Compliance Tips from IHCA's Survey Results Committee
December 2019

Total Number of Survey Reports: 28
Survey Composition:

Annual:	**10** Surveys	**0** Deficiency Free
Complaints:	**15** Surveys	**7** Unsubstantiated
Self-Reports:	**2** Surveys	**1** Unsubstantiated
Mandatory Reports:	**4** Surveys	**0** Unsubstantiated

State Fines: $8,750
State Fines in suspension: $39,550

Most Commonly Cited Iowa Tags:

F 658 – Services Provided Meet Professional Standards (7)

F 812 – Food Procurement, Storage, Preparation, Sanitization (5)

F 880 – Infection Prevention and Control (5)

F 657 – Care Plan Timing & Revision (3)

Tags Resulting in Actual Harm or Higher Citations and Fines:

F 686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers	**1 G Level Tag**
F 689 – Free from Accidents and Hazards	**1 G Level Tag, 1 J Level Tag**
F 760 – Residents Are Free of Significant Med Errors	**1 G 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=15611	Total Number of Surveys=62071
F0880	Infection Prevention & Control	5,717	32.9%	9.2%
F0689	Free of Accident Hazards/Supervision/Devices	5,412	26.8%	8.7%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	4,768	28.6%	7.7%
F0656	Develop/Implement Comprehensive Care Plan	4,236	23.8%	6.8%
F0684	Quality of Care	3,973	20.3%	6.4%
F0761	Label/Store Drugs and Biologicals	3,329	19.9%	5.4%
F0657	Care Plan Timing and Revision	2,696	15.6%	4.3%
F0677	ADL Care Provided for Dependent Residents	2,488	13.0%	4.0%
F0758	Free from Unnec Psychotropic Meds/PRN Use	2,401	14.5%	3.9%
F0609	Reporting of Alleged Violations	2,346	12.2%	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).

<u>Deficiencies and Fines</u> (sorted ascending by F-tag number)

F558 – Reasonable Accommodations of Needs/Preferences

- Facility failed to accommodate residents' needs/preferences to create individualized and home-like environment. Resident requested bed be removed from room because slept in a recliner. Facility declined request due to policy that beds must remain in rooms. D

F580 – Notify of Changes (Injury/Decline/Room, Etc.)

- Failure to notify physician, resident's family of significant weight loss of a resident. D

F582 – Medicaid/Medicare Coverage/Liability Notice

- Fail to give resident notice of Medicare Provider Non-Coverage at end of skilled stay. B

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

- Failed to complete a criminal background check and dependent adult abuse check prior to hire. **D Tag $500 FINE**
- Failure to properly screen temp staff prior to hiring. Failed to ensure employees completed DAA training for mandatory reporters. D

F623 – Notice Requirements Before Transfer/Discharge

- Failure to notify Ombudsman of resident transfer to hospital. B

F625 – Notice of Bed Hold Policy Before/Upon Transfer

- Failed to provide Bed hold Notice when transferred to the hospital and admitted. D

- Failed to provide a bed hold notice to the resident or responsible party prior to and upon transfer to the hospital. D

F637 – Comprehensive Assmt After Significant Change

- Significant Change MDS was not completed for resident with multiple falls, declined from independent mobility to assisted ambulation/transfers, declined from continent of B&B to incontinent of bladder. D

F640 – Encoding/Transmitting Resident Assessment

- Facility failed to complete and submit a discharge MDS in a timely manner, resident discharged, MDS completion record revealed the resident did not have a discharge assessment completed. B

F645 – PASARR Screening for MD & ID

- Facility failed to include specialized services on the plan of care. D

F655 – Baseline Care Plan

- Failure to involve resident and/or resident family during baseline care plan. B
- Facility failed to provide the Baseline Care Plan Summary to the resident and resident representative. Facilities standard is to provide the Baseline Care Plan Summary within 48hrs. B

F656 – Develop/Implement Plan of Care

- Failure to update care plan interventions for multiple residents. D

F657 – Care Plan Timing & Revision

- Failed to update care plan, care plan failed to identify use of an anti-anxiety, signs and symptoms to watch for, and or behaviors to report and monitor the usage of the anti-anxiety medication. Resident on Tramadol care plan lacked direction for what adverse effects staff should monitor for the scheduled opioid, lacked direction for the staff to monitor the resident for adverse effects related to the use of the opioid. D
- Fail to update care plan; resident had a history of seizures; care plan failed to include interventions specific to seizure disorder. Hospital report revealed resident presented to ER due to unresponsive episode physician concerns of possibly hoarding narcotics, care plan lacked information related to possibly hoarding medication and unresponsive episodes. Staff heard resident had a way of holding cup while taking medications in order to conceal them but did not think to place this on care plan. Physician stated resident had been in hospital twice due to this. D
- Resident stated was not always told about care conferences and facility could not produce documentation that resident had been invited to 4 of 5 conferences. D

F658 – Services Provided Meet Professional Standards

- Resident stated staff inconsistently placed pump on legs; inconsistently receiving nystatin under abdominal/skin folds; staff ran out of powder; TAR revealed staff omitted entries. Resident had order for Spiriva- staff omitted on TAR; Resident had order for Metoprolol Succinate- staff omitted Metoprolol; MAR indicated med not available; resident had order on admission for Metoprolol Succinate but staff transcribed the order incorrectly as metoprolol tartrate; the pharmacist noted the error that staff failed to order the medication, facility received the medication three days later. Order of Spiriva came in late and resident missed four doses. Dietician documented resident agreed to ground meat and ST 10/23 ST had not been evaluated by ST. New resident was admitted order sent to pharmacy, pharmacy failed to deliver meds; staff contacted the pharmacy who reported they did not have orders, so staff faxed again, and pharmacy failed to deliver medications. Pharmacy was contacted and again they said they didn't have orders; pharmacy records indicated they received order via fax resident failed to receive medications. D
- Facility failed to follow physician; facility failed to obtain the lab results for an INR
- Facility failed to administer insulin from insulin pens. Nurse did not demonstrate the wasting of 2U to prime the needle, prior to administering. D
- Fail to check the blood pressure and pulse of prior to giving a cardiac medication. Physician order to hold the 1x/day beta-blocker if systolic blood pressure less than 100 or heart rate less than 55. Order was not followed. D
- Nurse gave medications to residents and did not wait to watch residents take them. Meds found in cups with no one around. D
- Staff put medication directly in resident's hand, resident dropped the pill on the floor and the resident said he/she would take it anyway. Staff then picked up the pill and gave it to the resident without sanitizing hands or throwing away pill. D
- Resident was observed to be wearing supplemental oxygen. There was no order for oxygen therapy. MDS failed to reflect the oxygen use. D

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

- Walk to Dine program was not done for a resident that was to have it twice a day. Lack of documentation for resident refusal. D

F677 – ADL Care Provided for Dependent Residents

- Assisted residents were observed to be cared for by staff who failed to check for incontinence or toilet and reposition routinely. Incontinent care was incomplete- did not include cleansing all affected areas. D

F684 – Quality of Care

- Failure to document a resident's fall and notify physician of the incident .D
- Bowel protocol not followed. Resident was admitted to hospital for fecal impaction.D

F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers

- Care plan failed to identify a repositioning plan for a resident prior to development of a deep tissue injury heel pressure sore even though the resident required two staff to reposition and staff documented they observed the resident's heels pressing into the bed and chair. **G TAG $500 FINE**

F689 – Free from Accidents and Hazards

- Staff chose not to fasten the lift safety harness because the resident's husband said it was too tight and didn't like staff to use it. Resident's husband said he never told staff not to use the safety harness, just advised them not to make it too tight on the resident. Due to no use of harness, the resident slid out of chair and onto the floor. Resident had a femur fraction. Staff reported that the lift was malfunctioning. DIA report indicated staff wasn't using the lift properly per the instructions. **G TAG $29,500 FINE IN SUSPENSION- TREBLED**
- Facility van driver did not latch all four floor restraint straps/hooks and did not put seat belt on resident. Resident tipped over in wheelchair, fell out of chair and went into cardiac arrest and passed away. **J Tag $10,000 IN SUSPENSION**

F690 – Bowel, Bladder Incontinence, Catheter Care

- Failure to provide adequate incontinence care. D
- Failed provide appropriate perineal cares with catheter care. Catheter tubing on carpeted floor. Did not change surface of wipe during cleansing of groin/perineum. No cath provided to urethral site and 4" down catheter tubing. D

F692 – Nutrition/Hydration Status Maintenance

- Failure to ensure resident maintained an acceptable nutritional status to prevent weight loss. Resident had a significant unplanned weight loss of 5% in 30 days and had a mechanically altered therapeutic diet. D

F725 – Sufficient Nurse Staffing

- Failed to respond to call lights in a timely manner, resident stated he/she waited over 30 minutes, call logs revealed eights instances of call light responses over 15 minutes and under 30 minutes, 5 instances between 30-60 minutes, 1 instance between 60 minutes and 2 hours. Group interview resident in attendance reported the staff response to call lights exceeded 15 minutes. D
- Multiple residents wait up to an hour for call lights to be answered, mostly on the evening shift. D

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

- Facility failed to ensure a licensed RN worked in the capacity of a Director of Nursing. This occurred over 9 months. DON allowed her license to lapse. F

F732 – Posted Nurse Staffing Information

- Facility failed to accurately post nursing staff information at the beginning of each shift and failed to post the information in the prominent place readily accessible to residents and visitors. B
- Failed to post Nurse Staffing information 3 of 3 days observed. B

F760 – Residents Are Free of Significant Med Errors

- Failed to ensure residents received medication according to physician's orders to prevent a significant medication error. Diuretic ordered to be given 1x/week. Facility administered medication daily for nine days prior to resident being admitted to hospital with low blood pressure and low potassium. **G TAG $7,750 FINE**

F761 – Label/Store Drugs & Biologicals

- Facility failed to count all narcotics including mail order narcotics every shift. D
- Resident received the wrong dose of anti-seizure medication for one month due to a mislabeled pharmacy card that was not caught until observed by surveyor. D

F801 – Qualified Dietary Staff

- Fail to employ qualified Food/Nutrition Director in absence of a full-time dietician. E

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

- Failure to provide correct menu items as approved by the dietician. E

F804 – Nutritive Value/Appear, Palatable/Prefer Temp

- Resident complained that food was too cold being delivered to room. Surveyor measured temps of a test tray that measured temps too low. D

F806 – Resident Allergies, Preferences and Substitutes

- Fail to serve food to accommodate allergies/intolerances/preferences. Resident said facility served meals that include variations of beans, resident had allergy to beans, informed dietary staff several times, resident documented on calendar dates/times staff served her beans, menus reviewed for accuracy of resident's report. D

F812 – Food Procurement, Storage, Preparation, Sanitization

- Dietary staff did not secure their hair properly while in the food service area. D
- Failure to properly label and date food items. E

- Failed to maintain a clean and sanitary kitchen environment. Thick buildup of dust on baseboard of kitchen door. Black substance on both sides of door frame. Large grease buildup on steam table. E
- Failed to ensure kitchen was well maintained and sanitary, failed to ensure resident food items were properly covered/dated when opened. Food debris on floor, soiled white kitchen towels, milk, shredded cheese opened with no open date. Dishes of applesauce in refrigerator without cover. E
- Fail to maintain clean walk-in cooler. Fan contained furry residue as did ceiling. E

F880 – Infection Prevention and Control

- Tubing for oxygen concentrator not dated, humidification bottle not dated, and nebulizer mask was marked with a black marker with date. D
- Failed to wash hands after removing gloves for providing incontinent care. Failed to transport clean linen with covered carts, clean linen exposed. E
- Nebulizer mask and tubing were not dated for when last replaced. Glucometer placed on resident sink without barrier, then placed on med cart without barrier. Glucometer front side only cleansed with bleach wipe, then taken into another resident room with no barrier. D
- Fail to ensure infection/control measures maintained for residents with oxygen usage. D
- Fail to provide appropriate infection prevention measures when handling soiled linens or provide appropriate cath cares- allowed cath tubing to touch floor. Dirty linen placed on carpeted floor D

F921 – Safe/Functional/Sanitary/Comfortable Environment

- Facility failed to maintain adequate hot water essential for resident care, resident voiced concerned of being provided care with cold water, resident stated the water has been freezing cold for two months, staff stated there has not been hot water in the front halls for two months, staff stated it takes leaving the water on for 45-60 minutes before it gets warm. Maintenance stated they replaced the water heater and the recirculation pump and that didn't help so they replaced the mixing valve, maintenance stated he checks water temperatures weekly, surveyor checked the hot water in sinks of multiple residents water source was cold and never change after running in excess of two minutes. E

Nursing Facility Survey Frequency

As of December 17, 2019: CMS lists 34 Iowa facilities (7.8%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 8%. National average is 6.2%.

Provider	City	Survey End Date	Previous Date	Months Between
Hillcrest Home	Sumner	11/14/2019	9/6/2018	14.47
Story County Hospital LTC	Nevada	11/7/2019	8/23/2018	14.70
Bethany Home	Dubuque	10/31/2019	8/3/2018	15.13
Westhaven Community	Boone	10/31/2019	8/9/2018	14.93
Manor House Care Center	Sigourney	10/24/2019	8/9/2018	14.70
Westridge Quality Care & Rehab	Clarinda	10/31/2019	8/9/2018	14.93
Mill Valley Care Center	Bellevue	11/14/2019	9/6/2018	14.47
West Ridge Care Center	Cedar Rapids	11/6/2019	8/23/2018	14.67
Crystal Heights Care Center	Oskaloosa	11/6/2019	8/29/2018	14.47
			AVERAGE	**14.72**