Compliance Tips from IHCA's Survey Results Committee

July 2018

Survey composition: 29 annual surveys (6 deficiency free), 24 complaints (6 unsubstantiated), 7 self-reports (5 unsubstantiated), 10 complaint/self-report (4 unsubstantiated) and 7 mandatory reports (1 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 141 total deficiencies.

The following is a breakdown of severity level:

A =	0.00%	D =	63.12%	G =	2.84%
B =	4.26%	E =	21.99%	H =	0.00%
C =	0.71%	F =	4.26%	I =	0.00%
				J =	2.13%
				K =	0.71%
				L=	0.00%

Total # of Reports: 64
Total # of surveys/reports deficiency free or unsubstantiated: 19
Avg. # of deficiencies

- All = 3.24
- Annual = 3.21
- Complaints = 2.94
- Self-reports = 6.00
- Complaint/Self-Reports= 2.25
- Mandatory = 1.00

Total fines = $13,500 ($28,200 held in suspension)

<u>Deficiencies and Fines</u> (sorted ascending by f-tag number)

F 550—Resident Rights/Exercise of Rights

- 2 residents reported staff members talking on phones in rooms and in the dining room also they talked too much about personal lives. Resident reported if their phones ring, they stop during cares and talk on phone (E)
- Resident hollering out continuously for help and staff walked by room (D)
- Staff answered call light, but wouldn't take resident to BR during the night shift (D)

- Dependent resident with long facial hair, dirty face, bare back. Also, administrator told staff they were not allowed to speak to a resident when they were providing 1:1 care, only sit and observe, also Administrator went room to room looking for briefs that had been "stashed" without obtaining resident permission to search their rooms (D)
- Facility failed to ensure resident privacy. Staff knocked on resident doors and entered without waiting for response (D)

F 558—Reasonable Accommodations of Needs/Preferences

- Resident positioned at dining room table in a semi-recumbent position and had to place plate on his chest to eat (D)
- Failed to always meet the resident's needs for hearing aids, staff failing to put hearing aids in for a resident (D)

F 561—Self Determination

- A resident with dementia had a POA who signed a release and verbally requested res be able to leave with a companion. Care plan indicated the companion could not take resident out of building and the DON reported the facility would not allow resident to leave due to safety concerns. Companion also confirmed had been restricted from taking res out of building several times (D)

F 573—Right to Access/Purchase Copies of Records

- Facility failed to provide copies of medical records as requested. Administrator stated did not believe POA to be in effect due to no dementia dx, even though it was listed on MDS and careplan (D)

F 578—Advance Directives/Discontinuation of Treatment

- Staff misunderstood advance directives (D)
- Facility failed to ensure documentation was accurate and reflected a resident choice for CPR. Facility failed to update a resident’s choice of advanced directives (D)

F 580—Notification of Changes Injury/Decline

- No family notification of a fall 1 of 6 res (D)
- Facility failed to notify the physician when there was a significant change in the resident’s physical, mental, or psychosocial status. Resident experienced a seizure and the physician was not notified (D)

F 582—Medicaid/Medicare Coverage

- Facility failed to notify the resident or resident representative in writing in a timely manner of Medicare A services discontinuing (D)
- Facility did not issue Medicare non-coverage forms and rights to appeal for two residents (B)

F 583—Personal Privacy/Confidentiality of Records

- During peri care items fell to the floor, when staff brought more items didn't knock on door and resident exposed (D)

F 584—Safe/Clean/Comfortable Homelike Environment

- Dirty fan in resident room, dust, dirt and debris under a dresser in the resident's room, dirty siderail, dirt under a bed, dirty CPAP machine and oxygen concentrator (E)

F 609—Reporting of Alleged Violations

- Facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property were reported immediately, but not later than 2 hours after the allegation was made. Resident had bruises on left ribcage where they stated a CNA on the night shift had turned him too roughly and he was on baby aspirin and bruised easily, CNA reported it to the nurse, but an incident report had not been filled out. One resident stated another resident grabbed her shoulder and had a red mark (F)
- Facility failed to properly notify DIA of allegations of abuse for 2 residents (E)
- Facility failed to report an injury of unknown origin (D)

F 610—Not Employ Staff with Adverse Actions

- Facility failed to investigate alleged violations of abuse, neglect, exploitation, misappropriation of resident property, exploitation, and mistreatment, including injury of unknown origin. Resident complained that during cares a staff member pushed him too hard and it caused bruising. After the surveyor notified the facility they started their investigation (F)
- Failed to assure registry checks completed prior to working in the facility for temporary agency employees (B)

F 623— Notice Requirements Before Transfer/Discharge

- Res admitted to the hospital, after 7 days facility notified the hospital they would not take resident back. No notice given to resident or family. Admin stated did not give notice due to family not returning call about signing bed hold. LPN reported family did call and request bed hold (D)

F 625—Notice of Bed Hold Policy

- Bed hold notices not provided to 2 residents who were transferred to the hospital (D)

F 637—Comprehensive Assessment After Significant Change

- Facility missed a significant change MDS/assessment for 1 of 11 res (D)
- Failed to complete a significant change comprehensive assessment after discharge from hospice (D)

F 644—Coordination of PASRR and Assessments

- Failed to do Level II for PASRR (D)

- Added dx of major depression and this was submitted to PASRR (D)
- facility failed to refer a resident reviewed with a qualifying mental illness diagnoses for a level II PASRR (D)

F 645—PASRR Screening for MD & ID

- PASRR Level II not completed, deleted mental illness DX, but added next MDS so Level II was required (D)

F 655—Baseline Care Plan

- No baseline care plans within 48 hours and behaviors (D)
- Facility said they didn't know they had to give family/representative a copy of the baseline care plan (B)
- Facility failed to provide residents with a copy of the initial care plan after admitted to the facility (B)

F 656—Develop/Implement Plan of Care

- Care plans did not include insulin injections for 1 resident (D)
- Care plan failed to address antidepressant use (D)
- Facility failed to update and follow care plans. Resident's care plan did not have on it that he was grumpy with staff and what staff should do when it occurred, and careplan did not have that foley was no longer needed or that the client smoked (D)
- Staff failed to follow care plan interventions, such as gait belt use, positioning devices (D)
- Care plan did not identify use of psychotropic medications and direction to staff for monitoring for side effects of medications, care plan did not address isolation status on a resident with c-diff and another for MRSA, care plan did not address resident on Citalopram and Haldol (B)

F 657 Care Plan Timing & Revision

- Facility did not update careplan after catheter DC'd and another resident developed a blister and did not add to careplan (D)
- Failed to update a comprehensive care plan to reflect the resident had discharged from hospice care (D)
- Failure to update care plans on two residents. Resident returned from an outing and had a gun upon return. The facility staff found it upon searching the room - the care plan did not address finding the weapon and what unsafe items staff should look for when searching the room. Another resident eloped - care plan did not address the elopement or previous comments about wanting to leave the facility, failed to update the care plan on a resident with pressure areas (D)

F 658—Services Provided Meet Professional Standards

- Facility failed to properly document frequent respiratory stats checks despite declining resident status who was subsequently hospitalized (D)
- Medication change upon return to hospital not initiated. Another resident had two new meds upon return from hospital were to be 7 days only and were given

longer. Also, several times documented med was "not available" even though pharmacy reports med was delivered (D)

- Order was not clarified: nurse sent fax asking to discontinue Risperdal .25mg and physician wrote back to continue Risperdal .125 mg (D)
- Failed to notify physician of low blood sugars (D)
- Facility failed to clarify a physician order for Ativan as needed. Residents chart did not have an order for Ativan when it was originally being administered, the facility could not find original order. Resident had order to have a washcloth placed in left hand due to wound and contracture and there was not one (D)
- Care plan lacked interventions for resident's sexual behaviors (D)
- Failure to follow physician's order regarding obtaining a lab (BMP). Lab was obtained a week late (D)
- Facility failed to follow physician orders. A lab for March and a weight for April were missed (D)

F 660—Discharge Planning Process

- Resident expressed desire to return home. Not careplanned and documentation stated safety concerns and "discharge plan not known" No discharge planning charted (D)

F 661—Discharge Summary

- Facility failed to develop a discharge plan for a discharged resident. Record review revealed the absence of a summary of the resident's stay and absence of post-discharge plans for needed services (D)

F 667—

- Staff failed to completely cleanse perineal area during pericare (D)

F 675—Quality of Life

- Facility did not keep adequate incontinence briefs on hand. Employees complained that there were no large briefs available and had to use medium briefs instead (E)

F 676—Activities of Daily Living/Maintain Abilities

- Restorative not completed per care plan (E)

F 677—ADL Care Provided for Dependent Residents

- Facility failed to provide at least two baths a week for 5 of 8 residents (E)
- Staff failed to completely cleanse perineal area during pericare (D)
- Did not perform thorough peri cares for two residents. Clean incontinent pad touched dirty bedpads and then did not cleanse hips. Another resident did not have both hips washed and the clean bedpad touched the soiled bedpad (D)

F 678—Cardio-Pulmonary Resuscitation

- Facility staff failed to implement CPR for one resident who desired CPR. Resident was found unresponsive and CPR was not started (J) **$7,000 fine in suspension**
- Code status for one resident was not on electronic health record dashboard per policy. Could not locate residents IPOST, status was located within the electronic health record (B)

F 684—Quality of Care

- Resident had a change of condition that was not assessed. She was admitted to the hospital with pulmonary embolism, two blood clots in the left leg, hypoxia, BS 370, FX left arm (unknown to family), high white blood count (14.4), impaired kidney function based on labs. The resident was in this condition for a month with no intervention by staff (G)
- Failed to provide timely and accurate assessment and intervention following documented low O2 Sats (E)
- Failure to assess a resident who had abdominal pain. Aides stated she required 2 person assist to bed (typically 1) and complained of pain. Resident expired that night (E)
- Facility failed to complete a prompt resident assessment. Resident had watery eyes and the doctor wrote and order for warm compresses to eyes and there was no assessment of eyes noted (D)
- Facility failed to ensure assessments was completed timely to ensure proper treatment. Resident with reported skin issues did not receive a skin assessment in a timely manner (D)

F 685—Treatment/Devices to Maintain Hearing/Vision

- Facility failed to ensure residents that required hearing aides had them in place as planned (D)

F 686—Treatment to Prevent Pressure Ulcers

- Failure to provide care to prevent pressure ulcer formation and healing - pressure area was documented on a non-pressure sheet- the nurse stated she had not been trained on how to properly assess or stage wounds. Facility was using Calmoseptine on a pressure ulcer, which is not to be used on open skin. Also, the facility did not carry through the physician order when he changed to a different treatment (G)
- Wound not measured weekly as policy. Wound varied measurements, drainage, required debridement (D)
- Weekly skin assessment not completed (D)

F 688—Prevent Decrease in Range of Motion

- Residents did not receive restorative care as directed by therapists (E)
- Facility failed to provide restorative services as planned (E)
- Orders for restorative and not completed and PT discharge summary included restorative plan (D)

F 689—Free from Accidents and Hazards

- Resident eloped - same resident had brought a gun in after going on an outing. Room search was to be completed after each outing, but sheets had gaps for several outings where searches were not documented. A plan was not put into place immediately after the gun was found. Staff stated they were not educated regarding searching the resident when he returned from outings. The gun (pistol) was loaded when found in the resident room. The police came in and unloaded the gun. Same resident eloped through a window - intervention was to secure windows in the unit where he resided. Surveyors found several windows that were not secured. Also, staff stated they found the CCDI unit propped open several times. The resident went out a window, onto the roof, climbed down the roof and walked away. He was found by police officers. The facility did not have an elopement assessment (IJ) **$8,750 fine in suspension**
- Transferred resident not following care plan interventions, lowered to floor, no nursing assessment prior to moving resident back into chair, resident had femur fracture (G) **$4,500 fine**
- Failed to ensure that the resident's environment remained as free of accident hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents. Resident's violent toward residents and staff, staff indicated they didn't think it was safe to have certain resident in the facility and residents complained of not having adequate staff to prevent resident to resident incidents (E)
- Resident left unattended in the bathroom and fell while CNA stepped out to get washcloth. 4 other residents did not have foot pedals on wheelchair. Observations: beautician was pushing res 180 feet without feet on pedals, CNA pushed resident 5 feet no pedals, another CNA pushed res 55 feet, and another pushed 28 & 15 feet (E)
- During observation CNA transferred resident back into wheelchair and the brakes were not locked (D)
- Same as 550, but since resident hollers for help and no one comes, resident could have had an accident, not just behaviors (D)
- Resident was left alone on the toilet, fell, but no major injury (D)
- Wheelchairs were missing foot rest when staff pushed them (D)
- Facility failed to ensure that each resident received adequate supervision and assistance to prevent accidents. Client found on floor and transported to the hospital. Resident had angulated fracture of the distal left femur, a non-displaced oblique fracture through the proximal right tibia and fibula (D)
- Facility failed to keep unsecured chemicals secured in the food service area (D)
- Facility failed to ensure that the resident environment remained as free of accident hazards as possible. Resident got up by themselves on multiple occasions trying to use the restroom and fell over Foley tubing (D)

F 690—Bowel, Bladder Incontinence, Catheter Care

- Failed to provide catheter and incontinence care for 2 of 3 residents. During cath cares did not remove gloves used to cleanse BM from buttocks, prior to cleaning catheter. Another resident during suprapubic catheter care employee did not

clean hands between clean and dirty procedures. No barrier between canister and floor during emptying catheter. Both residents have had UTIs (D)
- Facility failed to ensure residents with an indwelling catheter received proper catheter care to prevent urinary tract infections. Washcloth with BM was continued to be used to clean around catheter (D)

F 692—Nutrition/Hydration Maintenance Status
- Facility failed to provide initiate timely interventions when a resident lost 21 pounds over an 18-day period (D)
- Facility did not monitor and report ongoing weight loss and hydration issues on one resident. Ordered Breeze supplement on 3/27, but it was not started until 4/9. Supplements were being refused repeatedly, but the physician was not notified. The resident continued to lose weight (D)

F 697—Pain Management
- Facility failed to provide ordered pain medication. Client had order from doctor to receive restless leg medication and had not had it for the month of May (D)

F 700—Bedrails
- Side rails on beds that don't meet new criteria for prevention of entrapment (K) **$3,500 fine in suspension**

F 725—Sufficient Nurse Staffing
- During group interview residents report call lights longer than 15 min. One resident stated BR call light did not work and had to bang on wall for help. CNAs report maint knew it didn't work and it hasn't been repaired. Surveyor observed call lights taking longer than 15 min. Resident reported not receiving showers-staff members report bath aide pulled to floor do to short. Staff member reported only person in building from 10p-11p. Family member reported visiting resident, told staff she was wet, left and came back 5 hrs. later and had not been changed (F)
- Failure to answer call lights in a timely manner. Time log from call light system showed response times of 19 to 34 minutes (E)
- Failure to answer call light in a timely manner, insufficient staffing, call light on for 18 minutes, 19 minutes, 20 minutes, and 31 minutes. Resident had concerns at resident's council (E)

F 727—RN Coverage 8 hrs. 7 Days per Week
- No RN coverage for 15 days between April 8th and May 18th (E)

F 730—Annual Nurse Aide Review
- Based on personnel record review and staff interview, the facility failed to complete 12-month evaluations for all certified nursing assistants employed greater than 12 months (C)

F 745—Medically-Related Social Services

- Social services felt resident depressed and didn't work with nursing to address (D)

F 756—Drug Regimen Review, Report Irregularities

- Facility failed to address each psychotropic medication on the drug regimen review (D)

F 757—Drug Regimen/Freedom from Unnecessary Drugs

- Physician did not review consultant pharmacist's recommendations regarding psychotropic drugs, failure to do GDR's (D)
- Facility failed to offer alternative interventions prior to the administration as needed anti-anxiety medications (D)
- Facility failed to adequately monitor laboratory values in conjunction with medication use. Resident who was diabetic did not have blood sugars routinely checked and had a blood sugar of over 700 (D)

F 758—Free from Unnecessary Psychotropic Medications

- Resident on Tylenol PM and pharmacy said not for elderly and extended use, also on antidepressant and no assessment after use (E)
- Non-pharmacologic approaches for anxiety not documented before administering anti -anxiety meds (D)
- No diagnosis for psychotropic meds and not careplanned for 3 residents (D)
- Failed to ensure appropriate diagnosis, indications, and clinical rationale that warranted continue use of psychoactive medications (D)

F 760—Freedom from Significant Medication Errors

- Nurse A administered 5ml (100mg) of morphine sulfate, rather than the prescribed 0.25ml (5mg) Nurse B called physician and he questioned her nursing skills as asked why it took 5 hours to report the error. Same nurse on the same day to the same hospice resident administered Lorazepam 1ml (2mg) and narcotic record contained the label to administer 0.5ml (1mg) PA-C stated staff did not inform her of the Lorazepam error and she learned error form the resident's family member. PA-C stated the excessive morphine and lorazepam doses contributed, or hastened, the resident's death (J) **$9,100 fine in suspension**
- Facility failed to ensure residents are free of significant medication errors. One resident was given pills of roommate who then became unresponsive and taken to ER and given Narcan (G)
- Sliding scale insulin order did not match physician orders (D)

F 791—Routine/Emergency Dental Services

- No dental referrals documented for resident who had no teeth and complained of problems chewing (D)

F 802—Sufficient Dietary Support Personnel

- Dietary staff failed to provide pureed foods that are palatable, failed to use appropriate dinner ware and failed to serve meals timely (E)

F 803—Menus Meet Residents' Needs/Preparation in Advance/Followed

- Residents on mechanically altered diet were not served correct amount of pureed foods (E)
- Failed to ensure residents on mechanical soft and pureed texture diets received the proper portion size (E)

F 805—Food in Form to Meet Individual Needs

- Failed to serve diet as ordered for 1 of 8 residents (D)

F 809—Frequency of Meals/Snacks at Bedtime

- Meals served late for two meals (45 min and 60 min) (E)

F 812—Food Procurement, Storage, Preparation, Sanitization

- Facility failed to maintain proper kitchen sanitation and failed to carry out adequate dietary infection control practices. The handwashing station had roll paper towels hanging above it and the paper towels on the roll were wet from the person who last used it. The ice machine had thick clumps of dust on door hinges. Stove hood had particles of dust handing from it. Meal trays were stacked under the stove hood (F)
- One meal sanitation conditions not met. Employees handling food bare hands, not washing hands, wearing gloves touching multiple items (F)
- Staff ran 11 cycles through dishwasher that was not proper temp while observed by surveyor (E)
- Facility did not ensure a sanitary environment for food preparation and storage and that outdated foods were not readily available for residents' use. Cob webs on ceiling above food prep area (E)
- Food temped outside of requirements twice (E)
- Staff serving meals in dining room touched multiple surfaces including pens, menu slips and food items without washing hands in between. Staff also donned gloves without washing hands first (E)
- Two incidences of cooks touching multiple surfaces and not washing hands and touching food items with bare hands (E)
- Hood vents, backsplash on stove and stainless doors of freezer and cooler with dust, dried food smudges and drips. Cleaning checklists did not include these areas (E)
- Dried food on serving table (E)
- Facility failed to maintain required chlorine concentration of 50-100 parts per million for complete dish sanitation (E)
- Facility failed to ensure staff utilized proper handling of resident food items to prevent foodborne illness. Hospitality staff wore gloves to serve sandwiches and then reached for skillet, open bread bags with same gloved hand (D)

- Facility failed to assure milk served at safe temperatures. Milk was 57.4 degrees (D)

F 839—Staff Qualifications

- RN did not know how to use feeding pumps. DON reported they did not have a training/skills checklist documented for any employees (D)

F 842—Resident Records—Identifiable Information

- Resident found on floor with apparent lividity, no pulse or respirations. Nurse documented resident was found in bed, deceased. No incident report completed. When interviewed by DIA nurse told conflicting stories regarding the incident. Nursing record was falsified **$500 fine** (E)
- Resident records were stored in a storage area that was not locked (E)
- Failed to ensure medical record on each resident were complete and accurately documented, nurses notes failed to contain information of an incident, nurses' notes failed to identify what the made contact was, nurses notes failed to contain any specific information regarding incident (D)
- Facility failed to document accurately regarding cardiac resuscitation when residents' expired (D)
- Facility failed to maintain medical records in accordance with the accepted professional standards and practices, the facility must maintain records on each resident that were complete and accurately documented. Staff interviews identified bruises, but the nurses' notes did not have record of it (D)

F 865—QAPI Program/Plan

- QAPI did not address all QM's with follow up (E)

F 868—QAA Committee

- Failure to address survey issues in the QAPI meetings (E)
- Surveyor cited several past surveys and determined there was not adequate QA monitoring in place, or possibly documentation not complete (D)
- Medical director not present for QA mtg 4 times during year (D)

F 880—Infection Prevention and Control

- Nurse did not change gloves or wash hands during dressing change after washing affected area and before proceeding to apply medication and dressing (D)
- Nurse did not cleanse scissors during dressing change when going from one wound dressing to another or change gloves (D)
- Res with stage 2 ulcer to coccyx. LPN did not change gloves between cleansing wound and adding clean dressing. No policy for wound care or dressing changes (D)
- Infection control-no barrier between urine collection canister and floor (D)
- 3 residents did not have catheter secured and tubing lying on floor as careplanned. All 3 with history UTIs (D)

- Staff failed to properly wash hands during pericare, failed to disinfect floor (D)
- Incomplete peri care didn't clean legs (D)
- The facility will conduct an annual review of its IPCP and update their program as necessary, failed to transport resident clothing using proper infection control technique, laundry pushed uncovered laundry delivering clothes, also staff dropped a hanger bent to pick it up, dragging pants hung on hanger on the floor (D)
- Facility failed to utilize proper infection control techniques during resident care. CNA held Kleenex to resident's mouth to spit into without gloves, then another CNA who donned gloves did not wash hands and then touched several things without changing gloves (D)
- Facility failed to ensure staff followed proper infection control techniques for handwashing/gloving. CNA wore gloves for peri-care and did not remove gloves or wash hands before turning on wheel chair alarm or flushing toilet (D)

F 921—Safe/Sanitary/Functional/Comfortable Environment

- Facility failed to maintain a safe and sanitary resident environment. Raw sewage that swept through a crack in the foundation of the facility from a broken sewer pipe and onto the floor of the tunnel below the B hallway of the facility (F)

N 101—Reporting

- Facility failed to report this unexpected death as it related to a fall **$500 fine**

Nursing Facility Survey Frequency-July 2018

Name of Entity	Exit Date	City	Previous Date	Months
Accura Healthcare -- Milford	5/17/2018	Milford	4/6/2017	13.5
Accura Healthcare - Sioux City	5/17/2018	Sioux City	2/2/2017	15.6
Bedford Specialty Care	5/10/2018	Bedford	3/9/2017	14.2
Bloomfield Care Center	5/24/2018	Bloomfield	3/20/2017	14.3
Creekside	5/3/2018	Grundy Center	9/28/2017	7.2
Davis Center	5/3/2018	Bloomfield	2/23/2017	14.5
Edgewater	5/31/2018	West Des Moines	3/30/2017	14.2
Eldora Specialty Care	5/17/2018	Eldora	2/9/2017	15.4
Fort Dodge H&R	5/10/2018	Fort Dodge	3/16/2017	14.0
Good Sam - Fontanelle	5/3/2018	Fontanelle	3/2/2017	14.2
Good Sam - West Union	5/10/2018	West Union	3/16/2017	14.0
Green Hills HCC	5/31/2018	Ames	3/30/2017	14.2
Griswold Rehab & HCC	5/3/2018	Griswold	3/2/2017	14.2
Heartland Care Center	5/3/2018	Marcus	3/9/2017	14.0
Heritage CC	5/17/2018	Iowa Falls	3/23/2017	14.0
Hubbard Care Center	5/10/2018	Hubbard	3/9/2017	14.2
Humboldt County Hosp.	5/3/2018	Humboldt	3/9/2017	14.0
Lake Mills	5/31/2018	Lake Mills	3/30/2017	14.2
Lamoni Specialty Care	5/24/2018	Lamoni	3/9/2017	14.7

Manorcare Health Services - WDM	5/17/2018	West Des Moines	2/9/2017	15.4
Monroe Care Center	5/4/2018	Albia	5/4/2017	12.2
Monticello N&R	5/10/2018	Monticello	3/2/2017	14.5
Oaknoll Retirement Residence	5/31/2018	Iowa City	3/16/2017	14.7
Pleasantview Home	5/10/2018	Kalona	3/2/2017	14.5
Risen Son Christian Village	5/10/2018	Council Bluffs	2/23/2017	14.7
Riverview Manor HC	5/31/2018	Pleasant Valley	3/23/2017	14.5
Stonehill	5/24/2018	Dubuque	3/30/2017	14.0
Sunnycrest Nursing Center	5/14/2018	Dysart	3/15/2017	14.2
The Alverno	5/3/2018	Clinton	3/23/2017	13.5
Thornton Manor	5/24/2018	Lansing	3/2/2017	14.9
Tripoli Nursing & Rehab	5/3/2018	Tripoli	3/9/2017	14.0
Union Park	5/24/2018	Des Moines	3/20/2017	14.3
Winslow House	5/24/2018	Marion	3/23/2017	14.2
			Average	14.2

Between 14-15 months is MOST