Compliance Tips from IHCA's Survey Results Committee

December 2016

The five most frequently cited tags from the 38 annual surveys (9 deficiency free), 25 complaints (17 unsubstantiated), 21 self-reports (7 unsubstantiated), 18 complaint/self-report (3 unsubstantiated) and 1 mandated reports (0 unsubstantiated reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 183 total reported citations.

The following is a breakdown of severity level:

A =	0.00%	D =	57.38%	G =	7.10%
B =	1.09%	E =	20.22%	H =	0.55%
C =	0.55%	F =	6.56%	I =	0.00%
				J =	4.37%
				K =	0.00%
				L=	0.55%

Total # of Reports: 98
Total # of surveys/reports deficiency free or unsubstantiated: 36
Avg. # of deficiencies

- All = 1.86
- Annual = 3.08
- Complaints = 1.14
- Self-reports = 1.22
- Complaint/Self-Reports= 1.79
- Mandatory =1

Total state fines for November Report = $8,500 ($102,500 held in suspension)

Be sure to read the Annual Survey Frequency December Survey Results on the last page!

Top 5 Most Frequently Cited Tags for November 2016 Report

F 323—Free of Accident Hazards/Supervision/Devices

- Multiple instances of resident-to-resident abuse causing bruising and redness **$24,000 fine** in suspension (G)
- A blind resident with a history of wandering eloped outdoors through a gated courtyard, alarms did not function; another resident rolled out of bed, head struck wall causing a hematoma **$15,000 fine** (J)
- Resident rolled out of bed during cares **$8,000** fine (J)
- Resident found on bathroom floor, barefoot, but care plan called for resident to wear gripper socks **$8,000 fine** (G)
- Facility clinical staff failed to follow resident's care plan concerning interventions to prevent falls, staff left the resident alone in his/her room, failed to use gait belt when transferring resident resulting in a number of falls **$6,000 fine** ($2,000 trebled) (G)
- Facility clinical staff failed to follow care plan to prevent a resident's fall, staff left a "fall risk" resident unattended, resident fell **$5,000 fine** (G)
- Facility clinical staff attempted one-person transfer when the care plan called for a two-person transfer, resident fell with fracture **$5,000 fine** in suspension (G)
- Staff sprayed resident in face with hand-held shower when resident became verbally abusive during shower **$500 fine** in suspension (G)
- Elopement from hospital-based nursing facility (J)
- Facility failed to provide proper supervision and implement interventions to prevent resident-to-resident abuse, and falls with injury (H)
- Resident-to-resident abuse—one resident slapped another (G)
- Facility clinical staff failed to provide accurate supervision for a resident needing a gait belt (that wasn't used) facility failed to investigate falls (G)
- Staff failed to follow care plan—plan called for two-person transfer; resident transfer was attempted by one staff, resulting in fall with fracture (G)
- Staff observed pushing residents in wheelchairs without foot pedals attached; failed to move bed rail side rail up for bed mobility (E)
- Facility's entrance/exit door not alarmed (E)
- Facility did not provide adequate supervision for wandering resident in CCDI unit which ended with resident suffering mouth laceration (D)
- Facility staff conducted a mechanical lift transfer of resident without locking the shower chair wheels (D)
- Facility failed to develop care plan interventions for resident who had fallen (D)
- Facility staff failed to use a gait belt per care plan, resident fell during transfer an sustained a bruise (D)
- Resident attempted suicide; facility failed to have interventions in place (D)
- Facility staff transporting resident in wheelchair failed to have foot pedals attached (D)
- Resident's care plan called for two-person transfer; staff attempted one-person transfer, resident fell with fracture (D)
- Resident put pillow over other resident's face when sleeping, resident had other incidents of resident-to-resident abuse behaviors, hit on back, threw hot coffee on another resident (D)

- Resident-to-resident abuse—one resident kicked another resident (D)

F-157—Notification to Family and Physician of Injury, Significant Change in Condition

- Facility failed to notify physician of missed trazadone and tramadol not given four times (D)
- Facility clinical staff failed to inform physician for a change in condition, resident developed abnormal heartbeat (D)
- After facility clinical staff began administration of a new medications, resident complained they were "groggy" but staff failed to report this to the resident's physician (D)
- Facility failed to notify resident's family of a change in condition for medication dosage increase, new pain medications (D)
- Facility failed to inform family and physician of resident's weight loss outside of parameters (D)
- Facility failed to notify family when the resident suffered a seizure at the dining room table (D)
- Facility failed to inform family and physician of resident-to-resident abuse; resident walked up behind another resident and squeezed his/her neck; was not reported until four days later (D)
- Facility failed to notify family and physician of resident decline who had been receiving tube feedings (D)
- Facility failed to notify family members regarding a medication change and a significant behavioral change (D)
- Facility staff failed to report a resident's new skin condition to the family in a timely manner; physician was not notified of blisters on resident's hand (D)

F 281—Professional Standards of Quality

- Physician ordered 88 mg Synthroid daily and directed clinical staff to test for thyroid level and lipids every 365 days; licensed practical nurse interviewed said resident failed to have blood work done this year due to a computer glitch; the test orders should have been entered every 364 days, as 365 days was in excess of one year (D)
- Facility clinical staff failed to follow physician's order for a pillow between resident's legs when turning (D)
- Facility clinical staff failed to document daily weight for resident with weight loss (D)
- Facility clinical staff administered expired (three days) Lantus insulin to resident (D)
- Facility clinical staff failed to prime insulin pen; also administered wrong oxygen administration rate for resident (D)
- Clinical staff recorded resident weight gain of more than three pounds within 24 hours; greater than five pounds within a week, five instances of weight measures exceeding these parameters but was not reported to ARNP; two-step TB test not completed (second step not completed); medications pass—resident observed

waiting for breakfast, staff failed to prime Novalog flex pen before administering (D)
- Resident's medication order lacked physician's signature (D)
- Facility staff failed to note order for laxative (D)
- Facility staff failed to complete a physician's orders for MMS test on resident (D)
- Facility clinical staff failed to follow physician's orders for application of skin ointment (D)

F 312—Necessary Services to Maintain Good Nutrition, Grooming, Hygiene (ADLs)

- Facility clinical staff failed to wash resident's face and hands or provide oral care (E)
- Staff provided incomplete incontinence care for three of nine residents and inadequate oral care for one of five residents; staff failed to wash front perineal area, clean soiled area twice daily, staff wiped with downward motion over genitalia five times, without changing cloth surface, staff failed to wash left hip and buttocks; oral care—resident lacked teeth, staff failed to offer daily mouth rinse (D)
- Resident's entire peri area not cleansed during cares (D)
- Resident t waited too long before staff helped him/her to the toilet (D)
- Facility clinical staff failed to complete peri care, staff did not cleanse the resident's front peri area, failed to wash left buttock (D)
- Perineal care—staff did not use wet or soapy cloths when providing care (D)
- Facility staff failed to shave male resident daily (D)
- Incontinence care—facility clinical staff cleanse rectal area from back to from (D)
- Facility staff failed to provide assistance with oral care (D)

F309—Services to Provide the Highest Practicable Physical, Mental and Pyscho-Social Well-Being

- A resident with declining respiratory status; staff did not administer CPR immediately **$10,000 fine** (J)
- Facility clinical staff failed to assess resident's skin impairments until one month later **$2,500 fine** (D)
- A resident's Hospice care plan was not updated to reflect the safety issues when the resident self-ambulated (D)
- Resident with multiple wounds—vital signs not measured, edema on legs not documented, weekly skin assessments not completed (D)
- Clinical staff failed to do a complete assessment on a change in condition (skin condition—blisters on resident's hand), poor assessment (D)
- Clinical staff used wrong sized lift sling when lifting resident (D)
- A resident with urinary tract infection symptoms did not get a urinary analysis for many days, antibiotic treatments not started for seven days (D)
- Facility clinical staff left resident on bed pan for more than three hours multiple times (D)

- Facility failed to develop interventions to prevent skin integrity from worsening 9D)

F329—Freedom from Unnecessary Drugs

- Facility clinical staff failed to monitor Coumadin and complete laboratory checks as physician ordered, and failed to assess resident's bleeding as a s/s of adverse side effects (J)
- Facility failed to document justification for the use of Risperdal, resident became lethargic and at times combative **$2,000 fine** (G)
- Facility clinical staff failed to attempt and document non-pharmacological interventions prior to administering PRN psychotropics—five instances (E)
- Facility failed to implement interventions for PRN hypnotics (D)
- Facility clinical staff did not attempt non-pharmacological interventions prior to administration of anti-anxiety medications (D)
- Resident was started on psychotropic drugs without supporting diagnosis—only had "dementia" listed (D)
- Facility staff failed to attempt non-medication interventions prior to use of lorazepam (D)
- Staff administered PRN Ativan to resident prior to attempting any non-pharmacological interventions (D)

Other notable deficiencies and fines

F-223

- Sexual assault—resident with extensive sexual behaviors sexually assaulted his/her roommate **$8,000 fine** (J)
- A resident pulled another resident from his/her bed causing hip fracture (J)

F-224

- Facility failed to develop interventions to prevent resident from pulling another resident out of his/her bed and cause further injury; resident had history of aggressive behaviors prior to admission (J)
- Facility failed to prevent resident-to-resident altercation (G)

F-225

- Certified Nursing Assistant posted photo on Snapchat of resident shower room **$5,000 fine** in suspension (L)
- Facility failed to report resident-to-resident abuse to DIA for four days**;** resident choked another resident **$500 fine** (F)
- A resident alleged that a staff member took a photo of them in the shower; not reported to DIA with 24 hours **$500 fine** (D)
- Facility failed to report incident of resident-to-resident abuse to DIA within 24 hours **$1,500 fine** ($500 trebled) (D)

F-226

- Facility failed to complete a criminal background check **$500 fine** (E)
- Facility failed to complete criminal background checks prior to employment **$8,000 fine**; and failed to provide dependent adult abuse training **$500 fine** (D)
- Facility failed to submit criminal background check to DHS for evaluation prior to hiring **$500 fine** (D)

F-241

- Facility staff failed to maintain resident's dignity; resident complained call light was not answered in a timely manner, resident was incontinent and it made her feel bad about herself; resident experienced past urinary tract infections **$1,500 fine** (G)

F-314

- Facility clinical staff failed to follow interventions to prevent pressure sores on resident's heel from worsening, interventions not always in place **$3,000 fine** (G)

L-257

- No Veterans' Administration screens completed

L 286

- Resident was not asked regarding eligibility for Veterans' Administration benefits with 30 days of admission

L1093

- Veteran's Administration checks not completed

Annual Survey Frequency
December Survey Results Meeting

Facility	City	Last Year	This Year	Frequency
Aase Haugen	Decorah	11/19/15	11/10/16	51 Weeks
ABCM Rehab West	Independence	12/17/15	11/17/16	48 Weeks
Accura Health Care	Ogden	12/3/15	11/10/16	49 Weeks
Arbor Court	Mount Pleasant	12/10/15	11/10/16	48 Weeks
Brooklyn Estates	Brooklyn	12/23/15	11/23/16	48 Weeks
Chautauqua Guest Home #2	Charles City	11/19/15	11/17/16	52 Weeks
Colonial Manor of Elma	Elma	11/12/15	11/3/16	51 Weeks
Country View Manor, Inc.	Sibley	1/7/16	10/27/16	42 Weeks
Fleur Heights Center Well/Rehab	Des Moines	12/3/15	11/17/16	50 Weeks
Fonda Specialty Care	Fonda	12/22/15	11/17/16	47 Weeks
Garden View	Shenandoah	12/17/15	11/3/16	46 Weeks
Happy Siesta	Remsen	10/15/15	9/22/16	49 Weeks
Hawkeye Care Center	Sioux Rapids	8/6/15	6/9/16	45 Weeks
Highland Ridge Care Center	Williamsburg	12/23/15	11/17/16	47 Weeks
Iowa Lutheran Hospital	Des Moines	12/30/15	11/23/16	47 Weeks
Iowa Masonic Home	Bettendorf	11/19/15	11/10/16	51 Weeks
Keystone Nursing Care	Keystone	11/25/15	11/23/16	52 Weeks
Little Flower Haven	Earling	1/7/16	11/10/16	45 Weeks

Lone Tree Health Center	Lone Tree	11/25/15	11/8/16	49 Weeks
Mechanicsville Specialty Care	Mechanicsville	11/12/15	10/27/16	50 Weeks
Mercy Medical Center	Dyersville	12/22/15	11/23/16	48 Weeks
Northbrook Manor	Cedar Rapids	11/19/15	11/3/16	50 Weeks
Oskaloosa Care Center	Oskaloosa	12/17/15	11/17/16	48 Weeks
QHC Ft. Dodge Villa	Fort Dodge	12/31/15	11/14/16	45 Weeks
River Hills Village	Keokuk	12/3/15	11/3/16	48 Weeks
Sheffield Care Center	Sheffield	12/10/15	11/23/16	50 Weeks
Shell Rock Senior Living	Shell Rock	11/25/15	11/23/16	52 Weeks
Southfield Wellness	Webster City	11/19/15	11/2/16	50 Weeks
Spurgeon Manor	Dallas Center	12/17/15	11/10/16	47 Weeks
The Bridges of Ankeny	Ankeny		11/10/16	(Initial Survey)
Tru Rehab of Grinnell	Grinnell	12/10/15	11/17/16	49 Weeks
Wellington Place	Decorah	12/3/15	11/17/16	50 Weeks

Of the (31) Tabulated Annual Surveys Reviewed in December:

All the Annual Surveys were earlier than last year:

Earliest Surveys:

Country View Manor, Inc.	Sibley	1/7/16	10/27/16	42 Weeks
Hawkeye Care Center	Sioux Rapids	8/6/15	6/9/16	45 Weeks
Little Flower Haven	Earling	1/7/16	11/10/16	45 Weeks
QHC Ft. Dodge Villa	Fort Dodge	12/31/15	11/14/16	45 Weeks

Average Survey Frequency:	**December Survey**	**48.52 (3½ Weeks Early)**
	November Survey Meeting	**48.03 (4 Weeks Early)**
	October Survey Meeting	**47.04 Weeks**
	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**
	May Survey Meeting	**46.60 Weeks**
	April Survey Meeting	**48.50 Weeks**