Compliance Tips from IHCA's Survey Results Committee

February 2017

The five most frequently cited tags from the 45 annual surveys (15 deficiency free), 46 complaints (18 unsubstantiated), 14 self-reports (8 unsubstantiated), 10 complaint/self-reports (5 unsubstantiated) and 1 mandated report (0 unsubstantiated reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 145 total reported citations.

The following is a breakdown of severity level:

A =	0.00%	D =	55.88%	G =	9.66%
B =	1.26%	E =	18.91%	H =	0.42%
C =	1.26%	F =	6.30%	I =	0.00%
				J =	1.68%
				K =	1.26%
				L=	0.70%

Total # of Reports: 109
Total # of surveys/reports deficiency free or unsubstantiated: 46
Avg. # of deficiencies

- All = 2.37
- Annual = 2.42
- Complaints = 1.35
- Self-reports = 0.80
- Complaint/Self-Reports= 4.10
- Mandatory =2.00

Total state fines for February Report = $209,500 ($6,500 held in suspension)

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

Top 5 Most Frequently Cited Tags for February 2017 Report

F 323--Free of Accident Hazards/Supervision/Devices

- Door alarms were not audible throughout wing of nursing facility, or on radio, resident fell down steps; alarm, when activated sounded for several minutes **$15,000 fine** (K)
- Resident received burns from a base board heater, 2 of 3 hallways had residents' beds parallel to base board heaters **$10,000 fine** (K to E)
- Elopement--community person called that resident was in wheelchair on side of road, Wanderguard not on, staff pushed wheelchair without pedals, resident fell with no new interventions in place **$24,000 fine** in suspension (J)
- Staff failed to provide adequate supervision for resident with fracture, resident received ice pack filled with hot water from a coffee maker, the ice bag burst and burned the resident, resident hospitalized in acute care burn unit **$15,000 fine** in suspension (J)
- Facility failed to ensure residents' environment remained free of hazards resident eloped out of service door, Wandergard did not sound, **$5,000 fine** in suspension (J)
- Resident eloped with Wanderguard no functioning consistently, hospital-based skilled nursing-no fine (J)
- Resident lowered to floor during ambulation to knees resulting in edema, no report of fall to physician, just the edema, another resident was not checked frequently enough **$7,000 fine** (G)
- Resident fell in bathroom, no new interventions were in place, resident suffered another fall 7 days later, with fracture to nose, knee and knee joint **$6,000 fine** (G)
- Resident found on bathroom floor, sent to ER and diagnosed with fractured tibia; another resident fell and sustained V-shaped laceration to scalp requiring 15 staples **$6,000 fine** in suspension (G)
- Resident fell with fracture, no care plan interventions in place at admission for resident at high risk for falls **$5,000 fine** in suspension (G)
- Resident fell out of tub hitting, had a 5-inch laceration to side of head **$5,000 fine** (G)
- Staff failed to protect resident from a fall resulting in right thigh hematoma, requiring hospital stay and surgery for compartment syndrome, resident had requested side rails and floor matt, resident was told the facility does not provide these, resident sustained fracture falling out of bed **$3,000 fine** in suspension (G)
- Care plan stated do not leave resident in wheelchair, but staff left unattended in wheelchair in room, attempted self-transfer, fell, was injured femur fracture **$3,500 fine** (G)
- Staff failed to follow interventions on residents' care plan, only used one person and not two Hoyer lift transfers, resident fell out of lift and was injured **$500 fine in suspension** (G)
- Resident with multiple bruises did not always have causative factors evaluated **$500 fine** (G)
- Resident was care planned to move with Hoyer lift, improperly done, resident fell suffered fracture (G)

- Facility staff failed to provide adequate supervision for resident requiring 2 person transfer when resident got up to be weighed had pain in right arm, sent to emergency room, had fractured humerus, resident should have been 2 person transfer, 1 staff attempted transfer (G)
- Staff failed to stay with resident when alarms were removed for toileting, staff failed to ensure motion sensor was on, and failed to turn the bed and motion alarms on (D)
- Staff pushed residents in wheelchairs without foot pedals 3 instances (D)
- Resident hit another resident and staff unaware of any new interventions, fall interventions not updated on care plan, change from electric lift chair to recliner (D)
- Resident touched another resident's breast, family stated hadn't seen any staff for 15 minutes; resident slapped another resident **$500 fine** (D)
- Resident slip off of bed when staff placed a Hoyer lift sling under the resident **$500 fine** (D)
- Staff failed to ensure exit door alarms functioned properly (D)
- Care plan stated bed in low position, but was often found in higher position (D)
- Staff failed to lock medications cart when unattended (E)
- Staff did not have alarm properly placed on resident, and unlocked cupboards (E)
- Staff failed to secure chemicals in beauty shop and one dirty utilizer room (E)
- Staff failed to lock unattended medications cart and failed to secure a stored oxygen tank (E)
- Inadequate nursing supervision for 9 of 13 residents who had accidents (no severity listed)

F 371—Food Sanitation and Safety

- Facility failed to follow sanitary practices for handling food, staff didn't change gloves after touching non-food items then touched food (E)
- Staff failed to maintain hot food at a safe temperature and improper handwashing (E)
- Dietary aide pushed cart with gloved hand, then handed out to residents multiple food items including cookies (E)
- Staff failed to maintain proper sanitizer solution levels for proper equipment cleaning (E)
- Many instances of undated and unlabeled food containers in refrigerator, cooks and aides used gloved hands and touched everything including foods (E)
- Stained coffee machine, dirty HVAC vents, unlabeled food in refrigerator (F)
- Staff failed to date food items in refrigerator, white fuzzy surface on cutting boards, staff didn't sanitize food preparation area, improper glove use (F)
- Crumbs and debris found in utensil drawer (F)
- Dietary staff failed to wear hair net over beard (F)
- Facility failed to maintain a current contract for a provider to provide potable and non-potable water supplies (F)
- Non-labeled opened food containers in refrigerator, staff touched food with dirty gloves (F)

- Dirty stove, no dishwasher temperature records (F)
- Expired milk found Jan. 9, 2017, dated Jan. 5, 2017, expired ham, dirty stove vent, no sanitizer in bucket, dietary staff touched food with soiled gloves (F)
- Orange juice was poured, sitting on a tray, no covers or dates, 3 bowls of lettuce not dated, milk at 53.2 degrees, dishwasher rack had lime buildup (F)
- Dietary staff served buns with bare hands, dirty items in kitchen, cleaning checklist not complete (severity not listed)

F 312—ADL Care for Dependent Residents

- Staff failed to give cares, resident had 1 bath in 30 days, resident not showered, incomplete peri care (E)
- Incomplete peri care, multiple times wiping but staff didn't turn cloth over to uncontaminated side, and wiped back to front (D)
- Staff failed to cleanse inner hip area during peri care (D)
- Staff failed to use different parts of wash cloth during peri care and staff used back to front cleansing motion (D)
- Staff did not provide baths twice weekly (D)
- Staff didn't cleanse all areas with peri care, 1 resident only had 1 shower in 2 weeks, lack of staff (D)
- Incomplete incontinence care-staff failed to wash hips, failed to fold wash cloth (D)
- Inadequate peri care, staff did not clean hip (D)
- Staff failed to help resident in a timely manner (D)
- Staff failed to change washcloth surface during cares (D)
- 3 residents with missed baths, 9 days without bath, 11 days without bath, 10 days without bath (D)
- Staff failed to wash hips during peri care (D)
- Resident had long fingernails with brown substance underneath them (D)
- Staff performed inadequate peri care, no nail care, no bathing of resident for 21 days (no severity listed)

F 281—Professional Standards of Quality

- Staff failed to apply Fentanyl patch as ordered by physician for 2 residents (E)
- Registered nurse asked if resident name was ____?, resident responded yes, later CNA addressed resident by another name, RN then knew she had a medication error, resident hospitalized (D)
- Staff failed to follow physician's orders for TED hose (no documentation on TAR (D)
- Fracture to DC a TX order before starting a new treatment and failure to get a physician's order before starting a TX. (D)
- Staff failed to follow physicians' orders for 2 residents, staff did not DC metoprolol per physicians' orders, wrong dose of Tylenol given (D)
- Missed lab work (D)
- Staff failed to follow physician's orders—daily weights, failed to give eye drops correctly (D)

- Staff failed to place pillow between resident's legs to reposition per physician's orders (D)
- Staff failed to complete tract care, did not obtain urine specimens, and failed to start order for wound care (D)
- Staff failed to follow physician's orders Vancomycin not administered (D)
- Staff failed to follow physician's orders for new medication order not transcribed correctly, staff administered medications to resident who had fallen on floor (D)
- Staff failed to change resident's oxygen tubing as ordered by physician (D)
- Staff failed to record resident's daily weights as ordered by physician (B)

F 309—Quality of Care

- Staff failed to provide ongoing assessment and interventions on a resident who needed respiratory interventions for resident having difficulty breathing, failed to ensure a suction machine was available for use **$3,000 fine** (G)
- Resident found leaning against a wall in bathroom with his/her arm caught in a rail, resident had swollen, deformed wrist which registered nurse did not assess **$2,000 fine** in suspension (G)
- Staff failed to assess and provide timely intervention when skin declined, 3 days with no update to physician when skin declined (G)
- CNAs' reported a resident looked different from normal, vital signs were assess and OK, but resident did not respond (D)
- Staff failed to record resident's bowel movements, and use of PRNs, request of ST evaluations due to coughing, and no follow-up or assessment due to coughing (D)
- Resident had extreme edema in legs, no report of a fall was made to physician (D)
- Staff failed to complete a full assessment to provide new interventions, resident was lethargic, elevated blood pressure, pulse, facial droop, could have been stroke (D)
- Resident was moved after a fall but before nurse completed a full set of VS, which violated policy (D)
- Physician's order for tube feeding was not followed since resident declined (D)
- Staff failed to properly assess or inaccurately assess resident's skin condition (D)
- Staff did not provide resident with sufficient fluid intake (H20 not passed) (E)
- Resident exhibiting stroke symptoms not assessed timely by staff, 3 residents fell and bruised face, staff failed to assess, 1 resident had open area on buttocks not assessed nor treated, pain medications not administered to cancer patient, no follow-up for resident who fell and fractured humerus (no severity listed)

Other notable deficiencies and fines

F-157

- Facility failed to promptly notify family of a fall resulting in head injury **$38,000 fine** in suspension (no severity listed)

F-223

- Resident had bruises around mouth, staff overheard a nurse say to resident "you can either do this the easy way or the hard way" resident then screamed **$1,500 fine** (G)

F-224

- Facility failed to identify residents whose personal histories rendered them at risk for abusing other residents (G)

F-225

- A family member complained of possible abuse, which was reported, but accused staff was not separated from the resident **$500 fine** (F)

F-314

- Staff failed to timely assess and provide appropriate care to pressure ulcers and failed to provide timely interventions to prevent development of avoidable ulcers on multiple areas of the resident's body **$30,000 fine** (K)
- Resident acquired a pressure ulcer after admission **$3,000 fine** in suspension (G)
- Facility staff failed to prevent pressure ulcers for 2 residents **$2,000 fine** in suspension (G)
- Open wound area on coccyx, but no care plan interventions for the wound or prevention **$2,000 fine** in suspension (G)
- Staff failed to prevent pressure ulcers under a resident's airboot/cast **$2,000 fine** (G)
- Resident suffered skin breakdown on heel under compression wrapped half-cast (G)
- Facility staff failed to prevent pressure ulcer, resident developed blister from TED hose **$500 fine** (D)

F-325

- Resident was not protected from substantial weight loss **$500 fine** in suspension (G)

F-333

- Staff failed to administer all medications as ordered by physician, one resident's medications given in error to another resident **$7,000 fine** in suspension (G)

F-353

- Call lights answered in more than 15 minutes **$500 fine** (D)

F-431

- Missing Fentanyl patch $500 fine in suspension (E)

F-496

- Staff failed to check CNA registry prior to hire **$500 fine** (D)

N-101

- Facility failed to report a major injury $500 fine
- Facility failed to notify DIA of an accident causing major injury within 24 hours, resident fell with subdural hematoma, lacerations and was admitted to hospital

L-1093

- Facility staff failed to submit for Veterans Affairs benefits for 2 of 4 residents

Annual Survey Frequency
February Survey Results Meeting

Facility	City	Last Year	This Year	Frequency
Accura Healthcare	Knoxville	12/31/15	12/29/16	52 Weeks
Belle Plain Specialty Care	Belle Plaine	1/7/16	1/19/17	53 Weeks
Cedar Falls Health Care Center	Cedar Falls	1/14/16	1/12/17	52 Weeks
Colonial Manor of Amana	Amana	1/21/16	12/29/16	48 Weeks
Corning Specialty Care	Corning	2/4/16	1/19/17	50 Weeks
*Crestview Nursing & Rehab	Webster City	6/9/16	12/15/16	SFF-Recently Graduated
Crestview Specialty Care	West Branch	2/4/16	1/12/17	49 Weeks
Davenport Lutheran Home	Davenport	2/4/16	1/12/17	49 Weeks
Faith Lutheran Home	Osage	1/28/16	1/12/17	50 Weeks
Fellowship Village	Inwood	1/21/16	12/22/16	48 Weeks
Fountain West Health Center	West Des Moines	1/14/16	1/24/17	53 Weeks
Friendship Home Association	Audubon	1/21/16	1/5/17	50 Weeks
Good Samaritan Society	Newell	2/4/16	1/5/17	48 Weeks
Good Samaritan Society	Postville	1/7/16	1/5/17	52 Weeks
Good Samaritan Society	St. Ansgar	12/31/15	12/22/16	51 Weeks
Grundy Care Center	Grundy Center	1/28/16	1/5/17	49 Weeks
Guttenberg Care Center	Guttenberg	12/10/15	12/1/16	51 Weeks
Hawkeye Care Center	Dubuque	1/28/16	1/5/17	50 Weeks
Hawkeye Care Center	Marshalltown	1/28/16	1/12/17	48 Weeks
Linn Haven Rehab & Health Ctr.	New Hampton	1/28/16	1/19/17	51 Weeks
Living Center East	Cedar Rapids	2/25/16	1/26/17	48 Weeks
Lutheran Retirement Home	Northwood	1/28/16	1/19/17	51 Weeks
Mercy Medical Center	Centerville	1/21/16	1/19/17	52 Weeks
New Hampton Nursing & Rehab	New Hampton	2/4/16	1/26/17	51 Weeks
Northern Mahaska Specialty Care	Oskaloosa	2/11/16	1/5/17	47 Weeks
Northgate Care Center	Waukon	1/28/16	1/26/17	52 Weeks
Northridge Village	Ames	10/7/15	1/19/17	67 Weeks
Oakwood Care Center	Clear Lake	12/17/15	12/8/16	51 Weeks
Parkview Manor Care Center	Reinbeck	1/21/16	1/12/17	51 Weeks
Pleasant View Care Center	Whiting	1/28/16	1/26/17	52 Weeks

QHC Winterset North	Winterset	12/23/15	12/27/16	52 Weeks
Rehabilitation Center of Allison	Allison	1/21/16	1/19/17	52 Weeks
River Hills Village	Keokuk	12/3/15	11/3/16	48 Weeks
Rolling Green Village Care Center	Nevada	2/11/16	1/5/17	47 Weeks
Sunnybrook Living	Fairfield	12/17/15	1/26/17	57 Weeks
Tabor Manor Care Center	Tabor	1/22/15	12/22/16	48 Weeks
The Ambassador	Sidney	1/14/16	1/12/17	52 Weeks
The Rehab Center	Des Moines	12/17/15	12/15/16	52 Weeks
Touchtone Healthcare Community	Sioux City	1/28/16	1/26/17	52 Weeks
University Park N & R	Des Moines	2/11/16	11/26/17	50 Weeks
Washington County Hospital	Washington	2/11/16	1/12/17	48 Weeks
West Point Care Center	West Point	11/25/15	11/23/16	52 Weeks

Of the (41) Tabulated Annual Surveys Reviewed in February:

38 of the Annual Surveys were earlier than or the same as last year &
3 of the Annual Surveys were later than last year.

Earliest Surveys:

Northern Mahaska Specialty Care	Oskaloosa	2/11/16	1/5/17	47 Weeks
Rolling Green Village Care Center	Nevada	2/11/16	1/5/17	47 Weeks

Latest Surveys:

Northridge Village	Ames	10/7/15	1/19/17	67 Weeks
Sunnybrook Living	Fairfield	12/17/15	1/26/17	57 Weeks

*** Special Focus Facility**

Average Survey Frequency:	**February Survey Meeting**	**50.88 Weeks**	**(1.12 Weeks Early)**
	January Survey Meeting	**49.69Weeks**	**(2.30 Weeks Early)**
	December Survey Meeting	**48.52 Weeks**	**(3.48 Weeks Early)**
	November Survey Meeting	**48.03 Weeks**	**(3.97 Weeks Early)**
	October Survey Meeting	**47.04 Weeks**	**(4.96 Weeks Early**
	September Survey Meeting	**46.72 Weeks**	**(5.28 Weeks Early)**
	August Survey Meeting	**47 Weeks**	**(5 Weeks Early)**
	July Survey Meeting	**45.12 Weeks**	**(6.88 Weeks Early)**
	June Survey Meeting	**45.31 Weeks**	**(6.69 Weeks Early)**
	May Survey Meeting	**46.60 Weeks**	**(5.40 Weeks Early)**
	April Survey Meeting	**48.50 Weeks**	**(3.50 Weeks Early**