Compliance Tips from IHCA's Survey Results Committee

July 2016

The five most frequently cited tags from the 37 annual surveys (2 deficiency free), 63 complaints (17 unsubstantiated), 30 self-reports (9 unsubstantiated), 19 complaint/self-report (4 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 238 total deficiencies.

The following is a breakdown of severity level:

A =	0%	D =	61.35%	G =	9.24%
B =	1.26%	E =	19.32%	H =	0.0%
C =	2.94%	F =	4.62%	I =	0%
				J =	0%
				K =	0.42%
				L=	0%

Total # of Reports: 103
Total # of surveys/reports deficiency free or unsubstantiated: 22
Avg. # of deficiencies

- All = 2.37
- Annual = 3.65
- Complaint/Self-Reports= 2.10

Total state fines for December Report = $44,000 ($40,000 held in suspension)

Top 5 Most Frequently Cited Tags for July 2016 Report

F 323—Free of Accident Hazards/Supervision/Devices

- Sling was not properly attached to a mechanical lift, resident dropped and fractured hip (G) **$15,000 fine.**
- Facility failed to provide supervision for three residents to prevent falls; three residents fell with injuries, pelvic fracture, and right humerus factures, spiral fracture of the right femur and rib fractures (G) **$8,000 fine.**
- Resident's Wanderguard malfunctioned, staff turned off alarm without checking on resident, resident was returned to building by visitors. Staff didn't respond to

resident's alarm, resident fell in dining room and fractured hip (J) **$6,000 fine in suspension)**.

- Resident with multiple falls and interventions had an additional fall with injury, not "enough" interventions (G) **$6,000 fine**.
- A resident had multiple falls during the night, two-hour checks were initiated, no other interventions initiated after subsequent fall (G) **$5,000 fine.**
- Floor mat not placed beside bed as called for in care plan; fall with fracture (G) **$5,000 fine**.
- Resident with BIMS of 3, wore Wanderguard, staff was to check Wanderguard every shift, doors alarms, staff was leaving shift to parking lot when saw resident on the grass, staff returned resident, alarm sounded but staff thought it was a different door in a different wing (J) **$4,500 fine.**
- Resident slid out of chair; was injured (G) **$3,500 fine.**
- Facility failed to ensure adequate supervision to prevent resident to resident abuse (D) **$1,500 fine.**
- Facility failed to provide supervision to prevent inappropriate touching by one resident to others (G) **$500 fine.**
- CP listed resident as two person lift, one staff attempted, resident fell, was injured, bed rail was down, resident fell out of bed (G).
- Facility failed to provide adequate supervision resulting in resident's fall (G) **$2,500 fine.**
- Resident fell out of shower chair two times, resulting in hip fracture (G).
- Facility failed to provider supervision to prevent a fall with fracture, resident had been moved to a room at the end of the hall (G).
- Facility failed to adequately supervise and staff in memory care unit, there was resident to resident contact and elopement (G).
- Resident fell and sustained fracture, lack of adequate supervision (G).
- Unsecured room being remolded, construction equipment including circular saw on floor (E).
- Environmental hazards including electrical cords with exposed wired, no generator to use during power failure, residents in facility with oxygen (E).
- Resident drank disinfectant (D).
- Improper use of a surge protector (D).
- A resident threatened suicide; made several attempts to choke self with clothing protector, facility took no additional interventions (D).
- CNA did not adequately secure safety belt in shower chair; resident at high risk of slipping out (E).
- Facility failed to provide adequate supervision in a memory care unit for 5 of 6 residents after incidents of resident to resident abuse (E) **$500 fine**.
- Resident had two recent falls; CP identified as high falls risk and required motion detection light at night. Res had cerebrovascular accident, was prescribed Keppra for three weeks, motion alarm put on CP, resident fell but no motion alarm in place in room, did not have non-skid socks (D).
- A confused wandering resident was found in the facility's basement (D).
- Staff failed to lock wheelchair upon transfer of resident (D).

- Hazardous chemical not locked and secured in a dementia unit (E).
- Facility did not have alarms on all exit doors; wanderguard only, cleaning supplies in unlocked room (severity not listed) **$500 fine**.

F 312—Quality of Care Prevention of Decline

- Surveyors observed an excessive call light response time, residents complained of long call light response times (E) **$500 fine**.
- Required bathing was not provided to multiple residents (E).
- Staff failed to provide toileting, adequate pericare, oral care and basic bedtime cares for four residents (E).
- Resident bathed only twice in one month (D).
- Staff failed to cleanse all areas soaked with urine (D).
- Incorrect pericare or no pericare given when required (D).
- Inadequate oral care, resident had debris in mouth during morning cares; peri care not provided during morning cares despite resident having a catheter (D).
- Staff failed to cleanse all areas touch by urine-soaked brief (D).
- Improper incontinent care, staff cleansed rectal area and groin but failed to cleanse resident's hips, buttocks and inner thigh. Staff wiped rectal area smearing feces, then applied sheepskin between resident's legs without regloving, and failed to cleanse resident's hips. Staff wiped back to front rather than front to back (D).
- Incomplete pericare, staff did not coach residents to wash hands after toileting (D).
- Staff failed to properly transfer resident, CNA lifted resident using underarms (D).
- Resident elopement, alarm system not in working order (D).
- Entire peri area not cleansed during cares (D).
- Peri care incomplete for two residents; staff did not cleanse all soiled areas (D).
- Incomplete pericare, failed to wash in a front-to-back motion. Went back to front, feces over vagina (D).
- Policy called for pericare staff to wipe resident with cloth once, then fold over cloth to clean surface and wipe again, and use clean wipes as needed, staff used same cloth for four wipes smearing feces and cloth turned brown (D).
- Staff failed to provide scheduled baths (D).
- Staff failed to provide oral hygiene for a resident (D).

F 281—Professional Standards of Quality

- Nurse administered crushed potassium caplet though G-tube even though manufacturer's manual stated crushed meds should not be administered through the G-tube (D).
- Nurse crushed resident medications and placed in chocolate milk at dining room table and another resident consumed ½ of the milk/medication mixture (D).
- A care plan was not put in place when a heel ulcer was identified; care plan not initiated for two weeks (D).

- Physician's orders for TED hose during days—surveyors observed no TED hose on during daytime, physician's orders were not on sheet, no physician's order for in-dwelling catheter (D).
- Staff failed to provide medications as ordered, wrong dosage and transcription error (D).
- A physician's order for Prozac was missed for a month following a return from the hospital (D).
- Staff failed to educate residents on the importance of taking antipsychotic consistently (resident frequently refused (D).
- Nurse failed to have resident rinse mouth after inhaler use as recommended by the drug manufacturer (D).
- Psychotropic medications ordered by physician not started in a timely manner (D).
- Staff failed to give resident sips from a spoon (per recommendation); CNA gave drinks from a glass (D).
- Failed to prime flexpen prior to use (D).
- Two instances of staff handling oral meds (pills) with bare hands, pushed through blister pack into cupped hand, then to cup. Resident returned from hospital with suprapublic catheter, staff didn't clean insertion sight, saying nurses would do it. Surveyor observed site crusty and reddened with no dressing, resident said neither staff nor nurses cleaned site unless resident asked them (D).
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- Dose of Warfarin was missed (D).
- Staff failed to apply TED hose per physician's orders (D).

F 279--Comprehensive Care Plan to Meet Needs

- Facility failed to care plan psychotropic medications for six residents, and monitor side effects, failed to intervene when slow weight loss occurred (E).
- Care plans for four residents: lacked social activities, ADLs, Resident's PASRR, level two required behavioral health services to resident with cerebral palsy, services were not provided (E).
- Resident with history of UTIs was not provided with a care plan or interventions for UTIs (E).
- Care plan didn't have adequate interventions to prevent pressure ulcers, no pressure relieving devices (D).
- Staff failed to update care plan to reflect Hospice services, but there was no Hospice care plan (D).
- Facility didn't address use of psychotropic medications in care plan and monitor for adverse side effects (D).
- Facility failed to ensure care plans were updated to include interventions and C-Diff protocol (D).

- Resident admitted, BIMS score not completed, resident exhibited physical behavioral symptoms directed towards others, resident at risk for suicide, PASRR requirements provisions of behavioral health services not followed. Care plan failed to include interventions for unwanted sexual advanced and bizarre behavior. Another resident with MR said staff members were his/her boyfriend/girlfriend, clinical record lacked any identification of this type of sexual behavior (D).
- Facility failed to develop interventions for resident's wandering and elopement (D).
- Alarm not in place as per care plan date, put in place later after a fall (D).
- Care plan did not identify safety concerns with shower which led to discontinuation of showers for resident, also another resident discontinued using safety strap in whirlpool but it was not addressed in care plan as to why (D).
- Facility failed to update resident care plan to show changes interventions.

F 371—Sanitary Conditions

- No backflow device on water softener (F).
- Staff exhibited improper glove use during serving meals, dirty cupboards and floors (F).
- Facility failed to store food under sanitary conditions (F).
- Dirty fan in kitchen, supplements not labeled as to when they were thawed, food temperature not within range (F).
- Food in refrigerator not labeled or dated when opened or placed in refrigerator (E).
- Outdated foods in refrigerator, hanging dust from ceiling, crumbs and debris in freezer, mop strings in wheels, poor glove use between food and utensils (E).
- Dust on air conditioner above food preparation area (E).
- Bag of cookies and pizzas not bagged and sealed or labeled and dated; not all hair was in hairnet (E).
- Utensil handles cracked, not sanitizable, staff used phone and failed to wash hands before returning to steam table, staff handled food with bare hands, dirty microwave and ice machine (E).
- Dust on kitchen ceiling, scoop stored in coffee, undated and opened food items, staff didn't cleanse thermometer between measure temperatures of different food types (E).
- No thaw dates on "thawed" milk shake, staff touched bread with bare hands then touched plates (E).
- Open food containers not dated (E).
- Multiple instances of opened, unlabeled and undated food items, stainless steel shelving with orange crud, bread crumbs and debris in corners of drawer, vent above steam table dirty, grayish debris hanging from it during food service (E).
- Dirty refrigerator, undated, unlabeled food containers, dried red drips on inside of bottom surface, spills should have been cleaned immediately (E).
- Items in refrigerator not dated (D).

F 225—Abuse Reporting, Background Checks

- Facility failed to separate a staff member accused of abuse for calling a resident a "cry baby" (D) **$1,500 fine.**
- Staff didn't report allegation of dependent adult abuse immediately to facility administration, CNA slapped and shook resident on 5/11, and staff didn't report to administrator until 5/24 (D) **$500 fine.**
- Facility did not separate and employee accused of abuse from all residents and the resident impacted (E) **$500 fine.**
- Facility failed to separate alleged abuser from the resident after an allegation of abuse, and failure to timely report that abuse (E).
- Facility failed to report allegations of abuse within 24 hours (D)
- Facility failed to report resident to resident abuse to DIA (D)
- Failure to report allegations of abuse (D).
- No investigation completed by facility for injury to resident that was of unknown origin; resident had a hip fracture (D).
- Facility failed to separate a potential abuser from residents during an abuse investigation (D).
- Facility failed to report in a timely manner an incident between two residents engaged in an altercation (D).
- Resident was trying to sit between another resident and staff at end of diner, sitting resident hit with closed fist by the resident they were sitting next to, no injury, facility failed to document the incident, resident who hit had history of displaying combative moods and behaviors, staff should have instructed to have others stay out of resident's personal space when moody. Administrator didn't report within 24 hours as he/she didn't think abuse was intentional (D).

Other notable deficiencies and fines

F-223

- Facility failed to prevent resident to resident abuse (G) **$3,500 fine**.
- Facility failed to separate an alleged abuser from the resident times (two instances) (D) **$500 fine.**
- Nurse told resident could not get out of bed to go smoke until medications were taken, resident called DON a "dumb bitch," DON replied "and proud of it," continued to antagonize resident by saying "I worked hard to earn that title," Resident had right to refuse medications (D) **$500 fine.**
- Undignified photos were put on Snapchat (D) **$500 fine.**
- Free from abuse; staff refused to take resident to bathroom to take care of it, staff was rude to the resident (D).

F-226

- Facility failed to report allegation of abuse in a timely manner, staff turned around wheelchair roughly and was in the resident's face (D) **$500 fine.**
- Facility hired an employee with a criminal background, then cleared them to work as a CNA; employee left Dec. 2016 and applied to work as an RN in April 2016,

facility did not do another clearance for the hit—working in another capacity (E) **$500 fine.**
- Facility failed to perform background check on a dietary aide prior to hire (D) **$500 fine.**
- Facility failed to do a DCI abuse check prior to hire, 30-day time limit had expired and a new one was required **$500 fine.**

F-241
- Facility allowed a resident with BIMs score of 15 to do comical "strip tease" for another staff member for her birthday (D) **$500 fine.**
- See F-223 dignity related to posting Snapchat videos (G) **$500 fine.**
- Facility failed to treat a resident with respect and dignity; staff was "rough, resident's head was against the wall, swearing" (G).

F 309
- Failure to timely assess a resident for pain control; following a fall resulting in fracture, failure to assess a resident who had not defecated in six days (G) **$3,000 fine.**

F 314
- Facility didn't initiate a repositioning program or use pressure-relieving devices resident developed stage 2 pressure ulcers on coccyx and heels (G) **$3,000 fine**.
- A resident at risk for skin breakdown did not have a care plan in place and a heel breakdown occurred (G) **$2,000 fine.**

F 333
- Staff administered wrong medication to a resident, resident became hypotensive, sent to hospital with low blood pressure and oxygen saturation of 70% (G).

F 367 Therapeutic diets
- Facility failed to follow physician's orders for thickened liquids which caused resident aspirate and subsequently be hospitalized for pneumonia and partial lung collapse (K) **$5,000 fine in suspension**.

N 101
- Facility failed to report major injury **$500 fine**.

L257
- Facility failed to conduct Veterans Administration checks on six of nine residents.

L 415
- Ace wraps not applied to resident's legs as physician-ordered.

W 249
- Facility didn't consistently implement active treatment program for residents with mental illness.

Annual Survey Frequency
July Survey Results Meeting

Facility	City	Last Year	This Year	Frequency
Accura Healthcare	Pleasantville	7/2/15	5/5/16	44 Weeks
Arbor Springs	W. Des Moines	8/27/15	6/23/16	43 Weeks
Chariton Specialty Care	Charitin	8/20/15	6/23/16	44 Weeks
Clarksville Skilled N & R	Clarksville	7/2/15	5/19/16	46 Weeks
Corydon Skilled N & R	Corydon	8/6/15	6/16/15	45 Weeks
Countryview N & R	Waterloo	8/6/15	6/9/16	44 Weeks
*Crestview N & R	Webster City	12/17/15	6/9/16	20 Weeks
Denison Care Center	Denison	8/13/15	6/2/16	42 Weeks
Dubuque Specialty Care	Dubuque	7/30/15	6/9/16	45 Weeks
Edgewood Convalescent Center	Edgewood	7/9/15	5/25/16	46 Weeks
Emmetsburg Care Center	Emmetsburg	8/13/15	6/16/16	44 Weeks
Friendship Village Retirement	Waterloo	8/13/15	6/9/16	45 Weeks
Genesis Medical Center	DeWitt	8/13/15	6/16/16	44 Weeks
Grandview Health Care	Dayton	7/9/15	5/26/16	46 Weeks
Granger Nursing & Rehab	Granger	8/6/15	6/9/16	44 Weeks
**Great River	McGregor	5/20/16		????????
Hawkeye Care Center	Spirit Lake	7/2/15	5/19/16	46 Weeks
Hillcrest Home, Inc.	Sumner	7/30/15	5/19/16	42 Weeks
Madrid Home	Madrid	7/23/15	6/16/16	47 Weeks
Manning Regional HC	Manning	6/25/15	5/12/16	46 Weeks
Maple Manor Village	Aplington	7/9/15	5/19/16	46 Weeks
Mercy Lining Center – North	Clinton	6/25/15	5/25/16	46 Weeks
Mill Valley	Bellevue	8/13/15	6/8/16	43 Weeks
**Osage Rehab & HCC	Osage	12/17/15		????????
Parkview Home	Wayland	7/16/15	6/2/16	46 Weeks
Parkview Rehab Center	Sac City	7/9/16	5/25/16	46 Weeks
***Pioneer Valley Liv. & Rehab.	Sergeant Bluff		4/28 16	
Plymouth Manor	LeMars	6/18/15	5/5/16	46 Weeks
Royale Meadows	Sioux Center	8/13/15	6/16/16	44 Weeks
Salem Lutheran Home	Elk Horn	7/30/15	6/16/16	46 Weeks
Solon Nursing Care Center	Solon	7/30/15	5/25/16	43 Weeks
St. Mary Healthcare & Rehab	Davenport	5/7/15	5/19/16	53 Weeks
Stratford Specialty Care	Stratford	7/30/15	6/2/16	45 Weeks
The Village	Indianola	7/2/15	5/25/16	47 Weeks
The Vinton Lutheran Home	Vinton	8/20/15	6/23/16	44 Weeks
Twilight Acres	Wall Lake	7/16/15	5/12/16	43 Weeks
Willow Gardens Care Center	Marion	8/6/15	6/16/16	45 Weeks

Of the 33 Tabulated Annual Surveys Reviewed in July:

1 Annual Survey was later than last year:

St. Mary Healthcare & Rehab	Davenport	5/7/15	5/19/16	53 Weeks

32 Annual Surveys were earlier than last year:

Earliest Surveys:

Denison Care Center	Denison	8/13/15	6/2/16	42 Weeks

Average Survey Frequency:

July Survey Meeting	**45.12 Weeks (6.88 Weeks Early)**
June Survey Meeting	**45.31 Weeks**
May Survey Meeting-	**46.60 Weeks**
April Survey Meeting-	**48.50 Weeks**

*Special Focus Facility
**No Current Survey Available
***No Previous Survey