, brown liquid spilled on top and bottom refrigerator shelves, large steel output fan in kitchen located above stationary mixer with significant amounts of dust hanging on blades, cart near the stove with three shelves containing multiple food crumbs on bottom two shelves especially heavy in corners, and opening of freezer door a medium spill of a light brown sticky substance running down onto top shelf. Lunch service staff handling food with gloved hands were not changing their gloves if they touched any other surfaces. E
- Food Procurement Store/Prepare/Serve-Sanitary- Failure to follow cleaning procedures, appropriate hygiene and use of hairnets. (NONE)
- Failure to distribute and serve food in a sanitary way in memory care unit. CNA wore same gloves to deliver plated food to multiple residents. Then rested gloves on counter and continued to serve plated food to residents. E
- Failure to handle food items as required and ensure they were properly labeled and dated in multiple kitchenettes. E
- Failed to prepare pureed foods properly and serve in a sanitary manner; only one bread serving added to five pureed diets, uncovered serving utensils transported, thermometer used to test food temps removed from staff pocket and not sanitized before temps taken, wiped thermometer on apron in between food temps and at the end of taking temps, same bowl was used twice to reheat soup. E

- Facility failed to serve food in accordance with professional standards for food safety; observation revealed fire suppression system over the stove burners contained a buildup of dust/debris. Staff had hair hanging out the back of her hairnet, hairnet failed to fully cover the back of staff's head, staff prepare and served food. D
- Failure to maintain a clean and sanitary kitchen. Staff used bare hand contact when preparing and serving meals to residents. Some food had black substance or mold. Oven doors and other kitchen equipment had stains and built-up substances. Improper use of sanitizer concentrations in dishwasher. E
- Failed to deliver residents' meals in a sanitary manner. Failed to perform appropriate hand hygiene before handling resident's plates/bowls that contained food. Staff touched face, hair, glasses, lips, neck, necklace, iPad while delivering food to residents without washing hands. E
- Failed to provide proper storage of food. Opened food items in community refrigerator without open dates (coffee creamer, juice, Wendy's cup of chocolate ice cream in freezer, ranch dressing, chocolate syrup, mustard). E
- Failed to properly prepare and test sanitizer, store clean serving utensils in a manner to avoid contamination and handle ready-to-eat food items in a manner to reduce risk of contamination and food-borne illness. Tongs hung on wall in front of air conditioner with dust present, dust build up on oscillating fan. Books present with grime/stain buildup. Red sanitation bucket could not be checked because had no strips available. Touching toast with bare hands to butter toast then use tongs to place toast on plate. E
- Failed to handle food under sanitary conditions; touched multiple surfaces with gloved hands then touched ready-to-eat food served to the resident. E
- Facility did not ensure a sanitary environment for food preparation and storage and that outdated foods were not readily available for residents. Cobwebs on ceiling and packages of bread with expired use by dates. E

F825 – Provide/Obtain Specialized Rehab Services

- Failed to provide restorative therapy as directed per resident's care plans as reported during group interview; failed to provide restorative services to multiple residents 3-6times per week. Staff reported due to call-ins, restorative staff would be pulled to the floor. E

F839 – Staff Qualifications

- Failure to verify nurse licensure prior to employment. (NONE)
- Facility failed to verify nursing license; failed to obtain information regarding the nurses' license for staffing agency. D

F 868 – QAA Committee

- Failure to hold Quality Assessment and Assurance Committee meetings at least quarterly; minimum attendance requirement not met. C
- Failure to ensure effective quality assurance program was in place to provide quality care to residents. No documentation to support the facility monitored or focused on these repeat citations. D

F 880 – Infection Prevention and Control

- Staff member, while performing peri care, did not wash hands after removing wet brief and prior to applying clean one; during catheter care, collection bag was lying directly on floor. D
- During dressing change, nurse failed to sanitize scissors stored in uniform pocket prior to use and did not sanitize them after use. D
- Facility failed to conduct an annual review of its IPCP and update their program; failed to prevent the indwelling catheter tubing from touching the floor. D
- Failure to place barrier between overbed table and supplies when completing blood sugar test. Failed to adequately disinfect glucometer machine after resident use. E
- Failure to maintain infection prevention; Resident's bag was hanging off back of the wheelchair and catheter tubing/clip drug on floor during meal and outdoor visit. D
- Failure to utilize proper infection control techniques when completing care. Cleansed scissors placed on medication cart without a clean barrier. Cath tube was sitting on floor near wheelchair. Failure to change gloves between cares. D
- Failed to use appropriate hand hygiene practices during catheter cares. D
- Failed to maintain infection control related to wound care and transport of clean laundry down hall without cover. E
- Failure to follow standard precautions when providing care and administering injections. Resident had bowel incontinence and loose bowel movement soiled the mattress, staff placed soiled linens directly on the floor, and used a disposable wipe to clean the soiled mattress; staff failed to disinfect the floor and mattress. D
- Facility failed to ensure staff utilized proper infection control technique when providing care; staff cleansed bowel movement from resident's rectum into the open wound on buttocks, RN proceeded to apply a dressing over soiled open wound. E
- Fail to follow infection control practice by ensuring laundry water temperatures are greater than 160 by covering linens when delivering clean laundry to storage. F
- Failure to place a barrier under supplies when completing dressing change to a pressure sore. D
- Failure to disinfect scissors after wound care; failed to keep indwelling catheter tubing off floor and keep the catheter bag in dignity bag; failed to follow proper infection control techniques with wound and dressing change; failed to utilize proper hand hygiene with incontinence care. E
- Staff failed to use alcohol pad to cleanse tubing when emptying collection bag. D
- Failed to follow appropriate measures for prevention of infection with application of eye drops. Staff placed the inside area of eye bottle cap onto countertop, then returned the bottle to the medication cart. Did not use a barrier, did not cleanse the bottle prior to putting in medication cart. D
- Failed to maintain proper infection control measures in accordance to professional standards for catheter cares. Catheter tubing dragging on floor from wheelchair Resident has history of UTI's. D
- Failed to provide safe, sanitary, comfortable environment and help prevent transmission of pathogens. Placed EZ stand sling on resident with soiled BM and sat

resident in wheelchair with no barrier or pad. Took to shower room, transferred to shower chair. Wiped off seat of wheelchair, placed resident's protective boots on seat during shower. No barrier between graduate/floor when emptying cath bag. D

F909 – Resident Bed

- Failure to conduct inspection of bed rails for multiple residents. Facility lacked documentation of a maintenance assessment completion. D

F918 – Bedrooms Equipped/Near Lavatory/Toilet

- Failure to assure all accessible toilet facilities were adequately equipped with a call light system. E

F921 – Safe/Functional/Sanitary/Comfortable Environment

- Facility failed to maintain sanitary toilet facilities and furniture for residents and visitors. Chairs had dried brown material on seat surfaces, in the bathroom between rooms were two spots of a dried brown substance on top of the floor's non-skid strips, toilet riser contained a 6x6 inch area of dried brown material on the inside surface, another riser contained an approximately 2x2 inch area of dried brown material on the inside surface, toilet riser in place underside contained approximate dried brown material; the riser itself appeared clean. E

F947 – Required In-Service Training for Nurse Aides

- Facility did not have records of annual dementia training for all direct care workers. B

L190

- Facility failed to provide documentation to confirm that a new employee received the required TB test prior to working.
- During peri care, a staff member wearing soiled gloves touched a mechanical lift and other surfaces without changing gloves.

Nursing Facility Survey Frequency

As of September 5, 2019, CMS lists 63 Iowa facilities (14.4%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 7.4%. National average is 5.8%.

SFY 19 - August Totals - LTC Surveys				
Provider	**City**	**Survey End Date**	**Previous Date**	**Months Between**
Accura Healthcare of Aurelia, LLC	Aurelia	6/20/2019	3/15/2018	15.40
Accura Healthcare of Marshalltown, LLC	Marshalltown	6/27/2019	3/15/2018	15.63
Accura Healthcare of Ogden, LLC	Ogden	5/2/2019	1/9/2018	15.93
Arbor Court	Mt. Pleasant	5/8/2019	1/9/2018	16.13
Belle Plaine Specialty Care	Belle Plaine	6/20/2019	3/15/2018	15.40
Briarwood Health Care Center	Iowa City	6/20/2019	4/12/2018	14.47
Burlington Care Center	Burlington	5/16/2019	1/30/2018	15.70
Cedar Falls Health Care Center	Cedar Falls	6/27/2019	3/22/2018	15.40
Chautauqua Guest Homes #3	Charles City	6/6/2019	3/1/2018	15.40
Cherokee Specialty Care	Cherokee	5/2/2019	1/18/2018	15.63
Clearview Home - Mt. Ayr	Mt. Ayr	6/12/2019	3/8/2018	15.37
Colonial Manor of Amana	Amana	6/15/2019	3/8/2018	15.47
Corning Specialty Care	Corning	6/26/2019	3/15/2018	15.60
Crestview Specialty Care	West Branch	6/12/2019	3/8/2018	15.37
Davenport Lutheran Home	Davenport	6/12/2019	3/22/2018	14.90
Dumont Wellness	Dumont	6/12/2019	3/29/2018	14.67
Fellowship Village	Inwood	5/30/2019	2/22/2018	15.40
Fountain West Health Care Center	Des Moines	6/27/2019	3/22/2018	15.40
Friendship Home	Audubon	6/15/2019	3/8/2018	15.47
Good Neighbor Home	Manchester	6/6/2019	2/22/2018	15.63

Good Sam - Postville	Postville	6/20/2019	3/22/2018	15.17
Good Sam - St Ansgar	St Ansgar	6/12/2019	3/8/2018	15.37
Guttenberg Care Center	Guttenberg	5/9/2019	2/8/2018	15.17
Hawkeye Care Center of Dubuque	Asbury	6/27/2019	3/15/2018	15.63
Little Flower Haven	Earling	5/11/2019	1/9/2018	16.23
Living Center West	Cedar Rapids	5/2/2019	2/8/2018	14.93
Lutheran Retirement	Northwood	6/20/2019	3/19/2018	15.27
Manorcare Health Services - Waterloo	Waterloo	05/08/2019	01/30/2018	15.43
Manorcare Health Services - Dubuque	Dubuque	06/20/2019	03/01/2018	15.87
Meth Wick Health Center	Cedar Rapids	5/16/2019	2/15/2018	15.17
Newton Healthcare	Newton	5/8/2019	2/15/2018	14.90
Northern Mahaska Specialty	Oskaloosa	6/12/2019	3/15/2018	15.13
Northridge Village	Ames	6/27/2019	4/17/2018	14.53
Osage Rehab & Health Care Center	Osage	6/6/2019	2/22/2018	15.63
Pearl Valley Rehabilitation & Healthcare	Estherville	5/8/2019	2/8/2018	15.13
Prairie View Home	Sanborn	6/6/2019	3/1/2018	15.40
QHC Winterset North	Winterset	6/20/2019	3/21/2018	15.20
Red Oak Health Care Center	Red Oak	5/8/2019	1/30/2018	15.43
Rehab of Allison	Allison	6/13/2019	3/29/2018	14.70
Rehab of Des Moines	Des Moines	6/6/2019	3/5/2018	15.27
Rolling Green Village	Nevada	6/12/2019	3/29/2018	14.67
Rose Haven	Marengo	6/27/2019	4/26/2018	14.23
Southern Hills Specialty Care	Osceola	5/16/2019	2/22/2018	14.93
Spurgeon Manor	Dallas Center	5/2/2019	1/18/2018	15.63
Sunny Brook Living Care Center	Fairfield	6/6/2019	4/5/2018	14.23
Sunrise Hill Care Center	Traer	5/11/2019	2/15/2018	15.00

Tabor Manor	Tabor	6/5/2019	3/1/2018	15.37
Tru Rehab of Grinnell	Grinnell	05/02/2019	1/30/2018	15.23
Union Park Health Services	Des Moines	06/27/2019	5/24/2018	13.30
			AVERAGE	**14.90**