Compliance Tips from IHCA's Survey Results Committee

February 2016

The five most frequently cited tags from the 39 annual surveys (1 deficiency free), 37 complaints (2 unsubstantiated), 21 self-reports (0 unsubstantiated), and 10 complaint/self-report (0 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 246 total deficiencies.

The following is a breakdown of severity level:

A =	0%	D =	62.18%	G =	4.66%
B =	4.62%	E =	20.17%	H =	0.0%
C =	3.78%	F =	4.20%	I =	0%
				J =	0%
				K =	0.42%
				L=	0%

Total # of Reports: 73
Total # of surveys/reports deficiency free or unsubstantiated: 3
Avg. # of deficiencies

- All = 3.36
- Annual = 4.36
- Complaint/Self-Reports= 1.83

Total state fines for December Report = $95,000 ($40,000 held in suspension)

Top 5 Most Frequently Cited Tags for February 2016 Report

F 323—Free of Accident Hazards/Supervision/Devices—The Facility must ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents

- Resident was on 15 minute checks which were not done, eloped through a window (J); abated to (G) **$30,000 fine, ($10,000 x 3), in suspension.**

- Resident left in a wheelchair outside of room, fell, sustained head injury. Care plan stated resident not to be left in wheelchair. Resident to have pad alarm, didn't, fell and dislocated hip. (G) **$24,000 fine ($8,000 x 3).**
- Resident eloped from the facility without staff's knowledge twice on 12/4/15 and again on 12/11/15. The main entrance door of the facility did not have an alarm to alert staff when resident had left the building, no safety provisions implemented after the elopements on 12/4/15, resident eloped again through the main door on 12/11/15 and no staff were aware the resident had left the building, resident continued to remove his/her Wanderguard devices both before and after these elopements (J) abated to a (D). **$15,000 fine ($5,000 X 3) held in suspension.**
- Resident fell; no alarm in place as per care plan; fracture; second resident fell, no alarm as per care plan, no injury (G) **$8,000 fine.**
- Staff failed to provide supervision for three residents; fall with fracture for resident who turned alarm off, staff failed to activate alarm, no clip alarm attached to resident per care plan (G) **$5,000 fine**.
- Facility failed to provide supervision during transfer, resident fell, no nurse assessment completed before resident was placed in a wheelchair (G) **$2,000 fine.**
- Unlocked chemicals (E) **$500 fine**.
- Staff failed to use gait belt during transfer, resulting in fractured arm for resident (G).
- Resident suffered pelvic fracture due to fall, alarm failed (G).
- Resident found on floor after evening activity, activities staff left early, CNA was left in charge (G).
- Staff turned door alarm off and never checked doors (E).
- Medications left on top of cart; cart left unattended (E).
- Facility failed to ensure 15 residents in a locked unit had access to a fully functioning fire escape; fire door would not open (E).
- Facility failed to secure 02; unlocked spa room and hazardous materials available in unlocked cabinets (E).
- Failed to ensure all exit doors were alarmed and failed to ensure electrical equipment used in safe manner; plugged into surge protectors (E).
- Two residents with frequent falls with no interventions initiated for resident with history of falls, alarm not sounded 4 times for resident with history of falls (E).
- Oxygen tank not secure, cabinet unlocked with hazardous chemicals, housekeeping cart with chemicals on top left unattended (D).
- Two residents had five falls with no interventions initiated, alarms failed on four of the falls (D).
- Staff failed to follow safe resident transfer; didn't use gait belt, fall with fracture (D).
- Oxygen tank not in holder, unsecured disinfectant and air freshener (D).
- Staff observed doing a lift transfer, staff did not connect sling straps correctly (D).
- Resident tripped over a Hoyer lift stored in hallway; staff used lift to transfer resident when it wasn't in the care plan (D).

- Facility failed to follow procedure following a resident being lowered to the floor; CNA did not tell nurse, who then did not fill out a report.
- Facility failed to follow fall prevention procedure, no gripper socks on resident per care plan (D).
- Facility failed to provide sufficient transfer assistance to minimize chance of resident fall; visitor helped transferred resident, resident fell (D).
- Two unlocked cupboards with cleaning supplies in nurses' station (D).
- Facility failed to properly utilize a mechanical lift (D).
- Staff used bear hug transfer on resident instead of EZ Lift (D).
- Failed to protect other residents from resident's inappropriate sexual behavior (D).
- Unsecured 02; unlocked cabinet with hazardous materials, unlocked unattended housekeeping cart with chemicals on top (D).
- Failure to follow care plan resulted in two cognitively-impaired residents engaging in inappropriate sexual activity in the dining room (D).

F 371 Sanitary conditions

- Food served uncovered, cutting boards unsanitizable, sanitation concentrations not per manufacturer's recommendation for sanitizing surfaces (F).
- Opened food containers not labelled or dated, ice scoop not stored properly, facial hair not covered for male dietary worker (F).
- Food in refrigerator and freezer uncovered, unsanitizable plastic cutting board, dust above food service window, dirty microwave (F).
- No backflow preventer on ice machine (F).
- Facility failed to store and distribute food and maintain equipment under sanitary conditions, sanitizing agent tested at 0 parts per million, opened, undated cake mix, residue buildup on baking pans (F).
- Multiple instances of open bags of food items subject to contamination (F).
- Opened food containers not labelled or dated (E).
- Dietary cook touching surfaces without gloves (E).
- Whipped topping spilling from a bag, items not dated when pulled from a freezer, box of gelatin leaking contents, covered muffins not dated, dietary worker didn't have all hair in hairnet, resin on shelves, etc. (E).
- A staff member didn't have hairnet over beard and mustache, hair was ½ inch long (severity level not listed).
- Grime on food storage shelving, dirty mixer (E).
- Improper glove use in kitchen, didn't change gloves during food preparation and touching cupboards, touched plates with bare hands (E).
- Dried debris and chunks on food storage shelf, opened, undated bottle of juice (E).
- Staff touched eating surfaces of silverware with bare hands, food in close proximity to open buckets of surface sanitizer (E).
- Cook wearing gloves touched multiple unclean surfaces while preparing food (E).

- Staff failed to cover all hair with hairnet, unclean floors, cabinets, exhaust fans (E).
- Floor in walk-in freezer contained debris (E).
- Staff failed to completely cover facial hair with a hairnet, improperly handling of food items (E).
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F 441—Infection control

- CNA placed an alarm pad on a trash can rim, it fell on feces-soiled brief, did not wash hands between glove changes, nurse placed container of glucose testing strips on floor then set on sink counter without a barrier, nurse placed eye drop containers on night stand without barrier (E).
- CNA failed to follow facility protocol concerning glove use—CNA donned gloves and assembled equipment (D).
- CNA failed to change gloves from dirty to clean during a dressing change; failed to handwash when reconnecting catheter drainage tube (D).
- Residents in isolation were provided cares without staff donning isolation gowns (D).
- Wipes on sink from Pericare-sink not disinfected, Accucheck machine not sanitized (D).
- Staff failed to sanitize glucometer, failed to put clean barrier between surface and dirty dressings during dressing change (D).
- Staff used same plastic measuring sheet to measure two separate wounds without sanitizing the instrument between wounds (D).
- Resident with supra-pubic catheter had a large BM during cares, staff didn't change gloves appropriately; touched bedding, clothing, etc. (D).
- Nurse didn't sanitize or change gloves between changing dirty dressing to clean dressing; CNA failed to use sanitizer or wash hands when changing gloves (D).
- CNA didn't wash hands after emptying catheter nor remove gloves (D).
- C-diff not addressed on care plan, staff dropped hand sanitizer on floor and placed in pocket (D).
- Nurse failed to wash or use gel after removing gloves after blood sugar check (D).
- Facility failed to ensure staff performed hand hygiene when indicated, staff failed to wash hands after a resident assessment (D).
- Staff failed to disinfect mechanical lift after use (D).

F 281 Professional standards of care

- Staff failed to apply Fentanyl patch according to physician's order due to patch being unavailable (D).
- Staff failed to provide preventative equipment to relieve pressure; protective boots (heals) (D).
- Staff didn't hold lacrimal sac for one minute following application of eye drops (D).

- Staff didn't administer sliding scale insulin as physician ordered; physician-ordered Companzine was not available on a Saturday; supplement to counter resident weight loss was not started on a timely basis (D).
- Staff failed to notify physician of a resident's morphine allergy (D).
- Staff failed to follow physician's orders concerning sensi-socks, surveyor observed socks not being worn by resident (D).
- Surveyor observed immobilizer not in place (D).
- Medication error due to computer error, dosage given at 1 mg rather than 0.5 mg (D).
- Resident lacked physician order for tube feeding to mix medications as ordered (D).
- Resident received wrong dose of Miralax due to a computer printout error (D).
- No documentation of physician-ordered PICC line dressing change; nurse didn't have resident rinse mouth after use of inhaler as directed per medications instructions (D).
- Nurse didn't check tube placement prior to administering medications via tube (D).
- Staff didn't administer insulin as ordered, no follow up, no blood sugar check (D).
- Staff failed to follow physician's orders for medications used to treat hypertension (D).
- Staff failed to follow physician's orders for reduction in medications, resident continued to receive full dose (D).
- Staff failed to clarify dosage of fentanyl, MAR didn't denote dosage (D).

F 309 Quality of Care

- Facility failed to assess three residents on ventilators: 1. Nurse failed to complete and document ventilator checks and vitals prior to administering medications, 2. Nurse failed to document ventilator checks and vitals every six hours for two residents (J) abated to (G) **$10,000 fine in suspension.**
- Staff failed to perform neurological assessment per policy with resident who had two falls; resident had a nosebleed, CNA had to stop nurse to assist (E).
- Staff didn't perform timely assessment of open area on buttocks (D).
- Blood sugar 556-1115 physician's order for insulin at 245 insulin was given at 650, no assessment performed in between the order and insulin administration (D).
- Staff took three days to assess a hip fracture and swollen ankle (D).
- Resident with fluctuating blood pressure and orthostatic hypertension was not continually assessed and physician was not informed of the drastic fluctuations; care plan to include daily weigh-ins for resident not done; resident not assessed for weight changes (D).
- Resident fell and complained of back and neck pain, physician said to monitor and call if changes. Resident and family wanted an X-ray, family took resident to hospital, resident diagnosed with vertebra fracture, physician not notified of family's request for X-ray (D).

- One resident found in bed with another, gowns were on, no assessment was completed (D).
- No full assessment completed after resident fell (D).
- Staff failed to assess resident with red, swollen leg who had a hip fracture, failed to complete weekly wound assessment (G).

Other G Level or Higher Notable Deficiencies and Other Fines

F-155

- CPR not provided per resident/family form when resident found unresponsive (K+500).

F-314

- Facility failed to identify, assess and promote healing in treatment of pressure sore, sore interventions not in place (G).
- No current care plan, open areas on resident, interventions (heels elevated, support boots) not in place (D) **$500 fine**.

L 1093

- Facility didn't check resident for Veterans' Administration benefits status (one instance in facility).
- Facility didn't check resident for Veterans' Administration benefits status (one instance in facility).
- Facility didn't check resident for Veterans' Administration benefits status (two instances in facility).