Compliance Tips from IHCA's Survey Results Committee

January 2017

The five most frequently cited tags from the 32 annual surveys (3 deficiency free), 28 complaints (2 unsubstantiated), 5 self-reports (2 unsubstantiated), 4 complaint/self-report (1 unsubstantiated) and 2 mandated reports (0 unsubstantiated reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 145 total reported citations.

The following is a breakdown of severity level:

A =	0.00%	D =	57.00%	G =	11.00%
B =	0.70%	E =	26.00%	H =	0.00%
C =	0.00%	F =	2.00%	I =	0.00%
				J =	0.70%
				K =	0.70%
				L=	0.70%

Total # of Reports: 58
Total # of surveys/reports deficiency free or unsubstantiated: 8
Avg. # of deficiencies

- All = 2.50
- Annual = 3.10
- Complaints = 3.60
- Self-reports = 1.30
- Complaint/Self-Reports= 3.00
- Mandatory =2.00

Total state fines for January Report = $3,000 ($44,000 held in suspension)

Be sure to read the Annual Survey Frequency January Survey Results on the last page!

Top 5 Most Frequently Cited Tags for January 2016 Report

F 323—Free of Accident Hazards/Supervision/Devices

- Facility failed to provide proper supervision—resident eloped from facility; citizen observed resident walking down the highway, resident eloped through window by removing screen (J) **$5,000 fine**
- Resident at risk for falls found on floor next to planter in lobby; another resident fell with fracture while trying to retrieve glasses from bed, CNA was distracted (G) **$5,000 fine**
- Staff failed to lay down floor mat as required by care plan, resident fell with injury; residents were pushed in wheelchairs without foot pedals (G) **$3,000 fine**
- Staff left resident unattended on toilet, resident fell and fractured pelvis, staff failed to follow care plan (G)
- A resident with a history of multiple falls had no new interventions put in place; resident again fell and sustained a subdural hematoma (G)
- Facility failed to provide adequate supervision to ensure against hazards; PT put a machine on leg and burned it (G)
- Clinical staff failed to use gait belt when transferring resident per care plan, resident fell, fractured wrist (G)
- Facility failed to ensure a medication cart was stored in a secured area, and failed to ensure appropriate electrical equipment was utilized; tube of Biofreeze in nurse's station, desk with no staff present, facility failed to use metal surge protectors (E)
- Facility clinical staff failed to use mobility alarms on resident at all times; scissors and razor in unlocked dresser drawer in dementia resident's room, failure to put things in place (E)
- Facility staff failed to use electrical equipment manner; surge protectors found to have nebulizer machine, phone charger, artificial Christmas tree, radio, oxygen concentrator plugged in (D)
- Sharp edges on door, splintered doors, no ends on handrails (D)
- Staff transferred resident without using gait belt as called for in care plan (D)
- Staff failed to use gait belt for transfer; resident had to be lowered to the floor (D)

F 281—Professional Standards of Quality

- Facility staff failed to following physician's orders for weighing resident on a daily basis (D) **$500 fine in suspension**
- Physician-ordered 15 minute checks on suicidal resident not completed (D)
- Facility staff failed to follow physician's orders to administer antibiotics as ordered within 48 hours (D)
- Clinical staff failed to document resident's medications as given for two doses (D)
- Records revealed Lantus insulin was continued to be administered three days after the medication expired (D)
- Physician's orders for two liters of oxygen was being administered at three liters per minute at the time of observation; another resident with an order for two liters per minute of oxygen had no oxygen on during meal (D)
- Facility staff failed to administer oxygen as ordered by physician; oxygen tank was empty and not changed during observations; no oxygen was on the resident during a meal (D)

- Facility failed to receive physician's order to place resident to secure special care dementia unit for two residents; and staff failed to ensure two residents completed taking their medications prior to leaving the area (E)
- Staff failed to follow physician's orders for 18 blood sugar checks, did not notify physician when out of parameters; CBC lab order not completed at four weeks every two months (D)
- Clinical staff failed to take and record resident's blood pressure readings prior to medication administration; if blood pressure was below physician's ordered range, medication was not to be given; resident's blood pressure not taken on a weekly basis as ordered by physician (D)
- Routine lab work not completed as physician had ordered (D)
- Facility staff failed to administer medications as ordered and document narcotics accurately; staff did not follow physician's orders; MARS failed to show all doses of narcotic doses signed out on the controlled substances sheet, missing drugs, fined (E)

F 371—Food Sanitation

- Facility failed to ensure kitchen equipment was maintained in a sanitary manner, staff failed to protect food from contamination, during meal service, staff failed to ensure ice machine was maintained in a clean manner (F)
- Dietary staff did not wash hands from dirty to clean (F)
- Improper handwashing by dietary staff; staff used food preparation sink to wash hands (E)
- Gray material on oven hoods, dirty freezer (E)
- Multiple instances of opened, undated and unlabeled food in freezer (E)
- Debris on kitchen floor, chipped paint on refrigerator, food spill in refrigerator, corroded vents on range (E)
- Store/prepare/serve--Facility dietary workers failed to date and label food items (E)
- Facility staff failed to maintain a clean and sanitary environment and equipment; failed to store foods appropriately; Teflon frying pan had scratches, open, undated food containers in the refrigerator, staff did not follow cleaning schedule for steam table (E)
- Facility failed to utilize cutting boards that were in good condition to prepare foods (E)
- Dietary staff wore gloves, but touched steam table, scoops and then bread (E)
- Dietary staff used bare hands to put bread in food processor (D)

F 226—Criminal and abuse background checks

- Criminal background checks—pool agency did not complete criminal and abuse background checks on temporary agency staff before assigning them to a facility; agency had received a prior abuse complaint about the staff member but didn't hear from the facility regarding the results of the investigation (F).
- Agency failed to complete criminal and abuse background checks prior to assigning staff (CNA) to a facility (D)

- Background check not completed for one employee prior to hire (D)
- A criminal history check of an employee was completed 45 days prior to hire date, rather than within the 30 day window required by the Iowa Administrative Code (D) **$500 fine**
- Mandatory adult abuse training for employee was completed 13 days late (D)
- Facility failed to complete criminal and abuse background checks on new hire (D)
- Facility failed to performing criminal and abuse background checks on employees before date of hire (D) **$500 fine**
- Facility failed to perform criminal and abuse background checks on employees before date of hire for one employee (D) **$500 fine**
- Facility failed to perform criminal and abuse background checks on employees prior to hire (D) **$500 fine**

F 441—Infection control

-
- Infection control—nurse failed to wash hands during medications pass and blood sugar checks between residents (E)
- Clinical staff emptied colostomy bag, then changed gloves but didn't wash hands and then emptied catheter bag; then staff didn't change gloves between emptying catheter bag and providing catheter care; staff performed pericare but staff failed to fold wash cloth, using the same side of washcloth multiple times (D)
- Facility staff failed to properly sanitize glucometer before and after resident use (D)
- Facility failed to ensure staff utilized appropriate infection control measures when administering intravenous medications; staff dropped syringe on the floor and did not reglove (D)
- Oxygen filter on concentrator was duty; resident was not instructed to wash hands after self-cares (D)
- Staff did not wash hands when changing gloves from soiled to clean procedures (D)
- RN did not wipe rubber vile top before drawing insulin from a vial of insulin (D)

Other notable deficiencies and fines

F-223

- Care plan called for two staff transfer, dressing, first aid to be administered after fall; nurse notes documented resident appear stiff and winced when cares were performed, resident could not articulate; administrator overheard staff members talking that resident may have been dropped; CNA then reported fall to administrator after "thinking about it for several days," was trying to protect other bath aide who asked the incident to not be reported; resident suffered fractured leg (G) **$5,500 fine**
- Resident turned on call light, agency staff responded, resident asked CNA to put lotion on back, stomach, arms; male CNA reportedly reached under sports bra and applied lotion to resident's breasts (D) $1,000 fine

F-225

- Injury of unknown origin not reported, care plan called for two staff transfer, dressing, first aid to be administered after fall; nurse notes documented resident appeared stiff and winced when cares were performed, resident could not articulate; administrator overheard staff members talking that resident may have been dropped; CNA then reported fall to administrator after "thinking about it for several days," was trying to protect other bath aide who asked the incident to not be reported; resident suffered fractured leg (L)

F-314

- Facility clinical staff failed to contact physician for resident open wounds that was getting larger and not responding to treatment (G) **$4,000 fine in suspension**
- Staff failed to complete a risk assessment prior to development of a pressure sore on resident; no skin mattress in place, no plan for repositioning or pressure reduction on the care plan for residents at risk (G) **$2,000 fine**
- Clinical staff failed to elevate resident's heels as mandated by care plan; heels were open, no Prafo boots in use on resident; no daily documentation on skin sheets (G) **$2,000 fine**

F-333

- Nurse left resident's medications at resident's bedside when they should have been administering medications (K)

F-328

- Facility staff did not administer up to eight liters per minute physician ordered of oxygen when resident exerted him/herself (G) **$2,000 fine**

F-329

- A resident on blood thinner had dark, tarry stools; INR ranged from 2.4 to 7.5 in one month's time; clinical staff did not follow orders for obtaining INRs; physician's appointment at follow-up was cancelled, and INR not obtained (G) **$5,000 fine**

F-353

- Clinical staff failed to answer call lights in a timely manner (D) **$7,000 fine in suspension**

L-182

- Facility failed to ensure staff had valid nursing licenses

Annual Survey Frequency
January Survey Results Meeting

Facility	City	Last Year	This Year	Frequency
Burlington Care Center	Burlington	1/14/16	12/1/16	46 Weeks
Chautauqua Guest Home #3	Charles City	1/7/16	12/22/16	50 Weeks
Cherokee Specialty Care	Cherokee	12/22/15	11/23/16	48 Weeks
Clarion Wellness and Rehab.	Clarion	1/14/16	12/8/16	47 Weeks
Clearview Home	Mt. Ayr	12/10/15	12/15/16	52 Weeks
Good Neighbor Home	Manchester	1/14/16	12/15/16	48 Weeks
Good Samaritan Society	Algona	11/19/15	12/1/16	53 Weeks
Guttenberg Care Center	Guttenberg	12/10/15	12/1/16	51 Weeks
Heritage Specialty Care	Cedar Rapids	1/4/16	12/1/16	47 Weeks
Karen Acres Care Center	Urbandale	1/21/16	12/15/16	47 Weeks
Living Center West	Cedar Rapids	1/14/16	12/8/16	47 Weeks
Manorcare Health Services	Dubuque	1/7/16	12/22/16	50 Weeks
Manorcare Health Services	Waterloo	12/3/15	12/1/16	52 Weeks
Maple Crest Manor	Fayette	12/24/15	12/15/16	51 Weeks
Mercy Medical Center	Dubuque	1/21/16	12/29/16	49 Weeks
Mercy Medical Center	Dyersville	1/8/15	11/23/16	46 Weeks
Meth-Wick Health Center	Cedar Rapids	12/17/15	12/1/16	50 Weeks
Midlands Living Center	Council Bluffs	1/14/16	12/8/16	47 Weeks
Newton Health Care Center	Newton	12/23/15	12/8/16	50 Weeks
Norwalk Nursing & Rehab Ctr.	Norwalk	11/19/15	12/13/16	56 Weeks
Oakwood Care Center	Clear Lake	12/17/15	12/8/16	51 Weeks
Osage Rehab & Health Care Ctr.	Osage	12/17/15	12/15/16	52 Weeks
Parkview Manor	Wellman	1/7/16	12/15/16	49 Weeks
Prairie Ridge Care & Rehab Ctr.	Mediapolis	1/28/16	12/8/16	45 Weeks
Red Oak Healthcare Community	Red Oak	12/22/15	12/1/16	49 Weeks
Southern Hills Specialty Care	Osceola	9/24/15	12/22/16	64 Weeks
St. Frances Manor	Grinnell	12/31/15	12/8/16	49 Weeks
Sunrise Hill Care Center	Traer	1/7/16	12/15/16	49 Weeks
Trinity Center at Luther Park	Des Moines	10/29/15	12/8/16	57 Weeks

Of the (32) Tabulated Annual Surveys Reviewed in January:

28 of the Annual Surveys were earlier than or the same as last year &
4 of the Annual Surveys were later than last year.

Earliest Surveys:

Prairie Ridge Care & Rehab Ctr.	Mediapolis	1/28/16	12/8/16	45 Weeks
Prairie View Home	Sanborn	2/4/16	12/22/16	46 Weeks
Burlington Care Center	Burlington	1/14/16	12/1/16	46 Weeks
Mercy Medical Center	Dyersville	1/8/15	11/23/16	46 Weeks
Rosewood Manor	Estherville	1/14/16	12/1/16	46Weeks

Latest Surveys:

Southern Hills Specialty Care	Osceola	9/24/15	12/22/16	64 Weeks
Trinity Center at Luther Park	Des Moines	10/29/15	12/8/16	57 Weeks
Norwalk Nursing & Rehab Ctr.	Norwalk	11/19/15	12/13/16	56 Weeks

Average Survey Frequency:

January Survey Meeting **49.69 (2.30 Weeks Early)**

December Survey Meeting	**48.52 (3½ Weeks Early)**
November Survey Meeting	**48.03 (4 Weeks Early)**
October Survey Meeting	**47.04 Weeks**
September Survey Meeting	**46.72 Weeks (5.28 Weeks Early)**
August Survey Meeting	**47 Weeks (5 Weeks Early)**
July Survey Meeting	**45.12 Weeks (6.88 Weeks Early)**
June Survey Meeting	**45.31 Weeks**
May Survey Meeting	**46.60 Weeks**
April Survey Meeting	**48.50 Weeks**