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

Compliance Tips from IHCA's Survey Results Committee
January 2020

Total Number of Survey Reports: 50

Survey Composition:

Annual:	29 Surveys 4 Deficiency Free
Complaints:	31 Surveys 7 Unsubstantiated
Self-Reports:	13 Surveys 4 Unsubstantiated
Mandatory Reports:	3 Surveys 0 Unsubstantiated

State Fines: $37,500
State Fines in suspension: $0

Most Commonly Cited Iowa Tags:

F 880 – Infection Prevention and Control (16)

F 812 – Food Procurement, Storage, Preparation, Sanitization (14)

F 689 – Free from Accidents and Hazards (14)

F 657 – Care Plan Timing & Revision (11)

F 658 – Services Provided Meet Professional Standards (9)

Tags Resulting in Actual Harm or Higher Citations and Fines:

F 684 – Quality of Care	2 G Level Tags
F 686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers	1 G Level Tag
F 689 – Free from Accidents and Hazards	3 G Level Tags
G 688 – Prevent Decrease in ROM/Mobility	1 G Level Tag

F 606 – Not Employ/Engage Staff with Adverse Actions **D Level Tag- $500 FINE**

N 101 – Notification for Major Injury **D Level Tag- $500 FINE**

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=15617		Total Number of Surveys=68491
F0880	Infection Prevention & Control	6,316	35.9%	9.2%
F0689	Free of Accident Hazards/Supervision/Devices	5,998	29.0%	8.8%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	5,246	31.2%	7.7%
F0656	Develop/Implement Comprehensive Care Plan	4,650	25.8%	6.8%
F0684	Quality of Care	4,387	22.1%	6.4%
F0761	Label/Store Drugs and Biologicals	3,680	21.9%	5.4%
F0657	Care Plan Timing and Revision	2,977	17.1%	4.3%
F0677	ADL Care Provided for Dependent Residents	2,768	14.2%	4.0%
F0758	Free from Unnec Psychotropic Meds/PRN Use	2,655	16.0%	3.9%
F0609	Reporting of Alleged Violations	2,603	13.3%	3.8%

*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

- Failure to knock on a resident's door before entering the room- multiple residents. E
- Privacy curtains and window blinds not pulled when providing cares to dependent resident. D
- Two incidences of staff not knocking and waiting for response. D

F559 – Choose/Be Notified of Room/Roommate Change

- Fail to provide written notice, family notification prior to room change for resident. D

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

- Fail to document/establish clear method to communicate code status decisions to IDT for multiple residents. E
- Failed to obtain an order for code status for residents. Resident admitted and did have a page in the front of chart indicating they were full code, but facility did not obtain an order for residents' preference until weeks later. Baseline care plan contradicted this preference and listed DNR. D

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

- Staff failed to notify family members of resident's weight loss, and another resident's skin and weight loss issues. D
- Resident with deep tissue injury to buttocks/coccyx was not measured/assessed properly, physician changed order, previous treatment continued. Another resident with open areas not measured weekly; assessments not signed by the nurse. D
- Physician not timely notified for skin condition. Physician DCd pain meds at hospital, later told family they inadvertently DCd medication, facility did not tell family meds were DCd at hospital. D
- Physician not notified timely for resident with weight loss. D
- Fail to notify physician of a wrong dose of fentanyl patch for a resident and failed to notify family of a missing fentanyl patch. D

F582 – Medicaid/Medicare Coverage/Liability Notice

- Not using correct NOMNC, ABN forms. B

F583 – Personal Privacy/Confidentiality of Records

- Failure to maintain adequate privacy for residents during a daily quality assurance and therapy meeting. E

F584 – Safe/Clean/Comfortable/Homelike Environment

- Marred doors, scuffed paint, stained walls and ceilings, partial missing floor tiles, strong urine odor in rooms, trash on floors around resident beds, broken light switch plate with sharp edges. D
- Urine odors throughout facility. E
- Environmental concerns including windows with rotted frames, warped glass, stains on carpet, etc. E

F585 – Grievances

- Facility failed to follow through with a plan established after a resident filed a formal grievance regarding physical condition of the room bathroom. Administrator pledged to make needed repairs including painting but months after the grievance was filed, work has not been completed. D
- Facility failed to post grievance policy – multiple residents were not aware of grievance officer. B

F606 – Not Employ/Engage Staff with Adverse Actions

- Facility did not check CNA registry for current status prior to employment of three CNAs. D

- Employee worked 8 days prior to return of record check evaluation from DHS giving them permission to work. **D $500 FINE**

F607 – Develop/Implement Abuse/Neglect, etc. Policies

- Fail to ensure staff received mandatory 2-hour dependent adult abuse training within 6 months of hire. Staff file only included combined child and dependent adult mandatory reporter training not the 2-hour dependent adult mandatory reporter training per state training requirement. B
- Staff had not completed adult abuse training. D

F609 – Reporting of Alleged Violations

- Failure to self-report an allegation of abuse. A resident struck another resident, and that resident struck back. Facility did not report. D
- Failed to report allegations of abuse to administrator and DIA. One employee was witnessed by hospice staff pushing a resident into recliner, employee denied. Facility staff believed hospice staff misrepresented what occurred and did not report. Another resident reported employee kicked him/her in abdomen and was mean; had bruise on arm. DON was notified by three employees. D
- Fail to report potential abuse to state agency- regarding missing fentanyl patch. D

F610 – Investigate/Prevent/Correct Alleged Violation

- Facility failed to conduct proper investigation of a resident with a fracture of unknown origin. Not all staff who may have had knowledge of the cause were interviewed. D
- Failed to immediately report suspected abuse and investigate/separate multiple residents. F
- CNA was witnessed grabbing resident's face with one hand to keep the resident from speaking and was reported to charge nurse. Next day the employee worked on same unit, opposite side of that hall. CNA was then notified about being suspended. Staff admitted CNA should have been suspended the day prior. D

F623 – Notice Requirements Before Transfer/Discharge

- Failure to notify LTC Ombudsman of resident discharge and transfer. B
- Fail to notify Ombudsman of residents transfer to hospital for residents reviewed for hospitalizations. B
- Facility failed to notify the Ombudsman of residents transfer to the hospital for residents reviewed for hospitalizations. B
- Ombudsman notification of discharge not done for hospital transfers. B
- No notice to Ombudsman regarding transfer from the facility for residents. B

F625 – Notice of Bed Hold Policy Before/Upon Transfer

- Failed to notify resident's representative of bed hold policy for several residents. B

- Facility did not provide a bed hold policy for residents prior to transfer to hospital. D
- Fail to provide notice to resident/POA of bed hold policy upon transfer to the hospital for residents reviewed for hospitalizations. B
- Facility failed to provide notice to the resident/POA of bed hold policy upon transfer to the hospital for residents reviewed for hospitalizations. B
- Bed hold not provided for resident. B
- Residents did not receive bed hold notice. D
- No documentation of bed hold provided at time of hospital transfer. B

F637 – Comprehensive Assmt After Significant Change

- Missed significant change MDS when ADLs declined and admitted to hospice. D

F638 – Quarterly Assessment At Least Every 3 Months

- Residents did not have a quarterly MDS completed. E

F640 – Encoding/Transmitting Resident Assessment

- MDS was not transmitted timely. B

F641 – Accuracy of Assessments

- Resident had three falls which were not captured on the MDS. D
- Five-day MDS assessment not completed in a timely manner. Facility did not have an MDS Coordinator. D
- Failure to assess for significant change MDS after Hospice was initiated. B
- MDS was not coded properly for residents on anticoagulants. D
- MDS did not include skin ulcers. B

F644 – Coordination of PASARR and Assessments

- Facility did not update PASRR when diagnosis of schizophrenia was added. D
- Facility did not submit a new PASRR with additional diagnosis of anxiety disorder with delusions. D
- PASRR not re-submitted with behavioral changes and medication changes. D
- PASRR did not include dx of depression, delusional disorder and generalized anxiety disorder. D

F655 – Baseline Care Plan

- Facility failed to develop baseline care plan for resident. B

F656 – Develop/Implement Plan of Care

- Failure to address specific interventions on the comprehensive care plan. D
- Failure to identify resident with pressure ulcer and document interventions. B

- Facility did not have comprehensive care plans developed for residents. D
- No development of care plan for several residents - insulin and side effects as well as eye patch. D

F657 – Care Plan Timing & Revision

- Failure to update a care plan with regard to history of UTI. D
- Facility failed to update the care plan for multiple residents. D
- Care plans were not updated as appropriate for residents. D
- Fail to update care plans for residents. Resident admitted with two unstageable pressure ulcers and later developed a diabetic ulcer. Wounds not identified on care plan. Second resident was care planned to be transferred with assist x1 gait belt. Resident utilized full body lift for transfers and care plan had not been updated. D
- Fail to review and revise the care plan for residents. Resident had quarter rails up in bed and this was not identified on their care plans. B
- Care plan not updated related to skin issues/treatments/antipsychotic medications. D
- Care plan did not address infusion port, chemotherapy and hair loss. D
- Isolation for c-diff precautions not on care plan. D
- Resident wearing gloves to protect self and staff-not on care plan. Resident on chemotherapy not on care plan. D
- Dialysis not on care plan. No dialysis contract. B
- Care plan conference not held as indicated - no documentation. D

F658 – Services Provided Meet Professional Standards

- Failure to administer medications as physician ordered for multiple residents. E
- Failure to ensure professional standards are followed during medication administration of an inhalant medication. D
- Fail to follow own bowel monitoring protocol to prevent constipation for a resident. D
- Facility did not follow therapy orders for use of heel protectors for resident. D
- Nurse, when administering insulin, recapped the insulin pen needle with the outer cap rather than using the correct inner cap. D
- Facility did not notify physician regarding treatment, family wish to discontinue trxt. D
- Failed to ensure physician's orders were followed, meds prepared and administered according to professional standards - regarding missing fentanyl patch. D
- Failed to ensure a resident was free of constipation. D
- Fail to follow physician orders for residents. Resident had an order of tubigrips on in the am off at HS. Multiple observations over consecutive days revealed no tubigrips and resident reported never wearing them. Second resident had order for Tubigrips on in am, off at HS also not on as ordered. D

F661 – Discharge Summary

- No discharge summary or recapitulation of stay available for a resident. D
- Recapitulation of stay not completed on discharge. D

F677 – ADL Care Provided for Dependent Residents

- Failure to respect the rights of residents. Resident has the right to refuse meals, and the right to have a substitute menu. D
- Failure to provide adequate, timely incontinence cares for multiple residents with incontinence issues. E
- Failure to shave a female resident's whiskers. D
- Residents did not receive showers twice a week as planned. Shower aid reportedly was on vacation and had been pulled to the floor. E
- Fail to complete grooming for resident. Resident had heavy facial stubble for multiple days and was not shaved. D
- Residents did not receive showers/baths as planned; shower and w/p tub were unable to be used. Staff reports residents being given bed bath but not documented. Resident did not receive peri care after incontinent episode and residents did not receive teeth brushing in the morning. E
- Staff performed peri care with contaminated gloves after involuntary episode. D

F684 – Quality of Care

- Fail to properly assess diabetic resident, including checking a blood sugar, reporting a UA showing high glucose reading. Resident exhibited symptoms of hyperglycemia over the next week and was transferred to the hospital with BS of 1037. D
- Skin assessments lacking for residents. IR lacked neuro checks after unwitnessed fall, resident was transferred to hospital with head laceration (within 15 mins) later died. Nurse reported resident was breathing when assessed; another nurse and CNA report resident was absent pulse/respirations. E
- Resident returned from hospital with purple bruise in groin and hip area. Upon admissions assessment bruise was not documented. Resident experienced pain/swelling to knee. Staff reported pain and that leg seemed floppy and was no longer contracted. Days after re-admission it was determined there was a hip fx. Guardian reportedly was not told about the bruise until they were returned to the hospital for fx-took a photo and shared it with the surveyor. **G $4,000 FINE**
- Resident with multiple co-morbidities admitted with pressure ulcer to coccyx. Later developed an abrasion to right Achilles. No IR or investigation available as to cause. Wound worsened over months to point of exposed tendon, fat layer, fascia then sepsis and later amputation of leg. **G $8,500 FINE**
- Nurse did not follow orders to place cone in resident's hand 4 hours/day x2. D
- Failed to adequately assess and intervene in a timely manner for a resident with the wrong dose of a narcotic patch and didn't report two residents that had an altercation. One resident placed their hand over another resident's face. D

- Facility sent a fax related to change in cognitive functions versus calling physician. D

F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers

- Failure to ensure pressure wound received proper treatment to promote healing. D
- Fail to provide admission assessment, physician clarification for use of ED boot resulting in development of stage 4 pressure ulcer. Boot doing more harm than good and causing ulcer. Resident continued wearing boot after physician order said shouldn't be worn. Documentation lacked update on foot condition. **G $4,500 FINE**
- TAR had no physician ordered wound care documented for several random days. D
- Resident with deep tissue injury to buttocks/coccyx was not measured/assessed properly, physician changed order, previous treatment was continued. Another resident with open areas not measured weekly and assessments not signed by the nurse. Observation of treatment revealed nurse applied Desitin paste to primary wound area but did not extend to surround macerated tissue. E
- Resident developed fluid filled blister (identified as pressure related) on heel apparently due to staff not following care plan for Prafo boot. D

F688 – Increase/Prevent Decrease in ROM/Mobility

- Fail to provide restorative therapy for a resident. Lack of documentation that resident was offered restorative program for various weeks over a 3-month period. D
- Resident had no ROM completed for multiple days and facility stated they have no regular program for ROM although ROM was care planned. D
- Failure to provide range of motion exercises for a resident. D
- Facility hasn't had restorative nursing program in place for 4 years. **G $500 FINE**

F689 – Free from Accidents and Hazards

- Fail to carry out assessments to ensure safety for multiple residents. Failure to secure chemicals for moderately impaired residents. Failure to have a call light within reach for residents. Fail to ensure safety during wheelchair transport. E
- Failure to assess a resident at last quarterly for continued use of smoking materials. No update smoking documentation in care plan. D
- Transfer without mechanical lift and no gait belt resulting in bruising no fracture. **G $6,500 FINE**
- Resident fell from Hoyer lift and suffered a large hematoma to posterior scalp. Staff operating lift used the wrong sling for the type of lift. D
- Facility did not have safety assessment for resident who smoked off grounds with family. Resident sometimes kept smoking materials rather than giving them to staff for safe storage when not off grounds to smoke. D
- Resident identified as an "at risk" smoker was not wearing a smoking apron while outside smoking as required by facility policy. D

- Facility failed to ensure assistive devices and wheelchair pedals for residents' wheelchairs to prevent accidents when residents not propelling themselves. Unit manager/RN was observed on pushing resident down hall while resident held their feet out in front. Next day an LPN observed pushing another resident down the hall to Dr. with no foot pedals on wheelchair. Resident's feet were rubbing against floor. CNA observed pushing resident down hall to the DR with no foot pedals. D
- Resident not wearing proper footwear as care planned at time of fall. D
- Failure to utilize gait belts with transfer of resident as noted on care plan. D
- Used wrong sling during transfer-no injury. D
- Staff propelled resident in wheelchair without pedals in place. D
- Failure to adequately supervise residents. Resident fell forward out of wheelchair and injured hip. Went to the ER and learned resident fractured femur- a major injury according to physician. Multiple staff indicated there was no pad alarm on resident's wheelchair and weren't aware a pad alarm was on care plan. A second resident was documented as a fall risk, used a floor mat alarm and motion sensor. Resident was found by nurse on floor of room; resident stated he/she fell by recliner. Moderate amount of blood on floor by resident, cut on shin. Resident was sent to hospital. Staff confirmed that prior to the fall staff assisted the resident into the recliner and covered resident with blanket but the FMA was not used. **G $7,500 FINE**
- No post fall assessment/care plan interventions for resident with several falls. D
- Care plan for resident with severely impaired decision-making skills called for staff to ensure all supplies were within reach prior to toileting resident. Staff member subsequently left resident unattended to retrieve supplies. Resident fell sustaining a head injury and fractures. **G $5,000 FINE**

F690 – Bowel, Bladder Incontinence, Catheter Care

- Failure to take appropriate measures to prevent a UTI with perineal care. E
- Peri-care done incorrectly, and gloves not changed properly between clean/dirty. D
- No policy for incontinent care. D
- Peri-care done incorrectly, and gloves not changed properly between clean/dirty. D

F692 – Nutrition/Hydration Status Maintenance

- Fail to provide dietary interventions for acceptable nutrition status. D
- No care plan intervention documented for resident with sig weight loss in 2 weeks. D

F693 – Tube Feeding Management/Restore Eating Skills

- Facility failed to provide proper services for a resident with a feeding tube. Resident was observed receiving in ROM by staff CNA's. The head of the bed was made flat even though the feeding was running. The resident did begin to cough so the aides raised the HOB but then lowered it flat again during the ROM. D

F695 – Respiratory/Tracheostomy care and Suctioning

- Failure to provide oxygen treatment for resident in accordance with professional standards. Resident's clinical record lacked an order for oxygen, but the resident's family insisted on oxygen and placed it on the resident themselves. Staff did not check to see if there was a physician's order for oxygen and just went ahead and used it on the resident. D

F698 – Dialysis

- Fail to provide dialysis care and treatment for resident receiving dialysis services. D
- Facility failed to document pre/post dialysis assessments for multiple residents. D
- No pre and post assessments with resident receiving dialysis. D

F700 – Bedrails

- Failure to assess for alternatives prior to utilization of bedrails for residents. E
- Informed consent lacking for use of side rails, gaps between rails/bed frames. D

F710 – Resident's Care Supervised by a Physician

- Failure to notify physician that a medication was unavailable for a resident. D

F725 – Sufficient Nurse Staffing

- Fail to answer call lights within a timely manner for multiple residents. E
- LPN worked alone on third shift after a CNA called in. D
- Multiple residents had call lights not answered within 15 minutes. E
- Insufficient staffing to meet the needs of several residents. Call lights taking too long to be answered. D
- Resident stated they do not have call lights answered within 15 minutes. E
- Call lights not answered in a timely manner. E

F730 – Nurse Aide Perform Review – 12Hr/Year In-service

- Multiple CNAs did not have in-services completed and one employee did not have a current performance evaluation on file. E
- CNAs did not have 12-hrs of training. D
- Several CNAs did not have 12-hrs of in-service training. D

F755 – Pharmacy Svcs/Procedures/Pharmacist/Records

- CMA on 2nd shift didn't want to wait to do narcotic count and gave keys to another CMA. Next morning keys were found under a newspaper on counter and a bottle of Ativan was missing. Narc count sheets were missing several counts. CMAs admit keys left on unlocked cart unattended. E
- Facility failed to follow policy related to fentanyl patch documentation. E

F756 – Drug Regimen Review, Report Irregular, Act On

- Lack of gradual dose reduction for resident receiving trazadone. D

F757 – Drug Regimen is Free From Unnecessary Drugs

- Lack of assessment to behavior symptoms. D

F758 – Free from Unnec Psychotropic Meds/PRN Use

- Failed to request gradual dosage reduction in psychotropic medications for multiple residents. D
- PRN psychotic meds for resident with use beyond 14 days. D
- PRN anti-anxiety med continued beyond 14 days; no rationale/records for GDRs. D

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

- Med errors greater than 5%-Med orders did not match what was given. D

F761 – Label/Store Drugs & Biologicals

- Facility did not perform inventory count of narcotics as required by facility policy. D
- Med fridge temps too high and several days missing. D
- Facility failed to ensure expired eye drops were not administered for residents. D

F800 – Provided Diet Meets Needs of Each Resident

- Food temps below minimum requirements related to hot foods. E
- After meal was served, ending temps were checked and food temped too low. E

F801 – Qualified Dietary Staff

- Failure to employ a qualified Director of Food and Nutrition Services in the absence of a fulltime dietician. F

F803 – Menus Meet Resident Needs/Prep in Advance /Followed

- No bread/ butter served with noon meal called for by menu prepared by dietitian. E
- Facility failed to follow the planned menu in multiple meals observed. Wrong scoop size used. No bread item added to the puree. E
- Not following the menu for residents' portion controls. D
- Failure to assure menus were followed for residents. D
- Fail to ensure all residents on a regular, mechanical soft and pureed texture, received proper portion size based on planned menu and meet individual preferences of all residents. E

F804 – Nutritive Value/Appear, Palatable/Prefer Temp

- Cinnamon rolls were doughy-not thawed prior to baking. E
- Failure to assure palatability of meats served. E

F805 – Food in Form to Meet Individual Needs

- Not providing therapeutic diets - mechanical altered. D

F806 – Resident Allergies, Preferences and Substitutes

- Residents did not have their preferred menu choices. E

F808 – Therapeutic Diet Prescribed by Physician

- Several residents needed pureed diets; not included on the spread sheet E
- Several residents did not receive mechanically altered foods as ordered. D

F812 – Food Procurement, Storage, Preparation, Sanitization

- Staff failed to check the strength of sanitizing solution in the dishwasher per manufacturer instructions. Facility did not have appropriate test strips. Staff were unaware they were supposed to test. Staff at dining wore gloves but touched multiple surfaces then handled food and drinks. F
- Staff failed to date food items upon opening and storing. E
- Food crumbs noted in clean steam table pans, staff member entered kitchen without hair covered, thick layer of dust on kitchen exhaust fan. E
- Dust and debris were found in multiple areas in the kitchen. E
- Numerous issues related to touching food with gloved hands, then touching other non-food items. E
- Food not dated or labeled or freezer clean. E
- Food not labeled or dated. E
- Wrong test strips being used on dish machine. F
- During service staff wore same gloves to touch food and multiple surfaces. E
- Pureed meat temped low. E
- Numerous pieces of equipment not clean - numerous drawers with crumbs. E
- Fail to label/date food items in freezer/refrigerator, fail to clean dishwasher/racks. E
- Cleaning schedules demonstrated numerous cleaning issues within the kitchen. F
- Failed to store and serve food under sanitary conditions to maintain food quality and prevent food borne illness. Staff did not wash hands prior to gloving before starting to serve meal. Multiple resident food items identified in fridge with no resident name or open date on them. E

F838 – Facility Assessment

- Administrator couldn't produce a facility assessment; admitted to not knowing what it was. C

F860 – Discharge Planning Process

- Resident was discharged, left without instructions. Later employee went to resident's home with meds and instructions. Home health received referral on day of discharge but did not pick up resident due to lack of staffing. Resident was unaware of this and reported difficulty getting around, needing a walker and wheelchair. D

F868 – QAA Committee

- Facility failed to ensure the required members attended the QA meetings. The medical director had not attended since April 2019. B
- Required committee members (DON & Admin) not present at QA meeting D

F880 – Infection Prevention and Control

- Failed to provide infection control education to a resident on transmission-based precautions, cover linen during transport and maintain a sanitary environment. E
- Staff used same pair of gloves to assist resident with indwelling cath and history of UTIs, and open a bathroom door, as well as three drawers. E
- Resident's draining bag was dragging on floor. D
- Catheter bag and tubing were observed touching floor. D
- Nurse, while administering medications, poured meds from the med cup into bare hand and then poured them back into cup. Nurse explained she was checking for stray plastic pieces from cassette lids prior to administration. D
- Direct care staff washed hands and gloved prior to doing peri care and then touched multiple surfaces in the room prior to doing care. Nurse, while completely a dressing change, failed to wash hands and changes gloves after removing dirty dressing before applying clean dressing. D
- Observation of dressing change showed a nurse wash hands and shut water off with bare hands. Did not disinfect glucometer. Applied ointment using soiled gloves. E
- Barrier not utilized for supplies on bed side stand when completing blood sugar. D
- Employees washed hands and shut water off with bare hands. Laundry did not have water temperature set high enough and laundry cart did not have a cover. F
- Shared glucometer not properly disinfected between residents. Disinfectant wipe requirement was to remain wet for 2 min, was only wet for 15 sec. D
- Employee put items on the floor and carried a package of wipes under armpit to carry them. Did not change gloves properly. A RN was performing a dressing change and was observed with no barrier between bed and supplies, did not wash hands between glove

changes. A resident with C-diff did not have a stop sign on the door as required in facility policy. D

- Improper peri care for residents, not washing hands after removal of gloves. D
- Staff using different products to clean glucometers, unaware of what procedure they should follow. Cath bag touching floor from bottom of wheelchair and side of bed. E
- Dressing changes observed not changing gloves, washing hands properly. D
- Failed to utilize proper infection control during wound care for resident. No barrier used for supplies. Did not disinfect scissors prior to cutting off soiled dressing. Did not wash and re-glove when treating multiple wounds to both feet. D
- Fail to ensure oxygen tubing was properly labeled, changed to prevent infection in resident. Observation revealed oxygen running at 3L and the tubing had no date. D

F883 – Influenza and Pneumococcal Immunizations

- No follow up for several residents related to pneumococcal immunizations. D

F909 – Resident Bed

- Gaps in bed rails--entrapment zones not assessed. E

F919 – Resident Call System

- Failure to ensure a resident's bathroom had a functioning call light. D

L347

- Failure to complete incident report for resident. D

N101

- Physician signed major injury determination form as "major injury". Report was put into website but never filed. **D $500 FINE**

Nursing Facility Survey Frequency

As of January 21, 2020: CMS lists 49 Iowa facilities (11.3%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 9.1%. National average is 6.9%.

FFY 2020- Jan. Totals - LTC Surveys				
Provider	**City**	**Survey End Date**	**Previous Date**	**Months Between**
Accoridius Health St. Mary	Davenport	10/3/2019	8/15/2018	13.80
Accura Healthcare of Carroll, LLC	Carroll	11/6/2019	8/23/2018	14.67
Anamosa Care Center	Anamosa	11/26/2019	10/11/2018	13.70
Dubuque Specialty Care	Dubuque	11/21/2019	9/20/2018	14.23
Elm Heights CC	Shenandoah	11/26/2019	9/13/2018	14.63
Elmwood Care Centre	Onawa	11/21/2019	9/20/2018	14.23
Emmetsburg Care Center	Emmetsburg	11/26/2019	4/1/2018	20.13
Eventide Lutheran Home for the Aged	Denison	11/21/2019	8/16/2018	15.40
Franklin General Hospital	Hampton	11/26/2019	9/13/2018	14.63
Grand Meadows	Asbury	11/26/2019	9/27/2018	14.17
Jefferson Place	Pella	11/26/2019	10/4/2018	13.93
Manorcare Health Services - Davenport	Davenport	11/21/2019	8/30/2018	14.93
Maple Manor Village	Aplington	11/26/2019	9/20/2018	14.40

Mayflower Home	Grinnell	11/14/2019	10/4/2018	13.53
Nelson Manor	Newton	11/6/2019	8/29/2018	14.47
Newton Village Health Care Center	Newton	1/26/2019	10/4/2018	3.80
Palo County Hospital	Emmetsburg	10/31/2019	8/9/2018	14.93
Parkridge Specialty Care	Pleasant Hill	11/6/2019	8/23/2018	14.67
Pearl Valley Rehab & Healthcare	Sutherland	11/21/2019	9/13/2018	14.47
Pioneer Valley Living & Rehab	Sergeant Bluff	11/21/2019	9/20/2018	14.23
Ridgewood Specialty Care	Ottumwa	11/21/2019	9/20/2018	14.23
Shady Oaks	Lake City	11/6/2019	8/23/2018	14.67
StoneHill Care Center	Dubuque	10/24/2019	5/24/2018	17.27
Sunny Hill Care Center	Tama	11/26/2019	8/13/2018	15.67
Sunny Knoll Care Centre	Rockwell City	11/14/2019	8/30/2018	14.70
The Cottages	Pella	11/14/2019	9/27/2018	13.77
The Vinton Lutheran Home	Vinton	11/14/2019	8/29/2018	14.73
Titonka Care Center	Titonka	11/6/2019	9/20/2018	13.73
Valley Vue Care Center	Armstrong	11/21/2019	9/20/2018	14.23
			AVERAGE	**14.85**