Compliance Tips from IHCA's Survey Results Committee
December 2018

Total Number of Survey Reports: 56

Survey Composition:

Annual:	32 Surveys	3 Deficiency Free
Complaints:	45 Surveys	15 Unsubstantiated
Self-Reports:	30 Surveys	9 Unsubstantiated
Mandatory Reports:	3	

State Fines:	$22,650
State Fines in suspension:	$62,250
Trebled Fines:	$30,750

Most Commonly Cited Iowa Tags (Ascending Order):

F 689 – Free from Accidents and Hazards

F 656 – Develop/Implement Plan of Care

F 880 – Infection Prevention and Control

F 658 – Services Provided Meet Professional Standards

F 684 – Quality of Care

F 623 – Notice Requirements Before Transfer/Discharge

Tags Resulting in Actual Harm or Higher Citations:

F 686 – Treatment to Prevent Pressure Ulcers	**3 G Level Tags**
F 689 – Free from Accidents and Hazards	**6 G Level Tags, 3 J Level Tags**
F 700 – Bedrails	**1 K Level Tag**
F 757 – Drug Regimen is Free from Unnecessary Drugs	**1 J Level Tag**

Top 10 National F-Tags*

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=15747		Total Number of Surveys=70021
F0880	Infection Prevention & Control	5,697	33.2%	8.1%
F0689	Free of Accident Hazards/Supervision/Devices	5,123	25.8%	7.3%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	4,413	26.5%	6.3%
F0656	Develop/Implement Comprehensive Care Plan	4,298	24.3%	6.1%
F0684	Quality of Care	3,793	19.8%	5.4%
F0761	Label/Store Drugs and Biologicals	2,884	17.5%	4.1%
F0657	Care Plan Timing and Revision	2,802	16.2%	4.0%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	2,421	13.1%	3.5%
F0758	Free from Unnec Psychotropic Meds/PRN Use	2,342	14.2%	3.3%
F0677	ADL Care Provided for Dependent Residents	2,289	12.3%	3.3%

*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 C-tag and F-tag number)

C 138 (State Tag)

- Facility did not report an accident causing major injury to DIA as required in state regulations

C 139 (State Tag)

- Facility failed to report a fall with major injury. Previous DON had been on vacation and no one else knew how to do a self-report. **$500 FINE**

F 557 – Respect, Dignity/Right to have Personal Property

- Staff nurse was rude to residents, rough during resident care & ordered residents to return to bed if up at night. (E)

F 558 – Reasonable Accommodations of Needs/Preferences

- Failure to ensure resident call light is in place. (D)
- Resident fell, sustaining facial lacerations, fractured nose. Call light not in reach as care-planned. (D)

F 561 – Self Determination

- Failed to meet the residents' right to self-determination; specifically, right to have their choice of beverages at meals. Facility was offering one type of juice per day on a rotating schedule, did not make residents' choice of beverage available.(D)

F 578- Advance Directives/Discontinuation of Treatment

- Failure to ensure code status was corrected (D)
- Failure to ensure the code status for residents was properly identified. (D)
- Failed to obtain an advanced directive from resident and/or family. Chart was labeled DNR but there was no IPOST or Advanced Directive in the chart. (D)
- Failure to allow resident to request/refuse/discontinue treatment. Failure to ensure code status for several residents was accurate. One resident had pocket care plan with advanced directive that indicated full code. The code status signed by physician and resident's rep said DNR, the face sheet stated full code, the MAR indicated full code, the current physician order stated full code. Separate resident had pocket care plan with advanced directive indicating DNR, physician and resident's rep signed DNR form, hospice instructions stated DNR, face sheet for re-admission indicated full code, MAR shows full code, Staff interviews revealed staff look in different locations for the code status. Some look at the face sheet, some look at the MAR etc. (D)

F 580 - Notification of Changes Injury/Decline

- Failure to notify the resident's interested family member of a fall (D)
- Failure to immediately inform the resident, consult with resident's physician, and notify, consistent with his or her authority, the resident's representative when there is a significant change in status. Failure to notify family when resident developed a pressure sore, as well as the severity of the sore. (D)
- Failure to notify resident rep with lab changes-increased white count. (D)
- Failure to notify resident representative of significant weight loss. (D)

F 582 - Medicaid/Medicare Coverage

- Failure to provide timely notice of Medicare Non-Coverage (NOMNC)- CMS Form 10123, and Mandatory Denial notice CMS form 10055. Failure to notify resident in advance of impending discharge notice by facility; or the right to have a claim submitted to Medicare and standard appeal rights. (D)
- Facility failed to inform residents of their right to appeal the decision for discontinuation of skilled services, facility issued a notice of Medicare denial form but failed to issue a Notice of Medicare Non-Coverage. (B)

F 583 - Personal Privacy/Confidentiality of Records

- Facility failed to maintain privacy during personal cares. Resident's perineal area was unnecessarily exposed during personal cares. (D)

F 584 – Safe/Clean/Comfortable Homelike Environment

- Wall behind headboard needed repair. Identified by maintenance but had not been corrected for approx. 2 wks. (D)

F 604 – Right to be Free from Physical Restraints

- Resident with a seatbelt did not have: physician's order, documentation of a nursing assessment every 12 hours for the ongoing need of a physical restraint and any documentation of when the belt was applied/removed. (D)
- Resident with merry walker did not have a renewed order for the restraint and no restraint documentation for the month. (D)

F 609- Reporting of Alleged Violations

- Facility failed to report medication misappropriation from the narcotic e-kit on three separate occasions and failed to report the misappropriation of residents' controlled pain medication. (E)
- Facility failed to report an allegation of abuse, staff use of foul and inappropriate language towards resident; RN overheard and didn't report because she didn't have a personal cell phone with her that day and didn't want to leave a note for the DON reporting what she witnessed; staff stated she should have reported it right away. Didn't report for six days. (D)
- Facility failed to report allegation of abuse. (D)
- Failed to report allegation of abuse to DIA. Allegation was that a resident was left on commode for two hours and was molested. (D)
- Failure to report three cases of unknown injuries to DIA. All were documented in notes as injuries of unknown origin. (D)
- Failure to report alleged exploitation in time frame required. Fentanyl patches missing from residents when nurse went to change them but never reported. (E)

F 610 – Investigate, Prevent, Correct Alleged Violation

- Facility failed to separate alleged perpetrator from a resident, staff was scheduled to work and assigned to provide cares for the resident for 6 days. (F)
- Failed to investigate allegation of abuse and separate staff member after allegation. (D)
- Failure to investigate three injuries of unknown origin. (D)

F 622 – Transfer and Discharge Requirements

- Failure to provide discharge and medical information to the receiving health care institution at the time of discharge for residents transferred to the hospital. (D)
- Resident discharged to another facility. No documentation of transfer form, including information at minimum, resident rep contact info, advanced directives, instructions/precautions for ongoing care, other necessary information. (D)

F 623 – Notice Requirements Before Transfer/Discharge

- Failure to notify the LTC Ombudsmen of resident transfers for multiple residents reviewed for hospitalization (C)

- Failure to notify the LTC Ombudsmen of resident transfers for multiple residents reviewed for hospitalization (B)
- Facility failed to notify the Long-Term Care Ombudsman of discharge/transfer of residents as required. (C)
- Failed to notify the Long-Term Care Ombudsman of discharge/transfer of residents as required. (B)
- Facility failed to notify the Ombudsman when residents transferred to the hospital and returned to the facility (B)
- Failed to notify LTC Ombudsman regarding resident transfers to hospital (B)
- Discharge documentation not sent to LTC Ombudsman (B)
- No documentation as to reporting hospital transfers to ombudsman (D)

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

- Failure to provide copy of the bed hold policy at time of transfer to hospital. (C)
- Facility failed to provide notice to the resident or representative of the facility's bed-hold policy prior to and upon transfer to the hospital. (C)
- Facility failed to provide a bed hold policy at time of transfer to the hospital. (C)
- Facility failed to provide a copy of the bed hold policy at the time of transfer to the hospital. (C)
- Facility failed to notify resident or representative of facility bed hold policy upon transfer to hospital (D)
- Bed hold information not given at transfer to hospital. (B)
- No documentation of bed hold policy issued (D)

F 626 – Permitting Residents to Return to Facility

- Failed to permit residents to return to facility for residents following a hospital stay. Resident left the facility for foot surgery. Administrator stated he told the hospital that they would accept the resident back but would be starting the involuntary discharge process upon return. The hospital reported the facility refused to take the resident back d/t non-payment. (D)

F 636 – Comprehensive Assessments & Timing

- Facility failed to ensure annual MDS assessment was completed timely. (B)

F 637 – Comprehensive Assessment After Significant Change

- Failure to complete a significant change assessment after discharge from Hospice Care. (D)

F 638 – Quarterly Assessment at Least Every 3 Months

- Fail to ensure quarterly review instrument specified by the state and approved by CMS was completed not less frequently than once every 3 months. (B)
- Missed quarterly assessment. (D)

F 639 – Maintain 15 Months of Resident Assessments

- Interventions for possible elopement were not included in care plan for resident with history of chronic wandering. (D)

F 644 – Coordination of PASARR and Assessments

- Level 2 PASRR expired.(D)
- PASRR not re-submitted after starting an antipsychotic medication. (D)
- Facility failed to provide accurate information on a level1 Pre-Admission Screening and Resident Review for one resident reviewed. (B)

F 655 – Baseline Care Plan

- Failure to provide copy of baseline care plan to resident and representative. (D)
- Baseline care plan summary not offered to resident representative for several residents. (D)
- Baseline care plan summary not offered to resident representative. (B)
- Baseline care plan summary not offered to resident representative. (D)

F 656 – Develop/Implement Plan of Care

- Failure to update the resident's care plan directing the size and type of sling to utilize with a mechanical lift. (E)
- Failed to develop comprehensive care plans with measurable goals and objectives to address a resident's indwelling catheter and hospice level of care, a resident's need for edema gloves for selling, resident's indwelling catheter. (D)
- Facility did not ensure development and implementation of a plan of care for the use of psychotropic medications. (D)
- Care plan did not address the use of Coumadin. (D)
- Facility failed to implement new care plan interventions when falls occurred. (D)
- Care plan did not address how CNA's should proceed with peri-care when the resident had an erection during the procedure. Expectation was that staff would discontinue care and return at a later time, but this was not documented. (D)
- Tracheostomy care and anticoagulants not addressed on care plans. (D)
- Comprehensive care plan listed the accurate transfer status for a resident. PT said resident should be standby assist and care plan said independent with transfers. (D)
- Failed to update care plans after falls and also did not address self-transfer issues. Resident had no intervention following fall with a head injury, resident later fell sustaining fracture. Another resident was care-planned as 1 or 2 staff for transfers. CNA transferred with 1 and resident and when asked told surveyors CNAs determined if resident should be 1 or 2 staff for transfers. DON confirmed CNAs should not be assessing the resident to make that determination. (D)
- Several residents with psychotropic meds and a resident with a seatbelt not addressed in comprehensive care plan (including indication for their use). (E)
- Comprehensive care plan did not address smoking, frequency resident wanted to go outside, or assistance required (D)

- Comprehensive care plan failed to address antipsychotics/antidepressants. (D)
- Facility failed to follow the plan of care for resident with fall history. Resident required extensive staff assistance with transfers/ambulation and had a fall since last assessment. The plan of care identified them as high risk for falls and an intervention stated they would use Dycem in the recliner. Later, the resident's transfer was observed by an RN and Dycem was not in place in recliner. Later, the resident was observed sitting in the recliner with no Dycem in the morning and again when transferred for the noon meal. (D)
- Comprehensive care plan for a dialysis resident did not include: fluid restriction, dialysis facility, provider contacts, days of dialysis, transportation or staff directives for monitoring the resident for adverse problems. (D)

F 657 – Care Plan Timing & Revision

- Facility failed to update care plans when needed. Care plan lacked any documentation regarding the resident's oxygen. (D)
- Failed to update care plan to meet resident's need to prevent falls. Fall mat, education, low bed were all implemented from various falls but never put in care plan. (D)
- Facility failed to ensure comprehensive care plan was reviewed with resident and family. No care plan meetings. (E)
- Care plan did not address recommendations on the PASRR. (D)

F 658 – Services Provided Meet Professional Standards

- Failure to follow physician's orders for blood pressure and sugar values measured outside the ordered parameters. (D)
- Failure to follow physician's orders as directed (oxygen) and ensure physician's order summaries were up to date. (E)
- Facility failed to follow physician orders; Resident had order for daily weights and the chart lacked documentation that this was done. (D)
- Facility failed to follow physician orders. Resident had order for edema gloves on in AM and off in PM, progress notes stated gloves unavailable, or could not locate on several occasions. (D)
- Facility failed to ensure professional standards of medication administration. Resident's medication left in cup in client’s room on tray table. (D)
- Facility failed to follow physician's orders receiving oxygen, order from hospital did not get transcribed by staff, order was for 4 liters prn, MAR had previous order for 2 liters prn and only showed use for 1 day, observation revealed resident in wheelchair wearing oxygen at 3 liters, next day revealed the resident having an episode of shortness of breath, nurse check oxygen saturation tank read 4 liters, approx 30 minutes later staff wheeled resident to the room and at that time the oxygen read 3 liters, and on the third day oxygen read 3.5 liters. (D)
- Facility nurse found resident's Ativan missing from medication cart so borrowed a dose from another resident rather than using medication from emergency kit. (D)

- Failed to provide physician contact regarding resident's condition. Nurse stated she did contact him but failed to chart it. (D)
- Failure to meet professional standards by having CMA perform wound care. (D)
- Staff failed to provide services that meet professional standards of quality. Nurse documented- on top of another nurse's documentation in the MAR. Medication administered without an order. (D)
- At surveyor observation, resident received eye drops from pharmacy that did not match MAR; may have been receiving wrong drops for a year. Nurse left meds in cup at bedside, upon return 10 min later resident had not taken meds. (D)
- Coumadin given without orders for two days. No follow up PT/INR . (D)
- Coumadin given without orders, INR high at 6.0. Another resident, warfarin given without order as it was supposed to be held. When PT/INR came back, order was to alternate 6 mg with 7 mg, nurse entered it wrong in MAR. Resident received one dose of 7.5mg, no follow up PT/INR after error. (D)

F 677 – ADL Care Provided for Dependent Residents

- Failure to ensure residents receive scheduled baths, are properly groomed (E)
- Failed to ensure staff provided pericare. Staff washed residents' abdominal folds, down front of the peri area without changing the areas of the washcloth. (D)
- Failed to provide toileting/encouragement of fluids to residents. One resident not toileted for 5 hours during day. When CNA's left the room, they never offered resident fluids. (D)

F 679 – Activities Meet Interest/Needs of Each Resident

- CNAs report they don't follow the activity schedule because it doesn't work for them. When the surveyor asked if this was a "social", employee laughed at surveyor. Activity director did not know activities weren't getting done. (D)

F 684 – Quality of Care

- Failure to assess and continue skin treatments. (D)
- Failure to ensure resident received prompt treatment for a newly assessed skin issue. (D)
- Failed to assess, monitor, and treat skin condition. (D)
- Failed to adequately assess resident after initial symptoms developed, failed to notify ARNP of temp, full vital signs; would have ordered blood work such as a CBC for white counts, asked for lung sounds assessment to rule out a respiratory issue. (D)
- Facility failed to assess after family reported a change in the resident's physical and mental status to the nurse; nurse did not respond immediately to resident with acute issues of unresponsiveness reported by family or assess well. (D)
- Nursing staff failed to follow physician's order to report low blood sugar when occurring. Treatment was provided to resident for blood sugar of 46, but no notification of physician documented for resident using sliding scale insulin. (D)

- Facility did not adequately assess/intervene for resident who hadn't had a BM for 3 days. No BM records for 5 days. Resident was taking Oxycodone. (D)
- Failed to complete timely assessment of change of condition of resident. Red areas on a resident were present but not documented for three days. (D)
- Resident with sexually and verbally inappropriate behaviors towards staff and residents; interventions not clearly care planned, physician not notified, and resident canceled psych appt without staff's knowledge. Residents voiced concern during group interview about resident's comments, masturbating publicly and hands in pants in dining room (D)

F 686 – Treatment to Prevent Pressure Ulcers

- Failure to ensure ongoing interventions in place to prevent pressure sore. (D)
- Failed to provide appropriate positioning on an alternating air mattress and utilize the proper control settings to assure appropriate pressure relief. (D)
- Facility failed to prevent pressure ulcers and did not doc pressure ulcers unless the individual's clinical condition demonstrated they were unavoidable, and received necessary treatment resident's did not always have pressure reduction in wheelchair/recliner during the investigation, resident stated she would use her wheelchair pressure reduction cushion if staff would place it in the recliner, resident was asked about using cushion in recliner again she stated she would allow staff to place cushion in her recliner, resident remained in recliner with no pressure reduction cushion, cushions on care plan but not in place. (D)
- Failed to ensure residents with pressure ulcers received necessary treatment. Resident with pressure on buttock was placed in recliner with no pressure reduction device which was not addressed in the care plan. Treatment of pressure was delayed by 15 days. Resident with heel wound found to have no dressing on it. Resident that was to be turned every two hours was in bed with a wedge in the same position for five hours. (G) **$3,300 FINE**
- Failed to ensure residents are free from pressures. Wounds got worse instead of better over three months to where one was necrotic and tunneling. Dressings were not changed after soiled. (G) **$4,500 FINE**
- Facility failed to provide appropriate services to prevent/heal pressure ulcers. Facility didn't complete ongoing assessment of one resident's open area. Resident's progress note identifies small red open area to coccyx. The physician and family were notified. Later, an order was received stating to apply Mepilex every 3 days and PRN. No skin sheet/further assessments documented. (D)
- Failed to assure adequate pressure reduction interventions and complete a dietary assessment related to the new onset of pressure ulcers. (G) **$4,500 FINE**

F 688 – Prevent Decrease in Range of Motion

- Facility failed to ensure staff completed exercises for residents observed with limited range of motion who had restorative programs recommended by physical and occupational therapists. (D)

- Facility failed to consistently provide restorative nursing services as care-planned, evidenced by gaps in the restorative nursing record documentation. (D)
- Restorative nursing aides were not given time to complete restorative programs as care-planned for two months due to chronic staff shortages. (E)
- Residents did not receive restorative therapy as required. Resident reported rehab aide being pulled to help on the floor, confirmed by DON. (E)

F 689 – Free from Accidents and Hazards

- Facility failed to ensure resident environment remained as free of accident hazards as possible, and each resident received adequate supervision and assistance devices to prevent accidents. Multiple resident falls related to alarms. Facility did not have criteria for alarm removal; Alarms removed from all residents at once- more than one resident fell during alarm free trial; Incidents where staff didn't hear alarm and failed to follow care plan interventions. (G) **$7,500.00 FINE**
- Failure to develop a systematic approach to lock exterior courtyards gates to ensure gates are locked at all times for wandering and elopement purposes; Resident who is risk eloped through unlocked gate. (J**) $3,750 FINE**
- Failure to implement procedures to monitor exit door alarms to ensure each resident received adequate supervision to prevent elopement and failed to respond to an exit alarm by Wanderguard, which resulted in a resident exit from the facility. Fail to ensure proper size sling for mechanical lift. (J) **$11,250.00 FINE TREBLED**
- Failed to provide adequate supervision to prevent accidents. Resident found on floor, sent to ER and had fracture. Resident had orders to be toileted every 2 hours and was not. (G) **$4,100 FINE**
- Failure to ensure safety of resident that was at high risk of falls. Care plan failed to provide interventions for resident's refusal to use call light. Resident was found on floor in bathroom with laceration and did not have a pulse, CPR was initiated, 911 called, and pronounced dead at the hospital due to cardiac arrest. Staff knew he was noncompliant with call light and had no interventions in place. (G) **$6,750 FINE**
- Failed to ensure a safe and secure environment. Resident slid out of bed while receiving cares as the air mattress shifted, client fractured finger. (D)
- Failed to ensure medications and hazardous items were stored in a secure manner. An unlocked treatment cart sat in the hallway with no staff visible. (D)
- Facility failed to follow care plan for safe transfers, plan of care directed staff to use 2 staff in room with all encounters until it can be revaluated at a later time, review of the progress notes was assisted to toilet using 1, resident had difficulty standing and bumped arm causing skin tears (D)
- Resident complained of rib pain after 1 CNA attempted to transfer without assistance of second CNA as care planned. (D)
- Survey staff observed CNA pushing resident in wheelchair without foot pedals in place. (D)

- Failed to provide adequate nursing supervision and assistance devices to prevent accidents when staff failed to transfer a resident according to the care plan resulting in a fracture (G) **$6,250.00 FINE**
- Facility failed to implement interventions for falls, nor did they always fully investigate what happened leading up to falls. Reports did not state if alarms sounded, where staff were, and if residents had been toileted. (D)
- Residents had falls with major injury in which staff failed to implement measures to prevent falls with injury. CNA transferred resident by self while resident was care-planned as a 1-2 person transfer. Resident sustained a fall during transfer resulting in fracture. Another resident was witnessed by dietary staff attempting to stand by self. Resident then fell unwitnessed, was care-planned that other dept should not leave resident unattended and should find nursing staff. Later resident had a fall in the dining room after dietary staff left resident alone, despite knowing resident was anxious/agitated, Resident sustained a fracture. Another resident fell in bathroom sustaining head injury with no added intervention. Resident later fell sustaining a hip/pelvis fracture. Resident then care-planned as 1-2 person transfer. Surveyor noted no incident report or investigation following another fall which resulted in humerus fracture. Several NN indicating resident crying/yelling out in pain for 3-4 days, then died. **(G) $6,000 FINE**
- Resident with history of getting up by self had intervention of tab alarm. Staff knew resident removed alarm, no new intervention placed. Resident fell resulting in a fracture. (G)
- Resident left alone on toilet fell; care planned for staff to be present in BR. (D)
- CMA let go of gaitbelt to wash hands and gather supplies leaving resident standing without support. (D)
- Facility failed to ensure adequate supervision/assistive devices to prevent accidents. Resident exited facility without being noticed by staff. Resident has a dx of Alzheimer's dementia and unable to complete BIMS indicating severe impairment. Required limited staff assistance with most ADL'S. The care plan indicates at risk to wander; A wanderguard was placed upon admission. No attempts to exit the facility and the wanderguard was later removed. After this, staff heard knocking on the back door and resident was returned to the facility by an outside community resident who stated resident was walking across yards outside. Some staff reported not knowing the wanderguard had been removed. One Staff reported that when the door is opened the alarm sounds but that it stops when the door is closed even without any staff intervention. DON agreed with this statement, stated she shared that info prior administration. Staff also said sound from alarm is faint. Door alarm check documentation not completed per policy. Doors didn’t alarm when tested. (J) **$6,500 trebled, $19,500 FINE**

F 690 – Bowel, Bladder Incontinence, Catheter Care

- Catheter change was ordered monthly but was not completed for 55 days. (D)

F 692 – Nutrition/Hydration Status Maintenance

- Facility failed to initiate interventions to prevent the risk of further weight loss for a resident who was identified as having a lot of weight loss. (D)
- Dietitian recommendations were not followed for a resident that was at high risk for pressures.(D)

F 695 – Respiratory/Tracheostomy Care and Suctioning

- Facility failed to ensure medication to thin respiratory secretions were available for a resident with a tracheostomy. (D)
- Facility did not keep emergency tracheostomy kit at the bedside as per facility policy. (D)

F 697 – Pain Management

- Numbered pain scale not used as care planned. Documentation showed "res c/o pain" when resident was non-verbal. No documentation of nonpharmacological intervention as required by care plan.

F 698 – Dialysis

- Failed to secure/provide necessary cares for resident sample for dialysis. (D)
- Failed to complete nursing assessments and monitoring of a resident before and after going to outpatient dialysis treatments and lacked documentation of communication with the dialysis facility. (D)

F 700 – Bedrails

- Facility failed to assess bedside rails for risk of entrapment to ensure gaps in side rails were not large enough for residents to be at risk of serious injury, impairment or death. (K) **$2,500 FINE**

F 725 – Sufficient Nurse Staffing

- Failure to ensure staff responded timely to residents' call lights. (E)
- Facility staff failed to answer call lights in a timely manner. Review of facility call light response time showed upwards of 31 minutes before being answered. (E) **$500 FINE**
- Failure to answer call lights within reasonable time. Residents stated it took 15 min, 28 min and 45 min for call lights to be answered. One resulted in a fall. (D)
- Failed to provide prompt response for residents of the nurse call system. Some call lights were not answered for 50 mins; wait time longer on the wknds. (D)

F 727 – RN 8 Hrs./7 days/Wk., Full Time DON

- Failure to have RN coverage 5 days. (D)

F 729 – Nurse Aide Registry, Verification

- Lack of showing a CNA was actually certified in the personnel file. (D)

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

- 3 CNAs did not meet 12-hrs of training requirement. (D)

F 755 – Pharmacy Services/Procedures/Pharmacist/ Records

- Failure to implement procedure to ensure accurate acquiring, receiving, dispensing, and administering of controlled medications and to ensure account of all controlled medications is maintained and periodically reconciled. (E)
- Facility failed to follow protocol and utilize appropriate safeguards to prevent drug diversions from the narcotic emergency kit and one that involved residents' controlled pain medications locked in the medication carts. The facility's records lacked the Controlled Medication Utilization Record and a running count sheet which tracked Residents' use and remaining quantity of Dilaudid. (E)
- Facility and pharmacist failed to have a system to adequately monitor and effectively track narcotics to deter and/or prevent loss, controlled medications that were discovered missing after facility staff realized someone removed them from the ER kit and substituted them with over the counter medication (E)
- Nurse documented destruction of 1 dose of resident's Clonazepam on three subsequent evening shifts without documenting the reason for destruction or having a witness to the event. (D)
- E-kit in the med room was not secure (locked). (D)
- Failure to ensure all drug records are in order and all controlled drugs reconciled. Nurses did their own narcotic count, not with another nurse. Facility policy revealed best practice was to count off with someone else. Liquid morphine count was off. (E)

F 756 – Drug Regimen Review, Report Irregular, Act On

- Facility failed to ensure gradual dosage reduction attempted. (D)
- Failed to provide a provider rationale for a GDR declination for resident on psychotropic medications. (D)

F 757 – Drug Regimen is Free from Unnecessary Drugs

- Failure to offer alternative interventions prior to administration of anti-anxiety meds; Fail to document why or what effectiveness was for as-needed meds. (D)
- Failed to adequately monitor lab values for resident on coumadin and the resident was hospitalized. (J)
- Nonpharmacological interventions not documented prior to administration of PRN Ativan (D)

F 758 – Free from Unnecessary Psychotropic Meds/PRN Use

- Failed to ensure resident remained free from unnecessary psychotropic med. (D)
- Failed to assure residents had clear indications for use of antipsychotic drugs documented. (D)
- PRN Lorazepam continued past 14 days. (D)
- PRN antipsychotic given past 14 days and scheduled antipsychotic added when increased confusion documented with a UTI. (D)
- Failed to provide a provider rationale for a GDR declination for a resident on psychotropic medications. (D)

F 745 – Provision of Medically Related Social Services

- SS documentation indicated resident needed new shoes and was to purchase at time of next dr appt. Two months later, shoes not purchased and was not taken at time of dr. appt. (D)

F 761 – Label/Store Drugs/Biologicals

- Fail to maintain medication refrigerators at adequate minimum temperature. (D)

F 801 – Qualified Dietary Staff

- Dietary department did not have a CDM. (E)

F 803 – Menus Meet Resident's Needs/Prep in Advance /Followed

- Failure to provide pureed buns as directed for residents on a pureed diet (D)
- Meal served did not match menu-scoop sizes did not match requirements. (E)

F 804 – Nutritive Value/Appearance/Palatability/Temp

- Failed to maintain the proper temperature of the ground meat during one meal service. (F)

F 812 – Food Procurement, Storage, Preparation, Sanitization

- Facility staff failed to maintain adequate hot food temperatures and properly store nutritional supplements in order to reduce the risk of food-borne illness. Refrigerator had Hormel mighty shakes and Hormel apple cranberry nutritional drink without thaw date, label states used in 14 days after thawing. Hormel Thick n Easy nectar, thick kiwi strawberry juice without an open date, label states use 10 days after opening. Reuben sandwiches that were not placed in steamtable which measured 105 degrees. (E)
- Facility failed to ensure staff utilized proper handling of ready to eat resident food items and ensure the temperature probe was sanitized between uses in order to prevent food-borne illness. Staff were to sanitize the probe for the food thermometer with a clean alcohol pad between each food measurement and to not touch the food with hands, when actually touching food products they should have gloved hands, wash hands first and use gloves; and if changes gloves,

should wash hands again and only touch one type of food product before changing gloves (E)
- Failed to properly label food items and remove expired items placed in refrigerator (F)
- Dietary employee served food, touched dietary carts, touched food without washing hands in between. (E)

F 842 – Resident Records - Identifiable Information

- Facility failed to completely and accurately document in residents' medical record. Facility staff failed to perform the treatments as ordered. (E)
- Dilaudid removed from e-kit over several days (4 doses), only 1 dose documented on resident's MAR. (D)

F 868 – QAA Committee

- Failure to have QA meetings at least quarterly. (C)
- Medical Director did not attend QA meetings. (C)

F 880 – Infection Prevention and Control

- Facility failed to follow proper infection control technique. Staff donned gloves and started wound care protocol and took gloves off and donned new gloves without washing hands first. Resident with soiled clothes had the clothes changed but staff did not clean cushion the resident was sitting on. (D)
- Facility failed to ensure placement of catheter bags to prevent contact with the floor and contaminated surfaces. (E)
- Facility failed to assure adequate infection control with oxygen. The resident's oxygen tubing was found lying on the floor. (D)
- Facility failed to utilize proper infection control techniques during resident care, removing gloves without performing hand hygiene when doing dressing change. Completed peri-care wearing the same gloves; placed a new incontinence brief under the resident and assisted the nurse manager to pull up the resident's underwear and slacks, removed gloves but did not perform hand hygiene. (D)
- Failed to ensure catheter tubing was not dragging on floor in order to prevent infection. (D)
- During survey observation, nurse removed medications from card and placed them in med cup with bare hand. (D)
- Facility failed to utilize proper infection control techniques when emptying a urine drainage bag for a resident with a urinary catheter. (D)
- Failed to maintain adequate infection control during a wound dressing change with someone with MRSA. No barrier between dressing items and side table, no glove change, and no cleaning hands between glove change. (D)
- Nurse coughed in her hand during med pass and did not wash or sanitize hands, proceeded to give meds. (D)
- CNA did not change gloves or wash hands prior to cleaning port of catheter during draining cath bag. (D)

- No barrier under glucose machine. (D)
- The facility failed to follow proper infection control technique in order to prevent infection in multiple residents. Resident had treatment completed by RN on to cleanse wound and used the same gloved hands to apply tx instead of washing and re-gloving. No barrier for treatment supplies used. LPN obtained blood sugar checks for residents with same glucometer without cleaning/disinfecting glucometer between residents. Another LPN completed blood sugar check without using a barrier under glucometer, did not disinfect the community glucometer, instead wiped with alcohol pad. RN opened the cart with her gloved hand after completing a blood sugar check. Staff cleansed glucometer again with just an alcohol pad and completed a blood sugar check without gloves. (E)
- Failure to utilize proper infection control techniques during resident cares (D)

F 881 – Antibiotic Stewardship Program

- Facility failed to create a comprehensive antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use. (F)

F 947 – Required In-Service Training for Nurse Aides

- Failure to provide a minimum of 12 hours of CNA training per year. (E)

Nursing Facility Survey Frequency - December 2018

- As of Dec. 28, 2018, CMS lists 57 Iowa facilities or 13% of all facilities in the state as being past 15 months since last annual survey. Region 7 average rate is7.4 %. National average is 7.2%.

FFY 19 - October Totals - LTC Surveys

Provider	City	Survey End Date	Previous Date	Months Between
Anamosa CC	Anamosa	10/11/2018	7/20/2017	14.93
Arbor Springs	West Des Moines	10/15/2018	7/20/2017	15.07
Bethany Life	Story City	10/2/2018	6/28/2017	15.37
Childserve	Johnston	10/25/2018	8/3/2017	14.93
Corydon Specialty Care	Corydon	10/18/2018	7/20/2017	15.17
Country View	Waterloo	10/29/2018	7/27/2017	15.30
Denison CC	Denison	10/29/2018	7/18/2017	15.60
Emmetsburg Care	Emmetsburg	10/4/2018	6/28/2017	15.43
Exira CC	Exira	10/11/2018	7/13/2017	15.17
Friendship Village	Waterloo	10/4/2018	7/13/2017	14.93
Genesis Medical Center – Dewitt	DeWitt	10/18/2018	7/20/2017	15.17
Grandview Healthcare	Dayton	10/18/2018	7/13/2017	15.40
Great River Klein	West Burlington	10/5/2018	6/15/2017	15.90
Jefferson Place	Pella	10/4/2018	8/10/2017	14.00
Madrid Home	Madrid	10/25/2018	7/13/2017	15.63
Manning Region Hospital	Manning	10/11/2018	6/22/2017	15.87
Mayflower Home	Grinnell	10/4/2018	8/3/2017	14.23
Mount Ayr HCC	Mt. Ayr	10/11/2018	6/22/2017	15.87
Newton Village	Newton	10/4/2018	8/10/2017	14.00
Parkview	Sac City	10/4/2018	7/13/2017	14.93
Parkview Home	Wayland	10/18/2018	7/13/2017	15.40
Pearl Valley -- Primghar	Primghar	10/18/2018	7/20/2017	15.17
Plymouth Manor	LeMars	10/11/2018	6/28/2017	15.67
Pocahontas Manor	Pocahontas	10/11/2018	6/22/2017	15.87
Polk City N & R	Polk City	10/25/2018	7/31/2017	15.03
Scenic Manor	Iowa Falls	10/18/2018	7/20/2017	15.17
Simpson Memorial	West Liberty	10/25/2018	7/27/2017	15.17
Stacyville Community NH	Stacyville	10/18/2018	8/10/2017	14.47
Stratford Specialty	Stratford	10/14/2018	8/17/2017	14.10
Strawberry Point Lutheran	Strawberry Point	10/11/2018	6/28/2017	15.67
Wesley Acres	Des Moines	10/4/2018	8/17/2017	13.77
Westbrook Acres	Gladbrook	10/21/2018	9/7/2017	13.63
			AVERAGE	15.06