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

Compliance Tips from IHCA's Survey Results Committee
July 2019

Total Number of Survey Reports: 72

Survey Composition:

Annual:	**24** Surveys	**2** Deficiency Free
Complaints:	**52** Surveys	**24** Unsubstantiated
Self-Reports:	**25** Surveys	**13** Unsubstantiated
Mandatory Reports:	**3** Surveys	**0** Unsubstantiated

State Fines: **$31,250**
State Fines in suspension: **$50,000**

Most Commonly Cited Iowa Tags:

F 812 – Food Procurement, Storage, Preparation, Sanitization (10)

F 880 – Infection Prevention and Control (15)

F 689 – Free from Accidents and Hazards (15)

F 625 – Notice of Bed Hold Policy Before/Upon Transfer (7)

F 658 – Services Provided Meet Professional Standards (7)

Tags Resulting in Actual Harm or Higher Citations and Fines:

F 580 – Notify of Changes (Injury/Decline/Room, Etc.)	**1 J Level Tag**
F 684 – Quality of Care	**1 J Level Tag**
F 686 – Treatment to Prevent Pressure Ulcers	**2 G Level Tags**
F 689 – Free from Accidents and Hazards	**5 G Level Tags, 1 J Level Tag**
F 697 – *Pain Management	**1 G Level Tag**

F 760 – *Residents Are Free of Significant Med Errors 1 G Level Tag, 1 J Level Tag

N 101 – 2 D Level $500 Fines

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=15573		Total Number of Surveys=29131
F0880	Infection Prevention & Control	2,665	16.1%	9.1%
F0689	Free of Accident Hazards/Supervision/Devices	2,434	13.4%	8.4%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	2,218	13.7%	7.6%
F0656	Develop/Implement Comprehensive Care Plan	1,997	11.9%	6.9%
F0684	Quality of Care	1,775	10.0%	6.1%
F0761	Label/Store Drugs and Biologicals	1,564	9.7%	5.4%
F0657	Care Plan Timing and Revision	1,278	7.7%	4.4%
F0758	Free from Unnec Psychotropic Meds/PRN Use	1,182	7.3%	4.1%
F0677	ADL Care Provided for Dependent Residents	1,126	6.3%	3.9%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	1,071	6.2%	3.7%

*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

- Failed to ensure each resident had the right to be treated with dignity and respect. Staff member yelled and used inappropriate language to residents. D
- Failed to treat a resident in a respectful, dignified manner; answered call light without knocking, stated I'll be right back and turned off the call light. Resident put call light on again and ADON answered and stated they would be right in to assist, leaving call light activated this time. Staff returned, answered in a "short, curt tone of voice". Resident stated on interview she did not like being talked to that way. D
- Failure to ensure residents were afforded privacy during incontinent care. D
- Resident had to wait 24-mins to use the bathroom while surveyor was observing, and resident was incontinent due to the wait. D

F553 – Right to Participate in Planning Care

- Failure to have care conference with family for a resident. D

F554 – Resident Self-Administers Meds-Clinically Appropriate

- Failed to complete a comprehensive assessment of resident's ability to self-administer, store, report intake of medications. Medications left at bedside for resident to take per self without assessment or Dr. orders for self-administration of medications. D

F557 – Respect ,Dignity/Right to have Personal Property

- Staff failed to show dignity and respect to a resident while giving a shower. Staff made comments about giving resident a cold shower and not appropriately acknowledging the pain the resident was in. D

F558 – *Reasonable Accommodations of Needs/Preferences

- Resident who liked to eat in his room and required special positioning and tray set up to eat independently had tray delivered and no one assisted with tray set up and repositioning for at least 20 minutes. D
- Failure to provide bottled oxygen for multiple residents, requiring them to use oxygen concentrators until the facility obtained liquid oxygen and portable oxygen bottles. E

F561 – *Self-Determination

- Administered PRN medications prior to 6AM; gave a Bisacodyl suppository prior to 6AM for a resident. D
- Failed to determine resident preferences for sleeping and waking times prior to scheduling administration of medications, awaking cognitively impaired residents to give Prilosec prior to 0600. E

F576 – Right to Forms of Communication with Privacy

- Failed to ensure that residents are receiving mail on weekends. Staff verified that mail is not delivered on weekends. C

F578 – Request/Refuse/Discontinue Treatment; Formulate Advance Directive

- Failed to ensure residents' choices for CPR reflected residents' wishes and were available. IPOST included resident's choice of full code. Resident's chart was flagged with a red envelop signify a DNR. D
- Failed to ensure code status in hard chart matched the residents' wishes for multiple residents. Stickers to identify code status not in place on spine of charts and a resident had orders for full CPR but IPOST stated DNR. E
- Failure to ensure all staff were aware of a resident's health decisions regarding advanced directives; Failure to document accurate code status for multiple residents reviewed for advanced directives. D

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

- Resident choked, was given Heimlich, but physician and family were never notified, no assessment done, no notes charted. Resident had new pressure and no treatment was started for three days because the physician wasn't aware for two days. Staff did not notify physician or family of abnormal renal failure results timely. Resident had blister on heel and sore on bottom and nothing was done - it was reported to nursing from CNA's multiple times. E

- Failed to notify Hospice staff of a change in physical status of resident. Resident had elevated pulse rate and left sided neck pain with no notification to hospice. D
- Failed to immediately inform the resident, consult with the resident's physician, and notify resident representative of a significant change in status. Resident developed loose stools and loss of appetite, later found to have C-diff and expired. Cause of death included c-diff. Resident had multiple loose stools x 5days, note was sent to physician on 5th day, physician did not respond for nine more days. Staff did not recontact physician during that 9-day time frame. Resident was admitted to hospital on the 9th day with dehydration, severe cramps, critical labs and dx of C-diff. Resident expired the next day with C-diff on death record. **J $9,500 FINE IN SUSPENSION**
- Family of a resident was not notified of condition change. D
- Multiple residents did not have family notification with condition of change. D
- Resident had worsening pressure ulcers and both the primary care ARNP and family report not being notified in a timely manner. D

F582 – Medicaid/Medicare Coverage/Liability Notice
- No notice of Medicare non-coverage for residents going from SNF to ICF LOC. C

F583 – Personal Privacy/Confidentiality of Records
- Resident's buttocks exposed when transferring to shower room. D

F584 – Safe/Clean/Comfortable/Homelike Environment
- Fail to timely and thoroughly investigate loss of a resident's missing leather jacket. D

F585 – Grievances
- Failed to ensure the residents received required information regarding their right to fila a grievance and ensure their grievance policy included required information. Several residents reported they did not know the name of the grievance officer. No posting noted in facility to identify grievance officer or information on how to file a grievance. C
- Multiple residents did not receive the required information regarding the right to file a grievance. B

F609- Reporting of Alleged Violations
- Staff transferred resident without gait belt and resident hit right ankle on bed frame, staff did not report it. Resident reported next day that ankle was hurting. D
- Failed to ensure 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 allegation. Heating pad was left under hospice resident's back overnight resulting in burn blisters. Major injury form was signed as not a major injury by physician. Neglect of resident was not reported to DIA. D
- Failed to report different allegations of potential abuse to DIA within 24 hours regarding missing money or valuables. Missing cell phone/money not reported. D
- Failed to ensure alleged violations involving misappropriation of resident property. Resident stated staff entered his/her room to fix resident's hair and after reporting

trouble with his cell phone staff tried to look at it, shut off mobile data. The resident left for a shower at upon return the phone was gone. The phone was reported missing to the DON/Administrator and was not found. Facility would not replace phone. Resident's mom bought a new one. Missing phone not self-reported. D

- Facility reported an allegation of abuse and while investigating saw video that led to another allegation. Second allegation was reported, however not as a second allegation but as an addendum to the first even though it involved different staff member and resident. D
- Failed to report alleged violations r/t mistreatment or abuse of residents to the proper authorities within prescribed time frames. Nurse did not notify administration of allegation of verbal abuse for 6days after incident. D

F610 – Investigate, Prevent, Correct Alleged Violation

- Staff were yelling at residents in dementia wing with foul language multiple times. Was not reported. F
- Facility failed to report an incident in a timely manner involving neglect with injury. D
- Failed to have evidence that alleged violations were thoroughly investigated, nurse allegedly knew that she left a heating pad on a resident leaving 3 burned areas. D
- Facility failed to initiate an investigation of alleged abuse. Resident was hospitalized and alleged that back in June abuse toward him/her occurred at the facility. Resident did not return to facility and facility did not initiate an investigation due to no report being made while the resident was at the facility. Resident reported to hospital liaison that staff groped her breast twice in stairwell. Staff reports she/he treated resident once in room for 35 min-applied a gait belt but did not take resident out of room, denies inappropriate contact. Attempts to contact resident- unsuccessful. D
- CNA was allowed back to work in a different area and different shift after an allegation of abuse. D

F623 – Notice Requirements Before Transfer/Discharge

- Multiple residents reviewed failed to have the Ombudsman's office notified. C
- Failed to notify Ombudsman for hospital discharges. B
- Failure to notify Ombudsman of transfer for multiple residents with medical concerns. B
- Facility failed to notify the LTCO of two resident transfers to the hospital. D
- Failure to notify State LTC Ombudsman of multiple residents transfer to hospital. B

F625 – Notice of Bed Hold Policy Before/Upon Transfer

- Failure to document bed hold policy for several residents. B
- Multiple residents reviewed failed to notify family of bed hold policy. C
- Failure to document that bed hold was offered for several residents reviewed for transfers to hospital. B
- Facility failed to provide bed hold notice to residents prior to transfer to hospital. D
- Facility did not notify several residents of bed hold rights prior to hospital transfer. D
- Failure to provide copy of bed hold notice at time of transfer for multiple residents. B

- Failed to provide residents with bed hold information upon transfer from facility to hospital. C

F637 – Comprehensive Assmt After Significant Change
- Failed to complete a comprehensive assessment after a significant change. Resident declined in areas of self-performance of transfers, walking in room, locomotion in unit, dressing and personal hygiene. Resident declined in mood. D

F641 – Accuracy of Assessments
- Failure to complete an accurate assessment. Baseline care plan had mistakes when compared to the CAA. B

F644 – Coordination of PASRR and Assessments

- Failed to incorporate recommendations from the PASRR. PASRR showed resident should receive specialized services of individual therapy. Care plan lacked documentation of individualized therapy being provided. Staff report resident refused to see psychologist but did not document refusal on care plan. D
- Failed to refer resident with negative level I for level II screen. Resident with depression, psychotic disorder, and schizoid personality disorder had "no" documented on PASRR under question of does the individual have any of the following major mental illnesses. B
- Failed to re-assess PASRR after new diagnosis of psychosis. B
- Failure to repeat a Level 1 screening for residents who developed mental disorders not diagnosed upon admission. D
- PASARR not completed for resident with newly diagnosed mental disorder. D
- Resident started on anti-depressant and antipsychotic for depression and self-harm, but facility did not initiate a new PASRR. Another resident, facility did not follow the recommendations of the PASRR on the care plan. D

F645 – PASARR Screening for MD & ID
- Facility did not submit a new PASRR for a resident that was newly diagnosed with a mental illness. D

F655 – Baseline Care Plan
- Failed to provide residents and or families with a written copy/summary of initial baseline care plan. Records lacked documentation of a baseline care plan. D

F656 – Develop/Implement Plan of Care
- Failed to follow care plan by having resident's feet lying on bed as opposed to floating which was not in the Aides Kardex. Care Plan was not updated to show a resident was on Hospice. D
- Failed to develop and follow care plans; no Roho cushion in chair as care planned; no care plan for dialysis services for a resident. D

- Failed to ensure care plans included all services required to ensure residents' medical/nursing needs were met for multiple residents. Failed to address diagnosis of diabetes or use of insulin. D
- Failed to develop and implement a person-centered care plan for a resident with a skin integrity impairment. D
- Psychotropic medications not listed on the care plans with specified targeted behaviors and interventions. D
- Failed to develop and implement a comprehensive person-centered care plan for each resident. Care plan lack documentation of resident with c-diff. D

F657 – Care Plan Timing & Revision

- Failed to update/revise care plans. Lack of updating care plan based on discontinuance of hospice services and when resident no longer required barrier after pericare. B
- Several residents failed to have care plans updated related to actual pressures sores of heels. D
- Failure to update care plan with pressure sore. D
- Care plan, advanced directive sheet, and code status orders did not match. D
- Failed to review/revise the resident's care plan to meet resident's needs. Care plan was not updated based on change in transfer status to a mechanical lift and resident now requiring someone to go with her when she went out to smoke. D

F658 – Services Provided Meet Professional Standards

- Staff failed to provide treatment to a wound for two days. Another resident had a wound and did not receive treatment five different times. Dressing was not changed as ordered on a wound of another resident. Labs were not done when scheduled. D
- Failed to follow physician orders/implement in timely manner. Medication ordered with a range of 1-2 and nurse entered it as 2. INR not completed when ordered. D
- Did not give morphine as prescribed by physician. D
- Failed to assure a resident rinsed after the use of an inhaler. CMA left room without instructing resident to rinse mouth after using the inhaler. D
- Failed to follow physician orders. No moon boots on as directed by physician. D
- Failure to follow physician's orders. Wound cares were reported in the computer, but staff didn't complete a final step that would've put the orders on resident's TAR. D
- Failure to follow physician's orders for a resident. Nurses failed to hold a resident's medication as ordered. D
- Multiple residents failed to have medications administered at the right time, thyroid or sequence, eye medications. D

F661 – Discharge Summary

- Facility discharge documentation did not contain a recap of the stay. B

F677 – ADL Care Provided for Dependent Residents

- Residents didn't receive bath two times within a month period. Dependent resident didn't receive incontinent cares for over 6 hours during day. Resident had brief

changed, staff did not wear gloves, put soiled brief on floor, didn't use wipes to clean resident. Failed to apply barrier cream or clean hands between glove changes. D

- Peri care done with front to side motion instead of front to back. D
- Diabetic resident needed to see a podiatrist and was put off for two months. D
- Failed to provide complete, proper incontinence care; didn't change gloves between dirty and clean linens or cleanse buttock/hip areas where urine had touched skin. D

F684 – Quality of Care

- Staff didn't perform CPR to standards; no rescue breathing was done and when EMT's arrived no one in the room was doing compressions. D
- Professional standards were not met when resident had choking episode and no assessment was done after or notification to family or physician. No record of assessment after resident hit ankle on bed frame. No wound assessment reports or measurement for two wounds. No documentation of reported pressures. Nurses not doing skin assessment. Dressing changes not done timely. Proper assessment not done on resident- resident ended up dying. Medications were administered late. E
- Failed to ensure residents received treatment and care in accordance with professional standards of practice, care plan and resident choice. Facility failed to assess residents condition changes r/t C-diff and later expired. Lack of nursing assessment/intervention. Lack of timely physician notification of condition change. **J $9,500 FINE IN SUSPENSION**
- Failed to provide adequate assessment and notify physician and family of change in condition; resident with a temp and low oxygen saturations (77%) without physician or family notification and lack of follow up of condition in the nurse's notes. D
- Facility failed to ensure a resident with complex medical needs attended specialty appointments. Resident had hospital summary record showing two specialty appts scheduled. Staff report the first appt was cancelled because the therapist said the resident was too ill to travel and the second appt was cancelled because the specialist was unavailable. Appts were re-scheduled but they were also cancelled because facility did not have a RN to travel with resident. Annual specialty appt also had to be re-scheduled due to transport aide being too busy. When resident went to the appt at a later date the resident had abdominal issues and was hospitalized. D
- Facility delayed obtaining a UA for 3 days after the order for no apparent reason. D

F686 – Treatment to Prevent Pressure Ulcers

- Failed to prevent new pressures and provide necessary treatment. Pressures were reported to nurse multiple times, and nothing was done. Proper treatments were not followed as ordered. **G $5,750 FINE IN SUSPENSION**
- Facility failed to develop interventions to prevent pressure ulcers in a resident. Resident (dx of hip fx) had a baseline care plan that identified a care area titled skin integrity with a goal to prevent breakdown and contained no staff interventions. An area was documented as a stage II pressure ulcer and NP assessed as a stage II two days later. Eight days later it was documented as unstageable. Resident reported he/she was not assisted with turning or repositioning regularly. Discharge to AL did not occur as planned due to pressure area. D

- Resident developed 1 stage 2, 2 stage 3, and 1 deep tissue wound, which then progressed, and resident ended up with exposed bone on sacrum along with osteomyelitis. Resident was eventually admitted to hospice. Second resident developed 2 stage 2, 1 stage 3, and 1 unstageable all on same day according to charting. However, medical record lacked follow-up documentation for over 2 weeks after the areas were first noted. The areas were then worse when evaluated. **G $6,250 FINE**

F 688 – Increase/Prevent Decrease in ROM/Mobility

- Failed to initiate a restorative exercise program for a resident admitted with a limitation in mobility. No ROM restorative for a resident with ROM limited. D
- Failed to ensure resident received range of motion exercises as planned. Resident reports he/she would like to receive ROM more often due to staff only doing it when there is enough staff. Plan was scheduled for 3-6x's per week, resident only received ROM 1-2 days per week. D

F 689 – Free from Accidents and Hazards

- Resident was supervised outside smoking but still had oxygen on and O2 on. E
- Staff didn't mitigate a resident's risk for resident-resident altercations well enough. D
- Resident left unattended on toilet and then found on bedroom floor. Resident was transferred without gait belt and hit ankle on bed frame. Transferred resident via Hoyer with only one staff in room. D
- Failed to ensure each resident received adequate supervision/assistance devices to prevent accidents. Resident assisted to bathroom with one assist per care plan -did not use a gait belt. Resident fell with fractured hip. **G $5,500 FINE**
- Failed to ensure the resident environment remained as free of accident hazards as is possible, and each resident received adequate supervision and assistance devices to prevent accidents. Resident was left on heating pad overnight and sustained burn blisters. No policy for use of heating pads or warm/hot packs. **G $5,500 FINE IN SUSPENSION**
- Failed to ensure a resident's safety for a fall that resulted in fracture requiring hospitalization. Resident being walked with therapy. The therapist turned away from resident to grab a chair and resident fell. Self Report. **G $3,250 FINE**
- Staff failed to ensure a resident was placed in a safe position before leaving the resident unattended during cares for a resident with a fall risk. The resident fell multiple times. D
- Facility failed to provide adequate supervision for multiple residents. CNA entered resident door and observed a second resident lying on the bed exposed from the waist down. Staff reports there was a similar incident-date unknown in the resident's room. Resident had overalls off and the other resident was adjusting pants with zipper down. Staff reports this resident frequently disrobes and likes to kiss and touch other residents. The second resident has a history of being sexually inappropriate with staff. Staff have reported that they try to keep these residents separated but it was not care planned. ADON thinks there may have been a 3rd incident a long time ago with a different resident involved. There was an incident with these two residents in the past

that they did not feel needed to be reported as the residents were put on 15 min checks for 24 hours. D

- Failed to ensure environment was safe for multiple mobile wandering residents, spa door left open. D
- CNA removed a portable O2 tank from its holder and laid it on the floor while toileting a resident. D
- A staff member attempted alone to transfer a resident requiring a two-person assist. Resident slipped from side of bed and fractured hip. Another resident care planned to stay in common areas after meals went to room unattended and transferred self resulting in a fall. Third resident was observed being transferred by two CNA's without the use of a gait belt. **G $4,500 FINE**
- Cognitively impaired resident eloped from facility during 32-degree weather. Later door alarm system found to be operating only intermittently. **J $7,250 FINE IN SUSPENSION**
- Resident eloped from the dementia unit by following a visitor out the door. Facility did not place a wander guard on the resident after this incident and resident attempted to elope again. D
- Cabinet containing whirlpool chemicals was unsecured. Multiple cognitively impaired residents who wander reside in the facility. D
- Resident being transferred from WC to toilet with assist of 1 when CP states 2. Resident fell to knees with patella fracture. **G $6,750 FINE**

F 690 – Bowel, Bladder Incontinence, Catheter Care

- Resident observed by surveyors for 4 hours without being offered toileting. Resident incontinent based on having to wait >24 minutes to go to the bathroom while being observed by surveyor. D

F 695 – *Respiratory/Tracheostomy care and Suctioning

- Failure to provide continuous oxygen therapy to resident as prescribed. D

F697 – *Pain Management

- No nursing assessment related to pain management, resident unable to participate in therapy or daily ADL's related to uncontrolled foot pain. **G $3,750 FINE IN SUSPENSION**

F 698 – Dialysis

- Failed to complete nursing assessments and monitoring before and after outpatient dialysis treatment. D
- Facility failed to do pre and post assessments for a resident on dialysis. D

F 700 – Bedrails

- Failed to review risks/benefits with resident or resident representative or obtain informed consent for the use of side rails; resident consents for grab bars but bilateral side rails were being used. D
- Several residents failed to have consents/risks explained prior to use of bed rails. E

F 712 – Physician Visits Frequency/Timeliness/Alternate NPPs

- Facility failed to ensure physician visits were completed every 60 days for multiple residents. Residents #1 (no visit for 8 months), 2, (no visit for 7 months) 11, (no visit for 4 months) 12, (no visit for 3+months) 14,(no visit for 3+months), 15, (no visit for 3+ months) 16,(no visit for 3+ months) and 17(no visit for 3+ months). E

F 725 – Sufficient Nurse Staffing

- Call lights not being answered timely. E
- Failed to meet residents needs in a timely manner for answering call lights and medication administration. E
- Staff failed to answer call lights in a timely manner, with residents waiting 30 minutes or more. Resident stated she sometimes used cell phone to call the front desk when call light was not answered. Another resident stated they waited over 30 minutes to have a full colostomy bag emptied. Another resident timed the response recently to a call light at over an hour. E
- Failed to provide sufficient numbers of staff to meet resident needs for multiple residents. Resident observation revealed resident started pushing call light for assistance at 2:31 pm and did not actually receive assistance until 3:34 pm. A second resident was observed after activities requesting to use bathroom and not taken until 4:39 pm. Resident is usually continent but had soiled pants. Staff report being understaffed to meet resident needs and review of call light log showed multiple instances of call lights not being answered within 15 min. D

F726 – Competent Nursing Staff

- Lack of skills testing or yearly eval in staff files. D
- Call lights not being answered timely. E

F 730 – Nurse Aide Perform Review – 12 Hours /Year In-service

- CNA's not attending in-service training; did not have their required 12 hours. D
- Failed to assure all certified nursing assistants received 12 hours of in-service education annually. Annual training not completed consistently. E
- Facility did not have documentation of 12 hours of training annually for CNA. B
- Failed to provide 12 hours of CNA in-service training. D

F 732 – Posted Nurse Staffing Information

- Failed to post current daily worksheets. After posting is posted, staff did not update form based on call-ins. B

F741 – Sufficient/Competent Staff-Behavioral Health Needs

- Failed to provide six hours of Dementia training education for new hire. B

F756 – Drug Regimen Review

- Pharmacist failed to document monthly medication regimen reviews. D

- Multiple residents with multiple psychotropic meds lacking appropriate diagnoses not addressed by the consultant pharmacist. D

F757 – Drug Regimen- Free from Unnecessary Drugs

- Failed to offer alternative interventions prior to the administration of PRN anti-anxiety meds; no non-pharmacological intervention prior to giving PRN Lorazepam. D

F758 – Free from Unnecessary Psychotropic Meds/PRN Use

- Failure to provide non-pharmacological interventions prior to an as needed antianxiety medication being administered. MARS indicated staff administered Lorazepam with no documentation. D
- Resident with psychotropic medication had no stop date after 14 days or rationale to maintain the order. D
- Resident on antipsychotic with a black box warning and only diagnosis was Parkinson's dementia. D
- Failure to attempt non-pharmacological interventions prior to administering prn psychotropic meds for several residents. Failed to complete a GDR for residents. D

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

- Failure to administer medications in accordance with physician's orders and manufacturer's directions for several residents. Of 44 medications reviewed there were seven errors, resulting in a 15.9% error rate. E
- Failed to prime insulin pen and gave wrong dose of Vitamin D. D

F760 – *Residents Are Free of Significant Med Errors

- Insulin was not given for a resident. D
- Resident administered wrong medications resulting in higher level of care. **G $4,000 FINE**
- Failure to administer medication to resident as ordered by physician- resulting in the resident becoming non-responsive and requiring hospitalization. Physician reported the overdose caused harm to the resident. Hospital documented an assessment of altered mental status due to possible unintentional overdose of Zyprexa. Staff indicated that he/she initialed the dates on the resident's MARS but couldn't remember and did not know the exact amount of Zyprexa that had been given. **J $8,750 FINE IN SUSPENSION**
- Resident received Levemir versus Novolog. D

F761 – Label/Store Drugs & Biologicals

- Medication count was off because of changing the range to 2 on a medication although not ordered by physician. D
- Schedule 2 meds were not stored securely. D
- Failed to label inhaler and nasal spray medications with resident identifying information; failed to properly store a controlled substance to prevent potential drug diversion (Lorazepam). D

F801 – Qualified Dietary Staff

- Failed to provide CDM or full-time dietitian. Dietary manger took class but not test. E
- Dietary manager did not have CDM classes yet. C

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

- Failed to assure menus followed. Residents had orders for regular diet with small portions. Wrong scoops used to serve food; resident received wrong portions. D

F804 – Nutritive Value/Appearance/Palatability/Temp

- Failed to serve and maintain food temps for all entrees served during breakfast and failed to ensure room trays were delivered in a timely manner to ensure food served hot and palatable. Scrambled eggs served at 99 degrees, hot cereal at 130 degrees, toast at 89 degrees, juice at 54 degrees and mixed fruit at 59 degrees. E

F812 – Food Procurement, Storage, Preparation, Sanitization

- Dish machine running while rinse additive was empty, 5 sheet pans contained a moderate amount of carbon build up, window air conditioner had moderate amount of dirt and just build up, squeeze bottles in the cupboard had brown substance down the side of them, storage room floor had box of Little Debbie's on it, empty boxes on floor outside of dry storage, double sink contained damp and discolored cloth & skillet stored in clean area contained dried food debris. E
- Kitchen/storage areas had clutter and debris. Freezer had buildup of frost; another had a nonfunctioning fan. Steam table and carts had tacky substance on them, floor had buildup of grime, stove vents contained a buildup of dust, dirt and debris. E
- Outdated food items in refrigerator. E
- Multiple dietary individuals had hair exposed when serving noon meal. E
- Failed to wash hands when needed during meal preparation and service. Touched inside of robot coupe then continued to scrape food from robot coupe into graduate and served to residents. Staff did not wash hands during any part of this process. Staff dropped a pan on the floor, picked up pan with bare hands and placed in the sink, then went to get another pan without washing hands. Touched multiple items in kitchen while preparing food without washing hands. E
- Failed to ensure dietary staff utilized proper gloving/hand hygiene when serving ready to eat food items in order to reduce risk of foodborne illnesses. With gloves on, staff touched multiple kitchen surfaces during food prep of sandwiches without washing hands. E
- Facility failed to ensure foods were served in accordance with professional standards for food service safety. Several residents had complaints of undercooked meats on multiple occasions. One provided pictures taken on cell phone dated and time stamped that showed undercooked meat including pink hamburger, beefy red chicken liver and pink chicken. E
- Staff handled residents' food with bare hands when providing feeding assistance. D
- Failure to handle ready-to-eat food items in a safe manner. Staff touched a contaminated surface, then prepared food. D
- Dust buildup in vents of kitchen and grooves in cutting boards. E

F835 – Administration

- The administration and governing board failed to provide an operating budget, staff and services to provide for residents' needs. Facility was past due on multiple payments to vendor (including the mortgage payment). Several vendors refused to continue providing services until paid. Facility cited two different accounting software systems as the reasoning behind the late payments to vendors. E

F 842 – Resident Records - Identifiable Information

- Dressing not changed timely. D
- Multiple residents in merry walkers without proper restraint documentation. E

F 849 – Hospice Services

- Failed to document coordination of Hospice services; no Hospice notes or care plans available at the facility. D

F 868 – QAA Committee

- Failure to ensure the QA committee meets quarterly and consisted of required members. Medical Director was not present. D

F 880 – Infection Prevention and Control

- Laundry was not covered in hallway while being delivered. Dignity bag with catheter bag inside was laying on the floor. D
- Failure to wash hands after removing her gloves between tasks and failed to obtain a barrier between supplies and resident's bedside table. D
- Failure to wash hands or sanitize them prior, during and after cares. E
- Failure to complete hand hygiene after assisting resident to get dressed. D
- Lack of hand hygiene following personal cares, transportation of uncovered linens. Laundry staff delivered clean clothes with no cover on linen cart. Staff did not wash hands after removing gloves after peri-care prior to walking resident down hall. D
- Failed to ensure staff change gloves in accordance with infection control techniques. Didn't remove soiled gloves after removing soiled dressing, after removing the inner trach cannula and after cleansing the inner cannula during trach care. D
- Failed to implement appropriate infection control measures; no barrier between dressing supplies/surface of dresser, no hand washing between glove changes. D
- Staff failed to sanitize hands in-between changes of soiled gloves or sanitize the surfaces after contact with visibly soiled bed linens. D
- During peri-care staff member wiped stool over and around open coccyx wound. D
- Failure to wash hands prior to/after completing personal cares when administering medications for multiple residents with severe cognitive impairments .D
- Failure to complete adequate infection control measures, sanitize a glucometer. D
- Failed to deliver clothes while maintaining infection control and to maintain infection control with catheters. Laundry cart was not covered completely during transport of clean clothes. Staff took clothes from one room, slung over shoulder to another resident’s room to gather more clothes in which he/she slung over shoulder. Foley catheter tubing noted dragging on floor while resident in w/c outside and inside. D

- Infection control issues related to clean linen cart not covered in laundry or when transporting linen; Proper glove usage with dressing change. E
- Failure to wash hands before donning gloves/providing dressing change to wound. D
- Peri Care and cleansing of resident after incident of involuntary episode when being transferred with Hoyer. D

F883 – *Influenza and Pneumococcal Immunizations

- Failed to obtain records for a pneumococcal vaccine and offer or provide a Pneumovax vaccination. D

F909 – Resident Bed

- Failed to provide maintenance assessments for side rails; maintenance logs for side rail safety not being logged by maintenance. D
- Residents' bedrails had gaps exceeding measure of more than 4 3/4 inches. E

F919 – Resident Call System

- Failure to provide a functional electronic call system for residents to call caregivers to assist with needs. Residents weren't certain the call lights worked. Reported it typically takes 30 mins to answer call lights. Staff say call lights often malfunction. E

N101

- Failed to report major injury of multiple rib fractures. Physician had signed "not a major injury" report. Due to resident requiring hospitalization for observation. D **$500 FINE**
- Facility failed to follow their protocol and report a fall with fracture that required admission to the hospital and resulted in a resident's death. The facility reported it in an untimely manner. **D $500 FINE**

Nursing Facility Survey Frequency

As of July 24, 2019, CMS lists Iowa facilities (15.4%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 8.7%. National average is 6.4%.

FFY 19 - July Totals - LTC Surveys

Provider	City	Survey End Date	Previous Date	Months Between
ABCM Independence West	Independence	4/18/2019	1/3/2018	15.67
Accura Health Care of Knoxville	Knoxville	5/22/2019	3/1/2018	14.90
Bettendorf Health Care Center	Bettendorf	03/07/2019	11/28/2017	15.47
Brooklyn Community Estates	Brooklyn	4/10/2019	2/8/2018	14.20
Chautauqua Guest Homes #2	Charles City	4/3/2019	12/28/2017	15.37
Country View Manor	Sibley	5/2/2019	11/28/2017	17.33
Crestview Nursing	Webster City	5/22/2019	2/22/2018	15.13
Fleur Heights Center for Wellness and Rehab.	Des Moines	03/28/2019	12/19/2017	15.47
Good Samaritan Society - Algona	Algona	5/16/2019	1/30/2018	15.70
Grundy Care Center	Grundy Center	05/30/2019	3/1/2018	15.17

Heritage Specialty Care	Cedar Rapids	4/25/2019	1/30/2018	15.00
Karen Acres Care Center	Urbandale	4/10/2019	1/30/2018	14.50
Maple Crest Manor	Fayette	5/30/2019	2/22/2018	15.40
MercyOne Dyersville	Dyersville	5/21/2019	2/8/2018	15.57
Morning Sun Care Center	Morning Sun	5/30/2019	2/22/2018	15.40
Oakwood Care Center	Clear Lake	5/21/2019	2/15/2018	15.33
Prairie Ridge Care & Rehab	Mediapolis	5/22/2019	2/8/2018	15.60
Ramsey Village	Des Moines	3/16/2019	11/16/2017	16.17
Rose Vista Home	Woodbine	4/25/2019	12/28/2017	16.10
Southeast Iowa Behavioral Health	Keokuk	3/21/2019	11/16/2017	16.33
St Francis Manor	Grinnell	5/23/2019	2/22/2018	15.17
Trinity Center at Luther Park	Des Moines	5/16/2019	2/15/2018	15.17
Washington County Hospital	Washington	06/15/2019	3/29/2018	14.77
West Point Care Center	West Point	5/2/2019	1/18/2018	15.63
			AVERAGE	**15.44**