**Compliance Tips from IHCA's Survey Results Committee**

**January 2018**

The five most frequently cited tags from the 16 annual surveys (3 deficiency free), 23 complaints (10 unsubstantiated), 9 self-reports (5 unsubstantiated), 8 complaint/self-report (5 unsubstantiated) and 2 mandatory reports (0 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 62 total deficiencies.

The following is a breakdown of severity level:

| | | | | | |
|---|---|---|---|---|---|
| A = | 0.00% | D = | 77.42% | G = | 8.06% |
| B = | 0.00% | E = | 11.29% | H = | 0.00% |
| C = | 0.00% | F = | 1.61% | I = | 0.00% |
| | | | | J = | 2.61% |
| | | | | K = | 0.00% |
| | | | | L= | 0.00% |

**Total # of Reports: 50**
**Total # of surveys/reports deficiency free or unsubstantiated: 24**
**Avg. # of deficiencies**

- All = 2.08
- Annual = 5.75
- Complaints = 2.80
- Self-reports = 1.00
- Complaint/Self-Reports= 3.00
- Mandatory = 1.00
- Special Focus = 0.00

**Total state fines for January Report = $26,750 ($43,250 held in suspension)**

***Be sure to see the survey frequency report on page 8!***

**This report includes a combination of old and new F Tag numbers**

**Deficiencies and Fines** (sorted ascending by f-tag number)

**F 157—Notification of Changes**

- Records lack physician and family notification of weight loss for 2 hospice residents (D)

**F 223—Abuse**

- CNA allegedly caused skin tear while trying to dress an agitated resident. Same staff member while using a lift to transfer an agitated screaming resident place the resident's shirt over the mouth of the resident to quiet the screaming. Staff members did not report the abuse according to facility policy in last incident (D) **$500 fine**

**F 281—Professional Standards of Quality**

- No gel cushion in gerichair or bedside mat as care planned (D)

**F 309—Highest Practicable Well-Being**

- Facility failed to ensure staff completed ongoing assessments for skin conditions. Staff administered medications with no follow up assessments of pain medications (D)

**F 312—Quality of Care; Activities of Daily Living**

- Facility failed to provide complete incontinent care. Staff failed to cleanse the entire area of the groin, buttocks, and hips (D)

**F 314—Pressure Ulcers**

- Failed to use float cushion to heels with Stage II and III Pressure ulcers. Pressure ulcers worsened. Wound documentation throughout episode changed from heels to ankles resulting in inaccurate documentation (G) **$3,500 fine in suspension**
- Resident developed a Stage IV open area due to contracture. The physician ordered pressure relieving cushion that was not on care plan for 4 months later. Then during observation by surveyor, the cushion was not in place (G) **$2,750 fine in suspension**
- Facility failed to always follow wound care orders. Resident had order for boot to foot and no compression hose and client had compression hose on (D)

**F 318—Increase/Prevention of Further Decrease in Range of Motion**

- Therapy recommended Restorative for ROM but no Restorative program could be found and none completed for resident with severe contractures. MD recommended OT that was not completed. Resident on Hospice but no documentation found that hospice denied OT (G) **$3,500 fine in suspension**

**F 323—Free of Accident Hazards/Supervision/Devices**

- Resident requiring help to ambulate had fall sustaining multiple skin abrasions and bruises. Surveyors felt there were inadequate care plan interventions in place to prevent this and future falls. A second resident fell in the bathroom when

CNA was assisting with toileting and changing clothes without the use of a gait belt. Resident sustained a fractured hip (G) **$5,000 fine in suspension**

- Facility failed to provide adequate supervision to prevent accidents for one of five residents. Staff pushed resident in wheel chair with no foot pedals, causing the resident to bend her knee and ankle and had swelling in the knee and ankle (D)
- Resident transferred with 2-3 staff chair lifting vs mechanical lift when resident does not bear weight. (Staff followed care plan but it appeared surveyors did not feel this was appropriate?) (D)

**F 325—Maintain Acceptable parameters of Nutritional Status**

- Resident with weight loss had recommendation for 2 chocolate milks with all meals and surveyor observed breakfast with no milk (D)

**F 363—Menus and Nutritional Adequacy**

- Resident received 4 oz instead of 8 oz of pureed main dish (D)

**F 371—Storage, Preparation, Distribution, and Serving Food Under Sanitary Conditions**

- Dietary staff had long hair hanging down in back of hat and another did not have mustache covered (E)

## NEW F TAGS

**F 550—Resident Rights/Exercise of Rights**

- Resident was uncovered completely during am cares for 10 min (D)

**F 558—Reasonable Accommodations of Needs/Preferences**

- A straight catheter urinalysis with culture was obtained at 2:00 am, violating the resident right to reasonable accommodation (D)

**F567—Protection/Management of Personal Funds**

- Office manager deposited $6,000+ of resident CP funds into petty cash account for use (D)

**F 568—Accounting of Records and Personal Funds**

- Residents were not receiving a quarterly accounting statement of the resident trust funds available to them as verified thru resident & staff interviews (E)

**F 578—Request/Refuse/Discontinuation of Treatment; Advance Directives**

- Medical record and IPOST did not accurately reflect residents code status (D)

**F 580—Notification of Changes Injury/Decline/Room)**

- Resident had multiple changes in skin condition including skin tears and no family notification documented (D)

- The facility failed to notify a resident's family of a fall that occurred. Staff verified during an interview that an incident report was not completed for the fall (D)

**F 600—Free from Abuse and Neglect**

- Facility staff failed to report suspected abuse involving 1 of 4 residents reviewed to facility administration in a timely manner. Resident told a staff member on day shift that the night shift person was rough with her and staff did not report it in a timely manner (D)

**F 609—Reporting of Alleged Violations**

- Resident reported cut (resulting in steri-strips) on hand from tablemate using table knife. Resident initially reported to surveyor fear of other resident then later reported no fear. Citation for failure to report to survey agency (D)

**F 610—Investigate/Prevent/Correct Alleged Violations**

- Facility failed to immediately separate a resident from the staff member she accused of physical abuse. Resident stated caregiver slapped them across the face and shook their arm and the alleged staff member was not separated from the victim (D)
- Resident reported cut (resulting in steri-strips) on hand from tablemate using table knife. Resident initially reported to surveyor fear of other resident then later reported no fear. Citation for failure to thoroughly investigate incident as per policy (D)

**F 625—Notice of Bed Hold Policy Before/Upon Transfer**

- Facility failed to give notice of the bed hold policy and return for 3 of 3 clients (D)

**F 636—Comprehensive Training and Timing**

- RAI was not completed for 1 of 18 residents reviewed. The resident received insulin injections daily per MAR & POS and this information was recorded on the MDS (D)

**F 644—Coordination of PASRR and Assessments**

- Facility failed to submit information regarding the addition of major mental illness for PASRR for 1 of 12 active residents reviewed (D)

**F 656—Develop/Implement Plan of Care**

- Facility failed to follow the care plan to ensure resident safety. Residents care plan called for an alarm at all times, but resident did not have one in chair and got up in dining room and fell (D)
- Staff had concerns of res with severe tremors, with call light being wrapped around arms/chest and inadvertently swung call light and hit self. All furniture was removed from room except bed, bedside table and recliner due to concern resident would hurt self. Call light and bed controls were also removed for concerns of hurting self. Above interventions not care planned (D)

**F 658—Services Provided Meet Professional Standards**

- UA not collected as ordered. Leaking PEG tube not replaced for over a month (D)
- Facility missed lab draw for liver function test. Failed to prime insulin pen prior to insulin administration (D
- Physician ordered the use of a chair alarm when in chair and a bed alarm when in bed. MAR documentation identified that NO alarm was in place after the physician had ordered it. The physician ordered pureed meat with meals and observation verified that ground meat was served (D)
- Facility failed to document medications administered and effectiveness following an episode of chest pain and failed to complete an assessment prior to the administration of medication (D)

**F 659—Qualified Persons**

- The care plan instructed staff to apply dermasavers to both hands at all times. Observations verified that often dermasavers were not in place as per the care plan (D)

**F 676—Activities of Daily Living**

- Facility failed to assure therapy recommendations obtained at the conclusion of skilled therapy services and failed to continue interventions to maintain ambulation as with skilled therapy services (D)
- Three residents did not receive restorative nursing as care planned. Documentation showed 1 res received 1 time in Nov, 1 res received 2 times in Nov, 1 res received 3 times in Nov. Restorative aide reported getting pulled to the floor to cover up to 5x/week (D)

**F 677—ADL Care Provided for Dependent Residents**

- Failed to keep HOB up with cares-tube feeding was infusing for 29 min (sign was posted above bed to keep HOB at 30 degrees) (E)
- Facility failed to ensure staff provided complete incontinent care. Staff failed to cleanse the resident's entire buttocks or hips (D)
- CNA wiped back to front during peri-cares and another resident's family member reported resident was found with smear of BM in brief from not being properly cleansed (D)

**F 684—Quality of Life**

- Facility failed to complete scheduled skin assessments on 2 residents (D)

**F 686—Treatment to Prevent Pressure Ulcers**

- The facility failed to provide weekly assessments of pressure ulcers for 3 of 4 residents reviewed (D)

**F 688—Prevent Decrease in Range of Motion**

- A restorative program was not initiated by facility staff after receiving recommendations from Physical Therapy or Occupational therapy for 3 of 7 residents reviewed (D)
- Facility failed to provide a restorative program as recommended (D)

**F 689—Free from Accidents and Hazards**

- Resident required one assist for transfer and ambulation. Per care plan known to self-transfer. C.N.A. (Agency) staff left res. Sitting on edge of bed as res. Stated, "I can get it from here." C.N.A. (Agency) left room. Res. Stated tried to get up to wheelchair but could not so turned from the wheelchair, lost balance and sat down. External rotation was noted to left leg. Nurse instructed to move to bed via Hoyer lift after injury was noted (G) **$10,000 fine in suspension**
- Memory impaired resident wandered outside secured unit to adjoining courtyard unnoticed by staff. Staff had been accessing the emergency exit door to leave MCU. Staff member exited emergency door to courtyard to leave unit, door did not latch. Alarm did not sound. Res. exited out courtyard door and fell resulting in abrasion and skin tear. Outside temp. 37 degrees (J) **$9,000 fine ($3,000 trebled)**
- Facility failed to provide adequate supervision to protect one of three residents from hazards. Staff failed to provide supervision and assistance with transfers/ambulation to a resident who attempted to stand and fell and fractured hip (G) **$6,750 fine**
- Two residents had skin tears related to wheelchair pedals during transfers and a faulty side rail which was missing a protective cover (G) **$3,500 fine in suspension**
- Staff transferred assist of 2 resident by herself and resident fell sustaining subdural hematoma and fractures (G)
- Care plan interventions such as a chair alarm and floor mat were not in place as observed by the surveyor. Resident was always to be in a staff supervised area when not in bed or with family. Resident had an order for mechanical soft with pureed meat. Ground meat was served (D)
- Facility failed to properly secure and store smoking materials of resident. Facility had inadequate interventions of room door stop signs to deter wanders from entering other res. Rooms resulting in missing items and one wandering resident urinated in another res. wheelchair. Inadequate supervision (D)
- Failed to provide adequate supervision. Dementia specific unit staffing 9p to 6a of 1 person. Nursing home staff assist during those hours but cannot hear fall alarms to provide safety for those resident on unit that use fall alarms. Res. Fell inside nurses' station. Staff forgot to close door to nurses' station (D)

**F 690—Bowel, Bladder Incontinence, Catheter Care**

- Incomplete peri-care. Failed to cleanse anterior, hips and full buttock areas (D)

**F 697—Pain Management**

- Failed to provide adequate pain management. Did not properly assess pain and provide intervention according to the care plan (D)

**F 700--Bedrails**

- 101-year-old resident with history of 10 incidences of falls or self-transfers from bed or toilet between 2/2/17 & 9/24/17. Physician's order sheets/plan of care dated from 9/20/17-12/18/17 ordered DME including low-air loss mattress & safety measures of call light in reach and low bed. 9/20/17 "Safety Device Audit Assessment Tool" dated 9/20 indicated resident would benefit from enabler/assistive device for repositioning as well as fall scale indicating high risk for falls. Placed on hospice 9/22/17. On 11/19/17 was last observed by staff 0500 sleeping in bed. At 0617 was pronounced dead after being seen kneeling on floor on floor mat with head between the mattress and the bed rail with hands gripping bed rail. RN & CNA report history of res attempting to stand on own and having made several requests for low bed. CNA stated to surveyor that all cognitively impaired residents with balance issues should have low beds. CNA states "if he had a high low bed it wouldn't have happened." RN also states that a low bed would have prevented this incident and resident would have been found on floor. A former employee, LPN was interviewed and reported resident would transfer self and was unsafe. Facility did not have a side rail policy. MDS coordinator reports it is the Maintenance Supervisor's responsibility to check beds. Maint Supervisor stated he checks the mattresses and distance between it and side rail. This mattress, however was provided by hospice. The room door was locked until the surveyor viewed, at this time it was noted the air mattress was not tethered to the bed. The complaint was coded as a J, immediate and serious jeopardy. The facility self-corrected on 11/19 by securing and removing of bed/side rails to prevent further unsafe. The facility investigated the other beds in the facility and found none after removal of the bed/side rails that this resident used (J) **$10,000 fine in suspension**

**F 725—Sufficient Nurse Staffing**

- Observation revealed that staff did not respond to a call light for 23 minutes. Interviewable residents complained of 5-30 minute call light responses (E)
- Facility failed to provide sufficient staffing. Res. Call lights not answered within 15 minutes resulting in incontinence and delay in care needs (E)

**F 756—Drug Regimen Review, Report Irregularities**

- No GDR attempted or rational for not attempting a GDR for 1 of 18 residents reviewed who was receiving Effexor (anti-depressant) (D)

**F 758—Free from Unnecessary Psychotropic Medications**

- Physician order given to decrease Risperdal. Res. Did not receive the reduced dose and continued to be given the higher dose of medication (D)

**F 804—Nutritive Value, Palatability, Appearance, Temperatures**

- Hot foods temped too cold and cold food temped too warm when tested by the surveyor (E)

**F 805—Food in Form to Meet Individual Needs**

- A resident with an order for a mechanically soft diet with pureed meat was served ground meat (see F658 & F689) (D)
- Resident with history of coughing and aspiration did not receive nectar thick liquids as ordered. Dietary supervisor reported no policy on how to thicken liquids and employees follow guidelines on the can of thickener (D)

**F 812—Food Procurement, Storage, Preparation, Sanitization**

- Dishwasher failed to reach the required 180-degree water temp. Soiled refrigerator, outdated food, no thermometer in a kitchenette refrigerator (F)
- Dietary staff donned gloves, touched multiple surfaces to contaminate gloves, then prepared a sandwich. Multiple surfaces touched with gloves before touching bread to toast (E)
- Facility failed to handle food being place in storage in a sanitary manner. Staff threw bags of frozen food on the floor (E)

**F 842—Resident Records—Identifiable Information**

- Resident records lacked progress noted from the Psychiatric ARNP; 11 of 23 residents did not have those records readily available (E)

**F 880—Infection Prevention and Control**

- Staff could not find the disinfectant, so they did not disinfect the shower chair between uses as observed by surveyor (E)
- Did not wash hands between glove changes during peri-cares x 2 (D)
- Nurse did not maintain aseptic technique during dressing change by placing bottle of NS directly on counter without barrier and then placed it back in the medication cart (D)
- Wash basin had fecal matter in it and wasn't sanitized prior to attempted use. (Surveyor intervened) (D)
- An LPN punched medications into her bare hand and the placed (D)
- Facility failed to provide personal cares with proper changing of gloves after contamination. In addition, the facility failed to provide safety equipment that allowed for appropriate sanitation (D)
- Blood glucose machine not cleaned before or after use. No hand hygiene performed after blood glucose check and prior to setting up insulin. Administered insulin injection with dirty gloves (D)
- 1st observation during peri-cares, CNA did not remove gloves or wash hands, opened closet to obtain clean clothes, returned to complete peri-cares then CNA put wet clothing and bed pads on floor. 2nd observation during peri-cares CNA threw wet clothing on floor near garbage can, then threw wet washcloths and towel near garbage can. 3rd observation during peri cares, used correct technique but did not change gloves before applying barrier cream (D)

**F 909—Resident Bed**

- Bedrails were not in safe condition (without rough edges) for two beds (F)

## Annual Survey Frequency
## January Survey Results Meeting

| Facility | City | Last Year | This Year | Frequency |
|---|---|---|---|---|
| Aase Hagen | Decorah | 11/10/16 | 12/18/17 | 57 Weeks |
| Accura Healthcare of Cresco | Cresco | 10/6/16 | 10/19/17 | 54 Weeks |
| Accura Healthcare of Pomeroy | Pomereoy | 10/27/16 | 11/27/17 | 56 Weeks |
| Chautauqua Guest Home #2 | Charles City | 11/17/16 | 12/28/17 | 57 Weeks |
| Fonda Specialty Care | Fonda | 11/17/16 | 12/19/17 | 56 Weeks |
| Garden View Care Center | Shenandoah | 11/3/16 | 12/19/17 | 58 Weeks |
| Good Samaritan Society | Estherville | 11/3/16 | 12/19/17 | 58 Weeks |
| Hillcrest Health Care Center | Hawarden | 10/6/16 | 11/16/17 | 57 Weeks |
| Iowa Masonic Home | Bettendorf | 11/10/16 | 12/28/17 | 58 Weeks |
| Lone Tree Health Carew Center | Lone Tree | 11/8/16 | 12/19/17 | 57 Weeks |
| Midlands Living Center | Council Bluffs | 12/7/17 | 12/8/16 | 52 Weeks |
| Northbrook Manor | Cedar Rapids | 11/3/16 | 12/7/17 | 56 Weeks |
| QHC Fort Dodge Villa | Fort Dodge | 11/14/16 | 12/7/17 | 55 Weeks |
| Rose Vista | Woodbine | 10/13/16 | 12/28/17 | 62 Weeks |
| Shell Rock Senior Living | Shell Rock | 11/23/16 | 12/6/17 | 54 Weeks |
| The Bridges at Ankeny | Ankeny | 11/10/16 | 12/7/17 | 56 Weeks |

**Of the ( 16 ) Tabulated Annual Surveys Reviewed in January:**

All surveys were later than last year

**Earliest Survey:**

| | | | | |
|---|---|---|---|---|
| Midlands Living Center | Council Bluffs | 12/7/17 | 12/8/16 | 52 Weeks |

**Latest Survey:**

| | | | | |
|---|---|---|---|---|
| Rose Vista | Woodbine | 10/13/16 | 12/28/17 | 62 Weeks |

**4 Facilities were "Deficiency Free" - (25 %)**

| | |
|---|---|
| Accura Healthcare | Cresco |
| Chautauqua Guest Home #2 | Charles City |
| Lone Tree Healthcare Center | Lone Tree |
| Shell Rock Senior Living | Shell Rock |

| | | | |
|---|---|---|---|
| **Average Survey Frequency:** | **2018** | | |
| | **January Survey Meeting** | **56.44 Weeks** | **(4.44 Weeks Late)** |
| | **2017** | | |
| | **December Survey Meeting** | **56.79 Weeks** | **(4.79 Weeks Late)** |
| | **November Survey Meeting** | **57.30 Weeks** | **(5.30 Weeks Late)** |
| | **October Survey Meeting** | **55.92 Weeks** | **(3.92 Weeks Late)** |
| | **September Survey Meeting** | **55.00 Weeks** | **(3.00 Weeks Late)** |
| | **August Survey Meeting** | **55.92 Weeks** | **(3.92 Weeks Late)** |
| | **July Survey Meeting** | **56.54 Weeks** | **(4.54 Weeks Late)** |
| | **June Survey Meeting** | **54.90 Weeks** | **(2.10 Weeks Late)** |
| | **May Survey Meeting** | **54.90 Weeks** | **(2.10 Weeks Late)** |
| | **April Survey Meeting** | **52.84 Weeks** | **(0.84 Weeks Late)** |
| | **March Survey Meeting** | **51.21 Weeks** | **(0.79 Weeks Early)** |
| | **February Survey Meeting** | **50.88 Weeks** | **(1.12 Weeks Early)** |
| | **January Survey Meeting** | **49.69Weeks** | **(2.30 Weeks Early)** |