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

# Compliance Tips from IHCA's Survey Results Committee
# February 2021

**Total Number of Survey Reports:** 58

| | |
|---|---|
| **Survey Composition:** | |
| **Annual:** | 3 Surveys 0 Deficiency Free |
| **Complaints:** | 26 Surveys 6 Unsubstantiated |
| **Self-Reports:** | 12 Surveys 2 Unsubstantiated |
| **Mandatory Reports:** | 0 Surveys 0 Unsubstantiated |
| **COVID-19 Infection Control Survey:** | 17 Surveys 1 Deficiency Free |
| **State Fines:** | $47,000 |
| **State Fines in suspension:** | $38,500 |

**Most Commonly Cited Iowa Tags:**

**F 689 – Free from Accidents and Hazards (7)**
**F 880 – Infection Prevention and Control (5)**
**F580 – Notify of Changes (Injury/Decline/Room, Etc. (3)**
**F656 – Develop/Implement Comprehensive Care Plan (3)**
**F658 – Services Provided Meet Professional Standards (3)**

**Tags Resulting in Actual Harm or Higher Citations and Fines:**

**F 686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers 1 G Level Tag**
**F 689 – Free from Accidents and Hazards 2 G Level Tags & 1 J Level Tags**

## 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=15340 | | Total Number of Surveys=9484 |
| F0884 | Reporting - National Health Safety Network | 1,161 | 4.2% | 12.2% |
| F0880 | Infection Prevention & Control | 787 | 4.8% | 8.3% |
| F0886 | COVID-19 Testing-Residents & Staff | 93 | 0.6% | 1.0% |
| F0689 | Free of Accident Hazards/Supervision/Devices | 93 | 0.6% | 1.0% |
| F0684 | Quality of Care | 74 | 0.5% | 0.8% |
| F0580 | Notify of Changes (Injury/Decline/Room, etc.) | 70 | 0.4% | 0.7% |
| F0883 | Influenza and Pneumococcal Immunizations | 62 | 0.4% | 0.7% |
| F0885 | Reporting-Residents,Representatives&Families | 61 | 0.4% | 0.6% |
| F0686 | Treatment/Svcs to Prevent/Heal Pressure Ulcer | 53 | 0.3% | 0.6% |
| F0609 | Reporting of Alleged Violations | 51 | 0.3% | 0.5% |

*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

- Violation of resident rights, facility failed to ensure resident was treated with dignity and respect. Staff removed resident from supper table before resident was done eating and resident had stated she did not want to go to bed yet. Staff CNA was verbally abusive and rough with resident. Resident reported staff CNA failed to help her to the bathroom tore her clothes and bent her glasses. Resident was upset. DON was notified immediately, and staff sent home. D

### F567 – Protection/Management of Personal Funds

- 2 residents were unable to access personal funds on the weekend. C

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

- Resident's electronic record stated the resident was full code status. Care plan entry and IPOST revealed the resident was DNR status. D

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

- Failure to notify family, physician and resident regarding worsening of resident's pressure ulcer and a significant weight loss. D.
- The facility failed to provide required notification for 3 of 8 residents. The POA and MD were not notified of a resident elopement nor were other responsible parties notified of falls, change of conditions and medical services provided to the residents affected. D
- Facility failed to report interested family members when the resident developed pressure ulcers. D

**F583 –Personal Privacy/Confidentiality of Records**

- Facility failed to provide privacy while providing perineal care to multiple residents. Window blinds open or patio facing window blinds open. Not closing door to bathroom. D

**F585 –Grievances**

- Facility did not have a public posting designating the facility Grievance Officer or contact information for that individual. C

**F609 – Reporting of Alleged Violations**

- Reporting allegation of abuse late. Large bruise on arm and resident stated staff grabbed and twisted the arm. D $500

**F644 – Coordination of PASARR and Assessments**

- 2 residents were not referred for a Level II PASRR after new mental health diagnosis. D

**F656 – Develop/Implement Comprehensive Care Plan**

- Care plans were not comprehensive. Both lacked information on PT and OT services that were provided and that restorative was being provided. D
- Care plan failed to identify significant weight loss or notification to physician or family about changes in the wound. Also did not state to free float the heels. D
- Facility failed to develop comprehensive care plans for 3 residents which included such things as narcotic meds use and side effects and the use of anticoagulants. D

**F657 – Care Plan Timing and Revision**

- Failed to complete a care conference for resident. Resident record did not have any explanation as to why the resident/their responsible party did not participate in the care plan or why it was impracticable for them to do so. Resident's spouse indicated she had never received updates relating to the resident's therapy while the resident lived there. D

**F658 – Services Provided Meet Professional Standards**

- Facility failed to meet professional standards of care for resident. Resident had instructions relating to food consistency, need for reminders of small bites and to swallow before next bite. Resident choked and later passed away. D
- Resident with prn orders for Excedrin was advised the facility had none to give; medications scheduled for 5 am administration were not given until 8:55 am; no documentation that a resident's colostomy bag was changed weekly was found for 4 weeks; no documentation of ordered dressing change was noted for 2 days. E
- Facility was found to have 169 doses of medications not given within time parameters noted in physician's orders or by facility medication administration policy. D

**F660 – Discharge Planning Process**

- Facility failed to ensure a resident that left AMA received the care needed to safely discharge resulting in hospital admission on night of discharge. Complex fact pattern involving fluctuating capacity. D

**F677 – ADL Care Provided for Dependent Residents**

- Failed to provide baths as requested for one resident. Resident representative had expressed concern that resident didn't have bath or change clothes for five days, requested bath 3 days per week due to open area on back. Received one bath all other days were marked N/A. D
- Resident waited 28 minutes for call light to be answered (surveyor was in the room waiting). D
- The facility failed to ensure residents received a bath at least once per week for 3 of 8 residents. Two of the residents did not receive a bath for 13 days the third resident did not receive a bath for 15 days. D

**F679 – Activities Meet Interest/Needs of each Resident**

- Resident was unable to play bingo with other residents as no staff was available to assist her. D

**F686 – Trmt/Services to Prevent/Heal Pressure Ulcers**

- Failure to provide care consistent with professional standards or practice to prevent pressure ulcers and to ensure the resident received necessary treatment to promote healing. When resident was taken to MercyOne Specialty Clinic nurse stated that she noticed foul smell coming from resident wound, it was black and appeared to have gangrene. Nurse stated communication from facility had been nothing for the last month. **G $8,000.**
- Restorative program was not reviewed in the care plan. D

**F688 – Increase/ Prevent Decrease in ROM/Mobility**

- Facility failed to perform regular ROM exercises as included in the restorative nursing program for 1 resident. D
- Hemiplegic resident with ordered restorative care plan failed to have brace applied to her hand at least 12 of 28 times during month of October. D

**F689 – Free from Accidents and Hazards**

- Facility failed to use wheelchair pedals for 3 of 3 observed residents. D
- Failed to provide adequate supervision for resident. Failed to follow elopement policy and procedures after door alarm activated when resident left facility. Facility did not complete thorough check of outside of facility to see if resident left. Residents family called facility that saw resident walking 2 blocks from facility and returned resident to facility. Resident had no injuries and wore winger coat etc. Staff walked by resident room during sweep and saw walker and assumed resident was in her room. They were still looking for residents when received call from resident

family re resident. Resident was not known to be an elopement risk. Staff failed to visually identify residents when doing search. E

- Improperly transferring resident with mechanical lift, not training staff on use of lift and failing to use per manufacturer guidelines. Resident had a rib fracture. The hoyer did not have clips on the hooks as the manufacturer instructions stated it should. Therefore the sling fell off one of the hooks causing the resident to fall. D
- Resident with severe cognitive impairment fell from bed suffering a fractured hip and head laceration. Care plan called for bed in low position and floor mat placed. CNA raised bed to high position and removed mat while getting resident up for meal. CNA was urgently called away, failed to lower bed and the resident fell. **G $15,000.**
- Cognitively impaired resident wandered through open kitchen door and touched hot steam table resulting in burns to 3 fingers. **G $13,500.**
- The facility failed to provide a safe environment for 2 of 8 residents. The door alarm system was turned off on 3 of 9 exit doors, which allowed resident #1 to exit the facility without staff knowledge. This resident wore a Wander Guard device, however, the nursing tasks to check the device had been discontinued 2/4/19. No documentation of monitoring since that time including at the time of the elopement. This resulted the Immediate Jeopardy to the residents' health and safety. Another resident was transferred to the bathroom with assist x1 without the use of a gait belt. The resident's care plan directed staff to transfer the resident with assist of one staff and a gait belt. The resident experienced a fall with this transfer resulting in a fractured hip requiring surgical repair. **J $10,000.**
- Resident with four falls during one day did not have documentation of investigation of fall causes or need for increase supervision during the day to prevent subsequent falls. D

**F690 – Bowel/Bladder/Incontinence, Catheter, UTI**

- Facility failed to provide appropriate perineal care. Staff removed new wipes from package for each wipe without hand hygiene 7 times. Resident requested staff wash their vagina staff replied they had. Staff did not cleanse the front periarea/groins/perineium or under abdominal fold. Resident developed UTI. D
- Staff did not provide treatment and services to restore incontinence for one resident and failed to provide adequate urostomy care for another as evidenced by no documentation of urostomy bag changes for over 2 months. D

**F755 – Pharmacy Svcs/Procedures/Pharmacist/Records**

- Facility did not have physician ordered medication available for 5 residents. E

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

- Facility could not administer medication as ordered because of late delivery, surveyor observed LPN during medications during med pass noted that some meds to be administered at the time were omitted by nurse. E

**F761 – Label/Store Drugs & Biologicals**

- Medication room refrigerator was not checked for temperature a handful of days and the day of survey it was too warm and a bottle of PPD was stored in it. D

**F801 – Qualified Dietary Staff**

- Facility did not have a certified dietary manager. The current manager is enrolled in a CMD course. C
- Dietary services manager did not have her CDM and had been working there for 2.5 years. D

**F812 – Food Procurement, Storage, Preparation, Sanitization**

- Roast beef thawing in refrigerator was not dated; Beverages in pitchers were not labeled or dated, one gallon of milk in cooler was outdated. E

**F880 – Infection Prevention and Control**

- Facility failed to provide appropriate infection control techniques, 48 of 48 residents got CPVID. Housed Covid positive resident with Covid negative in multiple cases and had empty rooms. 3 residents were hospitalized and five died. Failed to perform hand hygiene and wear PPE appropriately. Staff not wear face shields only mask. Staff worked with COVID. Didn't have designated COVID-19 unit until large number of residents were positive. Obtained wipes during perennial care without hand hygiene, failed to wash all areas. Picked up wall hanging that fell without hand hygiene. Then assisted resident to bathroom. Infection control nurse sat at desk without mask while doing screening. Staff wearing masks with nose exposed. F
- Facility failed to utilize PPE correctly. Failed to use gloves or gowns during physical contact with resident on quarantine unit. Failed to do hand hygiene after leaving room. E
- The facility assigned the same care giver to provide direct care for COVID-19 positive residents and two asymptomatic residents. They failed to ensure asymptomatic residents were not cohorted with COVID-19 positive residents to prevent cross contamination for 2 of 2 residents. F
- The facility demonstrated widespread noncompliance of appropriate PPE for infection control of COVID-19. Staff were entering and exiting resident rooms with known positive residents without wearing a gown or gloves. Upon exiting rooms with known COVID-19 positive residents, staff did not demonstrate disinfecting their eye protection or performing any hand hygiene and proceeded into other residents' rooms. The 2567 reports 15 individual observations of infection control breeches during this survey process. E
- Staff was not using an EPA approved, hospital grade disinfectant effective against COVID 19 to mop floors. E

**F886 COVID-19 Testing Residents and Staff**

- The facility failed to test a resident for COVID 19 following a new onset of respiratory symptoms including shortness of breath respiratory distress requiring a nebulizer treatment and use of oxygen at 5 L per minute. D

**F919– Resident Call System**

- Failed to provide call light for multiple residents. When surveyor was there one resident was incontinent but no call light in reach. Multiple instances of residents needing surveyor to hand them their call light. D

## Nursing Facility Survey Frequency

As of January 20, 2021: CMS lists 239 Iowa facilities (55.6%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 50.0%. National average is 58.8%.

| Provider | City | Survey End Date | Previous Date | Months Between |
|---|---|---|---|---|
| Westmont HealthCare Community | Logan | 12/5/2020 | 12/5/2019 | 12.20 |
| Carlisle Center for Wellness & Rehab | Carlisle | 11/24/2020 | 3/7/2019 | 20.93 |
| Tru Rehab of Grinnell | Grinnell | 12/28/2020 | 5/2/2019 | 20.20 |
| | | | **AVERAGE** | **17.78** |