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

Compliance Tips from IHCA's Survey Results Committee
February 2020

Total Number of Survey Reports: 47

Survey Composition:

Annual:	**36** Surveys	**3** Deficiency Free
Complaints:	**22** Surveys	**5** Unsubstantiated
Self-Reports:	**12** Surveys	**2** Unsubstantiated
Mandatory Reports:	**3** Surveys	**0** Unsubstantiated

State Fines: $33,000
State Fines in suspension: $ 57,000

Most Commonly Cited Iowa Tags:

F 812 – Food Procurement, Storage, Preparation, Sanitization (22)

F 880 – Infection Prevention and Control (19)

F 689 – Free from Accidents and Hazards (12)

F 658 – Services Provided Meet Professional Standards (12)

F 677 – ADL Care Provided for Dependent residents (9)

F 684 – Quality of Care (9)

Tags Resulting in Actual Harm or Higher Citations and Fines:

F 684 – Quality of Care	2 G Level Tags 1 J Level Tag
F 678 – Cardio-Pulmonary Resuscitation	1 J Level Tag
F 689 – Free from Accidents and Hazards	4 G Level Tags 1 J Level Tag
F 697 – Pain Management	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=15453		Total Number of Surveys=3285
F0880	Infection Prevention & Control	99	0.6%	3.0%
F0689	Free of Accident Hazards/Supervision/Devices	95	0.6%	2.9%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	78	0.5%	2.4%
F0684	Quality of Care	64	0.4%	1.9%
F0761	Label/Store Drugs and Biologicals	56	0.3%	1.7%
F0656	Develop/Implement Comprehensive Care Plan	53	0.3%	1.6%
F0677	ADL Care Provided for Dependent Residents	40	0.2%	1.2%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	39	0.3%	1.2%
F0609	Reporting of Alleged Violations	37	0.2%	1.1%
F0695	Respiratory/Tracheostomy Care and Suctioning	35	0.2%	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

- Curtain open during Peri Care D

F554 – Resident Self-Admin Meds-Clinically Appropriate

- Failed to provide ongoing assessments, care planning and physician orders for a resident to self-administer medications. Lack of completing a self-administering assessment. D

F558 – Reasonable Accommodations of Needs/Preferences

- Failed to ensure the residents call light was within reach. D
- Failed to ensure the residents call light was within reach. D

F565 – Resident/ Family Group and Response

- Failed to address grievance that clothing ruined by bleach in laundry for 3 months D

F576 – Right to Forms of Communication with Privacy

- Mail not consistently delivered on Saturdays due to no one at front desk every Saturday. E
- Facility did not deliver mail on Saturdays. D

F577 – Right to Survey Results/Advocate Agency Info

- Survey results kept on top of a coat rack, inaccessible to residents. E

F578 – Request/Refuse/Discontinue Treatment; Formulate Adv Di

- Facility failed to obtain an order for code status for 1 of 24 residents reviewed. Resident #33 admitted on 9/4/19 and did have a page in the front of the chart indicating they were full code but the facility did not obtain an order for the residents preference until 11/18/19. The baseline care plan contradicted this preference and listed DNR. D
- Failed to ensure one residents code status in the electronic health record matched the IPOST. D
- Advanced directives/code status not on chart for 2 residents. D
- No code status listed which would cause staff to assume the wrong code status. D

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

- Facility failed to notify resident's spouse of yelling behaviors that had occurred for four nights prior to the report. D
- Physician not notified of significant weight loss. D

F582 – Medicaid/Medicare Coverage/Liability Notice

- Facility failed to provide correct forms for Medicare Liability notices and Beneficiary Appeals when skilled services had been exhausted/no longer covered. D
- Resident Selected option 1 on ABN form, staff didn't understand what option 1 meant. D
- NOMNC not provided for 2 residents. B

F584 – Safe/Clean/Comfortable/Homelike Environment

- Dirt, dust clumps, and dead bugs in the windowsills of 9 resident rooms. D
- Dirty dining room floors, dirty birdcages, residents eating meals on trays, residents rooms not being cleaned each day D

F585 – Grievances

- Facility failed to inform staff/residents of facility grievance policy and grievance policy posting failed to list grievance officer. B
- Facility failed to post the Grievance Policy, identify a Grievance Officer, and residents did not have information regarding their right to file a grievance. B

F600 – Free from Abuse and Neglect

- Failed to ensure a resident was not touched by a visitor inappropriately. D
- Failed to provide adequate supervision to prevent resident to resident abuse. Resident exposed another residents breasts several times. Incident of resident grabbing another residents' breasts. D

F607 – Develop/Implement Abuse/Neglect, etc. Policies

- Facility failed to ensure 1 of 5 received the mandatory 2 hour dependent adult abuse training within 6 months of hire. Staff J an RN was hired 5/8/19 and employee file only included the combined child and dependent adult mandatory reporter training not the 2 hour dependent adult mandatory reporter training per state training requirement. B
- Facility failed to obtain criminal background checks within 30 days prior to hire for currently employed staff. E **$500 Fine**
- Two staff members started working and facility failed to get approval from DHS with criminal records. D
- Facility failed to verify a nurse's licensure status prior to employment. E **$500 Fine**

F609 – Reporting of Alleged Violations

- Facility failed to report a major injury within 24 hrs. D

F610 – Investigate/Prevent/Correct Alleged Violation

- Facility failed to thoroughly investigate an injury of unknown origin to determine if abuse/mistreatment had occurred. D
- Injuries of unknown origin, which included bruises and skin tears, for 3 of 3 residents reviewed, were not investigated by the facility. Facility's Abuse Policy did not identify measures to prevent abuse in the facility. F
- Facility failed to thoroughly investigate an alleged physical abuse w/ dignity concerns reported by complainant and a self-report, failure to interview staff involved in complaint in a timely manner. D

F623 – Notice Requirements Before Transfer/Discharge

- Facility failed to notify the Ombudsman of residents transfer to the hospital for 2 of 4 residents reviewed for hospitalizations. B
- Facility failed to notify the Ombudsman of residents transfer to the hospital for 2 of 2 residents reviewed for hospitalizations. B
- Failed to notify ombudsman of an ER transfer. B
- Failed to notify ombudsman of a hospital transfer. D
- Failed to notify ombudsman of discharges. D

F624 – Preparation for Safe/Orderly Transfer/Discharge

- Facility failed to document disposition of resident's belongings upon discharge. D

F625 – Notice of Bed Hold Policy Before/Upon Transfer

- Facility failed to provide notice to the resident/POA of bed hold policy upon transfer to the hospital for 2 of 4 residents reviewed for hospitalizations. B
- Facility failed to provide notice to the resident/POA of bed hold policy upon transfer to the hospital for 2 of 4 residents reviewed for hospitalizations. B
- Failed to provide the resident/resident representative notice of the bed hold policy at time of transfer for hospitalization. B
- Resident clinical record lacked documentation the resident and/or resident representative had been notified of the facility bed hold policy. D

F626 – Permitting Residents to Return to Facility

- Resident admitted to facility with a broken head rest. A month after admission, therapy ordered chair that would take two weeks to arrive. Two months after admission documentation that resident did not feel safe due to broken wheelchair and did not feel safe in bed, was subsequently transferred to hospital. Facility would not take resident back because resident did not have proper equipment. Reason for not taking resident back not documented per policy. D

F636 – Comprehensive Assessments & Timing

- No Level II PASRR completed upon admission for a resident with a diagnosis of schizophrenia. D
- MDS assessment of functional capacity not assessed within 14 days of admission. D

F637 – Comprehensive Assmt After Significant Change

- Significant Change MDS not initiated after condition change (hospice services). B
- Resident returned from hospital stay with multiple changes and no Sig change MDS was completed. D
- Noted x2 residents who experienced significant changes, did not have significant change assessments completed within 14 days of the change. D
- Facility failed to complete a Significant Change MDS within 14 days of a significant change in a resident's physical or mental condition change. D

F640 – Encoding/Transmitting Resident Assessment

- MDS not submitted timely for 6 of 48 residents. B

F641 – Accuracy of Assessments

- MDS marked anticoagulant but was really on antiplatelet. D
- 4 of 13 residents noted to have inaccurate MDS assessments. Didn't reflect their hospice services received; indicated resident was discharged to hospital when discharged to home; x2 MDS's coded for no to Level 2 PASRR screening although both had been screened. E
- MDS was coded incorrectly for a resident who was taking Xarelto. D

- Resident with diagnosis listed on the MDS did not have further documentation in the assessment that indicated a Level II PASRR evaluation needed. Resident admitted 1/4/2019. Level II screen completed 9/24/2019. D

F644 – Coordination of PASARR and Assessments

- Facility failed to implement care plan interventions related to Preadmission Screening and Resident Review recommendations. Care plan lacked the specific recommendation for the need for ongoing psychiatric services and to evaluate the ongoing need for additional behavioral health services. D
- PASRR not resubmitted after new diagnosis of anxiety.
- Two residents did not have PASRR Level II updates with medication & behavioral changes. D
- Failed to implement Level II recommendations for four residents. E
- PASRR not resubmitted after new diagnosis of major depression and anxiety. D
- Two residents did not have PASRR updates with new mental health diagnosis. D
- Facility failed to repeat a Level 1 PASRR for a resident with a new mental disorder diagnosis. D

F645 – PASARR Screening for MD & ID

- 30-day exemption on PASRR expired prior to being resubmitted by facility. D
- Facility failed to ensure completion of a PASRR. Resident admitted with a PASRR for 60day placement. No new PASRR was submitted when the 60 days expired. D

F655 – Baseline Care Plan

- Facility failed to complete a baseline care plan within 48 hours of admission. D
- Facility did not complete a 48 hours baseline care plan and provide a copy to the resident. D

F656 – Develop/Implement Plan of Care

- Failed to ensure care plan included all interventions regarding the use of trunk restraint. Care plan revealed to check for seatbelt placement when the resident was in the wheelchair but lacked documentation related when to release and check the seatbelt. Family requested white board on the wall in her room. Staff were not following care plan and the white board. D
- Comprehensive care plan failed to address cognition status, smoking interventions for a resident with safety concerns by smoking in facility and liver disease with fluid accumulation in abdomen requiring paracentesis. D
- Careplan not updated with PT/OT and restorative programs for two residents. D
- Two residents did not have coumadin or insulin addressed on care plan. D
- Failed to follow care plan interventions re nutrition and hydration. D

- A comprehensive care plan was not developed for one resident within 21 days of admission. D
- Resident's care plan identified high risk for falls, need for low bed, fall mat and one side rail for positioning. Resident was observed in bed on at least two occasions without bed rail up. An incident report detailing a fall did not provide documentation of family notification or interventions to prevent future falls. D
- Failed to complete a comprehensive care plan to accurately reflect needs. Lack of documentation related to monitoring of resident due to the need for Dialysis, the use of pressure relieving boots or a fluid restriction. D
- No hearing aides in resident's ears as care planned. D

F657 – Care Plan Timing & Revision

- Resident with new fluid restrictions but care plan said "encourage fluids". Care plan lacks specific enough information on pain. D
- Facility failed to update the care plan for 2 of 19 residents reviewed. Resident admitted with 2 unstageable pressure ulcers and later developed a diabetic ulcer. Wounds not identified on care plan. Resident was care planned to be transferred with assist x1 with gait belt. Resident was utilizing the full body lift for transfers and the care plan had not been updated. D
- Facility failed to review and revise the care plan for 4 of 4 residents reviewed. Residents had quarter rails up in bed and this was not identified on their care plans. B
- Care plan not updated for several residents: skin condition, anxiety, and anti-psychotic meds, edema/daily weights. D
- Antidepressant stopped and care plan not changed, care plan was "at risk" for skin issues but had "actual" skin issues, discontinued meds left on CP, no fall intervention after a fall. E
- Facility failed to revise the comprehensive care plan to address psychotropic medications. D
- Lack of side rails on care plan. B
- Facility failed to update 3 of 18 care plans for residents with condition changes , no care plan policy. D
- New interventions to prevent falls were not added to the care plan after falls occurred. D

F658 – Services Provided Meet Professional Standards

- Signed off on Eucerin cream order that they left the cream at bedside for resident to apply themselves when they did not. Daily weights not charted six times. D
- Physician's order sheets expired every 60 days, were not signed timely. PT/INR not drawn timely. E

- Resident not given anti-anxiety med as ordered, no documentation as to why med was not given. D
- Res had an order for UA, no documentation as to why it took four days to collect. D
- Nurse dropped a pill on the cart and picked it up with her bare hand and put it in the resident's med cup to give. D
- Failed to meet the professional standards of injecting insulin from an insulin pen. Nurse did not demonstrate priming the pen prior to dialing up the dosage and did not administer the dosage by depressing the dose button for 5 seconds. D
- Resident received the wrong strength of eye medication from February to December 2019, noted during the survey. The change of the order was not sent to pharmacy in Feb 2019. Nurse administered Miralax powder mixed in cranberry juice and left with the resident to drink, did not observe if the medication was consumed. The order for the Miralax indicated it was to be placed in the resident's coffee per their preference. D
- Facility failed to follow physician order for continous oxygen and clarify phsician order for wound treatment. D
- Resident with diabetes diagnosis, physician order sheet did not have order to check residents blood sugar. D
- Nursing staff did not administer antibiotics according to physician's orders. D
- Resident was receiving oxygen without physician's orders for oxygen. D
- Facility failed to follow physician orders for 2 of 19 residents reviewed. Resident had an order of Tubigrips on in the morning off at HS. Multiple observations over consecutive days revealed no tubigrips and resident reported never wearing them. Second Resident had an order for Tubigrips on in the am and off at HS. Also not on as ordered. D
- No blood sugar check orders for a resident on insulin. Staff applied medicated ointment to resident, no hand hygiene during process. Orders for cream outdated with physician order sheets. Did not follow physician orders for flushing feeding tube. D

F660 – Discharge Planning Process

- Facility failed to address a resident's discharge plans on their care plan. D

F661 – Discharge Summary

- No DC Summary with a discharge. D
- Facility was not completing discharge summaries and recapitulation of stay for residents. B

F675 – Quality of Life

- Resident was sitting up the table in the dining room as lunch was being served. The resident was slowly sliding down in her wheelchair. At 12:08 she slid down to

where her head was lower than the handles of the wheelchair. Resident was fed 50% of her meal which included cut up meat and sliced carrots. Finally at 12:29 CNAs escorted the resident out of the dining room and returned with her and the resident had been repositioned. D

F676 – Activities of Daily Living (ADLs)/Maintain Abilities

- Resident with therapy recommended restorative nursing program to maintain function did not receive those services. D

F677 – ADL Care Provided for Dependent Residents

- Facility failed to complete grooming, resident had heavy facial stubble for multiple days and was not shaved. D
- ADL cares cited for not addressing long, dirty fingernails. D
- Resident was not repositioned or provided incontinent cares for 5 hrs. Documentation missing for showers/bathing-DON reported lack of staff. D
- ADL care for dependent res, a resident waited 40 minutes to get up. D
- Staff performed incomplete incontinent care during observations of cares on 3 of 5 residents. D
- Oral care was not provided either before or after breakfast for one resident. D
- Resident was not being bathed 2 times weekly as scheduled. D
- Resident complained he had not bathed in two weeks. Observed by surveyors to have urine-soaked clothing and staff did not assist him to change for over an hour. D
- Failed to assist a resident with the necessary services of personal and oral hygiene. Resident reported not receiving assist with providing self AM cares since admission. D

F678 – Cardio-Pulmonary Resuscitation (CPR)

- Facility failed to obtain a physician's order for CPR Code Status. Nurse could not find an order for code status, no IPOST was located and therefore, the nurse decided not to begin CPR on a resident found unresponsive with no respiration, no blood pressure and no pulse. J **$7500**

F684 – Quality of Care

- Failed to provide assessment and intervention when resident reviewed with changes in condition. 10/19 resident inappropriately touched another resident's breast, progress notes revealed staff failed to document the incident that occurred between the residents, the progress notes failed to reveal staff assessed resident that had her breast touched after the incident occurred. Facility failed to provide an incident report for the resident that had her breast touched. The facility abuse prevention program and reporting policy included in the investigation section to do a physical assessment if injury may have occurred. D

- Resident with combative behaviors broke an employee's wrist, was not documented or addressed in documentation. A resident was hospitalized, no assessment or documentation indicating why the person was hospitalized. D
- Failed to assess measurements of skin areas routinely, later resulting in antibiotic use and new areas were also not assessed or measured. Employee revealed they "dropped the ball." D
- Res fell in room sustaining a small head laceration. Neuro sheets lacked pain and range of motion assessments. Approx 16 hrs later hollering in pain with movement of upper and lower extremities. Portable x ray revealed fracture of left distal femur and possible dislocated left hip as well as spiral fracture of right humerus. Hospitalized. During interview CNA reported resident told her she broke her leg, RN assessed ROM and thought WNL. Another resident had no documentation of sliding scale insulin given with high blood sugar. **G $5,250.00**
- Facility did not have enough wash cloths for evening shift cares. Only had one washing machine and wash cloths were getting thrown away. E
- Resident went greater than 3 days with no BM and no intervention. D
- Resident admitted to facility on 9/4/2019 did not have documentation of assessment of baseline condition at the time of arrival. Medical record did not show consistent assessments and timely interventions when resident had a significant change in condition, including a temp of 103.9 degrees. On 9/9/2019 the resident was hospitalized for sepsis. The resident returned to the facility on 9/17/2019 but required rehospitalization with intubation and emergency transport via helicopter on 9/25/2019. The resident expired on 10/16/2019. **J $10,000**
- Staff did not address resident's pain and implement interventions to prevent skin breakdown for one resident. D
- Failed to provide adequate assessment and timely intervention for 1 of 3 residents reviewed for hospitalizations. Low O2 sats (63%) with adding O2 per mask, no documented assessment r/t low O2. Next day continued SOB, O2 sat (70's) with elevated heart rate, O2 liters increased per mask, later sent to ER. Record lacked documentation of nursing assessment. Dr reported should have sent to ER sooner. **G $5,000**

F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers

- Staff failed to prevent a pressure ulcer. A review of the facilities policy for skin care and wound management instructed staff that in order to prevent development of pressure ulcers they should determine increased risk, including friction and shear to evaluate for consistent implementation of interventions and to modify interventions as indicated. In observation resident was reclined in a chair in her room with her feet up she was wearing slip resistant stockings and no shoes. On the other side of the room a padded protective boot was laying on the couch. D
- Resident seen by surveyors without foot buddies per care plan for open area. D
- Skin prevention items on care plan not followed and pressure ulcer got worse. D

- Facility identified a pressure ulcer but did not add care plan interventions for 12 days after the issue was noted. Dietitian was not aware of the pressure ulcer and had not addressed it. D
- Failed to provide appropriate standards of care related to the treatment and assessment of a pressure ulcer. Lack of Nutritional assessment regarding pressure ulcer. Air overlay in bed noted to be flat. Lack of weekly documentation of ulcer. D
- Failed to prevent pressure sores and provide complete documentation of assessments. Lack of interventions on care plan (Boots/Repositioning). Lack of disinfecting scissors. Lack of weekly skin assessments. D

F688 – Increase/Prevent Decrease in ROM/Mobility

- Facility failed to provide ROM to resident. Resident had no ROM completed for multiple days and facility stated they have no regular program for ROM although ROM was care planned. D
- Restorative program not updated in careplan. D
- Restorative programs not completed as careplanned, no documentation as to why days were missed. E
- Resident at risk for developing pressure ulcers developed a stage II ulcer. D

F689 – Free from Accidents and Hazards

- Facility failed to ensure assistive devices and wheelchair pedals for 3 of 3 residents wheelchairs to prevent accidents when residents not propelling themselves.
- Resident stated that she had been sitting there for a long, long time. Staff reported that she had investigated and found the sound had been muted on the computer which would silence the alarm. The alarm would have a visual at the computer, but stated the call light do not go to a pager or other device. Staff reported they have had concerns with staff muting the alarms, and she usually checks at the beginning of the shift but had been unable to check at that point. Resident reported she did call for help after had fallen and waited a long time, which she estimated was at least 2-3 hours. **G Fine $4,000**
- Res was two assist for transfers with gaitbelt, was transferred during observation without gaitbelt and with one. D
- Resident on psychotropic meds and assessed by therapy as having a decline in mobility and lethargic. Resident had call light on and was heard yelling for help. When CNA arrived, resident was on floor with laceration above eye. Neuro sheets lacked pain and range of motion assessments. Approx 16 hrs later hollering in pain with movement of upper and lower extremities (history of behavior with mental illness). Portable xray revealed fracture of left distal femur and possible dislocated left hip as well as spiral fracture of right humerus. Hospitalized. During interview CNA reported that resident refused cares throughout the day and at one-point resident told her she broke her leg, RN assessed ROM and thought WNL. **G Fine $8,500**

- Resident missing approx. 3 hours. Some staff members did not use the door alarms properly. Another cognitively intact resident saw individual outside 3 hours earlier and reported it to the LPN and CMA on staff. Each employee thought the other went to get the resident. Careplan did not address elopement risk fully. Did not follow elopement protocol, did not notify police. Resident returned by police. During investigation surveyor determined res had a two year old history of leaving the facility AMA. Staff thought the resident went out to smoke, alarm was turned off. **J Fine $9,750**
- Resident was pushed in wheelchair without foot pedals. D
- Facility used the wrong sling with a mechanical lift and resident had a fall with a fracture. Facility continued using the same sling and lift together even after the fall. **G Fine $8,750**
- Resident with severe cognitive impairment was allowed by staff to sit outside unsupervised. Staff were observed propelling residents in wheelchairs without foot pedals in place for safe transport. Hallway storage of chairs, end tables, laundry cart, walkers and dining room chair in the halls. E
- Facility failed to lock housekeeping closet and therefore to secure chemicals away from residents, Resident had cap span spray at bedside. D
- Staff were observed pushing two different residents in wheelchairs without pedals. D
- Facility left a pharmacy delivery unsecured at the nurses' station and failed to assess a resident for smoking safety. D
- Failed to appropriately supervise resident who fell from a lift chair and sustained cervical and left orbital fractures. Repeated falls from lift recliner with one resulting in fractures. Staff did not change out recliner. Much discussion re: placing remote out of reach or changing to a regular chair would be a restraint. **G Fine $8,500**

F690 – Bowel, Bladder Incontinence, Catheter Care

- Failed to provide perineal/catheter care in a manner to prevent infection. D
- Res was incontinent assessed as continent. Another resident had no bowel/bladder assessment documented. D
- During incontinent care staff mixed clean and dirty linen, did not properly turn the wash cloth, and did not clean all areas that the wet brief touched. D
- Did not rinse graduate after emptying urine from a catheter. CNA did not change gloves enough or wash hands when providing incontinent care. D
- Failed to assure proper catheter cares. Resident had recently been on antibiotic for UTI. Resident noted with foley catheter tubing dragging on floor while in wheelchair. Provided cath care without changing the side of the wipe. Wiped groin down towards the catheter. D

- Facility failed to provide appropriate care of a catheter. Bottom of bag touching floor. Catheter bag noted hanging on the trash can and resting on the floor. Lack of privacy cover for cath bag. D
- Failed to provide complete incontinence care for resident required assist with peri-care. Lack of changing gloves between dirty / clean surfaces. D
- Failed to provide adequate incontinence care D

F692 – Nutrition/Hydration Status Maintenance

- Failed to identify significant weight loss for resident 10.92% loss in 6 months. **G Fine $13,500**

F693 – Tube Feeding Management/Restore Eating Skills

- Facility failed to provide proper services for a resident with a feeding tube. Resident was observed receiving in ROM by staff CNA's. The head of the bed was made flat even though the feeding was running, The resident did begin to cough so the aides raised the HOB but then lowered it flat again during the ROM. D
- Nurses did not check feeding tube placement as per careplan and physician's orders. Surveyors corrected prior to water being instilled and asked nurse if planned to check placement. D
- Failed to provide appropriate services for 2 of 2 residents. D

F695 – Respiratory/Tracheostomy care and Suctioning

- Facility policy stated emergency trach supplies should be kept at bedside. Resident with trach did not have spare trach at bedside. Nurse reported resident's trach came out once and it was scary. D

F698 – Dialysis

- Facility failed to document pre/post dialysis assessments for 2 of 4 residents reviewed. Resident
- Failed to perform standard assessment regarding vital sign checks before/after dialysis treatments on multiple occasions for 2 residents, failed to show weight of resident. D
- Failed to update comprehensive care plans and failed to provide professional standards of practice. Care plan lacked documentation of how the facility and dialysis staff needed to communicate daily and in case of emergencies. CP lacked documentation related to pre-and post- dialysis assessments, monitoring of dialysis access site, location and type of dialysis access device and which arm staff needed to check for B/P's. D

F710 – Resident's Care Supervised by a Physician

- Facility failed to notify physician of 1 of 4 resident's weight loss. D

F725 – Sufficient Nurse Staffing

- The facility failed to respond to call lights within 15 minutes D
- Residents reported call lights take too long to be answered. Call light report demonstrated times ranging from 15 min 21 sec to 1 hr 27 min. Employees confirmed they could not get lights answered within 15 min due to staffing. **E Fine $500**

F726 – Competent Nurse Staffing

- Facility failed to ensure staff certified in CPR were scheduled 24 hours per day. E
- Facility failed to do neuros & other proper assessments after resident had a fall from a lift sling. D

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

- Did not have RN coverage for 2 days. D

F728 – Facility Hiring and Use of Nurse

- Unlicensed staff member transferring and walking a resident. E
- Facility failed to ensure completion of 2-hr Dependent Adult Abuse Mandatory Reporter Training within 6 months of hire for 2 of 6 employee files. D

F729 – Nurse Aid Registry Verification, Retraining

- Failed to obtain registry verification of a CNA prior to hire for currently employed CNA's. E

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

- Failed to ensure CNA's completed 12 hours of in-service education per year. E

F732 – Posted Nurse Staffing Information

- Facility did not have a policy for posting daily staffing levels and was not posting data for each shift. B

F741 – Sufficient/Competent Staff-Behav Health Needs

- Failed to provide required education to address needs of residents in the licensed CCDI unit. D

F755 – Pharmacy Svcs/Procedures/Pharmacist/Records

- Failed to assure a resident did not receive outdated medication. Insulin pen not discarded after 28days of being opened. D
- Failed to acquire and administer medications for new resident in a timely manner leading to the resident going without a majority of their scheduled medications for 24 hours. D

F757 – Drug Regimen is Free From Unnecessary Drugs

- Failed to implement physician's orders and promptly secure medication-related laboratory values. Lack of f/u INR lab as ordered. INR then elevated 7.31. D

F758 – Free from Unnec Psychotropic Meds/PRN Use

- Res with hypnotic medication was not assessed for sleep pattern and GDR attempt not completed. Another resident with antipsychotic med did not have response to med documented nor GDR attempt documented. D
- PRN anxiety med administration record did not demonstrate attempts of nonpharmacological interventions prior to administration and was continued past 14 days. Res with risperdone did not have GDR. D
- Physician provider did not provide specific rationale for not doing a GDR. D
- Facility failed to assure PRN psychotropic medication orders were limited x14 days unless the MD documented a rationale and indicated a duration for continuing the medication. D
- Failed to limit use of anti-anxiety meds, lacked documentation of interventions prior to administering anti-anxiety. D

F759 – *Free of Medication Error Rates of 5% or More

- Failed to properly prime insulin flex pens prior to administration for 2/2 residents. D
- Mixed medications for feeding tube w/out order. D

F761 – Label/Store Drugs & Biologicals

- Failed to store influenza vaccines at recommended temperatures. D
- Temp in med fridge 48 degrees too warm for TB serum. D
- Failed to store refrigerated medications properly. Alcohol and pudding stored in medication fridge with medications. D
- Failed to discard outdated medications. E
- Facility failed to ensure expired eye drops were not administered for 3 residents. D

F801 – Qualified Dietary Staff

- Dietary manager not a CDM. E
- Failed to employ CDM in absence of full-time dietician and failed have adequate dietician oversight & support. F
- The facility's current dietary manager had been employed for 18 months and was not certified. E

F803 – Menus Meet Resident Needs/Prep in Advance /Followed

- Facility failed to follow the planned menu in 2 of 2 meals observed. Wrong scoop size used. No bread item added to the puree. E
- Facility failed to follow the therapeutic menu. Did not puree crackers, tossed greens with dressing, or fresh baked bread, did not follow menu. E
- Did not follow menu multiple meds. E
- Pureed meat was stringy and lumpy when served to residents. Did not serve bread or roll to any pureed residents. D
- No bread and butter per menu served. E
- Failed to follow planned menu for 2 of 3 observed meals, didn't follow portion sizes in menu, staff not trained on puree process or menu spreadsheet. F
- Failed to serve correct portion sizes to meet nutritional needs of 5/5 residents w/ orders for ground meat and 1 w/ orders for pureed meat. E
- Improper puree measuring and scoop size resulted in wrong size servings for 10 residents. E
- Failed to serve correct portion sizes for residents with orders for mechanical soft texture (Ground meat). Used wrong scoop size for serving ground meat and ended up with 8oz meat left over after serving completed. E
- Facility failed to follow therapeutic menu for residents on a mechanical soft diet. Ground chicken not properly ground to equal the appropriate servings. D

F804 – Nutritive Value/Appear, Palatable/Prefer Temp

- Room tray food was not maintained at a proper temp. D
- Facility didn't address resident choice to serve trays w/ condiments, failed serve food at palatable temperature. E
- Residents complained of cold food. Food temps on resident tray varied from 162 degrees to 92 degrees. E

F809 – Frequency of Meals/ Snacks at Bedtime

- Failed to offer bedtime snacks. E

F811 – Feeding Asst-Training/Supervision/Resident

- Failed to utilize PNA appropriately for residents who required assistance. Resident with coughing episodes while being fed by PNA. D
- Failed to provide a call light for resident to directly contact caregivers. Care plan reports resident wears a call light pendant. Pendant found in drawer. Staff left room without putting on pendant. Spouse reported resident would probably not be able to use call light pendant. Call light not available for resident in room in w/c - out of reach. D

F812 – Food Procurement, Storage, Preparation, Sanitization

- Failed to provide residents with a nourishing and palatable diet by not maintaining the hot foods at 135 degrees or higher on the steam table, in order to prevent food borne illness. F
- Food handling without changing gloves on several occasions. Used gloved hands to pick up lettuce, sandwiches, french fries, etc rather than use tongs. F
- Food not covered prior to meal service and dietary manager was observed picking something off floor and serving lunch without washing hands. E
- Chemical not being dispensed properly in dish machine. Employee delivering liquids with fingers touching rim of glass rather than base of glass. E
- Dietary staff member turned off faucet with hand rather than paper towel. E
- Employee touching her face and hair and not sanitizing hands while feeding residents. E
- Dust on all pieces above the stove and Red Bucket with "sanitizer only" but had water in it. E
- Cook used gloves without changing them after touching food and nonfood items. E
- Water damaged wall, dirty towels in kitchen, undated hamburger buns, damaged cutting boards. D
- During meal service, dietary aide blew her nose, then "washed" hands with water, turned faucet off without a paper towel and did not use soap. Another dietary aide touching face/nose, then served food to residents without washing hands first. E
- Failed to maintain kitchen in clean sanitary manner, maintain clean food contact surfaces, failed ensure dish washing machine met requirements, fridge lacked thermometer, no log document temperature checks, number other issues. F
- Failed to maintain ice machine in clean sanitary condition. E
- Open condiments and cheese in refrigerator without labels or dates. Large buildup of ice on freezer walls, dust and debris found on floor. Old french fries found under a rack where clean pans were stored. E
- Staff assisting residents with ready to eat foods failed to perform proper hand hygiene between assisting multiple residents. E
- Kitchen staff member did not wash hands prior to pouring milk at resident tables. Staff member picked up glass by the rim prior to filling the glass. Another staff member dropped a dietary card on the floor, picked it up and returned to food service without washing hands. The staff member opened a bag of whipped topping with bare hands, handing the opening of the bag with ungloved hands.
- No thermometer in refrigerators and freezers. Unsanitary conditions in kitchen including no hairnet or covering on dietary aide, no labeling or dating of food items, food stored in refrigerator uncovered, carbon on frying pans and cookie sheets, drawers with debris and dust, marred cutting board.
- Facility failed to store and serve food under sanitary conditions to maintain food quality and prevent food borne illness. Staff L did not wash hands prior to gloving before starting to serve meal. Multiple resident food items identified in fridge with no resident name or open date on them. E

- Failed to maintain proper cleaning of equipment. Debris on wall behind garbage can, stove burners with carbon build-up, wall behind over with yellowish material. Sticky oven handles, oven doors with carbon build up. Lack of recent cleaning schedule. E
- Failed to serve food under sanitary conditions to prevent food borne illness. Touching multiple surfaces and touching food items with the same gloves. E

F838 – Facility Assessment

- Failed to include required individuals on facility based and community-based risk assessment and identify the CCDI unit on assessment. C

F849 – Hospice Services

- Failed to ensure the hospice plan of care was available in order to ensure the needs of the resident for both hospice care and nursing home care were met. B

F868 – QAA Committee

- Facility failed to ensure the required members attended the QA meetings. The medical director had not attended since April 2019. B
- Repeated past deficient practices which occurred during surveys were not addressed by the facility QAA Committee. D

F880 – Infection Prevention and Control

- Failed to ensure proper sanitization of blood glucose meter, glucose meter was wiped for approximately 10 seconds with a sani cloth disinfecting wipe, another staff member wiped for approximately 20 seconds, sani cloth packaging instructions unfold a clean wipe and thoroughly wet surface, allow treated surface to remain we for a full 2 minutes. Facility infection control logs revealed incomplete documents, lacking the site, culture, what the culture identified, if present upon admission or facility acquired, antibiotic, or follow up. The logs lacked any documentation of infections in January, March, and July 2019. E
- Failed to prevent cares in a manner to prevent infection for resident reviewed with a urinary catheter and failed to review the facility infection control procedures at least annually. Resident sitting in a recliner chair in room and a urinary collection bag without any type of privacy protective bag touched the floor, resident in her bed her urinary collection bag hanging on the side of the bed and the catheter tubing lay on the floor. E
- Infection control logs incomplete regarding culture/organism, location of infection and response to med. Failure to place barrier with glucometer, did not disinfect glucometer and failed to wash hands after removing gloves. F
- Combined dirty and clean linens prior to use, applied barrier ointment after incontinent care without washing hands, Nurse used gloved hand that had touched a

bottle to apply an ointment, Staff used the sink to wet washcloths for incontinent care after using same sink to wash hands. E

- Staff member did not wash hands appropriately during catheter and perineal cares. D
- Failed to appropriately change gloves and wash hands during incontinent cares. D
- Facility failed to provide appropriate infection control standards during observations including: gait belt placed over resident's urine soiled clothing and then over their clean clothes after changing the resident, clean washcloths placed in sink to wet them, throwing soiled washcloths, towels, soiled gown and bedding on floor after use, touching faucet handles with bare hands with hand washing and not performing hand hygiene between glove changes. E
- Facility failed to handle clean laundry appropriately and failed to handle resident equipment appropriately. Blood glucose machine was placed directly on a resident's bedside table without a barrier. Catheter bag was emptied with soiled gloves, no alcohol wipe used after draining urine from catheter bag. Clean laundry was transported in hallway in an uncovered laundry cart. Staff dropped a pillow on the floor, picked it up and placed it on chair then the resident's bed and placed a new pillowcase on pillow, placed it on the resident's bed. E
- Failed to maintain infection control (while transporting laundry sanitizing blood glucose meters wound care, and peri care). D
- Assisted w/ toileting wiped buttocks w/ gloved hands and refastened briefs, pull up resident pants and adjust her own clothes with same gloved hand, didn't sanitize or wash hands when removed glove before assisting resident to chair. D
- Nurse handled medications with bare hands during med pass without performing hand hygiene or donning gloves. D
- Oxygen and nebulizer tubing was not dated when replaced. D
- Catheter bag was laid on a carpeted floor in the lounge and covered with a hand towel. Later during catheter care the bag was disconnected spilling urine on the bathroom floor. The staff member did not wash hands before donning gloves to clean up the spills or after removing gloves prior to donning new pair to continue resident care. D
- Nurse checking resident blood sugar did not dispose of a used lancet in a sharps container but rolled it into a used glove and discarded. D
- Facility failed to utilize proper infection control during wound care for 1 of 3 residents reviewed. On 11/19/19 surveyors observed wound care for resident # 41. No barrier used for supplies. Did not disinfect scissors prior to cutting off soiled dressing. Did not wash and re-glove when treating multiple wounds to both feet. D
- Facility failed to ensure oxygen tubing was properly labeled and changed out to prevent infection in 1 of 1 resident. Observation on 11/25/19 for resident #19 revealed oxygen running at 3L and the tubing had no date. D
- Failed to assure appropriate infection control practices during dressing change and during medication pass. During wound treatment, did not wash hands when

changed gloves. Placed insulin pen, eye drop baggie & eye drop bottles on surfaces in resident room with no barrier and put items back into cart without sanitizing. E

- Failed to provide appropriate infection prevention practices while providing cares. CMA applying ointment to bilateral buttocks without removing gloves or completing hand hygiene. Nurse gave resident her meds, then picked up a cup from floor and then used a Kleenex to wipe residents mouth. Went back to cart without hand hygiene. Lack of hand hygiene at med cart while preparing insulin pen, applied gloves, turned off computer with gloves, and went to room and administered the insulin with same gloves. D
- Failed to utilize proper infection control practices during wound care. Did not disinfect scissors, lack of changing gloves from dirty to clean dressings. Used same betadine swab for each wound. D

F881 – Antibiotic Stewardship Program

- Failed to implemented antibiotic stewardship protocols to monitor antibiotic use. Surveillance reports had not been done each time a resident received a prescription for an antibiotic, and antibiotic report cards had not been done quarterly and as needed to communicate with the medical director t inform him/her of antibiotic use in the facility. D
- Failed to establish and implement antibiotic stewardship prior to survey. F
- Resident with odorous milky white urine was placed on antibiotic without urinalysis contrary to antibiotic stewardship program. D
- Failed to treat 1 resident for UTI. D

F883 – Influenza and Pneumococcal Immunizations

- Four residents did not receive pneumococcal vaccines as ordered. E
- No pneumococcal vaccine records for 1 resident. D

F908 – Essential Equipment, Safe Operating Condition

- Resident had wheelchair in poor condition: ripped, torn vinyl, brakes and foot pedals in poor repair. D
- Fall mat that had tears with foam exposed and tape on it where repairs had been attempted. D

F925 – Maintains Effective Pest Control Program

- Failure to maintain effective pest control, cockroaches, failed to follow recommendations of pest elimination specialists. E

F926 – Smoking Policies

- Facility policy did not allow smoking on the premises. Signs were not posted as required in the facility to indicate the non-smoking status and staff members smoked outside the rear door of the facility. D

F943 – Abuse, Neglect, and Exploitation Training

- Two employees did not have two-hour DAA training, but rather had the combo dependent adult/child abuse 2 hr training. D
- Failed to provide all staff the required abuse, neglect, and exploitation training. E
- Failed to assure the 2-hour adult mandatory abuse training completed within 6 months of hire. Staff completed a training that included Adult/Child Abuse. D

Nursing Facility Survey Frequency

As of February 24, 2020: CMS lists 31 Iowa facilities (7.2%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 7.6%. National average is 6.6%.

FFY 20 - Feb. Totals - LTC Surveys

Provider	City	Survey End Date	Previous Date	Months Between
Accura Healthcare of Le Mars	Le Mars	12/12/2019	10/11/2018	14.23
Accura Healthcare of Spirit Lake	Spirit Lake	12/5/2019	10/4/2018	14.23
Atlantic Specialty Care	Atlantic	12/24/2019	12/18/2018	12.37
Bethany Life	Story City	12/12/2019	10/25/2018	13.77
Chariton Specialty Care	Chariton	12/31/2019	11/1/2018	14.17
ChildServe Habilitation Center	Johnston	12/31/2019	10/25/2018	14.40
Corydon Specialty Care	Corydon	12/5/2019	11/9/2018	13.03
Crestview Acres	Marion	12/24/2019	11/1/2018	13.93
Denison Care Center	Denison	12/24/2019	10/29/2018	14.03
Denver Sunset Home	Denver	12/5/2019	11/7/2018	13.10
Exira Care Center	Exira	12/31/2019	10/11/2018	14.87
Good Shepherd Health Center	Mason City	12/19/2019	11/1/2018	13.77
Granger Nursing and Rehab	Granger	12/5/2019	9/27/2018	14.47

Great River Klein Center	West Burlington	12/12/2019	10/5/2018	14.43
Laurens Care Center	Laurens	12/19/2019	11/1/2018	13.77
Linn Manor Care Center	Marion	12/12/2019	9/7/2017	27.53
Madrid Home for the Aging	Madrid	12/12/2019	10/29/2018	13.63
Manly Specialty	Manly	12/4/2019	9/27/2018	14.43
Maquoketa Care Center	Maquoketa	12/12/2019	11/15/2018	13.07
Mount Ayr Health Care Center	Mount Ayr	12/12/2019	10/11/2018	14.23
Parkview Home	Wayland	12/24/2019	10/18/2018	14.40
Pearl Valley Rehabilitation and Nursing-Lake Park	Lake Park	12/12/2019	9/13/2018	15.17
Pearl Valley Rehabilitaion and Nursing-Primghar	Primghar	12/05/2019	10/18/2018	13.77
Polk City Nursing and Rehabilitation	Polk City	12/19/2019	10/25/2018	14.00
Rehabilitation Center of Hampton	Hampton	12/5/2019	2/17/2019	9.70
Rehabilitation Center of Belmond	Belmond	12/12/2019	11/13/2018	13.13
Rock Rapids Health Centre	Rock Rapids	11/14/19	9/6/2018	14.47
Sioux Center Health-Royale Meadows	Sioux Center	12/19/2019	11/1/2018	13.77
Stacyville Community Nursing Home	Stacyville	12/5/2019	10/18/2018	13.77
Stratford Specialty Care	Stratford	12/31/2019	10/14/2018	14.77
Valley View Specialty	Eldora	12/5/2019	11/10/2018	13.00
Wesley Acres	DSM	12/19/2019	10/4/2018	14.70
Westbrook Acres	Gladbrook	12/5/2019	10/21/2018	13.67
Westmount Healthcare Community	Logan	12/5/2019	9/27/2018	14.47
Westview Acres Care Center	Leon	11/14/2019	8/29/2018	14.73
Westwing Place	DeWitt	12/26/2019	10/18/2018	14.47
			AVERAGE	**14.15**