Compliance Tips from IHCA's Survey Results Committee

January 2016

The five most frequently cited tags from the 29 annual surveys (8 deficiency free), 38 complaints (13 unsubstantiated), 17 self-reports (7 unsubstantiated), and 5 complaint/self-report (1 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 165 total deficiencies.

The following is a breakdown of severity level:

A =	0%	D =	60.95%	G =	5.48%
B =	5.48%	E =	21.23%	H =	0.0%
C =	2.05%	F =	4.11%	I =	0%
				J =	0.68%
				K =	0%
				L=	0%

Total # of Reports: 73
Total # of surveys deficiency free or unsubstantiated: 26
Avg. # of deficiencies

- All = 2.06
- Annual = 3.79
- Complaint/Self-Reports= 1.43

Total state fines for December Report = $22,500 ($4,000 held in suspension)

Top 5 Most Frequently Cited Tags for January 2016 Report

F 323—Free of Accident Hazards/Supervision/Devices—The Facility must ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents

- Resident fell, fractured hip, CNA was not using gait belt per care plan. Failed to supervise dementia resident to prevent inappropriate sexual contact with another resident—inappropriate touching (G) **$5,000 fine.**

- Resident fell, sustained fracture after numerous previous falls and no interventions followed (G) **$5,000 fine.**
- Failed to provide adequate supervision and protection from hazards while traveling (G) **$4,000 fine.**
- Resident at risk for falls was left unattended in a standing position, fell and sustained a fracture, no gait belt used (G).
- Facility failed to develop interventions for falls, staff failed to use gait belt while transferring (G).
- Resident at risk for choking; no staff in dining room present to monitor (D).
- Medication cart left unlocked in hallway within proximity of residents (D).
- Failed to ensure door alarms were functioning (alarms did not sound when door opened) and failed to secure hazardous chemicals—unlocked cabinet contained Osiver Tb wipes, electronic equipment wipes; unlocked therapy room with hydrocollator (E).
- Facility had no door alarm, stairs with no alarms, open stairwells (E).
- Refrigerators, CPAP machine plugged into surge protector; cracks and uneven floor surfaces (E).
- Resident eloped, found outside on facility grounds; transported to hospital, admitted for hypertension (D).
- Resident failed to receive wheelchair pad alarm as directed by care plan (D).
- Staff didn't follow care plans, no gait belt used, no pedals on wheelchair (D).
- Refrigerator plugged into a surge protector (D).
- Facility failed to utilize wheelchair pedals while pushing resident in wheelchair (D).
- No formal policy in place to assess the level or type of mechanical lifts needed for each resident leading to improper and unsafe lift use (D).

F 441—Infection control

- Staff filled water pitcher with water and ice, but didn't wear gloves, many residents with infections (F).
- Laundry occasionally used biohazard bags to store laundry when out of clear plastic bags; staff thought they were handing contaminated bags (E).
- Staff placed wound dressing supplies on bedside table with no barrier, dropped cap of solution bottle on floor and placed back on solution, wiped BM across open would area of buttocks; failed to sanitize glucometer between use on different residents; staff failed to remove gloves and wash hands between cares (E).
- Laundry not covered during transfer from laundry to resident rooms (E).
- Failed to disinfect mattress after BM soaked through the sheets (D).
- Staff removed wet brief without wearing gloves, staff failed to wash hands properly during pericare (D).
- Glucometer not sanitized per manufacturer's instructions, must be wet with sanitizer for 2 minutes (D).
- Failed to use proper germicidal, disinfecting sanitizer solution for disinfecting glucometers used on multiple residents (F).

- Staff touched wet gown and held soiled linens against scrubs (D).
- Staff laid 2-way radio on bed with urine-soaked sheets, then put it back in her pocket; staff removed urine-soaked pants with bare hands (D).
- Staff failed to sanitize glucometer between uses on residents; nurse did not wear gloves while changing resident's wound dressing and digging in a bin of clean dressing supplies (D).
- Staff dropped eye drop bottle lid on floor and placed back on bottle; staff did not change dirty gloves after removing old dressing (D).
- CMA applied cream to resident's peri care area without changing a soiled wet brief (D).
- Resident's catheter bag on floor with no barrier, catheter tube not cleaned (D).

F 371 Sanitary conditions

- Steam table in kitchen issued steam that condensed on ceiling and then dripped back onto food (E).
- Failed to date food when opened, failed to maintain clean area under steam table, towels were used to plug a leak (E).
- Opened and undated bag of French fries, opened and undated hamburger patty bag, cracked spatulas (E).
- Residue on ice machine (E).
- Staff failed to change gloves while preparing and touching foods, especially sandwiches and food scopes (F).
- Dietary staff failed to reglove when serving entrée—repeatedly touch other services, then touched food items while serving (E).
- Staff failed to wear hairnets and properly contain beard while preparing food (E).
- Kitchen range, knobs, and stainless steel drawers, mixer head had not been cleaned; staff touched many surfaces with gloved hands and then touched hamburger buns (D).
- Shelf surfaces grimy and dusty, grease on sugar and spices container lid; undated open food in refrigerator (D).
- Pan of sliced turkey not labelled and dated, unlabeled bag of bread; PH test strips expired; dishwashing detergent dispenser failed to dispense appropriate amount of detergent, cutting boards extremely rough and unsanitary (F).
- Back of range was dirty with grey matter, failed to label and date opened food containers, failed to maintain milk temperature at 41-44 degrees during service, dirt and grime on front of refrigerator (F).
- Range grill area covered with black residue not easily removed, dirty exhaust hood, dirty ovens, oven glass doors covered with brown residue, opened and undated food items in refrigerator, kitchen staff did not wash hands between regloving, dishwasher water temperature did not meet minimum of 180 degrees.

F 281 Professional standards of care

- Medications unavailable for 2 residents; 9 instances of eye drops not administered, guaifsensen not administered because facility was out (E).

- Physician's orders to weigh resident daily and call if + - 3 lbs./day, resident had 5.4 lbs. weigh gain in one day and not reported to physicians (D).
- Staff failed to follow orders for skin care, failed to apply skin ointment (D).
- Failed to administer eye drops correctly; nurse failed to hold lacrimal sac for 1 minute or have resident hold as directed (D).
- Failed to hold pressure to the lacrimal sack after administration of eye drops (D).
- Failed to follow physician's orders for extra protein (eggs and peanut butter for breakfast) (D).
- Physician ordered morphine for a resident with a morphine allergy (end stage COPD) resident received 2 doses before passing away (D).
- Staff failed to check that insulin was ejected from pen prior to dispensing insulin (2 instances) (D).
- Resident's blood sugar was not reported to the physician as directed by the range established; numerous blank documentation entries for the 4 times per day resident was supposed to be checked.
- Pressure not placed on lacrimal sac after eye drops administration; mouth rinse not offered after cort inhaler (D).
- Staff failed to hold open lacrimal sac during eye drops administration (D).
- Eye drops administered missed eye and ended up on resident's check (D).

F 312 Assistance with Activities of Daily Living

- Incomplete incontinence care (D).
- Staff didn't encourage resident to finish breakfast (D).
- Failed to complete incontinence care; did not retract foreskin (D).
- Wet brief and no pericare provided (D).
- Staff cleansed from back to front and from base of penis to tip (D).
- Facility failed to assure residents received baths as planned, no bath document for a resident for 2 days (E).
- During incontinent care, staff failed to cleanse lower abdomen and genital area (D).
- Facility failed to ensure residents' received adequate grooming and oral hygiene; residents did not have teeth brushed; resident went for a week without a shower (D).
- Staff repeatedly used same side of washcloth during pericare and did not cleanse hip area (D).

G Level Deficiencies and Higher with Fines or Other Notable Fines

F-225

- Resident reported "Two girls threw him/her to the ground before the night shift," investigated, nurse noted no injuries, but bruise of unknown origin noted, nurse failed to report this to DIA (D) **$500 fine**.
- Facility failed to report an allegation of abuse, staff observed incident 10/19, reported to DIA 10/21 (D) **$500 fine.**

- Facility failed to fully investigate 1 resident's allegation of being left on bed pan all night, ADON did not chart or follow up incident (D) **$500 fine.**
- Allegation of abuse reported 1 month after occurrence (D) **$500 fine.**
- Facility did not report possible abuse, bruising not reported by staff nor investigated as possible abuse (D) **$500 fine.**

F-309

- Resident with multiple blood sugars under 40 and no glucogen in e-kit, sent to hospital 3 times in 2 weeks and facility still did not obtain glucogen (J) **$4,000 fine**.
- Staff failed to follow bowel elimination protocol; resident passed out in sit-and-stand lift and had compound fracture (G) **$500 fine.**
- Resident slid out of chairlift while placed in whirlpool (strap failed) facility failed to assess and provide timely interventions (G) **$500 fine.**

F-317

- Staff discontinued resident's range of maotion therapy due to "resident behaviors" but there was no documentation of said behaviors, resident had a decline in range of motion and function (G) **$500 fine.**

F-425

- Hydrocodone missing and outdated medications in ER box (D) **$500 fine.**