ATTENTION USERS OF THIS SERVICE!

Please take one minute to answer four questions to help better align "Compliance Tips" with your needs.

1. If you use this document, how is it used and who do you share it with?
2. What information do you find useful?
3. What information is not useful?
4. What changes would you recommend so this service better fits your needs?

Copy and paste your responses and send to Bill Nutty, VP/Government and Regulatory Affairs.

Thank you!

Compliance Tips from IHCA's Survey Results Committee

February 2018

The five most frequently cited tags from the 21 annual surveys (2 deficiency free), 29 complaints (11 unsubstantiated), 4 self-reports (1 unsubstantiated), 15 complaint/self-report (4 unsubstantiated) and 0 mandatory reports (0 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 134 total deficiencies.

The following is a breakdown of severity level:

A =	0.00%	D =	64.92%	G =	8.21%
B =	0.00%	E =	18.66%	H =	0.00%
C =	0.75%	F =	2.24%	I =	0.00%
				J =	2.61%
				K =	0.75%
				L=	1.49%

Total # of Reports: 70
Total # of surveys/reports deficiency free or unsubstantiated: 25
Avg. # of deficiencies

- All = 2.98 (deficiency free/unsubstantiated reports removed)
- Annual = 3.60
- Complaints = 1.71
- Self-reports = 3.00
- Complaint/Self-Reports= 3.00
- Mandatory = 0.00
- Special Focus = 0.00

Total state fines for January Report = $32,250 ($26,250 held in suspension)

Be sure to see the survey frequency report on pages 10 and 11!

This report includes a combination of old and new F Tag numbers

Deficiencies and Fines (sorted ascending by f-tag number)

F 159—Protection of Resident Funds/Property

- Multiple purchases of razor, deodorants, etc. were charged to resident accounts and not accounted for properly. Purchased items could not be located (D)

F 223—Abuse

- RN overheard a staff member yelling obscenities at a resident in the memory unit and was holding resident by both wrists when they entered the room (E) **$500 fine**

F 225—Failure to Report Abuse

- Facility failed to report (F223) to DIA on a timely basis (E) **$1,500 fine, $500 trebled**

F 241—Residents Rights

- Multiple staff observed walking into rooms without knocking (D)
- A nurse lifted a resident's shirt to inspect a possible yeast infection at the nurses station in view of other residents (D)

F 278—Accuracy of Assessment

- Facility failed to update care plans. No devices to prevent hand contractures, confusion existed whether a resident was independent, or staff assist, care plan was not correct (D)

F 281—Professional Standards of Quality

- Staff failed to watch residents consume medications as they were observed to remain at the dining room table with the nurse not present. An improper dose of medications was given to a resident (D)

F 309—Highest Practicable Well-Being

- Facility staff fails to assess skin condition and interventions to promote healing (D) **$500 fine**
- Family wanted a resident transported to ER by ambulance and nurse did not arrange the transfer without talking to the MD who did not call back in a timely manner, Resident with an unresponsive episode and no follow-up charted (D)

F 312—Quality of Care; Activities of Daily Living

- Baths were not provided as required or documented. Bath aide was pulled to floor to assist with daily cares (E)
- Hips were not cleansed when visible wet pad was observed being changed (D)

F 323—Free of Accident Hazards/Supervision/Devices

- Nursing staff failed to provide appropriate assessment of resident's CV and respiratory symptoms and failed to honor resident request to go to hospital. Resident arrested as ambulance personnel arrived at facility, but resident did not respond to CPR and subsequently died without transfer (G) **$6,000 fine**
- staff forgot to take resident's wheelchair pedals off during transfers as care planned due to fragile skin causing a 5-6-inch skin tear on a that had a high INR causing unstoppable bleeding. Resident waited more than an hour for help to the bathroom and finally attempted herself and fell receiving multiple lacerations requiring surgical repair (G) **$3,000 fine**
- A resident had multiple X-rays over 3 weeks after the resident’s arm was found stuck thru the siderails, the latest one showing a fx of humerous. This resident had sitter providing cares (G) **$1,500 fine ($500 trebled)**
- A resident presented with multiple bruises, probably related to a fall. No record of a fall existed as resident was alarmed and alarm did not sound. Alarms apparently did not operate properly (D)
- Staff were observed utilizing the EZ stand lift with only 1 person, not 2 as required (D)

F 353—Nursing Services

- Facility failed to respond to call lights on a timely basis (D)
- call light log showed multiple lights greater than 15 minutes, resident waited longer than an hour after asking for help and fell (D) **$500 fine**

F 431—Service Consultation

- One tablet was missing from the blister packs of alprazolam. Drug count were not correct (D)

F441—Infection Control

- Nurse passed meds to 10 residents without cleaning hands (E)
- No opened date on items in the refrigerator, discard by date items remained in refrigerator, poor glove change (E)

- Staff failed to wash hands before/after providing cares to a resident in isolation/receiving treatments (D)
- Staff did not wash hands when providing incontinence cares to residents and touched multiple items in the room including TV remote, combs items in drawer, etc. (D)

NEW F TAGS

F 550—Resident Rights/Exercise of Rights

- Employees not knocking or knocking and not waiting before entering rooms (D)

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

- At the conclusion of the day shift, resident asked aide to toilet. Aide told resident that 2nd shift would have to help them toilet and if unable to wait to "go in the brief while in bed and get cleaned up later. "At the conclusion of the day shift, resident asked aide to toilet. Aide told resident that 2nd shift would have to help them toilet and if unable to wait to "go in the brief while in bed and get cleaned up later" (D)

F 558—Reasonable Accommodations of Needs/Preferences

- 2 resident call lights not within reach (D)
- Call light not within reach (D)

F 568—Accounting of Records and Personal Funds

- Facility failed to keep proper records of resident personal funds for whom he former administrator served as payee (E)

F 580—Notification of Changes Injury/Decline/Room)

- Nursing staff failed to notify physician of resident fall (D)
- Resident with a large bruise not reported to the family or physician (D)

F 582—Medicaid/Medicare Coverage/Liability Notice

- No advance discharge notice from snf care for 2 residents (D)
- Residents were not provided with change of services forms when being discharged from SNF services (D)

F 583—Personal Privacy/Confidentiality of Records

- Staff failed to knock on resident door before entering. Room divider curtain was not fully drawn and resident receiving pericare was exposed to roommate and staff member entering room with laundry. Second laundry worker entered room without knocking during a surveyor resident interview (D)

F 584—Safe/Clean/Comfortable Homelike Environment

- Wallpaper coming off walls, paint coming off drawers exposing bare wood and splinters, wood molding coming off, exposed sheetrock, rust and sharp edges to heater grate, dirty curtain dividers, stained ceiling tiles (E)

F 600—Free from Abuse and Neglect

- Facility unable to stop 1 resident from repeated agitated and aggressive behaviors toward staff, visitors and other residents. No injuries have not yet occurred (D)

F 609—Reporting of Alleged Violations

- A staff member allegedly heard another staff member tell a resident that "you piss me off". It was not reported to facility management for three days (D)

F 622—Transfer/Discharge Requirements

- Resident sent to ER per sheriff without a transfer sheet, medical records, or call to the ER (D)

F 624—Preparation for Safe/Orderly Transfer/Discharge

- Referral made to a home health agency who declined to admit the resident, but the resident was discharged anyway even though home health services were needed (D)

F 656—Develop/Implement Plan of Care

- No infection control precautions noted on care plan for resident with trach and ventilator (D)
- Resident admitted with a pressure ulcer and it was not identified on the care plan (D)
- Care plan did not address interventions for resident behaviors, care plan did not address seat belt that was observed being used (D)

F 657—Care Plan Timing and Revision

- Facility failed to update a care plan after resident developed a contracture of the hand (D)

F 658—Services Provided Meet Professional Standards

- Nursing staff did not implement physician order for compression stocking and discontinued shakes for residents without physician order (E)
- Nasal spray administered with 2 sprays instead of 1 as ordered, nurse gave medications mixed in pudding to another nurse to administer due to a resident refusal, nurse left the resident's medications without supervising its administration for 6 residents (E)
- Failure to weigh 2 residents according to physician's orders (D)
- Failed to notify physician of FBS greater than 160 as ordered (D)
- TED hose ordered and not observed on multiple times during survey, daily weights ordered and not completed (D)
- Insulin pens were not primed with the correct dosage prior to administration (D)

F 659—Qualified Persons

- Care plan stated pressure relieving cushion in chair and observed multiple time without it, Foot straps not in place as care planned (D)
- Care planned to float heels and observed not floated (D)

F 677—ADL Care Provided for Dependent Residents

- Staff did not cleanse all areas exposed to urine from incontinence (D)
- Facility staff failed to offer oral care during morning cares (D)

F 684—Quality of Life

- Resident went 6 days without any bowel movement or intervention (E)
- Facility failed to provide timely assessment and interventions for wound care (D)
- Facility lacked a timely assessment for a large bruise (D)
- Facility failed to provide timely assessment and interventions for wound care (D)
- Facility did not monitor a resident for incontinence or provide toileting with any frequency as observed. Record did not reflect BM's or the use of laxatives as needed for bowel management (D)

F 686—Treatment to Prevent Pressure Ulcers

- Resident developed stage 3 pressure ulcer on heel after being admitted with none (G) **$2,250 fine**
- Uncontrolled pain due to pressure ulcer that worsened, and documentation lacked appropriate interventions including nutrition interventions in a timely manner (D) **$500 fine**
- Facility staff did not properly perform wound vac treatment as ordered by physician leading to delayed healing of wound (D)
- resident went 6 weeks without having pressure ulcer assessed (D)
- Nursing staff did not document wound care as ordered on two consecutive days. During observation of wound packing, nurse dropped packing on bed linen and then packed wound with same packing (D)

F 687—Foot Care

- No comprehensive care plan developed for resident within 21 days of admission (D)

F 688—Prevent Decrease in Range of Motion

- Therapist ordered walk to dine program for resident never implemented (G) **$3,250 fine**
- Staff did not prevent resident from developing a contracture of the hand after admission (G) **$2,000 fine in suspension**
- Restorative not completed as planned for 4 residents (E)
- No restorative nursing program for 2 residents that had limitations in range of motion (D)

F 689—Free from Accidents and Hazards

- Resident self-transferred, fell and sustained a hip fracture and subdural hematoma. No person-centered care plan interventions to prevent self-transfers for resident with dementia (G) **$6,000 fine**
- Resident fell from a lift after the leg strap of the sling came off the lift. The staff was using a bedpan between the resident and sling, the room was not setup in a way that was functional for a lift (G) **$5,750 fine in suspension**
- Resident fell and fractured hip after being left alone in her wheelchair in room when the care plan directed not to do this. Resident ended up on hospice without a surgical intervention (G) **$5,000 fine**
- Resident fell, and facility did not revise care plans to prevent further incidents. Resident fell in bathroom -fx pelvis. Resident was previously noted to get up on their own multiple times (G) **$5,000 fine is suspension**
- A resident with multiple falls; alarms not functioning at times, care plan approaches not being followed., etc. etc. (multiple residents) (G) **$3,750 fine**
- Resident was transferred using a sit to stand lift when unable to bear weight steadily. Resident was care planned for Hoyer lift. Transfer resulted in a dislocated shoulder (G) **hospital-based NF, no fine**
- Open shower room door with unlocked cabinet containing chemicals, full Morphine bottle unattended at nurses' station (E)
- Unlocked medication cart (E)
- Resident left alone in dining room and resident self-transferred resulting in a fall. Staff had been directed not to leave resident unattended in the dining room (D)
- Failed to implement fall precaution interventions (D)
- No gripper socks as care planned ad resident fell, staff performed a total lift without using gait belt (D)
- Resident received a black eye during an EZ stand transfer. Only one staff member attempted the transfer, should have been a 2-person transfer (D)
- Residents fell receiving a laceration and bed was in raised position when it was meant to be in low position, Resident left alone in room when care planned not to be and fell sustaining a laceration (D)

F 692—Nutrition/Hydration Status/Notice

- No care plan interventions existed for residents with documented weight losses (D)

F 693—Tube Feeding Management/Restorative Eating Skills

- Staff did not check placement of G tube or elevate head of bed prior to starting tube feeding (D)
- Bulb used for flushing G tube was dated 4 days prior instead of being disposed after 24 hrs. (D)

F 695—Respiratory/Tracheotomy Care/Suctioning

- A resident was nor receiving oxygen as ordered and their oxygen sats. fell below desirable levels (D)

F 698—Dialysis

- Facility failed to address the assessment of a fistula in the care plan or charting (D)

F 700--Bedrails

- Five residents were in beds that the gap between the side rail and the mattress measured greater than 4 3/4 inches (K) **$9,500 fine in suspension**

F 713—Physician Care for Services 24 Hours a Day

- A resident with a respiratory infection did not have a physician available to treat the resident appropriately (L) **$3,500 fine in suspension**
- Facility did not arrange for physician services 24 hours per day (See F713) (L)

F 725—Sufficient Nurse Staffing

- Call lights not answered in a timely manner (E) **$500 fine**
- Failure to answer call lights within 15 minutes for 4 residents (E)
- Multiple resident call lights greater than 15 minutes verified by the call light log (E)
- Call light response times exceeded 15 minutes on multiple occasions (E)
- Call light response times exceeded 15 minutes on multiple occasions (D)

F 732—Posted Nurse Staffing Information

- Nurse staffing posting not completed daily (C)

F 757—Drug Regimen Free of Unnecessary Drugs

- Family refused GDR and facility did not educate family on importance of GDR attempts. Documentation lacked clinical rationale for continued psych med use (D)

F 758—Free from Unnecessary Psychotropic Medications

- Facility did not do autostop on prn hypnotic and pain meds when exceeding 14 days (D)

F 759—Free of Medication Errors 5%

- Did not administer eye drops to both eyes as ordered; mixed up number of drops on different eye drop solutions (D)

F 761—Label/Store Drugs and Biologicals

- Insulins in labeled bags but bottles themselves not labeled (D)
- Facility did not follow own procedure for documenting & visualizing the narcotics delivered from the facility pharmacy (D)

F 800—Provided Diet Meets Needs of Each Resident

- Improper measurement of ground meat and use of wrong scoop size resulted in wrong serving size (E)

F 803—Menus Meet Residents' Needs/prep in Advance

- Residents not always receiving morning meal service or meal service which was skimpy and did not meet menu guidelines (D)
- No menu had been created for a resident on liquid only diet (D)

F 804—Nutritive Value, Palatability, Appearance, Temperatures

- Milk temps greater than 41 degrees (E)

F 805—Food in Form to Meet Individual Needs

- Room tray temperature were not maintained at 140 degrees before service (D)

F 809—Frequency of Meals/Snacks at Bedtime

- Bed time snacks not offered regularly. One resident complained of low am blood sugars (D)

F 812—Food Procurement, Storage, Preparation, Sanitization

- Dietary staff moved between dirty and clean dishes without washing hands, dietary staff wiped clean spoon on apron to dry before placing in storage (F)
- Undated open lettuce, cereal, pie crust, and buns. Butter not refrigerated, staff walking thru kitchen with no hair net, dirty fan (F)
- Blue and brown substances in refrigerator door, meat in freezer dated as opened 6 months prior, dirty inside freezer door, carbon build-up on 4 sheet pans. Cook touching multiple kitchen appliances and then food without washing hands (F)
- Staff serving meal touched eating surface of plates with ungloved thumbs. Staff failed to wash hands before serving food in dining room. Cook let handle of tongs touch bread that was to be served (E)
- Thickener scoop left in can, shakes without thaw dates, expired yogurts (E)
- Grey/brown debris hanging from shelves above pots and pans, dirty Hobart mixer legs, dirty fan blades, dirty microwave, brown stained coffee carafes (E)
- Cutting boards in kitchen were deeply grooved and discolored (D)

F 835--Administration

- Failure of the administration in directing the assessment for bed entrapment (D)

F 842—Resident Records—Identifiable Information

- Incomplete charting regarding one resident pushing another resident, one nurse documented unsafe footwear after a fall and the other nurse documented no safety issues (E)

F 868—QAA Committee

- Facility failed to hold QAA meetings quarterly (D)

F 880—Infection Prevention and Control

- Improper glucometer sanitizing, touching dirty then clean surfaces in the resident room while serving food trays, hair touching the food plate cover, laundry

employee touching dirty and clean surfaces in hallway with washing hands or changing gloves, staff removing gloves during cares without washing hands, placing disposable wipes on the top of the wipe container, touching garbage container then continuing with cares, touched catheter bag then other objects in room without changing gloves or washing hands (E)

- Aide used peri care wipe to cleanse catheter bag drain rather than alcohol wipe while emptying catheter bag (D)
- Proper handwashing not completed during catheter cares (D)
- Improper glove use during pericare (D)
- Did not administer 2nd step of TB test in a timely manner and when given the test read positive and was not acted on for 4 days (D)
- Staff performing trach care did not wash hands between glove changes, utilized used med cup stored uncovered in resident bedside drawer for saline needed for trach care. Another staff member when suctioning trach did not put down clean barrier on which to lay disconnected vent tubing during procedure (D)
- Aide did not change gloves during peri care when resident was incontinent of stool (D)
- Staff provided incontinence care then without removing gloves touched bedding, handled the bed controller, touched clothes (D)
- RN applying ointment to resident toes without applying gloves. After applying gloves, failed to wash hands after removing dirty gloves. No barrier placed between wound supplies and dirty surface. Staff did not wash hands upon entering a resident room, providing care and then left without washing hands. Improper cleansing of glucometer after use and did not use barrier under glucometer in resident room. No barrier placed on overbed table before laying syringe with medication on overbed table (D)

F 583—Personal Privacy

- Window curtains left open while resident was exposed during pericare (D)

F 919—Resident Call System

- Battery on wrist call light was inoperable. Call light system did not function properly (D)

F 921—Safe/Sanitary/Comfortable Environment

- Marred and chipped paint on walls, marred and chipped closet doors and furniture (E)
- Doors with heavy scratches and veneer missing (E)
- Water temps found at 85 degrees in resident rooms - deemed not comfortable for bathing or personal care (D)

F 947—Required In-Service Training for CNAs

- Facility failed to ensure staff attended all required in-services (D)

F 949—Behavioral Health Traning

- Facility failed to ensure staff attended all required in-service training for 3 of 4 CNA's reviewed (D)

L1093

- Facility failed to determine VA status for 2 residents

N101

- Failure to report a major injury **$500 fine**
- Facility failed to notify DIA of a fall with major injury within the required time frames **$500 fine**

Annual Survey Frequency
February Survey Results Meeting

Facility	City	Last Year	This Year	Frequency
ABCM Rehab West	Independence	11/17/16	1/18/18	61 Weeks
Accura Healthcare of Ogden	Ogden	11/10/16	1/9/18	61 Weeks
Arbor Court	Mount Pleasant	11/10/16	1/9/18	61 Weeks
Cherokee Specialty Care	Cherokee	11/23/16	12/28/17	57 Weeks
Good Samaritan Society	Algona	12/1/16	1/30/18	61 Weeks
Heritage Specialty Care	Cedar Rapids	12/1/16	1/30/18	61 Weeks
Highland Ridge	Williamsburg	11/17/16	1/9/18	60 Weeks
Iowa Lutheran Hospital-SNF	Des Moines	11/23/16	12/28/17	57 Weeks
Karen Acres Care Center	Urbandale	12/15/16	1/30/18	59 Weeks
Keystone Nursing Care Center	Keystone	11/23/16	1/18/18	60 Weeks
Little Flower Haven	Earling	11/10/16	1/9/18	60 Weeks
Manorcare	Waterloo	12/1/16	1/30/18	61 Weeks
Oakview, Inc.	Conrad	8/31/16	10/5/17	57 Weeks
Red Oak Healthcare Center	Red Oak	12/1/16	1/30/18	61 Weeks
River Hills Village	Keokuk	11/3/16	12/19/17	59 Weeks
Sheffield Care Center	Sheffield	11/23/16	1/9/18	59 Weeks
Southfield Wellness	Webster City	11/2/16	12/28/17	60 Weeks
Spurgeon Manor	Dallas Center	11/10/16	1/18/18	62 Weeks
Tru Rehab	Grinnell	11/17/16	1/30/18	62 Weeks
Wellington Place	Decorah	11/17/16	1/18/18	61 Weeks
West Point Care Center	West Point	11/23/16	1/18/18	60 Weeks
Earliest Survey:				
Iowa Lutheran Hospital-SNF	Des Moines	11/23/16	12/28/17	57 Weeks
Oakview, Inc.	Conrad	8/31/16	10/5/17	57 Weeks
Latest Survey:				
Tru Rehab	Grinnell	11/17/16	1/30/18	62 Weeks
Spurgeon Manor	Dallas Center	11/10/16	1/18/18	62 Weeks

2 Facilities were "Deficiency Free" - (10 %)

Highland Ridge	Williamsburg
Wellington Place	Decorah

Average Survey Frequency:	**2018**		
	February Survey Meeting	**60.00 Weeks**	**(8.00 Weeks Late)**
	January Survey Meeting	**56.44 Weeks**	**(4.44 Weeks Late)**
	2017		
	December Survey Meeting	**56.79 Weeks**	**(4.79 Weeks Late)**
	November Survey Meeting	**57.30 Weeks**	**(5.30 Weeks Late)**
	October Survey Meeting	**55.92 Weeks**	**(3.92 Weeks Late)**
	September Survey Meeting	**55.00 Weeks**	**(3.00 Weeks Late)**
	August Survey Meeting	**55.92 Weeks**	**(3.92 Weeks Late)**
	July Survey Meeting	**56.54 Weeks**	**(4.54 Weeks Late)**
	June Survey Meeting	**54.90 Weeks**	**(2.10 Weeks Late)**
	May Survey Meeting	**54.90 Weeks**	**(2.10 Weeks Late)**
	April Survey Meeting	**52.84 Weeks**	**(0.84 Weeks Late)**
	March Survey Meeting	**51.21 Weeks**	**(0.79 Weeks Early)**