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

Compliance Tips from IHCA's Survey Results Committee
February 2019

Total Number of Survey Reports: 48

Survey Composition:

Annual:	21 Surveys	1 Deficiency Free
Complaints:	28 Surveys	8 Unsubstantiated
Self-Reports:	16 Surveys	3 Unsubstantiated
Mandatory Reports:	1 Surveys	

State Fines:	$9,500
State Fines in Suspension:	$62,750
Trebled Fines:	$42,000

Most Commonly Cited Iowa Tags:

F 689 – Free from Accidents and Hazards (15)

F 658 – Services Provided Meet Professional Standards (10)

F 625 – Notice of Bed Hold Policy Before/Upon Transfer (8)

F 812 – Food Procurement, Storage, Preparation, Sanitization (8)

F 880 – Infection Prevention and Control (8)

F 677 – ADL Care Provided for Dependent Residents (7)

Tags Resulting in Actual Harm or Higher Citations:

F 689 – Free from Accidents and Hazards:	4 G Level Tags, 1 J Level Tag, 1 K Level Tag
F 686 – Treatment to Prevent Pressure Ulcers	2 G Level Tags
F 692 – Nutrition/Hydration Status Maintenance	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=15617		Total Number of Surveys=6774
F0880	Infection Prevention & Control	1,685	10.3%	24.9%
F0689	Free of Accident Hazards/Supervision/Devices	1,560	9.1%	23.0%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	1,381	8.6%	20.4%
F0656	Develop/Implement Comprehensive Care Plan	1,247	7.6%	18.4%
F0684	Quality of Care	1,171	6.8%	17.3%
F0761	Label/Store Drugs and Biologicals	932	5.7%	13.8%
F0657	Care Plan Timing and Revision	793	4.8%	11.7%
F0758	Free from Unnec Psychotropic Meds/PRN Use	752	4.7%	11.1%
F0677	ADL Care Provided for Dependent Residents	718	4.1%	10.6%
F0550	Resident Rights/Exercise of Rights	678	4.0%	10.0%

*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)

F 550 – Resident Rights/Exercise of Rights

- Facility failed to treat a resident with dignity during personal cares. Nurse aide made a resident sit on a stool that had visible stool on it. D
- Facility failed to ensure reviewed were treated in a manner that enhanced their quality of life. Resident was under covers in bed fully dressed with shoes on; resident stated he preferred to sleep with shoes. Resident's buttock left exposed while staff went residents to get treatment supplies. D
- CNA told resident after completing HS catheter care and transferring resident to bed that he must stay there until day shift arrived and he would not be allowed to be up in his chair if he requested it. D
- Fail to maintain dignity of resident with a catheter. Bag on floor, no dignity, bag in place over catheter bag. Bag could be seen by visitors. D

F 567- Protection/Management of Personal Funds

- Residents did not have access to trust account balances. D
- Fail to assure residents have access to personal funds on weekends and have resident funds in interest bearing account. Resident reported having to request money prior to weekend as not able to access personal funds over weekend. E

F 578- Request/Refuse/Discontinue Treatment; Formulate Adv Directive

- Failed to ensure code statuses were accurate. D

F 600 – Free from Abuse and Neglect

- Fail to prevent an employee from verbally abusing, intimidating a resident. D

F 607- Develop/Implement Abuse/Neglect, etc. Policies

- Employee did not receive 2 hours of DAA training within 6 months of hire. D

F 610 – Investigate, Prevent, Correct Alleged Violation

- CNA who witnessed an alleged incident of verbal abuse did not report it to management. Facility did not separate the alleged victim and perpetrator and failed to educate staff on abuse following the alleged incident. D

F 622 – Transfer and Discharge Requirements

- Fail to provide appropriate info. to transferring facility at time of discharge D

F 623 – Notice Requirements Before Transfer/Discharge

- Failed to notify LTC Ombudsman of resident transfers for hospitalization. B
- Facility failed to notify the Ombudsman of a resident transfer to the hospital. B
- Failed to notify the Ombudsman of transfers to the hospital. D
- Fail to notify the Ombudsman of an emergency transfer/admission to hospital. B
- Failed to notify the Ombudsman to discharge/transfer to hospital. B

F 625 – Notice of Bed Hold Policy Before/Upon Transfer

- Fail to provide bed hold policy to resident representative at time of discharge to hospital. B
- Fail to provide a copy of the bed hold policy at the time of transfer to the hospital for residents who required bed hold notification. B
- Failed to provide a written copy of the bed hold policy. B
- No signed bed hold notification for residents sent to hospital. B
- Failed to provide bed hold notice upon discharge to hospital. B
- Failure to provide bed hold. D
- Fail to provide resident or rep of facility bed-hold policy prior to/upon transfer to hospital. B
- Failure of bed-hold policy notice. D

F 636 – Comprehensive Assessments & Timing

- Failed to complete an accurate assessment, resident had a level 2 PASRR and the MDS had not been marked correctly. D

F 641 – Accuracy of Assessments

- Fail to accurately complete MDS assessments. Medication section lacked that resident received antidepressant medication and antipsychotic medication. E

F 644 – Coordination of PASARR and Assessment

- Resident care plan did not list specialized psychiatric services as required by the Level II care plan. D
- Failed to update PASRR with new diagnosis of Schizophrenia. B
- Failure to do a new Level 1 PASRR with new mental health diagnosis. B
- PASARR not resubmitted with addition of mental illness diagnosis. D
- Fail to provide specialized psychiatric services as directed by PASARR. D

F 655 – Baseline Care Plan

- Fail to review baseline care plan with resident within 48-hrs after admission. D
- Failed to provide a baseline care plan to resident and family members. D

F 656 – Develop/Implement Plan of Care

- Facility failed to care plan goals and interventions addressing behavioral symptoms and use of psychoactive medications. D
- CNA failed to follow resident care plan which called for 2-person lift transfer when she self-transferred a resident using a lift. D
- Failed to update comprehensive care plan to address specific interventions required for resident with a feeding tube. D
- Failed to develop comprehensive care plan to address weight loss nor interventions as well as psychotropic medications. D
- Failed to address specific areas of care regarding activities, pain and potential for or actual pressure sores on the comprehensive care plan. D

F 657 – Care Plan Timing & Revision

- Fail to update care plan, lacked information regarding need for ongoing psychiatric services by psychiatrist to evaluate effectiveness of psychotropic medications on target symptoms and to evaluate the ongoing need for additional behavior health services. D
- Fail to update care plan: new interventions not addressed; resolved interventions not removed. D
- Fail to review and revise resident plan of care. Care plan did not have a falls risk problem in place and plan of care lack documentation of increased risk of falls due to antianxiety medication and no mention of side effects to watch for. D
- Comprehensive care plan failed to document attendance of family members at care plans. Failed to document care plan conferences in the care plan. E
- Failure to update care plan to include a blood thinner. Failure to update care plan to include interventions for a resident who had thoughts of dying. D
- Failed to ensure residents and/or representatives were notified and provided the opportunity to participate in care planning conferences. B

F 658 – Services Provided Meet Professional Standards

- Fail to follow physician orders as directed, order to change catheter drainage bag twice monthly, treatment record lacked evidence the catheter drainage bag was changed and lacked evidence the catheter was changed as planned. D
- Failed to follow physician orders as directed, had an order to wear bunny boots, several observations of resident not wearing the bunny boots. D
- Fail to ensure professional standards of practice during staff handling and administration of narcotic medications. Staff signed out the narcotic but did not give it at the time it was checked out. D
- Fail to follow physician orders as directed for resident. Resident had an order for oxygen at 2L and was found to be running at 3L. D
- CNA failed to apply TED hose during am care as ordered by physician. There was no instruction for application of the hose on CNA assignment sheets. D
- Failed to watch resident consume delivered medications. Fail to follow physician orders. Left medications in bowl at meal table and nurse walked away and left unattended. Upon return from hospital Miralax order was changed to every day, staff still administering every other day. D
- Not following physician's orders. D
- Fail to follow physician order for blood sugar testing; follow up with physician. D

- Fail to follow professional standards of medication administration- placement of G tube not checked prior to administering water flush; crushed meds without physician's order (one staff member prepped meds; different staff gave meds. D
- Failed to provide wound care as ordered by the physician and changed a wound care treatment without authorization of the physician. D

F 661 – Discharge Summary

- Failed to reconcile pre-discharge and post-discharge medications. Clinical record lacked a list of discharge medications provided to the resident or a reconciliation of the residents pre and post-discharge medications. D
- Failed to complete a recapitulation of residents stay after discharge.

F 677 – ADL Care Provided for Dependent Residents

- Failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene, resident had urine odor at several observations and did not receive timely incontinence care and had a urine contaminated mattress. D
- CNA performing pericare did not change gloves used to clean feces before applying barrier cream. D
- Fail to provide complete incontinence care, complete baths. Fail to clean end of penis and scrotum. Fail to cleanse hips. One bath provided per week rather than 2 per protocol and care plan. D
- Fail to provide completed, proper incontinence care. Fail to wash hands upon entering room, touched multiple items in room with gloves prior to initiating peri-care. Failed to cleanse resident buttocks where the soiled brief had been. D
- Failure to offer baths at least twice a week. D
- Failed to provide complete incontinence care. D
- Fail to provide incontinence care, didn't change soiled linens prior to care. D

F 678 – Cardio-Pulmonary Resuscitation (CPR)

- Failed to ensure availability of a staff member certified with CPR for each shift. D

F 679 – Activities Meet Interest/Needs of Each Resident

- Fail to provide sufficient activities on weekends. Fail to provide activities for those with dementia. E
- Failed to provide and document the involvement in activities for resident. D

F 684 – Quality of Care

- Fail to ensure receipt of prompt treatment after verbalizing increased pain. D
- Fail to assess newly-acquired moisture associated skin damage. Wound care nurse wasn't notified of new open area on patient's coccyx so it could be assessed. D

F 685 – Treatment/Devices to Maintain Hearing/Vision

- Failed to ensure a resident with impaired vision received proper treatment and assistive devices to maintain vision. D

F 686 – Treatment to Prevent Pressure Ulcers

- Fail to ensure resident didn't develop pressure sore unless their clinical condition demonstrates it was unavoidable for one of four residents. Client who had risk for pressure sores didn't have

anything care planned to prevent. Resident was left on bedpan for extended period of time, causing current pressure ulcer. G **($4,250 FINE)**

- Failed to provide interventions to prevent pressure ulcers from developing. Matrix reported no pressure ulcers in facility. Resident admitted with no ulcers and developed open areas on bottom with interventions added to plan of care. DON reported ulcers were avoidable. D
- Resident with pressure on heel didn't have required heel protectors. Resident came with a pressure and it got worse as no treatment was provided. Another resident had a heel pressure which also worsened due to improper treatment. D
- Fail to properly assess, carry out interventions/prevent pressure ulcer. D
- Fail to provide care to resident to prevent the development of pressure ulcers. G **($5,000 FINE IN SUSPENSION)**

F 688 – Prevent Decrease in Range of Motion

- Fail to implement interventions to prevent development of contractures. Resident care plan stated resident had full range of motion in upper/lower body, but resident was observed to have in fist with no range of motion of thumb and also had no restorative therapy program in place. D
- Failure to follow the restorative program to maintain proper range of motion. D
- Fail to provide ongoing interventions to prevent healing of a pressure ulcer. D

F 689 – Free from Accidents and Hazards

- Fail to complete ongoing smoking assessment for resident that smoked independently to ensure ability to continue smoking independently safely. D
- Fail to ensure that resident environment remained as free of accident hazards as possible and each resident received adequate supervision and assistive devices to prevent accidents; resident eloped from facility after voicing she wanted to go home several occasions, exhibited increase restlessness, no evidence of increased monitoring the day of incident, was found outside by visitor, no one knew resident was gone or how she could get out undetected. D
- Resident eloped w/o staff knowledge- had previous attempts. Resident tried to elope w/in 30 minutes of actual elopement, no evidence of increased monitoring, resident walked 750ft on uneven ground in dark, across county road to store where they called to alert facility. Delivery was made to facility and resident eloped through that door, staff confirmed they disable local alarm but thought they turned it back on, no routine door alarm checks performed, failed to follow elopement policy by failing to identify high risk residents on care plan. J **($18,000, Trebeled)**
- Fail to provide adequate supervision to ensure each resident's safety. Resident routinely wandered, found in another resident bed when resident was supposed to be a one on one. D
- Fail to ensure staff transferred/repositioned a resident in a safe manner as care planned. Resident had care plan that required 3 people to reposition client with Hoyer lift. Aide used Hoyer by herself without looking at the care plan and the patient ended up on the floor with skin tear and bump/abrasion. D
- Door alarms were not checked daily as required by facility policy when the alarm system check log was reviewed. E
- Fail to provide adequate supervision to prevent accidents. No documentation r/t if alarm was on and functioning at time of fall. Resident fell with fractured hip; no nursing staff present in unit and husband reported alarm did not sound. Another resident fell during self transfer with fractured nose, alarm did not sound. G **($4,750 FINE)**
- Fail to provide adequate supervision to prevent accidents. Resident sustained injury to face, nasal bone fractures, laceration above eye which required sutures and glue to close. G
- Fail to ensure resident environment remains free of accidents and hazards in the hallway where equipment was being stored. E

- Resident was transferred using a Sara Lift instead of a Hoyer lift and resident suffered bilateral femur fractures. G
- Fail to ensure safe transfers, used 1 assist instead of 2 required by care plan. D
- Fail to implement a safe system with regard to smoking, smoking areas and smoking safety for residents identified as independent smokers. K
- Fail to ensure adequate supervision when resident was at appointment. D
- Fail to ensure staff performed safe resident transfers, resulting in serious injury. CNA transferred resident without gait belt, resident was care planned as assist of 2 for transfers. CNA lifted resident, lowered her to knees on floor, lifted her to bed. CNA didn't report incident. G **($24,000, Trebeled)**
- Fail to provide adequate supervision to ensure resident safety. Left resident on toilet unattended, not following plan of care. D

F 690 – Bowel, Bladder Incontinence, Catheter Care

- Fail to provide adequate incontinence care for resident with history of urinary tract infection. CNA did not clean front areas with peri care. D
- Fail to provide appropriate catheter care. Catheter tubing touched wheel on wheelchair. Catheter tubing touching floor when catheter bag changed to dignity bag on walker. Tubing on floor when resident was transferred to recliner. D

F 692 – Nutrition/Hydration Status Maintenance

- Residents had excessive weight loss. Dietitian recommendations of magic cups as supplements were not served with meals. G **($2,750 FINE IN SUSPENSION)**
- Failed to prevent significant weight loss. Dietitian did not address significant weight losses, as she felt resident needed hospice instead. D

F 698 – Dialysis

- Failed to provide ongoing assessment of resident's condition and monitoring for complications before and after dialysis treatments. D

F 700 – Bedrails

- Failed to obtain informed consent prior to the installation of bedrails/bar. E

F 725 – Sufficient Nurse Staffing

- Failed to answer resident call lights in a timely manner in order to meet resident needs. Residents stating having to wait up to an hour for help. D
- Failed to answer resident call lights in a timely manner. E
- Fail to ensure adequate staffing in order to answer resident call lights timely to meet resident needs. E
- Fail to ensure prompt staff response to resident's use of the nurse call system. E

F 727 – RN 8 Hrs./7 days/Wk., Full Time DON

- Failed to have a director of nursing on a full-time basis for the past 12 weeks. F
- Failed to provide 8 hours of RN coverage for three day in November. E

F 744 – Treatment /Service for Dementia

- Failed to implement care plan interventions identified for a resident with dementia to attain/maintain highest practicable well-being. Staff report multiple different attempts to redirect - interventions used not captured on plan of care.

F 758 – Free from Unnecessary Psychotropic Meds/PRN Use

- Failed to ensure a resident did not receive unnecessary medications. PRN Anti-anxiety medication ordered without review for 8months. D
- Failure to complete a gradual dose reduction of Remeron. D
- Record review lacked documentation of physician's order for rationale for continuation of Ativan beyond 14-days and an ending date for re-evaluation. D

F 760 – Residents Are Free of Significant Med Errors

- Nurse prepared insulin for administration drawing up 17 units w/ DON observing, order called for 14. Surveyor stopped nurse from administering. D
- Fail to ensure residents are free of significant medication errors. Insulin checked by 2 nurses and attempted to administer in front of surveyors - wrong dose. D

F 803 – Menus Meet Res Needs/Prep in Advance /Followed

- Fail to provide bread/margarine for residents, cook served residents meals using paper menu the dietary supervisor typed from dietician's meal plans, paper menu failed to have bread/margarine included, no residents on regular or mechanical soft diets received bread/margarine as original menu called for. B
- Facility failed to provide correct portion size of ground chicken for residents.
- Failed to follow the menu for residents on pureed diets. E

F 804 – Nutritive Value/Appearance/Palatability/Temp

- Failure to serve food at warm enough temperatures E

F 805 – Food in Form to Meet Individual Needs

- Fail to serve residents on regular mechanical soft diet correct Rx diet. D

F 806 – Resident Allergies, Preferences and Substitutes

- Menu did not list alternate food choices available. Cabbage was the only vegetable offered and applesauce was given to a resident as a substitute. E

F 812 – Food Procurement, Storage, Preparation, Sanitization

- Fail to maintain clean and sanitary kitchen. There was buildup of dust, dirt and debris on floor, buildup of black substance along the wall and baseboard. F
- Failed to ensure resident food items were labeled and dated when opened. E
- Fail to maintain clean kitchen, dust on vents, pot racks, air ventilation. Window frames gouged, couldn't be sanitized. Dirty pot hung w/ clean pots. E
- Failure to maintain sanitary environment in kitchen and did not follow proper procedures for food transport (desserts were not covered). E
- Failed to ensure dietary staff utilize proper gloving. E
- Failed to adequate cleaning of food service equipment. E
- Failed to maintain clean and sanitary kitchen equipment. E

- Food in freezer was not labeled or dated, food in activity room refrigerator not dated when opened. E

F 868 – QAA Committee

- Failed to provide documentation of quarterly QA meetings since the last survey; Fail to ensure appropriate number personnel attend Quarterly QA meetings. D

F 880 – Infection Prevention and Control

- During dressing change, nurse removed scissors from uniform pocket, cut soiled dressing, used same scissors to cut clean dressing w/o first disinfecting. D
- Nurse failed to change gloves/wash hands between dirty dressing change and application of new dressing. D
- Fail to utilize proper infection control techniques: lack of handwashing after removing gloves, Foley catheter tubing touching floor, didn't remove soiled gloves after finger stick for blood glucose testing, touched med cart, inside scrub pocket. E
- Fail to utilize proper infection prevention techniques during wound care for resident with pressure ulcers. D
- Fail to utilize infection control techniques while providing care. E
- Fail to utilize proper infection control technique while providing cares. Placed eye drop bottle in baggie on shower counter without barrier, then placed inhaler med on baggie. Later placed med containers on counter without barrier. Took med containers/baggie back to med cart without cleansing bag or containers. D
- Fail to maintain infection control practices during provision of care. Fail to change gloves between handling soiled and clean linens/briefs. Placed plastic graduate on resident's sheet, placed graduate directly on floor to drain urine. Placed graduate on back of toilet after emptied. D
- Fail to ensure staff followed proper infection control practices during peri-care prior to wound care. D

F 925 – Maintains Effective Pest Control Program

- Fail to maintain environment free of vermin; mouse droppings along wall, pipe that ran along floor in clean dish area. Medium sized dead winged bug on top of refrigerator in kitchen, Maintenance Supervisor confirmed cock roaches at central nurse's station/red ants throughout facility which had been treated monthly. E

L 1093 –

- Fail to submit eligible resident name to the Iowa Department of Veterans Affairs.

N 101 –

- Facility failed to report an injury that required admission to a hospital.
- Failed to report a major injury to DIA within 24 hours of injury. **($500 FINE)**

Nursing Facility Survey Frequency

As of March 7, 2019, CMS lists 84 Iowa facilities (19.1%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 8.4%. National average is 7.1%

2018 - December Totals - LTC Surveys				
Provider	**City**	**Survey End Date**	**Previous Date**	**Months Between**
ABCM Rehab Centers of Independence East Campus	Independence	12/6/2018	9/14/2017	14.93
Adel Acres	Adel	12/6/2018	9/5/2017	15.23
Atlantic Specialty Care	Atlantic	12/19/2018	10/12/2017	14.43
Buchanan County Health Center	Independence	12/5/2018	9/7/2017	15.13
Colonial Manors of Columbus Community	Columbus Junction	12/6/2018	10/12/2017	14.00
Good Samaritan Society - Waukon	Waukon	12/13/2018	8/4/2017	16.53
Hallmark Care Center	Mount Vernon	12/19/2018	9/28/2017	14.90
Lantern Park Specialty Care	Coralville	12/13/2018	8/30/2017	15.67
Lexington Square (Now Mississippi Valley)	Keokuk	12/19/2018	9/5/2017	15.67
Morningside Care Center	Ida Grove	12/13/2018	8/30/2017	15.67
Oakview Nursing and Rehabilitation	Burlington	11/1/2018	7/20/2017	15.63
Oakview, INC	Conrad	12/13/2018	10/5/2017	14.47
Greenfield Rehabilitation and Health Care	Greenfield	12/8/2018	9/7/2017	15.23
Pearl Valley Rehab	Washington	12/3/2018	8/14/2017	15.87
			Average	**15.24**