Compliance Tips from IHCA's Survey Results Committee
January 2019

Total Number of Survey Reports: 50

Survey Composition:		
Annual:	29 Surveys	0 Deficiency Free
Complaints:	32 Surveys	3 Unsubstantiated
Self-Reports:	16 Surveys	1 Unsubstantiated
Mandatory Reports:	3 Surveys	

State Fines:	$0
State Fines in suspension:	$29,000
Trebled Fines:	$24,500

Most Commonly Cited Iowa Tags:

F 689 – Free from Accidents and Hazards (13)

F 658 – Services Provided Meet Professional Standards (11)

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

F 684 – Quality of Care (9)

F 623 – Notice Requirements Before Transfer/Discharge (8)

F 656 – Develop/Implement Plan of Care (8)

F 812 – Food Procurement, Storage, Preparation, Sanitization (12)

F 880 – Infection Prevention and Control (12)

Tags Resulting in Actual Harm or Higher Citations:

F 689 – Free from Accidents and Hazards	**2 G Level Tags, 2 J Level Tags**
F 760 – Residents Are Free of Significant Med Errors	**2 J Level Tags**
F 686 – Treatment to Prevent Pressure Ulcers	**2 G 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=15748		Total Number of Surveys=70246
F0880	Infection Prevention & Control	5,719	33.3%	8.1%
F0689	Free of Accident Hazards/Supervision/Devices	5,149	25.9%	7.3%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	4,434	26.7%	6.3%
F0656	Develop/Implement Comprehensive Care Plan	4,317	24.4%	6.1%
F0684	Quality of Care	3,814	19.9%	5.4%
F0761	Label/Store Drugs and Biologicals	2,892	17.5%	4.1%
F0657	Care Plan Timing and Revision	2,818	16.3%	4.0%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	2,432	13.1%	3.5%
F0758	Free from Unnec Psychotropic Meds/PRN Use	2,356	14.3%	3.4%
F0677	ADL Care Provided for Dependent Residents	2,295	12.3%	3.3%

*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)

F 550 – Resident Rights/Exercise of Rights

- Staff member attempted to feed a resident with dementia who stated she did not want any more to eat, by repeatedly attempting to put food in her mouth when she opens her mouth to speak. When resident attempted to leave the table the staff member pulled on the resident's sleeve to get her to remain seated and told resident if she didn't eat, she could not call her spouse that evening. (D)
- Resident's care plan stated resident should not be allowed to be in wheelchair in room unattended due to issues with prior falls. After lunch the resident asked the nurse to wheel him to his room. The nurse told the resident it would be better for him to wheel himself. Once in his room the nurse was outside his door and saw the resident transfer himself from the W/C to the floor and then began to yell repeatedly for help. The nurse remained outside the room and did not respond as she saw the transfer to the floor and saw the resident was not injured. (D)
- Meals in dementia unit were served on paper plates. Residents complained that staff did not knock before entering rooms. (E)
- Facility served desert on paper napkins during noon meal service. (E)
- Failure to maintain dignity for residents with catheters. (D)

F 554 – Resident Self-Admin Meds-Clinically Appropriate

- Resident with order to keep eye drops at bedside did not have a self-administration assessment. (D)

F 561 – Self Determination

- Facility administered as-needed meds to residents prior to 6:00 am, when most in society consider hours between 10 PM-6 AM as normal sleep hours. (D)

F 577- Right to Survey Results/Advocate Agency Info

- Failure to post the survey results in an area readily accessible to residents, family members, and resident representatives. (C)

F 582 - Medicaid/Medicare Coverage

- Notices (CMS form 10123) not being given at completion of SNF services for residents returning home. (B)
- Notices (CMS form 10123) not being given at completion of SNF services. (D)
- Failed to provide Medicare Notice of Non-Coverage for residents. (B)
- Fail to provide appropriate notifications on discharge from Medicare services. (D)

F 600 – Free from Abuse and Neglect

- Facility failed to provide appropriate services and caused physical and mental abuse in resident by giving medications rectally against their wishes. Staff gave resident evening medications rectally although the order stated orally. Physician was notified and ordered not to give meds incorrectly. Staff again instructed aides to assist in positioning this resident and again administered meds rectally after resident reused orally. Staff didn't have order to give meds rectally. (D)

F 604 – Right to be Free from Physical Restraints

- Failure to ensure resident was free from physical restraints unless needed for a medical reason. (D)

F 607- Develop/Implement Abuse/Neglect, etc. Policies

- Facility failed to follow pre-employment policies regarding screening prospective employees for drugs prior to hire.

F 609- Record Violations

- Residents report that a few months prior, one resident pinched LPN and made a comment about her skin being like leather and that the resident could not see an underwear line on LPN. LPN then pulled the top of her pants down showing the top of her buttocks. Citation for failure to report as abuse and not following policy on separation of LPN and resident. (D)
- Facility failed to assure staff immediately report allegations of abuse. Aide did not timely report that another aide was rough with a client and slapped resident. (D)

F 610 – Investigate, Prevent, Correct Alleged Violation

- Facility failed to separate an alleged perpetrator from the resident victims. (D)

F 623 – Notice Requirements Before Transfer/Discharge

- Ombudsman not notified upon transfer to hospital/not documented in clinical record. (B)
- Failed to send notice to Ombudsman for resident transferred to the hospital. (D)
- Failed to notify the Ombudsman of resident transferred to the hospital. (B)
- Failed to notify the Ombudsman of resident transferred to the hospital. (B)
- Facility failed to notify ombudsmen of transfers for residents. Resident was transferred to the hospital and returned 4 days later with no documentation of Ombudsmen notification. (D)
- Fail to notify the ombudsman regarding transfers from facility to the hospital. (B)
- Failure failed to provide the mandated notice of discharge. (D)
- Failure to notify the LTC Ombudsman of transfer or discharge. (B)

F 625 – Notice of Bed Hold Policy Before/Upon Transfer

- No documentation of notifying family of bed holds upon transfer to hospital. (B)
- No documentation of notifying family of bed holds upon transfer to hospital. (B)
- Failed to provide notice of the facility's bed-hold policy prior to and upon the transfer to the hospital for resident. (B)
- Failed to notify residents regarding bed hold option for residents. (D)
- Fail to notify resident/POA of bed hold notice upon transfer. Residents had no documentation that facility gave notice of facility policy for bed hold. (D)
- Failure to provide notice to resident or resident rep of facility's bed hold policy prior to and upon transfer to the hospital or another facility. (B)

F 636 – Comprehensive Assessments & Timing

- MDS's not accurate for residents: PASRR Level II not coded, side rails coded as restraints when actually used as assistive device for residents. (E)
- Failed to accurately code the MDS to reflect PASRR level II. (D)

F 641 – Accuracy of Assessments

- Fail to accurately code MDs to reflect behaviors/antidepressant med use. (D)

F 644 – Coordination of PASARR and Assessment

- Residents with new mental health diagnoses and antipsychotic medications not being reported to ASCEND for a PASRR update. (D)
- Failure to develop a PoC for a resident following PASRR. (D)
- Failed to complete PASARR referrals when indicated for residents. (D)

F 645 – PASARR Screening for MD & ID

- Failed to complete PASRR screen for residents. Resident lacked a PASRR screen in their chart. (D)

F 655 – Baseline Care Plan

- Fail to provide baseline care plan to resident or rep after admission. (D)
- Fail to provide summary of baseline care plan with resident or rep after admission. (B)
- Failure to provide resident and rep with a summary of the baseline care plan. (D)
- Fail to provide summary of baseline care plan with resident or rep after admission. (D)

F 656 – Develop/Implement Plan of Care

- Resident's care plan called for Hoyer lift transfers. On several occasions resident states transfer was completed by staff without the use of a lift. (D)
- Failure to develop/implement a comprehensive care plan that included residents' use of psychotropic meds and address potential adverse side effects. (D)
- Failed to develop care plans regarding the use of antipsychotic med for resident and behaviors for resident. (D)
- Failed to develop care plan for resident related to a toileting program. (D)
- Failed to update care plans with pressure sores. No documentation of orders to treat gluteal pressure sores. Residents blood sugars were not being taken before meals as ordered. (D)
- Failed to follow a care plan. Care plan said to have sheep skin between the legs or the Hoyer pad for protection and it was not there. (D)
- Failure to develop and update care plans. (D)
- Failure to document in PoC adverse side effects for psychotropic meds. (E)

F 657 – Care Plan Timing & Revision

- Failed to have a comprehensive assessment for residents, several items not on care plan: side rails and eye drops at bedside. (D)
- Failure to ensure the PoC was up to date and followed. (D)
- Failed to revise and update resident's care plans. (E)
- Failure to update PoC. (D)
- Failure to update the comprehensive care plan. (D)

F 658 – Services Provided Meet Professional Standards

- LPN's were administering TPN, flushing the PICC line and changing PICC site dressing routinely without having completed an IBON approved IV therapy course as required in Chapter 6.5(3) of board rules. (D)
- Resident suffering from disorganized schizophrenia/severe manic-depressive disorder allowed to leave facility on several occasions in company of family despite an order by medical providers that resident shouldn’t leave facility. (D)
- Physician not notified of weight gain as ordered. (B)
- Failure to ensure consumption of medication during med pass. (D)
- Failure to follow physician's orders. (D)
- Failed to clarify a physician's order for catheter care for resident. (D)

- Failed to appropriately assess/implement interventions/did not meet professional standards of quality for residents. Resident admitted on 9/18/18. The discharge summary included orders for Holter monitor and f/u with cardiology in 2-4 weeks, f/u with ortho on 9/24/18 and PT in the facility. The MAR/TAR showed no Holter monitor documentation or staff directives. On 10/18/18 there still had not been a cardiology appt made. Facility could not take resident to f/u ortho appt on 9/26/18 due to van issues and the appt was re-scheduled for 10/1/18 and the sister provided transport. Therapy orders were not rec until 10/2/18. (D)
- Fail to follow physician orders r/t accuchecks for residents. MAR shows missing check for resident. (D)
- Fail to provide skin treatments as ordered. Treatment record revealed orders to apply solution on skin and treatment was not completed on 5 separate days. (D)
- Fail to document medications brought into facility by family on admit; failed to obtain a physician order for a discharge. (D)
- Failure to administer meds according to professional standards. (D)

F 661 – Discharge Summary

- Fail to provide recapitulation/final summary of resident's status for discharged resident. (D)
- Fail to document discharge summary/disposition of medications at discharge. (D)

F 677 – ADL Care Provided for Dependent Residents

- Residents complained that showers/baths only available sporadically, not two times per week. (E)
- Facility did not have adequate staff to assist all diners needing assistance at meal time. (E)
- Residents did not receive baths as scheduled/care planned due to staff being short-handed. (E)
- Residents did not receive baths as scheduled/care planned. Staff report previously had a bath aide and no longer do. Residents with room trays did not receive assistance as required and room trays delivered late. (E)
- Failure to carry out ADLs necessary to maintain good nutrition/personal hygiene.
- Failed to ensure resident received a bath as planned/desired (D)
- Fail to provide bathing services for residents according to bathing schedule. (D)
- Failure to ensure residents aided with grooming. (D)
- Failure to provide complete and proper incontinence care. (D)

F 684 – Quality of Care

- Fail to adequately assess/follow resident with blood clot in arm despite family informing facility of condition. Resident transferred to hospital with deep vein thrombosis. (D)
- Nursing staff failed to assess residents for injuries after falls. (D)
- Skin assessment not completed for resident with altered skin integrity. (D)
- Resident with no blood sugar parameters as to when to notify physician, facility did not follow policy of notifying physician for glucose greater than 200. (D)

- Fail to provide quality care/facility; fail to always provide timely and accurate assessment and intervention for residents with a change in condition. Resident required oxygen and orders were to keep o2 sats above 89%. Resident developed a pressure area from tubing. Assessments were not completed every shift for O2 usage. Assessments were lacking vital signs on multiple entries while resident was symptomatic. Resident expired. Separate resident had multiple skin issues and the facility failed to assess bruises weekly. (D)
- Fail to complete assessment after a suspected fall for residents. Resident was observed on the floor by an aide. Staff stated that resident did not fall but that resident is an attention seeker and placed self on the ground. Fall protocols and f/u documentation not completed. No physical assessment completed. (D)
- Fail to ensure assessments were thoroughly completed/documented in clinical record after resident experienced acute change in condition. Record lacked assessments after resident's return from ER after chocking episode. (D)
- Failure to provide care in a manner to assist the resident to meet the highest practice physical, mental and psychosocial well-being needs. (D)
- Fail to provide ongoing assessment of identified skin condition. Skin assessment sheet was not filled out after a reddened area noted on resident's arm. (D)

F 686 – Treatment to Prevent Pressure Ulcers

- Fail to prevent resident with moderate risk of pressure ulcer development from developing heel pressure ulcer which eventually became inflamed and necrotic. (No fine issue?) (G)
- Failed to prevent the development of two pressure sores. Resident chart not updated after seeing wound care nurse. (G)

F 688 – Prevent Decrease in Range of Motion

- Failure to ensure restorative programs were completed. (E)

F 689 – Free from Accidents and Hazards

- Resident eloped through an alarmed door and was outside 400 foot from building without knowledge of staff until a dietary staff member arrived for work. Alarm sounded, staff responded by looking out window but did not search outside. Resident was outside unattended for approximately 5 minutes. (J) **$4,500 FINE**
- During observation CNA was observed by surveyor transferring resident without locking brakes on wheelchair and without gait belt. Resident sat down hard, causing wheelchair to move. (D)
- Nurse looked for resident to give meds. Resident found outside in screened in porch/gazebo lying on floor. Had slid to floor four hours earlier and laid on cement, temp was 90 degrees-no injuries. (D)
- During observation surveyor noted an unlocked cupboard in activity office with Clorox disinfectant, mikroquat, oasis multiquat, miracle gro plant food. (D)
- Failed to provide adequate supervision in dining room to prevent accidents. (G)
- Failed to ensure safety devices were in place as planned for resident. (D)
- Failed to always implement individualized interventions or provide sufficient transfer assistance to prevent or minimize falls for resident. (D)

- Resident found standing on other side of hall door, aide immediately went outside. Door alarm was going off and no one checked to see if anyone had gone out door; policy stated alarm can't be reset until all residents accounted for.
- Facility failed to ensure that each resident received adequate supervision to prevent resident's unplanned exit from the facility. Door alarmed sounded and staff looked out window and did not see anyone and when an aide took some residents outside and found a resident sitting in a lawn chair and redirected them back inside. There was not a head count done before the alarm was reset. (J)
- Fail to ensure resident environment remains free of accidents/hazards by not following manufacturers guidelines for preventative maintenance on EZ stand lift resulting in lift failure for resident. (D)
- Failure to ensure facility always remained free of hazards to ensure residents remained free of injury. (D)
- Failure to ensure adequate nursing supervision and ensure resident safety for residents with high risk behaviors. (D)
- Fail to ensure residents receive adequate supervision to protect against accidents; Fail to provide safe method of transfer. Fail to evaluate ability of resident to safely operate power mobility device in facility, resulting in fall with a major injury; Med cart was unsecured and unattended in resident care area. (G)

F 690 – Bowel, Bladder Incontinence, Catheter Care

- Failure to ensure residents received proper and timely incontinence care. (D)
- Fail to provide incontinence care for residents. Resident was incontinent and sit to stand lift used to clean resident's buttocks by aides, but no anterior peri care provided. (D)
- Fail to ensure resident with incontinence received treatment/care related to bladder incontinence. Aide failed to wipe resident's hips and thighs which were soiled with urine. (D)
- Failure to provide incontinence to minimize the risk of cross-contamination and infection; Failure to ensure resident's catheter as stored in sanitary manner. (D)
- Resident did not have a clinical condition or medical diagnosis to justify maintaining an indwelling Foley catheter since long after hip surgery. (D)

F 692 – Nutrition/Hydration Status Maintenance

- Failed to identify, assess, intervene with a resident documented with significant weight loss. The clinical record failed to address the weight loss. (D)

F 693 – Tube Feeding Management/Restore Eating Skills

- Fail to ensure staff checked placement of gastrostomy tube prior to med administration.

F 695 – Respiratory/Tracheostomy care and Suctioning

- Resident with order for continuous oxygen at 2-5 liters was observed with E tank registering empty. (D)

F 697 – Pain Management

- Fail to provide timely scheduled pain meds for residents as ordered by physicians. Resident did not receive requested pain med. Resident's scheduled pain med given 2 hours late. Residents had to wait and request pain meds multiple times before they would be administered on other occasions. (D)

F 698 – Dialysis

- Resident assessments not completed prior to/after renal dialysis treatments. (D)
- Documentation lacking- pre/post-dialysis assess to monitor health status. (D)
- Fail to ensure ongoing assessment of residents undergoing dialysis. (D)
- Failure to provide pre and post dialysis assessments. (D)
- Failure to consistently complete nursing assessments and monitoring of a resident after returning from dialysis. (D)

F 700 – Bedrails

- Fail to assess residents for proper bed rail installation to prevent entrapment. (D)

F 725 – Sufficient Nurse Staffing

- Facility failed to answer call lights in a timely manner (E)
- Residents report call lights taking up to an hour to answer; Employees going on break after assisting to commode- not coming back causing pain. Staff report inadequate staffing levels. (E)
- Failed to answer resident call lights in a timely manner in order to meet the resident's needs. Resident call light was on the floor and not within reach. (E)
- Facility failed to answer and address call lights in a timely manner. Resident had to wait as long as 45 minutes to have call light answered.
- Failed to provide sufficient nursing staff to meet the needs of residents. Resident stated they had missed showers and has waited 45 mins or more for responses to call lights. Residents stated the facility does not have enough staff, agency staff are scheduled but they do not come when assigned. (D)

F 727 – RN 8 Hrs./7 days/Wk., Full Time DON

- Failed to designate a RN to serve as DON as required. (C)

F 729 – Nurse Aide Registry, Verification

- Failed to assure nurse aide registry verification for 2 of 5 staff. (D)

F 730 – Nurse Aide Perform Review – 12Hr /Year In- service

- CNA's did not have 12 hours of in-service training in the last year. (E)

F 755 – Pharmacy Services/Procedures/Pharmacist/ Records

- Med cart keys left unattended at nurse's station. Night nurse gave them to CMA to deliver to day shift nurse, CMA left them on counter. Narc count not completed

until 18 minutes later. DON & policy reflect narcotic count should be done upon exchange of keys. (E).

F 756 – Drug Regimen Review, Report Irregular, Act On

- Pharmacist failed to identify and notify physician of potential med irregularities for residents reviewed for unnecessary meds. (D)

F 757 – Drug Regimen is Free from Unnecessary Drugs

- Fail to offer alternative interventions prior to administration of as-needed anti-anxiety meds, fail to follow resident's order for reduction of psychotropic med. (D)

F 758 – Free from Unnecessary Psychotropic Meds/PRN Use

- Resident records did not indicate CPR choice for staff review. (D)
- PRN Ativan given past 14 days. (D)
- Failure to implement non-pharmacological interventions prior to using an anti-anxiety med and failed to have PRN orders for psychotropic meds. (D)
- Failure to document pharmacological interventions attempted prior to administering as-needed (PRN) psychoactive med for resident. (D)

F 759 – Free of Medication Error Rates of 5% or More

- Failure to maintain a medication administration error rate of less than 5%. (D)
- Fail to ensure medication error rates are not 5% or greater. Resident supposed to have TUMS administered after their meal instead of before their meal. (D)

F 760 – Residents Are Free of Significant Med Errors

- Resident given meds through feeding tube simultaneously in a "cocktail" format despite physician orders to give all meds separately with 10cc fluid each. (E)
- Nurse did not prime insulin pen needle prior to dialing the prescribed dosage. (D)
- Prior to hospitalization, resident had orders for sliding scale insulin. Upon return from hospital there were no orders for sliding scale insulin, however it continued to be given. There was no documentation of clarification with physician. (D)
- Failed to ensure residents remained free of significant medication error. (J)
- Fail to prime Insulin Pen as per manufacturer’s recommendations. (D)
- Fail to ensure residents were free of any significant medication errors. Resident was given wrong dose of morphine and sent to the ER and given Narcan. (J)

F 761 – Label/Store Drugs/Biologicals

- Failure to date a multidose vial of med for administration to residents. (D)
- Fail to assure all resident medications were secured and prohibited from unauthorized access. Medication cart was found unlocked and unattended. (D)

F 801 – Qualified Dietary Staff

- The facility failed to have a certified dietary manager. (C)
- Dietary manager not a CDM and no full-time RD on staff. (D)

F 803 – Menus Meet Res Needs/Prep in Advance /Followed

- Fail to serve correct size of ground meat/pureed diets when compared to diet sheets. (E)
- Dietary manager asked surveyor how much spaghetti/meat sauce to serve. Cook & manager pureed meals incorrectly; had left-over pureed food at end of service and should have had none left. Cook & manager reported not understanding how to read pureed portion/scoop size chart, not having policy on puree process. (E)
- Fail to serve menu as written to meet nutritional needs of residents on pureed diets. (D)
- Failed to provide the correct meal portions for residents on pureed diet and failed to provide the correct diet consistency for resident. (E)

F 804 – Nutritive Value/Appearance/Palatability/Temp

- Facility served food that was not at proper temps. (E)
- Failure to maintain hot holding temperatures. (E)

F 809 – Frequency of Meals/Snacks at Bedtime

- Residents complained all meals consistently served late, as much as 30 minutes on average. (E)

F 812 – Food Procurement, Storage, Preparation, Sanitization

- Dirty walls and dusty fan blades in kitchen, staff members in food prep area without hairnet covering facial hair or hair. (E)
- Dirty ice machine, several types of meat were thawing in the same container. (F)
- CNA assisting meal time grabbed rim of the drinking glasses multiple times. (E)
- Dietary employees not washing hands, sink not sanitized, touched ready to eat foods with bare hands. (E)
- Dietary staff using gloved hands to take bread out of wrapper also handling ready to eat items and also touched cabinets, utensils, etc.
- Fail to maintain adequate kitchen sanitization and/or carry out proper food handling practices. (E)
- Fail to properly store nutrition supplements, ensure staff utilized proper handling of residents' food items; wear hairnets in order to prevent food borne illness. (E)
- Failed to serve food under sanitary conditions. (D)
- Failure to always ensure resident meals are stored and distributed under sanitary conditions to ensure food service safety. (F)
- Failure to maintain clean and sanitary conditions in the kitchen in order to reduce risk of food-borne illnesses. (E)
- Fail to serve meals in manner to prevent contamination during meal service. (E)
- Failed to ensure the kitchen environment was clean and sanitary and failed to ensure dietary staff utilized proper food handling and failed to completely cover their hair with a hairnet. (E)

F 842 – Resident Records - Identifiable Information

- No documentation of changing of abdominal dressings or ostomy appliance when performed by nursing staff. Resident was constantly picking at dressing and appliances which necessitated changes several times per day. (D)
- Failed to ensure accurate/complete documentation maintained in med record. (D)

F 868 – QAA Committee

- Failed to maintain a QA&A committee consisting of at a minimum the DON, the Medical Director and at least 3 other members of the facility's staff (C)

F 880 – Infection Prevention and Control

- Nurse failed to cleanse insulin pen rubber tip before attaching needle as per manufacturer's instructions. During med pass nurse dropped medication from unit dose container onto surface of med cart and then placed it with bare hands into med cup with other medications. Catheter tubing noted touching floor. (D)
- Staff member dropped tube of barrier cream on floor, picked up tube with gloved hand, and then proceeded to apply cream without changing gloves. (D)
- Failure to ensure adequate cleansing of a shared glucometer. (D)
- Failure to ensure proper infection control practices to prevent infection. (E)
- Failure to utilize proper infection control techniques during resident care. (D)
- Failure to utilize proper infection control techniques during resident care. (D)
- Failed to provide proper catheter care for resident. (D)
- Fail to follow infection control practices in order to prevent spread of infection. Oxygen tubing/cannula fell on floor, CNA put back on the client. (D)
- Fail to maintain infection control program to provide safe, sanitary, comfortable environment to help prevent development/transmission of communicable diseases/infection during med pass. Administered insulin without gloves. (D)
- Failed to ensure staff followed infection control practices. Wound nurse did not wash hands before donning gloves. Nurse took old dressing off and did not wash hands before applying new gloves again. (D)
- Fail to maintain infection control practices to provide safe, sanitary, comfortable environment, help prevent development/transmission of communicable disease/infection. Staff donned gloves before washing hands, gave cares, did peri care and didn’t change gloves before proceeding with other cares. (D)
- Failure to maintain infection control policy, staff failed to maintain infection control practices to provide a safe, sanitary, and comfortable environment and prevent development and transmission of communicable diseases and infections. (E)

L 1093 –

- Facility failed to check veteran's eligibility for a number of residents.
- Assessments were not completed every shift for O2 usage. Assessments were lacking vital signs on multiple entries while resident was symptomatic. (D)

Nursing Facility Survey Frequency - January 2019

As of January 16, 2019, CMS lists 69 Iowa facilities (15.7%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 8.4%. National average is 8.1%.

FFY 19 - November Totals - LTC Surveys

Provider	City	Survey End Date	Previous Date	Months Between
Brio of Johnston	Johnston	11/7/2018		
Chariton Spec. Care	Chariton	11/1/2018	7/27/2017	15.40
Crestview Acres	Marion	11/1/2018	7/27/2017	15.40
Denver Sunset Home	Denver	11/7/2018	10/5/2017	13.27
Dunlap Specialty Care	Dunlap	11/29/2018	8/3/2017	16.10
Ennoble N&R	Dubuque	11/7/2018	8/3/2017	15.37
Goldenrod Manor	Clarinda	11/7/2018	5/24/2017	17.73
Good Shepherd Home	Mason City	11/1/2018	8/17/2017	14.70
Halcyon House	Washington	11/7/2018	9/28/2017	13.50
Harmony House	Waterloo	11/20/2018	8/24/2017	15.10
IOOF Home	Mason City	11/29/2018	8/17/2017	15.63
Iowa Jewish	Des Moines	11/10/2018	8/24/2017	14.77
Kahl Home	Davenport	11/29/2018	8/17/2017	15.63
Kingsley	Kingsley	11/21/2018	8/24/2017	15.13
Laurens Care Center	Laurens	11/1/2018	6/30/2016	15.40
Linn Manor	Marion	11/20/2018	9/7/2017	14.63
Maquoketa Care Center	Maquoketa	11/15/2018	8/10/2017	15.40
Martin Health	Cedar Falls	11/7/2018	8/3/2017	15.37
Mercy Medical Center NF	Sioux City	11/20/2018	8/22/2017	15.17
Mill Pond	Ankeny	11/20/2018	9/7/2017	14.63
Montezuma Specialty	Montezuma	11/15/2018	8/10/2017	15.40
Oakview N & R	Burlington	11/1/2018	7/20/2017	15.63
Panora Specialty Care	Panora	11/20/2018	10/9/2017	13.57
Pearl Valley of Washington	Washington	11/29/2018	8/14/2017	15.73
Pleasant view Home	Albert City	11/7/2018	8/3/2017	15.37
Prairie Vista	Altoona	11/15/2018	8/24/2017	14.93
Rehab Center of Belmond	Belmond	11/15/2018	8/10/2017	15.40
Rotary Senior Living	Eagle Grove	11/15/2018	8/10/2017	15.40
Salem Lutheran Home	Elk Horn	11/29/2018	7/27/2017	16.33
Sanford Senior	Sheldon	11/29/2018	8/3/2017	16.10
Shady Rest	Cascade	11/20/2018	7/14/2017	16.47
Sioux Center Health Royal Meadows	Sioux Center	11/1/2018	7/20/2017	15.63
The New Homestead	Guthrie Center	11/7/2018	7/20/2017	15.83
Valley View Specialty	Eldora	11/10/2018	8/31/2017	14.53
Willow Gardens	Marion	11/1/2018	7/13/2017	15.87
			AVERAGE	**15.31**

Educational Topics identified by Committee:

- Resident Transfer Notification to Ombudsman – documentation and forms needed, bedhold notices required. (Education planned for 2019 Spring Quarterly)
- DIA interpretation of “ambulatory” as described in Chapter 58 as it relates to reporting of major injuries (Bulletin article)
- Distinction of state and federal deficiencies (Bulletin article)
- Determination of final date of compliance for survey revisits (Bulletin article)