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

Compliance Tips from IHCA's Survey Results Committee
December 2020

Total Number of Survey Reports: 48

Survey Composition:

Annual:	0 Surveys	0 Deficiency Free
Complaints:	20 Surveys	0 Unsubstantiated
Self-Reports:	10 Surveys	0 Unsubstantiated
Mandatory Reports:	0 Surveys	0 Unsubstantiated
COVID-19 Infection Control Survey:	18 Surveys	0 Deficiency Free

State Fines: $14,000
State Fines in suspension: $ 37,250

Most Commonly Cited Iowa Tags:

F 880 – Infection Prevention and Control (17)

F 689 – Free from Accidents and Hazards (7)

F677 – ADL Care Provided for Dependent Residents (6)

F658 – Services Provided Meet Professional Standards (5)

F 684 – Quality of Care (5)

Tags Resulting in Actual Harm or Higher Citations and Fines:

F 689 – Free from Accidents and Hazards	**3 G Level Tags**
F760 – Residents are Free of Significant Med Errors	**1 J Level Tag**
F 880 – Infection Prevention and Control	**1 K Level Tag & 1 L 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=15461		Total Number of Surveys=95610
F0880	Infection Prevention & Control	8,913	37.4%	9.3%
F0884	Reporting - National Health Safety Network	3,637	10.9%	3.8%
F0689	Free of Accident Hazards/Supervision/Devices	2,477	12.7%	2.6%
F0684	Quality of Care	1,785	9.3%	1.9%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	1,587	9.4%	1.7%
F0656	Develop/Implement Comprehensive Care Plan	1,461	8.3%	1.5%
F0609	Reporting of Alleged Violations	1,181	6.3%	1.2%
F0761	Label/Store Drugs and Biologicals	1,125	6.7%	1.2%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	1,105	5.9%	1.2%
F0677	ADL Care Provided for Dependent Residents	1,026	5.4%	1.1%

*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

- Failure to treat residents with respect. Staff called one resident a fat, lazy piece of shit. Resident was asked if this staff had ever said anything mean to her and resident said yeah she's always mean. Staff was immediately discharged. D
- The facility failed to ensure residents are treated with dignity and respect for 5 of 11 residents reviewed. Multiple interviews and reports from other staff of staff member treating residents rudely or impatiently. E

F552 – Right to Be Informed/ Make Treatment Decisions

- The facility failed to provide the resident and/or resident representative the right to be informed and make decisions related to pharmacy provider for 1 of 1 resident reviewed. Resident #17 had veteran status confirmed on 5/30/19. POA reports the facility did not discuss pharmacy options/VA eligibility with her when resident became private pay. Facility staff could not confirm whether this information was discussed or not.

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

- The facility failed to notify POA of change in condition for 3 of 3 residents reviewed. On 6/9/20 CNA was assisting Resident # 8 to the BR and noted a blister like wound to coccyx. No family notification documented of wound or ordered tx is documented. Resident # 14 had documented falls on 7/14, 7/16, and 7/25 without POA/family notification documented. Resident # 26 spilled coffee in her lap on 4/17/20 in the DR resulting in a 4.7x2.8 blister. On 5/22/20 resident fell in room causing a 2.8 cm skin tear. Neither incident had any POA/family notification documented. D

F583 – Personal Privacy/Confidentiality of Records

- Failure to provide privacy. During peri care the resident door was wide open. D

F584 – Safe/Clean/Comfortable/Homelike Environment

- Environmental tour revealed strong smelling urine in hallways and apparent mold in shower rooms. D
- The facility failed to maintain and provide an adequate supply of linens in good condition that included a completed change of bed linens. 5 residents laid on mattresses without bed linens. E

F609 – Reporting of Alleged Violations

- Facility failed to investigate and report mistreatment of a resident in 1 of 1 resident reviewed. Staff R CMA reported that she informed the Administrator over 2 months ago that she needed to discuss concerns about Staff J and Staff P's behavior toward residents. Her letters to the Administrator were not addressed. She witnessed Staff J yell at residents and Staff P throw a bag of garbage on Resident #26 and not getting resident a snack because he was having behaviors. Both the Interim DON and Administrator stated they were not aware of the incident. D

F622 – Transfer and Discharge Requirements

- The facility failed to provide discharge instructions to the resident/representative who left the facility AMA for 1 of 4 residents reviewed. On 9/25/20 notes indicate Resident #20 left the facility AMA with son. Physician notified. No documentation present regarding the resident/POA being notified of return of medications, instructions on medications and treatments. D

F658 – Services Provided Meet Professional Standards

- The facility failed to meet professional standards of care for 1 of 5 residents reviewed. Resident #1 had admission orders dated 5/22/20 with Warfarin 1 mg tablet- take one tablet as directed and Warfarin 5mg tablet-take one tablet every day. The DON stated in an interview that the Warfarin order should have been clarified. The facility rec an order to have PT/INR drawn on 6/11/20. On 6/11/20 the facility was directed to give same amount that was ordered prior to coming to the facility which was 5mg Sun and Wed and 5.5 mg all other days. This is not what had been given to resident. Weekly skin assessments were ordered on 5/23/20. Assessment tab in PCC showed no weekly skin assessments. D
- The facility failed to meet professional standards of care for 1 of 1 residents reviewed. Resident #17 did not follow up with the neurologist as ordered. On 10/30/20 Phys ordered resident to follow up in three months. Neurology department stated resident was a no show for appt on 1/30/20. D
- Facility failed to follow physician orders observed during medication pass and failed to administer medication according to the medication administration rights. The old medication order had not been updated with new physician parameters for medication administration. D
- The staff failed to obtain physician orders for narcotic medications of one resident failed to obtain admission orders for all medications for another resident. D
- Facility failed to ensure all staff administering eye drops, wear gloves and instill eye drops per the facility's policy. D

F677 – ADL Care Provided for Dependent Residents

- Failure to provide baths at least twice a week. Residents went between 7 and 12 days without a bath. E
- Facility failed to provide baths twice per week for 1 of 3 residents reviewed. Resident said she does not get her bath done regularly. Staff K CNA said baths are usually given once per week. D
- The facility failed to provide baths for 5 of 5 residents reviewed. Resident #1 was interviewed on 10/26/20 and they stated they had not had a bath in a long time. No baths documented in the last 14 days. 3 baths documented in the last 30 days. Resident # 2 also had no baths documented in the last 14 days. 3 baths documented in the last 30 days. Resident #3 had no baths documented in the last 30 days. Resident #4 had no baths documented in the last 14 days. 3 baths documented in the last 30 days. Resident # 5 had one bath documented in the last 14 days. 3 baths documented in the last 30 days. E
- Facility failed to bath 3 residents as least 2 times weekly as required. D
- One resident was found to be bathed only 1 time weekly on average. D
- The facility failed to provide oral hygiene to residents per resident interviews 'unless they ask for it' and 'only on bath days'. Observations revealed toothbrushes dry and occasionally unwrapped in packaging; observed ADL's omitted oral cares. Residents observed with 1" long facial hair. Staff identified a resident as declining but was offered no assistance with meal completion and room trays were provided unsupervised in room. Resident only consumed bites to 10% of meals observed, however, documentation showed 50-75% meal consumption. E

F684 – Quality of Care

- Failure to complete assessment after resident fell. Nurse did not do head to toe assessment. D
- Facility did not complete post fall assessments on 3 residents. D
- No physician order found for resident with catheter, facility failed to complete and document skin assessments for 9 residents, failed to perform blood sugar and administer insulin for 1 resident as ordered and did not notify the physician when error was discovered. D
- The facility failed to document pain level and evaluate the effectiveness of pain relief medications. There was an additional failure to document the need for antianxiety medications, the non-pharmacological interventions used prior to use, and the effectiveness of the medication. E
- Facility failed to ensure all staff provided care with professional standards of practice. Unlicensed staff moved a resident following a fall before the nurse assessed the resident for injuries. D

F689 – Free from Accidents and Hazards

- Resident with history of multiple falls was left alone in bathroom, fell and sustained a right hip fracture. **G $5,000.**
- Care plan not contain clear direction for how a resident was to be transferred. Some used the hoyer some used stand by assist, resident fell multiple times. D
- Facility failed to adequately supervise residents in the DR for 1 o1 resident reviewed which resulted in a second degree burn. Resident # 26 spilled coffee in her lap on 4/17/20 in the DR

resulting in a 4.7x2.8 blister. Some staff reported the resident was supposed to have a lid on the coffee cup and some said she did not have lids on her cups. She required supervision with meals and hot liquids. The lid was not on and there were no witnesses to the incident. **G $2500.**

- Facility failed to provide adequate supervision. Resident eloped, and the local police department returned the resident to the facility, unharmed. The resident's room window was ajar with the screen popped out and a chair in front of it, the resident stated "I climbed out the window". The resident was suppose to be checked on hourly and was last checked on at 12:30AM and was returned by the police at 5:30AM. D
- Resident on anticoagulant with history of falls due to attempts to self transfer without using call light, fell and suffered fracture and subdual hematoma. Resident's room door was kept closed due to pandemic conditions and facility did not have a plan in place to increase supervision or prevent falls. **G $9,000.**
- Resident with a dx of TBI was not provided adequate supervision and the resident was able to enter a staff office, push out a window and exit the facility. The resident was located approximately 2 blocks from the facility by a nurse searching via car, after a search within the facility revealed the resident was missing. The resident was not injured. D
- Staff left a resident strapped in a sit-to-stand lift unsupervised, seated on the side of the bed. Staff left resident alone to seek assistance to transfer the resident. The resident slid from the bed to the floor suffering a compression fracture. G

F695 – Respiratory/Tracheostomy care and Suctioning

- Oxygen tubing and BiPap filters for one resident not changed according to facility policy and manufacturer's instructions. D

F698 – Dialysis

- The facility failed to complete nursing assessments and monitoring of a resident before and after the resident went to outpatient dialysis. D

F725 – Sufficient Nursing Staff

- Facility failed to assure there were sufficient qualified nursing staff available at all times to meet residents needs by answering call lights in a timely manner. 2 of 5 residents reviewed did not have lights answered in a timely manner. Review of call light showed the resident 2 waited anywhere from 16 min - 35 min on 7 different occasions. Resident #3's call light record revealed 37 times that the call light was not answered within 15 minutes. D

F726 – Competent Nursing Staff

- A deficiency was noted involving competent nursing staff when the facility failed to have an LPN work within their scope of practice as allowed by the IBN. An untrained LPN completed a central line dressing change on 1 of 4 residents reviewed. Staff A stated that on 8/3/20 at 11 am that she was in resident #1's room (who has a Groshong central line) for a visit and witnessed Staff B LPN change the dressing on a central line. Staff A stated that Staff B did not look like she knew what she was doing and asked who requested that this task be completed. Staff B stated the DON assigned the task. D

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

- Facility was using an LPN and RN to split the duties of the Director of Nursing position, but had no written description of the duties each nurse was to perform as required. D

F730 – Nurse Aide Perform Review- 12 Hr/Year In-Service

- Staff evaluations not completed timely. C

F755 – Lab Reports in Record-Lab Name/Address

- The facility failed to establish an accurate system of records of disposition for all controlled medications in sufficient detail to enable an accurate reconciliation of medications. Staff were not documenting and balancing the controlled substance record for an as needed Controlled Substance. E

F760 – Residents are Free of Significant Med Errors

- The facility failed to obtain medication orders for a resident who admitted on 8/11/2020 until 8/25/2020. **J $3,000.**

F810 – Assistive Devices- Eating Equipment/Utensils

- Resident with physician's order for adaptive silverware, weighted utensils was not provided to the resident during mealtimes. D

F880 – Infection Prevention and Control

- Failure to implement an effective infection control program and screening process. Failed to use proper hand hygiene and failure to utilize transmission based precautions. Screening form only asked for a temperature. Staff member screened self in and did not sanitize hands. Multiple staff with symptoms continued to work due to poor screening processes. Staff seen not wearing masks, staff not wearing gowns into isolation rooms. COVID positive hall had no N95's available. Did not use biohazard bags. COVID hall staff intermingled with non-covid hall staff within 6 feet of each other**. L $8,500.**
- Failure to screen all staff prior to entering building. Staff worked while COVID test was pending, which ended up positive. Staff self screened and did not document she had a headache and tiredness, she ended up positive. E
- Failure to implement comprehensive infection control plan to mitigate spread of COVID19 during an outbreak. Residents were not wearing masks, staff worked with symptoms, including fevers and coughs. Maintenance man worked with symptoms and touched multiple doors and items with no hand hygiene. F
- Infection control procedures not followed by not changing gloves appropriately during peri care. Staff also pulled their mask down to talk to resident. D
- The facility failed to utilize appropriate infection control practices during resident care for 2 of 3 residents reviewed. They also failed to provide a clean and sanitary home like environment due to excessive amounts of bio hazard waste stored in the facility for extended amounts of time that created severe odor and health risk to residents. Staff B LPN performed a blood sugar check and insulin administration on for Resident #1 on 9/17/20. Observation revealed that Staff B placed glucometer on bedside table with no barrier and placed insulin syringe on med cart with no barrier, did not complete hand hygiene before leaving residents room, and then touched the glucometer to return it to drawer as well as the drawer handle and lock on cart. Staff B LPN also completed a tx/dressing change for Resident #6 who has a

skin graft on the left ear on 9/21/20. Observation revealed Staff B remove old dressing and then wash hands. Hands were dried with paper towels and then the faucet was turned off with bare hands. Following the new dressing application Staff B washed hands and used wet paper towels to turn off faucet. Staff B then assisted CNA with toileting resident and again washed hands and turned faucet off with the used/wet paper towels. During a facility walk through on 9/22/20 (800 hall) a large accumulation of red biohazard bags were noted in the biohazard room. A second overflow room was observed in an empty resident room adjacent to this room. The approximate 15 bags created a very strong offensive odor in the hall. An additional 2 rooms on another hall were noted to have around 100-120 more bags of biohazard waste stacked 5 to 6 feet high. Staff interviews revealed the bags have been accumulating since August and the smell is horrible. F

- The facility failed to implement a comprehensive infection prevention and control program and an effective screening process for staff and visitors, knowingly allowing a staff member with COVID symptoms to work. This staff member tested positive for COVID-19. During an interview on 8/26/20 with Staff A CNA reported she had a low grade temp and body aches from head to toe on 8/18/20. She called the facility on 8/20/20 and reported having a low grade temp all morning. The administrator directed her to the DON who directed her to report to work. She was instructed not to avoid residents. Around 9pm she felt worse with body aches and sweating. Staff B LPN took her temp and it was 100.1. Staff B informed Administrator who told her to have her finish the shift and then leave. Staff A had a COVID test on 8/20/20 with positive results received on 8/24/20. Cell phone text messages between Staff A and the DON show that Staff A reported being ill prior to her shift starting on Aug 19th and 20th and the DON still asked her to report to work. The DON denied being contacted prior to the CNA's scheduled shift on the 19th despite cell records. Review of screening sign in sheets revealed several incomplete entries. **K $23,350.**
- Facility failed to ensure employees with signs/symptoms of COVID were not working with COVID negative residents. Staff A filled out the screening log with no times documented on 10/13/20 and 10/16/20 twice and once on 10/14/20 and 10/15/20. On 10/18/20, 10/19/20, 10/20/20x2, 10/21/20, 10/22/20, 10/24/20 the time was missing again as well as symptoms marked yes for cough/sore throat/ SOB/chills/headache. Staff A was sent home on 10/24/20 and tested positive for COVID on 10/24/20. F
- The facility failed to implement transmission based precautions for acute respiratory symptoms for 3 of 8 residents reviewed. Resident #2 c/o not feeling well on 8/19/20 with noted cough and green phlegm, had pain and loose stools. Wheezing and other symptoms continued. Resident moved to iso on 9/13/20. Resident tested positive for COVID on 9/14/20. Resident # 12 reported to have barky cough on 9/18/20. Symptoms continued including sore throat. Resident was not placed in iso until 9/25/20. COVID positive test results received on 9/30/20. Resident #15 noted to have coarse lung sounds on 9/30/20. Symptoms continued including cough until 10/5/20 when resident had a positive COVID test. Resident then moved to iso. Observation on 10/8/20 of Staff N LPN showed her knock her face shield off on the floor during med pass. Staff proceeded to wipe he forehead multiple times with the gown and then replaced the face shield without disinfecting it first. E
- Facility failed to implement and monitor an effective screening process for employees and failed to utilize appropriate PPE in accordance with Centers for Medicare and Medicaid Services for Disease Control and Prevention recommended guidelines for COVID 19. The

staff entrance Focused Employee Temperature and Signs/Symptoms Log revealed 2 staff members had no screening questions answered. Staff had surgical mask and faceshield on, but no gown worn. A resident sat in a wheelchair in the hallway and had no mask on. Staff forgot to change mask to an N95 when she came into the COVID unit. E

- Facility failed to comply with current infection prevention and control standards. CAN who exited a quarantine room folded the gown with the front of the gown to the outside and placed in a zip-lock bag, touching the outside of the gown to her arms and clothing. CNA who provided peri care removed gloves and did not wash or sanitize hands and proceeded to touch the blankets and bed remote. D
- Facility failed to consistently screen staff, visitors and hospice personnel entering and leaving the facility. Screener took temps but did not ask any screening questions. Another entrance used by staff did not have a screener present when staff entered the facility. Screener not always present at main entrance. E
- Facility did not screen at least 5 residents daily for signs and symptoms of COVID. E
- CNA did not follow facility infection control policy for measuring catheter output and disposing of urine. D
- The facility failed to wear adequate PPE with new admissions during observations. Staff failed to wear appropriate eye protection during care, failed to actively screen staff for symptoms of COVID-19 and to wear adequate PPE after an outbreak in the facility. F
- Multiple activities and dining observations with residents approximately 36″ between them rather than the 6-feet of distancing required. Activity observed with residents playing card game with cards and spoons, all handling multiple items which is prohibited and no hand hygiene was observed. The medication room refrigerator had ice buildup and needed to be defrosted. E
- The facility during an outbreak failed to complete the screening process related to COVID-19 before employees started their shift. Several staff were self-screening and taking own temperatures and staff were not always taking post-shift temperatures. E
- Facility did not notify residents, resident representatives and family members by 5 pm the day after positive COVID results were identified in the facility. E

F885 – Infection Prevention and Control

- Facility failed to inform residents family of positive COVID resident. C
- The facility failed to notify families of confirmed COVID cases by 5 pm the next calendar day for 4 of 5 residents reviewed. Resident #1 had a positive COVID test on 10/18/20 and documentation of family notification was completed on 10/21/20. Resident # 2 had a positive COVID test on 10/22/20 and documentation of family notification was completed on 10/25/20. Resident # 5 had a positive COVID test on 10/19/20 and documentation of family notification was completed on 10/21/20. D
- Facility did not notify residents, resident representatives and family members by 5 pm the day after positive COVID results were identified in the facility. E
- The facility failed to inform residents, their representatives and families of those residing the in the facility by 5 pm the next calendar day following the subsequent occurrence of confirmed infection of COVID-19, including information on mitigating actions implemented

to prevent or reduce the risk of transmission, including if normal operations of the facility would be altered. F

F921 – Safe/Functional/Sanitary/Comfortable Environment

- Facility failed to maintain a safe and functional environment due to lack of automatic closure of fire doors. The fire alarm panel displayed a note documented: IF the fire alarm sounds, close the Memory Lane fire doors immediately, they will not close automatically. D

F925 – Maintains Effective Pest Control Program

- The facility failed to provide adequate pest control for a bed bug infestation present from Sept 2019-April 2020. The facility had their pest control services withheld in Nov and Dec 2019 for non-payment of services creating a prolonged risk of the spread of bed bugs throughout the facility. Staff E stated the bed bug issues started in July 2019 when resident #12 moved in with infested furniture. Staff E said the furniture was quarantined to the basement so it could be sprayed but despite knowing this the Administrator moved it to the residents room anyway. The facility reports trying to treat the facility themselves (ineffective) as well as eventually getting a new pest control company following the lapse in service for the 2 month period. Various staff interviews revealed reported evidence of many live and dead bed bugs and evidence of infestation in all areas of the facility including resident rooms/lounge areas/nursing station. The medical director was aware and noted rashes on residents. E
- Facility failed to maintain an effective pest control program to remain free of pests/rodents. Resident #21 stated she had mice in her drawers that eat her snacks and that she informed staff. Resident # 24 stated he had mice in his room and maintenance put sticky pads in the room. Pest control logs do not show an identified concern with mice by the facility. The pest control company reported the facility did not mention mice as a concern. Multiple staff have noted mice and reported to maintenance/Administrator. Maintenance reports administrator was aware of the issue and did report concern to the pest control company. The administrator was interviewed and was not aware of a problem with mice and did not report to Pest Control. E

F947 – Required In-Service Training For Nurse Aides

- Facility failed to ensure 12 hours of training for CNAs. C

Nursing Facility Survey Frequency

As of December 11, 2020: CMS lists 200 Iowa facilities (46.4%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 42.1%. National average is 50.0%.