Compliance Tips from IHCA's Survey Results Committee

July 2017

The five most frequently cited tags from the 39 annual surveys (8 deficiency free), 31 complaints (9 unsubstantiated), 6 self-reports (2 unsubstantiated), 14 complaint/self-report (5 unsubstantiated) and 3 mandatory reports (0 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 170 total deficiencies.

The following is a breakdown of severity level:

A =	0.00%	D =	52.94%	G =	5.29%
B =	2.94%	E =	31.18%	H =	0.00%
C =	2.94%	F =	2.94%	I =	0.00%
				J =	1.76%
				K =	0.00%
				L=	0.00%

Total # of Reports: 58
Total # of surveys/reports deficiency free or unsubstantiated: 22
Avg. # of deficiencies

- All = 3.10
- Annual = 3.17
- Complaints = 2.78
- Self-reports = 1.33
- Complaint/Self-Reports= 3.75
- Mandatory = 2.25
- Special Focus = 0.0

Total state fines for May Report = $21,500 ($45,000 held in suspension)

Five Most Cited Tags for July 2017 Report

F 323—Free of Accident Hazards/Supervision/Devices

- Resident used door code to exit the facility and was found on busy street trying to talk to police officer. Resident had prior elopement attempts. Door code was posted at the door for resident to see (J) **$15,000 fine.**
- Resident bit another resident, resident fell when staff was to be observing resident and staff left the area and hit face, sent to ER and returned (G) **$6,000 fine.**
- Facility staff failed to transfer resident in a safe manner which resulting in multiple skin tears and bruising, care plan called for two-person transfer, one staff member attempted to life resident out of bed, resident resisted, was injured against bed rail (G) **$2,000 fine**.
- Facility failed to assess all beds for potential gaps that could create entrapment risks (J) **$2,000 fine**.
- Facility failed to properly secure chemicals for 9 cognitively impaired, independently mobile residents. Blue hall shower room was not locked (E).
- Facility failed to ensure an environment free of accident hazards with sharp edges exposed to metal frames to the bathrooms in 31 0f 34 residents rooms (E).
- Items not secure such as disinfectant spray and Glade spray (D).
- Two resident falls attributed to not following care plan intervention of 2 staff assisting with all transfers. In both case, only 1 staff member was assisting at the time of the falls (D).
- A resident wheelchair tipped while exiting the facility van, causing minor superficial injuries with associated pain (D).
- Resident fell without alarm attached as care planned (D).
- Resident with history of falls did not have call light within reach or alarm properly activated as stated on care plan (D).
- Care plan lacked fall interventions after 4 falls (D).
- Facility failed to implement new interventions for falls on one resident (D).

F 279—Comprehensive Care Plans

- Facility failed to develop care plans to address residents' statements of being better off dead, a residents hydration needs, and a residents need for a pressure cushion (E).
- Care plan: facility failed to monitor side effects of psychotropic medications for 5 of 9 residents (E).
- Care plan did not address side effects of psychotropics and anticoagulant medications (D).
- Resident had indwelling catheter and nothing on care plan about it (D).
- Comprehensive care plan: care plan and pocket care plan CNAs used did not match residents' needs and interventions (D).
- Facility failed to develop a care plan with goals and interventions to prevent the development of pressure ulcers. Although the care plan listed a pressure reducing device on the bed and chair, the approaches lacked multiple other

interventions to prevent the development of pressure ulcers and prevent infection when caring for an open pressure ulcer (D).

- Resident's care plan and care card hanging in closet detailed using a Hoyer lift and that resident required extensive two-person transfer; Hoyer lift required for all transfers; care plan needed updating (D).
- Staff did not instruct a resident to call for assistance before self-ambulating to the bathroom. Resident had a fall, documentation noted resident should be assisted when ambulating. Care plan did not address the intervention of a one person assist while ambulating (D).
- A resident slipped from a wheelchair during a lift transfer, no new interventions were added to the care plan after the resident fall (D).
- Failed to update the care plan timely for new catheter care (D).
- Care plan did not identify the use of oxygen (D).
- Comprehensive care plans: facility failed to review and revise care plans for turning schedule for one resident per his request and call light not useable (D).

F 281—Professional Standards of Quality

- OxyContin given scheduled and PRN, resident hospitalized, dressing not changed as ordered (E).
- Facility failed to ensure staff administered routine medications in order to meet the needs of 4 0f 4 residents. An observation revealed 16 resident medication cards still stored medications ranging between the dates of 5/20-6/19 All medications confirmed as present by the MDS (E).
- Facility failed to follow physician orders. Order for weekly B/P and pulse which was not done. Order for weekly weights not done (E).
- Nurse failed to properly observe residents consume oral medications by turning her back to them after handing them their medications (E).
- Aide completed tx dr. ordered, lab not completed, tx not completed (D).
- Lab work not completed as ordered, TED Hose not provided as ordered (D). O2 administration for two residents did not match physician orders (D).
- Facility did not make arrangements for resident to have trach tube replaced every 3 months as ordered (D).
- Facility failed to follow physician orders. Did not follow physician order for weight 3x/wk on Mon, Wed, Fri. (D).
- Facility failed to follow physicians' orders for 2 of 21 residents; Fentenyl patches not applied properly; left ankle orthotics not applied (D).
- A resident require that an Infusaport be flushed on a monthly basis. The order failed to document the flush solution to use or any specific amount of solution to use (D).
- Medication aide did not administer inhalers in proper order according to physician orders (D).

F 371—Food Preparation-Sanitary Conditions

- Facility failed to deep kitchen clean. Hood over the stove had debris, stove griddle with tan greasy residue, fire extinguisher with grey fuzz and filaments,

wall behind the stove with 100% oil/grease film, vent over toaster contained black discoloration (F).

- Facility failed to properly use single-use gloves or change gloves between tasks and failed to wash their hands when contaminated (F).
- Kitchen areas revealed worn cupboards, and the back of the stove had grim, dust and debris on the openly visible cord, plug and mechanisms (F).
- Open packages of food not dated when opened. Kitchen staff failed to wash hands or change gloves between tasks of dirty and clean in the dining room. Frost build-up in freezer (F).
- Improper use of gloved, touched other items than food when serving meals (E).
- Failed to ensure all hair covered by hairnet (E).
- Improper glove use during food service, worker touched multiple unclean surfaces while wearing gloves that subsequently touched food, failure to wash hands before donning gloves (E).
- Staff handled dirty dish towels and then put away clean kitchen utensils without first hand washing (E).
- Facility failed to store, handle and serve food under sanitary conditions in order to reduce the risk of contamination, walk in cooler revealed the walk-in cooler had thawed nutritional shakes dated 5/16 and manufacturer recommendations was to be used within 14 days of being thawed. Dining staff donned gloves without washing hands (E).

F 309—Highest Practicable Well-Being

- Resident had thumb injury; staff did not answer call light timely (unusable); injury did not get assessed and treated promptly (G) **$8,000 fine in suspension**.
- Facility did not accurately assess resident pain, implement interventions to relieve pain which led to suicidal thoughts and actions by resident (G) **$2,000 fine**.
- Nurses documented an assessment of a fall in resident's room but the video camera did not show any nurse assessed the resident and meds were charted as given x 2 days but Granny Cam shows the nurse did not enter the room.
- Morphine not available due to not reordering and staff didn't use or get other medication (D).
- Failed to administer MOM as ordered for constipation (D).
- After a heel blister was noted, no additional documentation/assessments were completed after the initial assessment (D).
- A resident did not receive an assessment of a dialysis fistula on days when the resident returned from the dialysis unit, or on days when the resident did not go for dialysis (D).
- Facility failed to assess and implement interventions for bowel management program for 2 residents (D).
- Failed to timely assess residents with pain and significant weight variances (D).

Other Notable Deficiencies and Fines (sorted by f-tag number)

F 156—Notice of Eligibility

- Failed to give ABN notice (E).
- ABN and other required disclosures not given to resident (D).
- Failed to inform 3 residents of their appeal rights following discharge from skilled services (C).
- Two residents were not provided with CMS Notice of Medicare Provider non-coverage (B).

F 157—Notice of Changes to Family, Physician

- Resident found on DR floor, mild head pain, and physician not called, fax sent 3 hours later, and physician called back next day (D).
- Facility failed to inform a family member of a change in condition. Responsible party discovered from the hospital that the resident had wounds (D).

F 158—Protection of Resident Funds

- Notice of CMS Form 10123 "Notice of Medicare Provider Non-coverage" not provided at the end of Medicare services (D).

F 159—Management of Personal Funds

- Money (cash) was missing from a resident trust account balance Key to the locked cash drawer were available to anyone in the office (D) **$500 fine**.

F 164—Right to Privacy

- Privacy curtain was left open during the course of care in view of the room-mate (D).
- Failed to close door when providing cares per Nanny Camera (G) $500 fine.

F 167—Examination of Survey Results

- Most recent survey results not posted by facility (D).
- Facility failed to post the annual survey results in a location readily accessible to residents, family, and legal representatives of residents (C).
- Most recent life safety survey not posted for public view (B).

F 203—Resident/Family Notification of Discharge

- A resident was discharged to the hospital because of a resident to resident altercation. Facility failed to re-admit the resident. No notification was given to the resident, guardian or case manager informing them of the involuntary discharge (D).

F 223—Freedom from Abuse

- The surveyor tripped on a transition strip with an edge sticking up. In the dining room. Facility staff verified that a resident could be a tripping hazard (E).
- 2 CNA's took photos of resident not wearing dentures. One sent picture to other CNA's via Facebook private messaging (D).

F 225—Reporting to the Department

- Reported staff hit resident, police involved and said no abuse, not reported to DIA timely (D) **$1,500 fine**.
- Staff failed to report incident of abuse; three residents were mistreated by agency staff (D) **$500 fine.**
- Facility failed to maintain separation of Staff B from Resident #1 until the outcome of the DIA investigation. Staff slapped resident had when they were trying to grab her during cares. The facility determined there was no concern regarding staff B's care, the facility would retrain both aides on how to handle combative residents safely and during cares (D) **$500 fine**.
- Hand with pain and swelling not investigated as possible abuse, staff thought it was a "bug bite" (D).
- Facility failed to report incidences of agitated resident striking three other residents to DIA as required (D).
- Resident had a fractured toe with no known source of injury and the facility did not investigate possible causes (D).
- Facility failed to report resident to resident altercations within 24 hours for 3 of 3 residents: resident slapped arm of resident #2, who then slapped arm of resident #3 (D).

F 226—Staff Treatment of Residents

- Failed to timely obtain criminal and abuse background check (D) **$500 fine.**
- One employee did not complete approved DAA training course within 6 months (D) **$500 fine**.
- Facility hired RN prior to receiving final Abuse Registry approval. Resident had no abuse training after 9 months of employment (D) **$500 fine.**
- Employees failed to follow facility policy regarding photos and social media despite instruction (D).
- The facility failed to operationalize the abuse policy and procedure for protection of residents from potential further abuse during an investigations by failing to report immediately, and failed to implement a comprehensive policy to maintain separation of an alleged perpetrator from an alleged victim until the outcome of the DIA investigation (D).

F 241--Dignity and Respect of Individuality

- Staff failed to display respect for residents when caring for and speaking about them in order to affirm their dignity as human beings; said resident "shit their pants" to another staffer in front of the resident (D) **$1,500 fine ($500 trebled).**
- Staff got resident out of bed for a meal even though the resident did not want to get up and informed the staff (D).

F 242--Dignity

- Facility failed to allow decisions to be made by residents for 9 of 21 residents; e.g. facility removed bed rail but never asked resident if that's what they wanted (E).

- Facility did not make arrangements for resident to dine in courtyard with assistance per their request (D).

F 250—Social Services

- Failed to complete social services assessments on 9 residents for over a year (E).
- Facility failed to provide medically-related social services for 4 of 9 residents. The care plan did not address the resident's history of negative comments. SW did not care plan or follow up on the resident with suicidal statements (E).
- Social worker and charge nurse failed to notify administration, family and physician of resident having suicidal thoughts related to severe pain. Resident took scissors and created superficial lacerations on neck (D).

F 252—Safe, Clean, Homelike Environment

- Dusty fans, stained wallpaper with gapped seams, sticky stained floors (E).
- Safe and homelike environment: no screen on windows, resident was wishing to open windows (D).
- White streaks on aviary (C).

F 253

- Brown stool found on toilet seat in resident room, high rise toilet seats in several rooms had brown and yellow stains, family complained of tall weeds growing between pavers in resident courtyard (E).

F 257

- Facility failed to keep room temp at comfortable levels for 10 residents. Temps ranged from 70-71 degrees and all residents complained that they were too cold (E).

F282—Services Provided per Written Plan of Care

- Services not provided by qualified person per care plan; care plan and pocket care plan carried by CNAs did not match toileting plan for bathroom use (in just stated resident incontinent) (D).

F 312—Quality of Care; Activities of Daily Living

- Staff did not provide complete peri-cares per Granny Cam (E) **$500 fine**.
- Facility failed to provide routine toileting assistance and positioning for 3 of 5 residents. POC stated for staff to check and change for incontinence, provide pericare after each incontinence and reposition every 2-3 hours which was not done (E).
- Residents did not receive at least 2 baths a week and one went over 8 days without a bath (E).
- Incomplete perineal area cleansing of all areas soiled brief touched (D).
- Staff failed to cleanse entire peri area during incontinence cares. Did not cleanse buttocks that were exposed to moisture (D).

- Facility did not reposition a dependent resident at risk for skin breakdown during survey for a period of five hours (D).
- Resident's fingernails needed trimming (D).
- Resident had suppository, requested staff to check to see if BM had occurred and staff refused. Resident was found next morning to have been incontinent of stool. Staff did not check another resident who was incontinent of bowel and bladder for several hours (D).
- Did not assist a resident with per cares or cleanse the resident when the previous pad was visibly wet, when toileted (D).
- Facility failed to provide proper incontinence cares for 1 of 8 residents. Staff failed to wash front to back and did not cleanse the hips (D).
- Facility failed to provide the necessary services (incontinence and positioning) to maintain personal hygiene needs and repositioning needs in accordance to their care plans (D).

F 314—Pressure Ulcers

- Facility failed to provide healing services for resident with pressure ulcers, also failed to measure ulcer, and didn't reposition resident enough when sleeping in recliner, ROHO cushion delated (G) **$4,000 fine**.
- Care plan did not identify pressure ulcer risk when the assessment showed high risk and the resident developed heel ulcers. Care plan did not identify risk for pressure ulcer due to use of oxygen and tubing (G) **$2,500 fine**.
- Facility failed to implement interventions to prevent the development of an avoidable pressure sore, located on the ischial tuberosity and failed to perform a treatment without contamination of wound by the soiled brief (G) **$2,000 fine**.
- Pressure ulcers were not assessed on resident upon admission (G) **$2,000 fine in suspension**.
- Facility failed to prevent the continued healing of an open pressure sore, facility did not follow own policy and position client to be off buttock (D).
- Daily treatment records to a foot wound were not documented daily as per physician orders (D).
- Care plan stated to float heels and use heel protectors but resident observed without those in place (D).
- Facility failed to document weekly assessments, use the correct technique to apply medicated ointment to the pressure sore to the right heel and follow physician orders to ensure the protective heel boot had been placed on the right heel with the pressure sore for one of two residents (D).
- Resident with pu and order for Prevalon boot and not applied as ordered (D).

F 315--Incontinence Care

- Improper catheter care by not cleansing the tubing and back to front cleansing motion (D).
- Failed to store catheter tubing appropriately and clip was placed on a waste basket (D).
- Catheter bag and tubing laying on the floor (D).

- CNA assisting with pericare on resident who was incontinent of urine and feces, wiped from back to front perineal area potentially contaminating the area. Resident suffered from UTI that was caused by E. Coli. Another CNA was observed performing pericare and did not change gloves after removing a soiled brief and then touched multiple surfaces including faucet, pager, clean brief, bottom of shoes, etc. (D).

F 318—Range of Motion to Prevent Decline

- Facility failed to provide restorative nursing as recommended and care planned (E).
- Facility did not provide adequate PT and range of motion to prevent decrease in resident's range of motion (B).

F 322—Gastrotube Feeding

- Facility failed to properly follow physician orders for water flushes and failed to administer medications separately for one resident (D).

F 327--Hydration

- No water in resident water pitchers in several rooms (D).
- Facility failed to monitor fluid intake for 1 of 9 residents. Resident had an order to force fluids but did not have a water pitcher and staff said they had no formal method to monitor the resident's intake (D).

F 329—Unnecessary Drugs

- No non-pharmacological interventions were attempted prior to the administration PRN anti-anxiety medication. Facility stated that 3 non-pharmacological should be attempted prior to medication administration (D).
- Facility failed to conduct non-pharmacological interventions before administration of psychotropic medications (Lorazepam) (D).
- Clinical record documentation did not support use of psychotropic medications (D).

F 332—Medication Error Rate

- Two instances of med error rate of over 5% for two residents (D).

F 353—Sufficient Nurse Staffing

- Resident had to eat lunch in bed because staff did not get resident up prior to lunch time. Resident did not have access to call light while sitting on commode (E).
- Sufficient staffing; staff not providing baths/showers twice weekly; not answering call lights timely (15 minutes) (E).
- Residents complained of slow call light response. Electronic call light logs show response times in excess of 20 minutes up to 80 minutes in one instance (D).
- Staff failed to answer call lights on a timely basis. This was verified thru the facility call light logs (D).

- Resident interviews revealed long call light response times (25-60 minutes) and observation by the surveyor revealed call light responses up to 20 minutes (D).
- Call lights greater than 15 minutes (D).

F 356—Other Staffing

- Facility failed to post updated information regarding the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care (C).

F 363—Menus, Nutritional Adequacy

- Didn't measure liquids for pureed, food left after serving (E).
- Facility failed to provide the correct serving amounts of pureed diet (E).
- Pureed and mechanical Soft diet residents did not get broccoli and rice per the menu. Failed to serve a cookie per the menu (E).
- Facility failed to follow the planned menu and serve correct portions for 4 of 4 residents. Pureed portion size was inaccurate (E).
- Facility failed to ensure staff provided the correct amount of protein for 7 residents with pureed diet, used a wrong size scoop for meat portion (E).
- Facility failed to serve the correct serving size of pureed foods to seven of seven residents. Facility used wrong sized scoops to serve food and also did not give some residents pureed bread (E).
- Failed to provide bread in the pureed menu (B).

F 364—Food-Proper Temperature

- Cook plated eggs well before serving time and eggs temped at time of resident service at 90 degrees and cook could not identify the proper temp needed for food service (E).

F 365—Food Prepared to Meet Individual Needs

- Facility failed to provide the bread & butter to residents on pureed as stated on the menu (C).
- Facility failed to ensure staff served food in a sanitary manner. Staff did not change gloves as needed (E).
- Facility failed to maintain proper kitchen sanitation and food handling/preparation practices and failed to maintain proper refrigerator/freezer minimum temperatures to prevent foodborne illness. A thick dust on the underside of the ice machine, a thick red substance, multiple crumbs, and cheese shreds on the bottom of the maximum refrigerator, utility room freezer thermometer stated 45 degrees F. Multiple crumbs in cupboard, dust in crevices of door hinge (E).

F 428—Drug Regimen Review by Pharmacist

- Facility failed to provide an individual form ad clinical rational for continued use of psychotropic medication (E).

F 431—Labelling of Drugs and Biologicals

- Facility failed to dispose of outdated medications from one of three nursing unit carts and mediation rooms. Facility had outdated insulin and aquapor cream (D).

F 441—Infection Control

- Failed to provide proper hand hygiene and handling of linen (E) **$500 fine**.
- Staff failed to use gloves or wash hands after handling cath bag (E).
- Nurse administered meds to 5 residents prior to sanitizing hands (E).
- During pericare staff touched multiple surfaces with feces contaminated gloves; nurse observed dropping two meds on the surface of the med cart and then scooped meds up with two clean meds cups and added them to other meds (E).
- Facility failed to ensure appropriate cleaning of a universal blood sugar meter used for all residents (E).
- Staff was to run disinfectant through whirlpool jets but did not do so (E).
- Staff failed to cleanse/sanitized. No policy existed as to when and how to sanitize the lift sling between residents (D).
- CNA assisting with pericare on resident who was incontinent of urine and feces, wiped from back to front perineal area potentially contaminating the area. Resident suffered from UTI that was caused by E. Coli. Another CNA was observed performing pericare and did not change gloves after removing a soiled brief and then touched multiple surfaces including faucet, pager, clean brief, bottom of shoes, etc. (D).
- Incontinence care: staff tucked two urine-soaked disposable bed pads and a urine-soaked brief under resident's right hip (D).
- Staff failed to reglove between cleaning feces or resident's buttocks and applying peri guard ointment (D).

F 461—Resident Safety

- All beds not assessed for gaps of more than 4.75 inches creating potential entrapment issues (D).

F 465—Safe, Sanitary Environment

- The facility failed to maintain the kitchen environment in a clean and sanitary manner. Kitchen floor had buildup of visible grime, grease trap had pool of dark liquid, and ceiling vent in the dish machine had visible dust covering it, oven doors with visible grime (F).
- Dirty kitchen, splatters on frig, no liner in trash can, dirty vent and shelves (E).
- Failed to maintain and sanitize cabinets in kitchen ad medication rooms, cupboards marred and dirty (E).

F 496—Registry Verification

- Facility hired 2 CNAs without checking the CNA registry (D).
- Failure to check nurse aide registry prior to hire (D).
- Facility did not check SING site for CNA registry verification prior to hire (D).
- Facility did not verify nurse aide registry status at time of hire (D).

F 499—Staff Qualifications

- Facility Failed to verify Iowa Nurse Licensure after verifying another state licensure that had expired (D).
- Facility did not verify nursing licenses for 2 nurses at time of hire (D).

F 514—Clinical Records

- Failed to accurately document assessments of residents (E) **$500 fine**.

L1093 & 441-58.12(1)

- Facility failed to submit info to VA for a resident whose spouse was a veteran.
- Facility failed to submit 5 of 8 resident admissions reviewed to the Iowa Department of Veteran Affairs within 30 days of the residents' admission.

N-104

- Facility did not report elopement of resident; door alarms did not functioning, facility did not report to DIA within 24 hours.

481-50.7(1)a(2) Additional Notification to the Department

Facility failed to notify department of major injury, unwitnessed fall **$500 fine**.

Annual Survey Frequency
July Survey Results Meeting

Facility	City	Last Year	This Year	Frequency
*Accura Healthcare-Newton West	Newton	--------	6/22/17	--------
Clarence Nursing Home	Clarence	5/12/16	6/1/17	55 Weeks
Clarksville Skilled Nursing	Clarksville	5/19/16	6/1/17	54 Weeks
Clearview Home	Clearfield	5/5/16	6/15/17	58 Weeks
Crystal Heights Care Center	Oskaloosa	5/12/16	6/15/17	57 Weeks
Elm Heights Care Center	Shenandoah	4/14/16	6/1/17	59 Weeks
Elmwood Care Center	Onawa	4/28/16	6/8/17	58 Weeks
Emmetsburg Care Center	Emmetsburg	6/16/16	6/28/17	54 Weeks
Eventide Lutheran Home	Denison	4/28/16	6/8/17	58 Weeks
Granger Nursing & Rehab Ctr.	Granger	6/9/16	6/22/17	54 Weeks
Hawkeye Care Center	Spirit Lake	5/19/16	6/22/17	57 Weeks
Hillcrest Home	Sumner	5/19/16	6/15/17	56 Weeks
Manly Specialty Care	Manley	5/19/16	6/15/17	56 Weeks
Manorcare Health Services	Davenport	5/19/16	6/8/17	55 Weeks
Maple Manor Village	Aplington	5/19/16	6/15/17	56 Weeks
Mill valley Care Center	Bellevue	6/8/16	6/28/17	55 Weeks
*Monroe Care Center	Albia	--------	5/4/17	--------
Mount Ayr Care Center	Mount Ayr	5/19/16	6/22/17	57 Weeks
Pearl Valley Rehab & Nursing	Sutherland	4/28/16	6/8/17	58 Weeks
Pioneer Valley Living & Rehab	Sergeant Bluff	4/28/16	6/15/17	59 Weeks
Pocahontas Manor	Pocahontas	5/25/16	6/22/17	56 Weeks
Rock Rapids Health Center	Rock Rapids	4/21/16	6/1/17	58 Weeks
The Village	Indianola	5/25/16	6/1/17	53Weeks
Titonka care Center	Titonka	5/19/16	6/15/17	56 Weeks

Valley Vue Care Center	Armstrong	4/28/16	6/15/17	59 Weeks
Westhaven Community	Boone	5/12/16	6/8/17	56 Weeks
Westmont Healthcare Community	Logan	4/28/16	6/15/17	59 Weeks
Westview Acres Care Center	Leon	4/28/16	6/1/17	57 Weeks

***Previous Survey Results were not available on the DIA Website**

Of the (26) Tabulated Annual Surveys Reviewed in July:

0 of the Annual Surveys were earlier than last year.
All of the Annual Surveys were later than last year

Earliest Survey:

The Village	Indianola	5/25/16	6/1/17	53 Weeks

Latest Surveys:

Elm Heights Care Center	Shenandoah	4/14/16	6/1/17	59 Weeks
Pioneer Living & Rehab	Sergeant Bluff	4/28/16	6/15/17	59 Weeks
Valley Vue Care Center	Armstrong	4/28/16	6/15/17	59 Weeks
Westmont Healthcare Community	Logan	4/28/16	6/15/17	59 Weeks

Average Survey Frequency:

2017		
July Survey Meeting	**56.54 Weeks**	**(4.54 Weeks Late)**
June Survey Meeting	**54.90 Weeks**	**(2.10 Weeks Late)**
May Survey Meeting	**54.90 Weeks**	**(2.10 Weeks Late)**
April Survey Meeting	**52.84 Weeks**	**(0.84 Weeks Late)**
March Survey Meeting	**51.21 Weeks**	**(0.79 Weeks Early)**
February Survey Meeting	**50.88 Weeks**	**(1.12 Weeks Early)**
January Survey Meeting	**49.69Weeks**	**(2.30 Weeks Early)**
2016		
December Survey Meeting	**48.52 Weeks**	**(3.48 Weeks Early)**
November Survey Meeting	**48.03 Weeks**	**(3.97 Weeks Early)**
October Survey Meeting	**47.04 Weeks**	**(4.96 Weeks Early**
September Survey Meeting	**46.72 Weeks**	**(5.28 Weeks Early)**
August Survey Meeting	**47 Weeks**	**(5 Weeks Early)**
July Survey Meeting	**45.12 Weeks**	**(6.88 Weeks Early)**
June Survey Meeting	**45.31 Weeks**	**(6.69 Weeks Early)**
May Survey Meeting	**46.60 Weeks**	**(5.40 Weeks Early)**
April Survey Meeting	**48.50 Weeks**	**(3.50 Weeks Early**