Compliance Tips from IHCA's Survey Results Committee

June 2016

The five most frequently cited tags from the 31 annual surveys (3 deficiency free), 31 complaints (4 unsubstantiated), 13 self-reports (2 unsubstantiated), 7 complaint/self-report (1 unsubstantiated) and 1 mandatory abuse report (0 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 198 total deficiencies.

The following is a breakdown of severity level:

A =	0%	D =	61.10%	G =	7.07%
B =	1.01%	E =	21.21%	H =	0.0%
C =	0.50%	F =	4.55%	I =	0%
				J =	2.02%
				K =	1.01%
				L=	1.02%

Total # of Reports: 60
Total # of surveys/reports deficiency free or unsubstantiated: 10
Avg. # of deficiencies

- All = 3.30
- Annual = 4.28
- Complaint/Self-Reports= 2.15

Total state fines for December Report = $67,500 ($47,500) held in suspension)

Top 5 Most Frequently Cited Tags for June 2016 Report

F 323—Free of Accident Hazards/Supervision/Devices

- Resident displayed exit-seeking behaviors eloped through unalarmed front door without staff knowledge, 9 residents at risk for elopement, resident had been very restless for days prior to elopement, found in parking lot after 5 minutes, no Wanderguard (K) **$3,500 fine**
- Door alarm didn't work and resident eloped, wind chill of 5 degrees, alarms were only checked monthly, resident with Wanderguard not working, facility failed to follow care plan interventions for falls, resident not to be in wheelchair while in

room, staff didn’t use gait belt, staff lowered resident to floor resulting in fracture (J) **$8,000 fine**

- Resident not using walker per care plan, laundry cart hit him/her, fell, and suffered fracture (G) **$6,000 fine**
- Staff posted humiliating photo of resident on Snapchat, staff “snapped” photo of resident with pants around ankles, covered in feces, soiled brief near lower calf area, resident wore long shirt covering torso down to upper thighs, shirt was soiled and resident’s left hand was between knees, calf was soiled, caption read “shit galore” staff admitted taking photo and was terminated (G) **$5,000 fine**
- Staff failed to have walker available nearby for resident who was cleaning their wall, resident fell and fractured pelvis and hip (G) **$3,500 fine in suspension**
- Resident sustained fractured clavicle during a 2-person transfer, without a gait belt, resident unable to stand and had to be lowered to floor during transfer (G) **$2,000 fine**
- Facility failed to protect resident from inappropriate sexual touching by another resident on multiple occasions, staff failed to follow care plan instructions to supervise resident and protect others from sexual abuse (G) **$2,000 fine**
- Facility failed to provide supervision against hazards and failed to develop care plan, resident fell with subdural hematoma, and died, resident lay in bed for 86 minutes before staff checked, didn’t check resident every 15 minutes per policy in CCDI unit, failure to provide new interventions after falls, failed to investigate and report resident incidents (G)
- Staff failed to secure wheel chair seatbelt in van (D)
- Resident transferred independently without assistance and fell, resident stated no gait belt so staff didn’t use (D)
- Staff failed to install alarms on resident at risk for fall as directed by care plan (D)
- Resident pushed in wheelchair with no foot pedals (D)
- Clinical record lacked documentation of resident to resident altercation where one resident threw a glass of water in the face of another resident, no interventions in place for resident who demonstrated aggressive behaviors towards others (D)
- Three unsecured oxygen bottles in storage closet (D)
- Resident operating scooter allowed other residents to hang on (D)
- Front door alarm not functioning when tested, resident pushed in wheelchair without foot pedals (D)
- Water temperature at 123 degrees (E)
- Hand rail had splinters and gouges (E)

F 371—Sanitary Conditions

- Black substance on ice machine surface (F)
- Lack of test strip testing for dishwasher (F)
- Improper glove use while doing food prep (F)
- Cutting board with deep cuts (unsanitizable), food items not properly sealed or dated when received and opened (F)
- Kitchen walls and ceilings dusty and dirty (F)

- Staff failed to properly use gloves when touching ready-to-eat foods, aide failed to wash hands when contaminated from going from one task to another (F)
- Staff failed to follow and document cleaning of equipment and surfaces (F)
- No open dates/labels on multiple bags of foods in refrigerator (E)
- Lids off flour/sugar bins, tongs placed on buns after togs were handled without gloves, poor glove use, freezer temperature too high (E)
- Facility failed to seal and date open food items in refrigerator, failed to replace worn equipment, deep grooves in 2 cutting boards, cheese in refrigerator not dated, or sealed, chicken breasts in freezer not labelled or dated (E)
- Gouged cutting boards used in kitchen (E)
- Open food containers in refrigerator not labelled, dated nor covered (E)
- Dirty items in kitchen (E)
- Fire suppression system extinguishers had dust and dirt hanging from them directly above stove burners, staff placed bowl of stewed tomatoes on resident's plate, bowl came in contact with mashed potatoes (E)
- Open food containers in refrigerator not labelled, dated nor covered (E)
- Dirty grimy kitchen fan blowing on clean dishes exiting dishwasher, cutting boards nicked and unsanitizable, no regular cleaning schedule, food temperature checks showed temperature dropped below safe level, surveyor tasted food and it was cold (E)

F 281—Professional Standards of Quality

- Facility failed to follow physician's order to start new medications, facility didn't apply leg wraps as ordered, facility gave medication on March 30 when was supposed to start April 6, wound vac not applied as ordered, nutritional supplements not given as ordered, Bactum given for 2 weeks after was supposed to be discontinued, resident with pressure ulcer didn't receive ensure plus as ordered (E)
- TED hose not in place per physician's orders, all contents of Arginaid drink not consumed by resident, routine dilation values not drawn for resident with low levels in history, all labs not completed as physician ordered, incorrect APAP order administered (E)
- Elbow protectors not in place, as physician ordered and care planned (D)
- Potassium chloride were crushed and administered through a "G" tube, manufacturer recommended medication not be crushed (D)
- Eye drops were not administered as ordered by physician, no physician orders in record for Namenda for several months, no order for Senna administration (D)
- Incorrectly transcribed order for Haldol (D)
- Sliding scale insulin not given as ordered (D)
- On return from hospital, oxygen not provided on night shift (D)
- Facility failed to appropriately train staff on IV flushes and topical medications (D)
- Multiple instances of medication administration conducted outside of time parameters (D).
- Nurse failed to apply pressure to lacrimal sac when administering eye drops (D)

- Physician's order was for knee high TED hose to be worn in the morning and off in the afternoon. Surveyor observed resident in wheelchair in the morning without TED hose (D)

F 441—Infection Prevention & Control

- Resident on contact precautions (MRSA), staff observed walking into room applying gloves and gathering linen in red bag, staff saw surveyor observing, then donned mask and gown, staff used Hoyer lift to transfer, then used saniwipes to disinfect which dried too quickly, staff applied gloves, performed catheter care, then removed gloves and performed other tasks without using hand sanitizer (E)
- Resident in contact isolation, no gloves nor gowns available per policy (E)
- Staff didn't replace soiled abdominal binder during incontinence care (D)
- Staff didn't fold cloth for pericare, moved in back and forth motion (D)
- Improper pericare, staff didn't have separate wipe, CNA wiped back and forth during care, and failed to wash hands after care (D)
- No barrier on floor when emptying catheter bag (D)
- Personal care items fell to floor and returned to storage without cleaning (D)
- Staff failed to cleanse skin prior to ointment application (D)
- Nurse placed eye drop container in pocket, and donned gloves without handwashing, and failed to wash hands when leaving resident's room (D)
- Gloves not changed between soiled and clean dressing (D)
- Improper glove use during pericare, staff failed to clean glucometer after use (D)
- Staff performed pericare then didn't change gloves before helping resident pull up pants, staff removed old dressing then didn't change gloves to apply new dressing (D)
- Staff failed to have resident wash hands after toileting (D)

F 312—Quality of Care Prevention of Decline

- Facility failed to provide baths for residents (E)
- Facility failed to offer 6 residents baths as requested and planned for (D)
- A resident (BIMS 12) had long, jagged toe nails (D)
- Staff didn't fold cloth for pericare, moved in back and forth motion (D)
- Staff failed to wash hands after pericare and before putting on resident's clothes (D)
- Staff failed to cleanse all areas touched by wet brief during pericare (D)
- Facility failed to provide thorough incontinent care, aide didn't use proper techniques nor clean all areas (D)
- Staff failed to remove gloves after pericare and before putting resident's clothes on (D)
- Incorrect cleaning of entire buttocks and groin (D)
- CNA didn't cleanse entire area covered by wet brief during pericare (D)
- Not all soiled areas of skin were cleaned during incontinence care (D)

F 279--Comprehensive Care Plan to Meet Needs

- Facility failed to care plan psychotropic needs and wound care treatment (E)
- Resident displayed signs of anxiety and repetitive anxious complaints, no interventions on care plans on how to intervene, resident #2 attempted to leave building and had delusions with no interventions on care plan (D)
- Resident had body alarm, not on care plan how to apply (D)
- Resident on Coumadin with no monitoring system in place (D)
- Resident's care plan didn't include assistance required for ambulation (D)
- Facility failed to develop care plans that included measurable objectives and timetables to meet resident's needs (D)
- No care plan interventions for use of sedative or hypnotic use (D)
- Incomplete care plans without evidence of interdisciplinary team involvement for 3 residents (D)
- Care plan not updated for interventions for potential side effects of new medication (Lexapro) (D)
- Pressure not applied to lacrimal sack when administering eye drops (D)
- Care plan didn't list guidelines for psychotropic medications, nor psychiatric services provided (D)

Other notable deficiencies and fines

F-155

- Facility failed to perform CPR for resident with advance directive for CPR (it was on IPOST form), staff found resident unresponsive failed to start CPR until 2:53, (20 minutes later) thus denying resident his/her right to self-determination, facility did not have a CPR policy (L) **$10,000 fine in suspension**

F-223

- Facility failed to prevent a resident from inappropriately touching/grabbing another resident (G)

F-225

- Report of suspected abuse on April 22 not reported to DIA until April 25 (D) **$500 fine**
- Resident complained of "rough" treatment by staff but facility didn't follow up, a large bruise was reported no investigation for cause or appropriate assessment existed (D) **$500 fine**

F-226

- Staff hired prior to completion of background check (D) **$500 fine**

F-328

- Staff had no current training on trachea care, no deep suctioning, resident died of respiratory failure (J) **$10,000 fine**

F-241

- Staff posted humiliating photo of resident on Snapchat, staff "snapped" photo of resident with pants around ankles, covered in feces, soiled brief near lower calf area, resident word long shirt covering torso down to upper thighs, shirt was soiled and resident's left hand was between knees, calf was soils, caption read "shit galore" staff admitted taking photo and was terminated (G) **$3,500 fine**
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- Resident reported it took 90 minutes for staff to respond to call light, when ostomy bag was full and leaking, resident reported staff didn't knock before entering room, another resident reported 90 minute call light response, resident left in bed all day with night clothing on, resident preferred to be dressed in day clothes (G) **$500 fine**
- Inappropriate staff interaction with a resident (G) **$500 fine**

F 309

- Resident on Coumadin and labs not done, had hematoma, admitted to hospital (G) **$2,000 fine**
- Facility failed to prevent pressure ulcer (G)

F 314

- Resident with high risk for pressure sores developed multiple open areas, no documentation that pressure relieving boots were utilized, open areas developed on catheter port (G) **$2,000 fine**
- Facility failed to assess resident and care plan to prevent development of pressure ulcer (G)

F 329

- Facility didn't report low INR to physician for 4 days, wrong dose of Coumadin 9low) given, resident had a fall with multiple bruises, and skin tears, INR was critically high at time of fall, and hospitalization requiring vitamin K administration, lab value at time of fall was missing, documentations of labs being missed related to INRs, 1 resident struck another resident, not reported to DIA (J) **$6,000 fine**.
- Resident on Coumadin, INR not done, resident hospitalized (J)

F 353

- Staff failed to answer call lights in a timely manner, inadequate staffing (D) **$500 fine**

N 104

- Facility failed to report elopement to DIA $500 fine.

L190

- Lack of employee physical exam and TB test prior to hire

L 1093

- Failed to check for Veteran's Administration eligibility upon admission
- No VA check for eligibility at admission

Annual Survey Frequency
June Survey Result Meeting

Facility	City	Last Year	This Year	Frequency
Altoona Nursing & Rehab Ctr.	Altoona	7/2/15	5/5/16	43 Weeks
Bethany Home	Dubuque	7/16/15	5/12/16	43 Weeks
*Calvin Community	Des Moines	???????	4/21/16	?????????
Clarence Nursing Home	Clarence	4/24/15	5/12/16	49 Weeks
Crystal Heights Care Center	Oskaloosa	7/16/15	5/12/16	43 Weeks
Elmwood Care Center	Onawa	6/15/15	4/28/16	45 Weeks
Eventide Lutheran Home	Denison	4/3/15	4/28/16	55 Weeks
Exira Care Center	Exira	4/30/15	5/24/16	55 Weeks
Good Samaritan	Forest City	5/28/15	4/14/16	45 Weeks
Grandview Heights	Marshalltown	6/19/15	4/14/16	43 Weeks
Hawkeye Care Center	Carroll	4/23/15	4/7/16	50 Weeks
Lake Park Care Center	Lake Park	6/25/15	5/5/16	45 Weeks
La Porte City Specialty Care	La Porte City	7/16/15	5/12/16	43 Weeks
Manly Specialty Care	Manly	7/30/15	5/12/16	41 Weeks
Manorcare	Cedar Rapids	7/8/15	4/21/16	40 Weeks
Mercy Health Services	Mason City	6/25/15	4/28/16	44 Weeks
*Mount Ayr Health Care Center	Mount Ayr	???????	5/19/16	?????????
Odebolt Specialty Care	Odebolt	5/7/15	4/21/16	50 Weeks
Oelwein Care Center	Oelwein	6/25/15	4/14/16	42 Weeks
Parkridge Specialty Care	Pleasant Hill	7/23/15	5/12/16	42 Weeks
Southridge Specialty Care	Marshalltown	7/16/15	5/5/16	42 Weeks
Sutherland Care Center	Sutherland	7/28/15	4/28/16	40 Weeks
The Cottages	Pella	7/2/15	5/25/16	47 Weeks
Titonka Care Center	Titonka	7/16/15	5/19/16	45 Weeks
Valley Vue	Armstrong	6/11/15	4/28/16	46 Weeks
West Bridge Care/Rehab	Winterset	5/14/15	4/21/16	49 Weeks
West Ridge Care Center	Cedar Rapids	6/18/15	5/5/16	46 Weeks
Westhaven Community	Boone	7/9/15	5/12/16	44 Weeks
Westmont Heallthcare Community	Logan	6/11/15	4/28/15	46 Weeks
Westview Acres	Leon	6/11/15	4/28/16	46 Weeks
Windmill Manor	Coralville	6/11/15	4/19/16	45 Weeks

Of the 29 Tabulated Annual Surveys Reviewed in June:

2 Annual Surveys were later than last year:

Eventide Lutheran Home	Denison	4/19315	4/28/16	55 Weeks.
Exira Care Center	Exira	4/30/15	5/24/16	55 Weeks

27 Annual Surveys were earlier than last year:

Earliest Surveys:

Manorcare	Cedar Rapids	7/8/15	4/21/16	40 Weeks

Sutherland Care Cdenter	Sutherland	7/28/15	4/28/15	40 Weeks

Average Survey Frequency: 45.31 Weeks (6.69 Weeks Early) in May- 46.6 Weeks, April - 48.5 weeks

*Unable to find previous survey on website