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

Compliance Tips from IHCA's Survey Results Committee January 2021

Total Number of Survey Reports: 53

Survey Composition:

Annual:	1 Survey 0 Deficiency Free
Complaints:	20 Surveys 4 Unsubstantiated
Self-Reports:	9 Surveys 0 Unsubstantiated
Mandatory Reports:	3 Surveys 0 Unsubstantiated
COVID-19 Infection Control Survey:	20 Surveys 0 Deficiency Free

State Fines: $42,250
State Fines in suspension: $ 42,250

Most Commonly Cited Iowa Tags:

F 880 – Infection Prevention and Control (8)

F 689 – Free from Accidents and Hazards (7)

F677 – ADL Care Provided for Dependent Residents (5)

F684 – Quality of Care (4)

Tags Resulting in Actual Harm or Higher Citations and Fines:

F 684 – Quality of Care	**1 J, 1 K, & 1 G Level Tag**
F 686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers	**1 G Level Tag**
F 689 – Free from Accidents and Hazards	**1 J Level Tag**
F 880 – Infection Prevention and Control	**1 K Level Tag**

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=15341		Total Number of Surveys=892
F0884	Reporting - National Health Safety Network	289	1.9%	32.4%
F0880	Infection Prevention & Control	47	0.3%	5.3%
F0886	COVID-19 Testing-Residents & Staff	7	0.05%	0.8%
F0883	Influenza and Pneumococcal Immunizations	4	0.03%	0.4%
F0684	Quality of Care	4	0.03%	0.4%
F0885	Reporting-Residents,Representatives&Families	4	0.03%	0.4%
F0580	Notify of Changes (Injury/Decline/Room, etc.)	2	0.01%	0.2%
F0760	Residents are Free of Significant Med Errors	2	0.01%	0.2%
F0725	Sufficient Nursing Staff	2	0.01%	0.2%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	2	0.01%	0.2%

*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

- Resident with bilateral nephrostomy tubes which required draining each shift alleged that no night shift staff provided care for her. Morning shift CNA's reported that resident was wet from knees to shoulders and that her gown and blanket were saturated with urine their arrival. D

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

- The facility failed to ensure physician orders and resident/family wishes for code status matched resident records in 2 of 4 residents reviewed. Resident #53 had a physician order to resuscitate with start date/admission date of 9/18/20 but the profile face sheet, sticker on chart, IPOST, and DNR form indicated do not resuscitate. Resident #15 had a physician order to resuscitate with start date/admission date of 2/3/20 but the sticker on chart, IPOST, and DNR form indicated do not resuscitate. D

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

- Facility did not notify resident representatives of significant changes in resident condition that included positive results of COVID 19 testing. One resident served by a guardian and conservator was not notified of a relationship the female resident was having with another male resident. D
- The facility failed to notify 3 of 3 resident's POA of a positive COVID test result. Resident #3 tested positive for COVID on 11/06/20 and POA was not notified until 11/10/20. Resident #4 tested positive for COVID on 11/5/20 and was not notified until an interview with surveyors on 11/12/20. Resident # 5 tested positive on 11/9/20 and POA was not notified until 11/12/20. D

- The facility failed to notify 3 of 3 resident's POA of a positive COVID test result. Resident #3 tested positive for COVID on 11/06/20 and POA was not notified until 11/10/20. Resident #4 tested positive for COVID on 11/5/20 and was not notified until an interview with surveyors on 11/12/20. Resident # 5 tested positive on 11/9/20 and POA was not notified until 11/12/20. D
- Family not notified of changes in conditions - lost eyeglasses, possible stroke, pressure sores, resident refusing air mattress. D

F584 – Safe/Clean/Comfortable/Homelike Environment

- Facility did not provide a safe homelike environment. Cupboards had grime on them, floors had heavy buildup of grime and dirt, and toilets had dark stains around them. Laundry and maintenance stated they are short staffed. E

F604 – Right to be Free form Physical Restraints

- Failure to properly assess wheelchair restraint. Resident had seizure and was found sitting on floor with seat belt restraint around upper chest. D

F608 – Reporting of Reasonable Suspicion of a Crime

- Failed to report allegation of abuse on time and separate a staff from residents. Staff told resident they hoped they choked and died. RN did not report it that evening. Staff had previous inappropriate comments and was not separated from the resident. D

F610 – Investigate/Prevent/Correct Alleged Violation

- Facility did not investigate the reason for resident injury of unknown origin, a bruise under the right eye, which the family noted during a Facetime call. D

F622 – Transfer and Discharge Requirements

- Care plan did not mention discharge goals or plans for a resident. Involuntary discharge papers not filled out appropriately. Resident broke room window and crawled out. Went to ER and facility did an involuntary discharge. D

F658 – Services Provided Meet Professional Standards

- The facility failed to follow manufacturer instructions when using skin prep while completing wound treatment one resident. Staff completed wound treatments and dressing changes by spraying liquid skin prep and shield then immediately applied the dressing. The manufacturer instructions directed indicated to apply then allow 30 seconds to dry before applying a dressing. D
- Facility failed to administer physician ordered medications and did not notify the physician of missed doses. D

F677 – ADL Care Provided for Dependent Residents

- According to facility documentation, resident received only 1 bath during a 21-day period. Another resident received only 2 baths during same time period. Another resident reported she received only 1 shower in five weeks. D

- The facility failed to provide bathing services in accordance with professional standards to maintain good hygiene for 4 of 4 residents reviewed. Resident # 1 was admitted on 12/16/19 and did not receive a bath/shower until the 8th day of their stay. Resident # 2 was not provided a bath on 4 scheduled days between August through October 5th, 2020. Resident # 3 was not provided a bath on 2 scheduled days between August through October 5th, 2020. Resident #7 was admitted on 9/17/20 and was not provided a bath/shower on 2 scheduled days in September. E
- The facility failed to complete baths, oral care, and nail care for 2 of 6 residents reviewed. Resident # 2 was observed on 11/3/20 with long nails and a dark brown substance under them. Cares were only completed once this day on 1st shift and staff member explained she had been working alone since 10 am and he requires 2 assists so she did not provide cares. On 11/5/20 at 7:50 am the resident was observed soaked in urine with dried urine on gown. Staff reported there was only one aide on the hall the night before and it appeared cares had not been completed. In Sept documentation showed 2 of 9 baths completed and in October 4 of 9 baths completed. Nails were still long with a brown substance under nails and teeth had a brown substance on them. Resident #4 reported the staff do not help her brush her teeth and shower records show In Sept 4 of 9 baths were completed and in October 2 of 9 baths completed. D
- Failure to maintain grooming for residents, toe nails long and jagged, heavy growth of facial hair, baths not given at least twice a week, female with long facial hair, resident brief hadn't been changed for 4 hours, and resident waiting for care while staff was on break. E
- Failure to provide proper incontinence care - clean from front to back. D

F684 – Quality of Care

- Facility failed to act in accordance with professional standards of practice related to assessment and intervention when a resident experienced a significant change in condition and did not follow physician's orders for 2 residents. Facility sent a fax to the physician on 8/3/2020 at 12:30 PM to advise of resident change in condition. Physician returned a response on 8/3/2020 at 3:14 PM to send to the emergency room. Facility failed to send the resident to the ER because they did not see the return fax. On 8/4/20 at 2:15 a.m., staff identified the resident was not breathing, had no pulse or blood pressure. The resident was transported to hospital but subsequently died. Review of the fax the physician had sent back to the facility on 8/3/20 revealed it had been noted by the nurse on 8/17/2020 - 14 days later. **J $8,500**
- Bowel protocol not followed, resident had to go to ER. Order for treatment of buttock not documented, resident had pinpoint spot and became a necrotic pressure. - failure to provide timely assessments. D
- Failed to provide proper nursing care that followed professional standards of care including not following physician orders for pressure sores and bowel management resulting in a visit to the ER. Dressings not changed for 10 days. **G $6,000.**

- Failed to complete timely skin assessments, failed to report to physician change in condition, and failed to assess a resident with complaints of hip pain post fall. Care plan did not state resident had risk for skin impairment or state resident had behaviors in refusing cares, did not state she used oxygen or that she had pain in shoulder. Staff did not report to physician increased swelling and pain. Blisters occurred on the residents back and staff failed to tell PCP. Resident had gurgling noises and lots of pain in her shoulder. PCP not aware of any of this for over a week. Resident sent to ER and passed away from respiratory failure. At ER PCP noticed resident was not clean, no urine output, vomit in hair and on back, and drainage from open pressures. **K $10,000.**

F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers

- Proper wound care not followed per physician orders therefore causing resident to acquire more pressure sores and current ones worsened. Wound vac was to be on continuous and it was not. Maggots found in wound. **G $5,500.**

F688 – Increase/Prevent Decrease in ROM/Mobility

- Failure to provide restorative nursing programs as scheduled. E

F689 – Free from Accidents and Hazards

- Cognitively impaired resident left facility and was observed by staff and returned without harm on 11/6/2020. The care plan did not reflect any changes following elopement attempt. On 11/10/2020 the resident was reported outside by a neighbor. Resident exited the facility when a family member turned off a door alarm. D
- 13 resident rooms had extension cords plugged into devices which had motors such as rans, refrigerators, oxygen concentrators, etc. E
- The facility failed to provide adequate supervision and proper use of assistive devices to mitigate a resident's risk for elopement. The facility failed to ensure kitchen doors remained locked, failed to check a door alarm properly, and failed to have policies and procedures to address what to do when responding to a door alarm. Resident #3 was care planned to have a wander guard. Incident report dated 9/19/20 stated resident was found outside in the parking lot. Staff A (cook) reportedly heard an alert for a door alarm at 3:21 pm and looked out and did not see anyone so she turned the alarm off. At about 4:05 she witnessed the resident outside through a window. The resident was brought inside. Staff member reports she did not know she was to initiate a head count when an alarm sounds and there is no known reason. **J $5,000**
- Facility failed to keep 1 of 3 residents free of accidents. Resident was found to have rolled out of her bed on to the floorboard heater that her bed was next to. Resident sustained 2nd degree burns to her left upper arm, left posterior axillary area, and left anterior and lateral thigh. G
- Facility failed to provide safety measures to assure the safety of 1 of 6 residents at risk for wandering behaviors which resulted in a resident exiting the building undetected. The resident exited the facility to the outside from a doorway between

the nursing home and the assisted living wings of the building. A construction worker discovered the resident in the parking lot and alerted facility staff. When staff are in resident room they cannot hear the alarm if it goes off in the west hallway. D

- Facility failed to safely transfer a resident in with the POC. POC directed staff to use a gait belt and two staff for transfers due to confusion and balance problems. Resident states a CNA was helping him and he could not stand and fell. The resident stated the CNA got angry and punched him in the chest and jerked him up. Resident had a 3 cm by 2 cm bruise to his left bicep. D
- Failure to provide adequate nursing supervision and assistive devices to prevent a fall. Recliner had no dysom in it as it was to have, and sling was left under them. D

F690 – Bowel/Bladder/Incontinence, Catheter, UTI

- Facility staff was observed providing improper and incomplete catheter care for a resident which included allowing catheter tubing and drainage bag to be on the floor and failure to properly cleanse catheter tubing or peri area during pericare. Resident has had 3 UTI's in the past 6 months requiring treatment with antibiotics. D

F697 – Pain Management

- Facility staff failed to assess and record the pain level of 3 residents after administering prn pain medications. D

F712 – Physician Visits-Frequency/Timeliness/Alternate NPPs

- The facility failed to ensure physician visits are completed every 30 days for the first 90 days and every 60 days thereafter for 2 of 4 residents reviewed. Resident #2 was admitted on 4/26/19 and was not seen in July for her last 30 day visit. She was also missing an every 60 day visit in December. Resident #3 was admitted 12/23/19 and was not seen until 2/10/20. C

F725 – Sufficient Nursing Staff

- Not enough nursing to staff to answer call lights timely. Call lights answered anywhere from 26 to 30+ minutes before answered. Call lights were not in reach of residents. E
- Call lights were not answered within 15 minutes. Call light log indicated anywhere from 20-65 minutes of wait time. E

F755 – Pharmacy Svcs/Procedures/Pharmacist/Records

- Schedule II drugs records were inconsistent for doses given and did not account for the administration or destruction of liquid Ativan doses. D

F758 – Free from Unnec Psychotropic Meds/ PRN Use

- Staff did not attempt to offer non-pharmacologic interventions prior to the administration of prn anti-anxiety medications. D

F759 – Free of Medication Error Rate of 5% or More

- The facility failed to properly prime insulin flexpens for 1 of 2 residents. Resident #19 has orders to prime the flexpen with 2 units prior to giving and the needle was not primed by Staff A on 2 observations on 10/6/20 at 7:55 am and 11:43 am. D

F761 – Label/Store Drugs & Biologicals

- The facility failed to safely secure and limit access to controlled drugs. Resident # 1 had an order for Morphine 0.25 ml under the tongue as needed. During a facility investigation in September 2019 the DON identified that Staff B reported seeing Staff A use a code to open the narcotic lock box. The DON stated they was not aware of a code because staff had always used a key. They assume Staff A must have accessed a manual to obtain a code to the box. The week of 12/5/19 the facility found that the morphine had been replaced with cough syrup. Multiple nurses were aware of the code but state were instructed to use the key. Staff A admitted she had programmed boxes for easier access and that the DON was aware. D

F790– Routine/Emergency Dental Services in SNFs

- Resident was admitted to hospital and appeared to have had no oral care for some time as indicated by oral cavity foul odor, dried blood, pus at gum line and resident pain. Facility had no records of an oral assessment or dental evaluation. D

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

- Residents did not the meal at noon as ordered, gluten free not available for lunch. Bread not included with lunch. D

F812 – Food Procurement, Storage, Preparation, Sanitization

- The facility failed to maintain a proper functioning dishwasher to sanitize dishes. During an observation on 10/5/20 Staff E (dietary cook) ran the dishwasher through 3 cycles and on the 3rd cycle a chemical strip was used that failed to turn black indicating the proper chemical sanitation had occurred. Wash temp was 156 degrees and rinse cycle 164 degrees. Staff E did not know what to do when the strip failed. The Dietary manager also ran a cycle with the strip and again it failed to turn black and the same temps were reached. The manufacturer posting says the rinse cycle should be 180 degrees. Documentation for September and October showed 15 blanks for test strip entries and multiple rinse cycle temps recorded in the range of 113-123. D

F842 – Resident Records- Identifiable Information

- Facility failed to document an incident in the medical record of potential sexual activity between cognitively impaired residents and significant changes in condition such as lethargy, refusal to eat or drink or take medication. D
- Medical record not accurately kept regarding a residents eating. D

F880 – Infection Prevention and Control

- Facility failed to properly screen a DIA inspector prior to entrance to the facility. Staff failed to perform hand hygiene correctly when completing a treatment and dressing change. LPN was observed removing her face shield when moving in hallways. Facility had large number of COVID 19 positive residents. Nurse was also observed wearing an N95 mask on her chin while sitting in the nurse station. Night staff reported inconsistent PPE use by staff with both COVID positive and negative patients. E
- Facility failed to implement infection control practices to prevent the spread of COVID such as: housing COVID positive and COVID negative residents in same room, COVID positive residents wishing to smoke gathered at the nurse' s station without masks or social distancing, staff entered COVID positive resident rooms wearing regular face masks when N95 masks were required by facility policy, and COVID testing samples collected 4 days previous had not been sent to lab for analysis and facility had supplies to do rapid testing. F
- Facility did not assess all residents daily for sign and symptoms of COVID. Staff observed wearing facemask on chin when answering facility door. Hand sanitizer station had no sanitizer available. Staff observed wearing eye protective googles on head, not covering eyes. E
- The facility failed to adhere to hand hygiene between glove changes, cleanse the whole peri area during peri care, and remove dirty gloves before touching surfaces for 2 of 2 residents observed. Resident # 2 was observed on 10/7/20 during peri care provided by Staff B (CNA). They provided peri care and then touched resident's walker with dirty gloves and then proceeded with pericare with the same gloves. Resident then touched the walker where the staff had touched it and the resident was not offered hand hygiene after toileting. Resident #27 was observed during peri care on 10/6/20 performed by Staff C and D (CNA'S) and they did not cleanse the left buttock. On another observation with the same resident and staff members the right buttocks was not cleansed, no hand hygiene completed with a glove change, and skin was also touched with a dirty glove during repositioning. D
- The facility failed to exhaust all efforts to mitigate the spread of COVID. The facility cohorted positive and negative residents in the same room, allowed COVID positive staff to work with negative residents, and failed to implement an effective screening process in accordance with CDC and CMS guidance. The administrator who oversaw the schedule allowed Staff F who had just tested positive to work in October due to a staff shortage. On 10/22/20 the resident roster showed that residents #1,3,4,8 who were negative were each sharing a room with a positive resident even though there were 8 vacant rooms. 3 of the 4 residents who were previously negative ended up COVID positive. During an interview on 1/27/20 the DON was unsure of what staff were to do if they were experiencing symptoms or whether they were allowed to work or not. Screening forms for October 2020 showed blanks and

various symptoms marked for staff. Multiple staff reported feeling ill with symptoms recorded on the screening but were tested and told they were negative, so they continued working. Multiple staff became ill in the middle of a shift and finished their shifts before testing with positive results. Staff F tested positive at the beginning of her shift and stated she informed the Administrator but was approved to work her shift. She admitted to working with negative residents including residents # 1,3, and 4. Some negative staff confirmed they were not asked to work some of the shifts that positive staff worked. **K $7,250**

- Facility failed to implement a comprehensive infection control program for effective screening of staff for COVID 19, provide CDC guidance on PPE extended use, perform hand hygiene, and sanitation of equipment. 4 staff members worked with symptoms of COVID, then tested positive for COVID 19. One staff member entered the facility without screening with symptoms of COVID 19 and tested positive, and one staff failed to complete employee COVID screening prior to her shift. Staff reported she developed a cough and shortness of breath and reported the symptoms to the DON, who stated she didn't have a temperature so she didn't meet the COVID criteria and could continue to work. Staff delivered meal trays to rooms without washing their hands between rooms. Staff unaware of how long to wear their N95 masks before they needed cleaned or replaced. Staff did not don and doff equipment properly. Staff were not properly trained on how to clean their equipment after they were done using it. F
- Failure to follow infection control practices to prevent spread of COVID 19. Multiple staff members went in isolation rooms with no gowns or gloves, there were signs on the door. Staff member said she didn't know what the expectations were. Dirty linens thrown on floor in isolation room with no barrier. Passed lunch trays in isolation rooms without using hand sanitizer in between. E
- Staff had symptoms of COVID for 2 days and denied symptoms, then was tested and was positive. Tray of food delivered uncovered, staff held plate against chest while delivering. E

F886

- Facility failed to ensure that COVID testing results of staff and residents were returned within 24-48 hours. Test samples collected 4 days previous had not been sent to lab for analysis. F

F919– Resident Call System

- Call lights were not functioning properly for four residents. E

F947 – Required In-Service Training for Nurse Aides

- The facility failed to provide sufficient in-service training to ensure staff competency. Of 10 employee records reviewed 5 Staff (L, M, N, O, P) did not have the minimum 12 hours of in-service training documented. C

Nursing Facility Survey Frequency

As of January 20, 2021: CMS lists 239 Iowa facilities (55.6%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 50.0%. National average is 58.8%.

FFY 2020- November Totals - LTC Surveys				
Provider	**City**	**Survey End Date**	**Previous Date**	**Months Between**
Friendship Village Retirement	Waterloo	10/12/2020	12/19/2019	14.43