Compliance Tips from IHCA's Survey Results Committee

June 2017

The five most frequently cited tags from the 38 annual surveys (10 deficiency free), 34 complaints (19 unsubstantiated), 16 self-reports (6 unsubstantiated), 28 complaint/self-report (11 unsubstantiated) and 3 mandatory reports (0 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 144 total deficiencies.

The following is a breakdown of severity level:

A =	0.00%	D =	54.90%	G =	10.42%
B =	1.39%	E =	24.30%	H =	0.00%
C =	1.39%	F =	3.47%	I =	0.00%
				J =	3.47%
				K =	0.69%
				L=	0.00%

Total # of Reports: 92
Total # of surveys/reports deficiency free or unsubstantiated: 46
Avg. # of deficiencies

- All = 1.51
- Annual = 2.42
- Complaints = 0.93
- Self-reports = 1.00
- Complaint/Self-Reports= 1.86
- Mandatory = 3.33
- Special Focus = 0.0

Total state fines for May Report = $21,500 ($94,500 held in suspension)

Top Five Cited Tags for June 2017 Report

F 323—Free of Accident Hazards/Supervision/Devices

- Facility failed to provide adequate nursing supervision to prevent accidents when staff failed to utilize the EZ Way Smart Lift as recommended for two of four residents that utilized this lift equipment, with one resident suffering from a severe eye injury, resident tipped forward, causing metal "S" bar to flip up and strike resident's eye **$7,000** fine in suspension (K).
- Resident fell while two staff were working in another room for 10 minutes and did not hear alarm, after interview with staff, it was determined alarm audibility was an issue, staff failed to toilet resident as detailed by care plan, resident had history of attempting to self-ambulate to toilet when staff were late answering call light **$10,000 fine** in suspension (J).
- Resident 4 fell onto baseboard heater sustaining a large burn on right calf, Res #1 side rail down during cares with bed in high position. No fall. Side rail not functioning **$8,000 fine** in suspension (K-IJ to E)
- Failed to provide adequate supervision r/t unnoticed elopement **$5,000 fine** in suspension (J).
- Resident with cognitive impairment, unable to be educated regarding use of call light, fell and suffered an intracranial hemorrhage; 2nd resident, cognitively impaired with history of not using call light, fell and sustained a hip fracture **$5,000 fine** in suspension (G).
- Resident rolled out of bed, unwitnessed, suffered contusion to left elbow, was later being assisted to wheelchair when grasp on bar slipped and fell again, care plan called for gait belt use, which was not done **$15,000 fine** ($5,000 trebled) in suspension (G).
- Uneven concrete in the outdoor seating area (E).
- Oxygen storage closet door not locked and secured (E).
- Facility failed to provide interventions to prevent resident to resident altercations (E).
- Two med carts unlocked and unattended in dining room. Unlocked shower room with cleaners in it. Nurse turned her back to an unlocked med cart (D).
- Resident experienced a fall in his/her bathroom, was found with pants around ankles, care plan called for staff to take resident to bathroom immediately after meals, resident had history of syncope, staff helped toilet resident, resident's pants fell around ankles, staff grabbed pants to pull them up, resident fell, was injured (D).
- Failed to provide supervision to keep a wandering resident from entering other resident rooms for 7 of the 7 residents interviewed (D).
- Resident left unattended on lift on toilet (D).

F 157—Quality of Life; Notification of Changes to Family/Physician

- One resident pinched another but neither family or physician were notified, the same resident attempted to hit a resident with a book and family was not notified, a resident slept in the sunroom instead of his room due to a roommate being admitted and family stated that they were not informed of a roommate moving in

and would have requested that not to happen if they would have been informed (D).

- Resident with dementia required extensive assistance with dining and weighed 65 pounds, care plan showed resident had propensity for inadequate food intake, resident experienced significant weight loss, but DON failed to notify physician of weight (D).
- Facility did not notify family of resident fall in a timely manner (D).
- Failure to inform family, physician, resident climbed out of bed and fell to floor crawled to door to call for help, staff responded and returned resident to bed, no apparent injuries, but staff did not do an assessment, resident complained of hip pain next morning, injuries noticed during shower, resident should have been assessed and sent to ER (D).
- Failed to notify physician of change in condition for significant wt loss (D).
- Failed to report to physician/family a change in condition r/t wt. loss (D).
- Failed to notify the physician of an adverse change in condition r/t two episodes of coffee ground emesis, res had GI Bleed and acute stay (D).
- Resident stated wanted to kill self and physician not notified until next morning (D).
- Resident with hypnotic and not on care plan (D).

F 281—Services to Meet Professional Standards of Quality

- Resident not offered a rinse of water to mouth after inhaler use (E).
- Failed to date insulin when opened (D).
- Hospice said not to get Roxonal as ordered, family didn't want it (D).
- Failed to carry out lab orders on anticoagulant, failed follow-up on tube feeding orders (D).
- Resident observed resident being ambulated in gripper socks when Dr. ordered that shoes be worn when ambulating (D).
- B12 injection, ordered 1x daily, was documented on MAR twice and was administered 2 times daily instead; prn Haldol order that was to be OK'd by family before use given without family permission (D).
- Services did not meet professional standards: facility failed to document medications administration, failed to assess pain prior to use of narcotics or attempt at non-pharmacological interventions; staff failed to document pain level prior to giving Oxycodone to resident, resident stated they did not take the Oxycodone, but nurse stated she did and documented each administration (D).
- Failed to follow physician orders to obtain lab value (D).
- Resident admitted to facility on 4/5/2017 with orders to have PT and OT services. Therapy was not initiated until 4/25/2017 (D).

F 309—Highest Practicable Physical, Psychological, Mental Well-Being

- Staff did not assess resident after a fall, resident was later found to have three fractures, did not receive medical care for eight hours after fall, staff did not conduct neuro and ortho assessments for two residents after falls **$10,000 fine** in suspension (J).

- Treatment notification for a resident stroke; staff faxed notification to physician rather than called **$5,000 fine** (J).
- A resident with a right ankle fracture an obvious pain was not given pain meds as ordered to control that pain. Pain meds were not always available in the facility $**500 fine** in suspension (G).
- Care and services for the highest well-being; staff failed to perform ongoing assessment, interventions and physician notification on change of condition **$15,000 fine** (G).
- Care and services for highest practicable well-being, facility failed to complete skin assessment and documentation of skin opening (D).
- Laxatives were continued to be administered when a resident had loose stools - no assessment was completed when bowel conditions changes (D).
- Care and services for highest practicable well-being; staff failed to provide adequate assessment and provide appropriate interventions for resident's pain level (D).
- Timely wound size and appearance assessments not completed by nursing staff (D).

F 441—Infection Control

- Failed to track what organisms caused infections or track staff infections (F).
- Failed to implement infection control surveillance in an effort to prevent the development and transmission of disease and infection and failed to review the facility infection control policies and procedures on an annual basis (F).
- Nurse failed to change gloves throughout wound treatment of multiple areas with visible soiling to the gloves and CNA used same gloves throughout peri-care (E).
- Failed to properly sanitize a kitchen food preparation area (E).
- Failure to complete handwashing between glove changes (E).
- Resident had brownish discharge in brief, staff applied Triad cream, staff reached contaminated glove into pocket, obtained an alcohol prep, and then wiped the exposed end of the resident's catheter with contaminated gloved hand (D).
- Failed to provide appropriate infection control practices r/t catheter bag on the floor (D).
- Dressing change by DON and scissors not cleaned (D).

Other notable deficiencies and fines

F 148—Reporting Requirements

- Failed to notify to DIA within 24 hours of attempt to self-harm **$500 fine** in suspension (C).

F 156—Notification of Entitlement Benefits

- Facility failed to provide two of three liability notices in a timely manner, for change in status from skilled level of care to another level of care, notice lacked

documentation indicating whether or not the resident had requested an appeal (D).

F 164—Quality of Life: Privacy

- Resident not given privacy during care (D).

F 223—Quality of Life: Restraints and Abuse

- Staff failed to adequately assess resident for injury after fell out of bed, was neglect **$8,000 fine** in suspension (G)
- Resident to resident Abuse. A res. was witnessed fondling another resident's breast Another resident was witnessed masturbating in public areas and with room door open\, disturbing other residents **$6,000 fine** trebled in suspension (G).
- Female staff found in bed kissing male resident **$500 fine** (G).
- A resident presented with a large hematoma to the left side of forehead. Injury was of unknown origin, size of hematoma and resident condition could have been abuse. Possible abuse was not investigated (G).
- Res to res altercation, one res hit the other over a Bingo chair and fell and sustained hip fracture (G).
- Male resident touched perineal area of severely cognitively impaired female resident (G).

F224—Quality of Life: Freedom from Abuse, Neglect

- Facility admitted a resident into a room with another resident that had a history of aggressive behaviors and struck the newly admitted resident (D).

F 225—Quality of Life Freedom from Abuse; Reporting

- Resident had head bruise, although no traumatic events had been witnessed by staff; also bruises to right hip and knee, staff failed to report to DON as they thought the resident fell unobserved (D).
- A resident presented with a large hematoma to the left side of forehead. Injury was of unknown origin, size of hematoma and resident condition could have been abuse. Possible abuse was not investigated **$500 fine** in suspension (G).
- Drug diversion by nurse and not investigated timely (E).
- Facility failed to investigate and report to DIA resident to resident altercation (D).
- Facility did not investigate nor report a large bruise of unknown origin (D).

F 226-- Quality of Life Freedom from Abuse: Staff Training

- Facility failed to complete dependent adult abuse training for one employee within six months of hire (D).
- Failed to have 2 staff members complete the mandatory 2 hour dependent adult abuse training within 6 months of hire (D).
- One staff did not complete mandatory reporter training within six months of hire (B).

F 241--Dignity and Respect of Individuality

- Residents suffered mental anguish and physical pain during incontinent episodes while they awaiting staff response to call lights for toileting **$2,000 fine** (G).
- Staff disrespectful to residents "I already took you to the BR 100 times this shift". During group interview stated staff did not act real nice **$500 fine** (D).
- Facility failed to treat resident with dignity and respect, staff failed to knock on doors prior to entering residents' rooms (D).
- Failed to provide dignity and respect during med pass when resident spit out meds and was scooped up twice from res chin and then told res she would get crazier if she doesn't take the meds (D).
- Failed to answer call lights in a timely manner causing 1 resident to have an incontinent episode (D).
- Failed to answer call lights within 15 minutes (D).

F242—Quality of Life: Resident Dignity

- A resident presented with a large hematoma to the left side of forehead. Injury was of unknown origin, size of hematoma and resident condition could have been abuse. Possible abuse was not investigated **$500 fine** (G).

F 246—Quality of Life: Reasonable Accommodations

- Resident and family wanted window open a crack and staff removed window cranks (B).

F 253—Quality of Life: Housekeeping and Maintenance Services

- Hair, grime, and lime buildup in whirlpool (E).
- Dirty environment-dirty floors, toilets. etc. (E).

F 279—Resident Plans of Care

- Failed to care plan psychoactive meds and monitor for adverse effects (D)
- Resident not offered to sleep in bed as per care plan interventions (D).
- No dycem per care plan, care plan stated independent but staff did 2 person transfers and charting indicated that as well, admission risk assessment showed resident at risk but care plan did not identify fall potential or any interventions (E).
- Failed to list specific psych med and its potential side effects on the care plan (E).
- Comprehensive care plans: facility failed to include side effects of psychotropic medications on care plan, failed to address pain on care plan (E).
- Failed to care plan psychotropic meds and monitoring for adverse side effects and residents with antidepressant meds (E).

F 282—Services Provided per Each Resident's Plan of Care

- Alarm not on per care plan while left unattended in BR (D).
- Failed to follow the care plan; resident received skin tears to arm and leg and did not have geri-sleeves on as indicated on care plan (D).

F285—Screening for Mental Illness (PASSR)

- No plan for crisis intervention as recommended by the PASSR - Level 2 recommendations (D).
- Failed to implement PASRR Level 2 recommendations by not having resident see psychiatrist and family felt staff did not know how to properly handle his/her behaviors making them worse (D).
- PASRR approved for 60 days without level II and not completed when admitted stay more than 60 days (D).

F 311—Services for the Prevention of Decline

- Facility failed to provide planned restorative activities for three of 15 residents, resident required extensive eating assistance, was not provided (D).

F 312—Quality of Care; Activities of Daily Living

- Did not cleanse entire perineal area during cares (D).
- Resident not toileted for 2.5 hours (D).
- Adequate showers/baths not completed as required. Not all areas were cleansed during incontinence cares. Turning & repositioning not provided as per the care plan (E).
- Improper peri-care - not all perineal areas completely cleansed during care (E).
- Failed to wash BM from front peri-area and failed to give peri-care to a resident and sat him/her back onto a wet wheelchair seat (D).
- ADL care for dependent residents: facility failed to provide complete incontinent care, staff washed one side and not the other (D).
- Failed to provide complete peri care. Did not cleanse all areas (D).

F 314—Pressure Ulcers

- Failed to develop interventions to prevent the development of pressure ulcers for 1 of 4 residents **$2,500 fine** (G).
- Resident who developed pressure ulcer was care planned to have position change every 2 hours, during survey, resident was up in wheelchair without position change for much longer as observed by surveyors **$500 fine** (G).
- Failed to follow sanitary practices with treatment to a pressure ulcer. Staff cleansed BM with rectum and used same soiled towel to cleanse the PU (D).
- Did not cleanse entire perineal area during cares (D).
- Facility did not provide care plan interventions as written to promote healing of two residents with pressure ulcers (D).
- Tegaderm was displaced and nurse not notified (D).
- Treatment records did not include orders for wound treatment nor show records of treatment completed (D).

F 315—Infection Prevention/Catheter Care

- Cloth not folded and clean each wipe (D).

- Failed to provide catheter care that prevented infection, staff failed to regloved between emptying catheter and cleaning catheter tube (D).

F 317—Prevention of Decline: Range of Motion

- No reduction in range of motion unless unavoidable, failure of facility to provide restorative/functional maintenance program (E).

F 318—Services to Prevent Decline

- Resident with limited range of motion did not receive range of motion PT, resident did not receive range of motion exercises nor restorative therapy during the MDS look-back period (D).
- Facility failed to prevent decrease in range of motion, failed to provide planned restorative programs (D).
- Restorative not provided per Dr. order (D).

F 325—Nutrition and Hydration

- Failed to provide nutritional interventions for 4 res with wt. loss **$500 fine** in suspension (G)

F 326—Therapeutic Diets

- Residents not given supplement per order (D).

F 329--Freedom from Unnecessary Drugs

- Failed to do GDR attempts for residents and psych meds, nurses gave greater than max daily recommended dose of Acetaminophen on multiple occasions (D).
- Failed to initiate non-medication interventions prior to giving an antianxiety med (D).
- GDR not completed (D)

F 332—Medications Error Rate

- Two medications not administered prior to or after meal as ordered by physician (D).

F 333—Freedom from Medication Errors

- Resident received 10 times the ordered Lorazepam dose three times in one day due to a transcription error **$7,000 fine** in suspension (J).

F 353—Sufficient Nurse Staffing

- Failed to have sufficient staff to meet needs of residents and prevent a major injury of subdural hematoma from fall. Res got up and fell when couldn't get staff to help **$5,000 fine** in suspension (G)
- Group interview didn't get 2 baths per week (E).
- Insufficient 24 hour nurse staff per care plan, resident's alarm sounded but no available staff to assist, they were helping other residents (E).
- Facility did not answer call lights in a timely manner for 3 residents (D).

F 363—Menus and Nutritional Adequacy

- No bread/roll was served with the pureed meals. Fresh baked bread not served as per menu. Resident group meeting revealed residents would like fresh baked bread (E).

F 368—Frequency of Meals/Snacks

- Four Residents complained that no bedtime snacks offered routinely. Documentation showed they were not always offered snacks with no documented reason when not offered (E)
- Staff said they don't have HS snacks any more (E).

F 371—Food Preparation under Sanitary Conditions

- Failed to have backflow preventers on coffee makers and ice machines (F).
- Kitchen sanitation r/t lime build-up in ice-machine, dusty ceiling vents, inadequate handwashing by dietary staff (E).
- Failed to maintain clean and sanitary kitchen equipment including the 4 shelf stainless steel shelving unit had a green vinyl coating coming off exposing a brown like substance, the 4 sprinkler heads above the stove had a grayish substance hanging down, microwave had red, brown dried debris on the inside plastic cover and the stand-up mixer on a stainless steel counter top had black, dark brown substance around the edges of the base (E).
- Kitchen staff gloves touched other surfaces when serving (E).
- Sticky cabinets in kitchen (E).
- Water mugs refilled in unsanitary manner (E).
- Food for one resident not reheated to proper temp (C).

F 425—Unlicensed Personnel Administering Drugs

- A resident brought medication from home when admitted. Medications vanished from the facility and were found by police in the car of an employee. There was no policy concerning medications brought from home (no severity listed).

F 431—Storage of Drugs/Biologicals

- Failed to dispose of outdated mediations (F).
- Survey sample of seven resident medical records revealed a controlled medication as "dropped" by five different nurses, with no second initial indicating a nurse had a witness when the medication was discarded or destroyed, DON said there was no formal policy regarding controlled meds destruction (E).
- Multiple residents had missing norco medication (stolen?). Poor or no records of counts/check-ins maintained **$500 fine** (E).
- Medications were not always available in the facility for residents who required the medications. Medications were continuously borrowed from other residents. Medications were found in medication cups and were left unsecured and unsupervised (E).
- Drug records: labels, store drugs in a biological, failure to maintain individual narcotic count, records not in order to reconcile narcotics count **$500 fine** (D).

F 465—Safe, Sanitary and Comfortable Environment

- Ice machine had brown and white crusty substance in seams of the door (E).
- Chipped paint on walls, scratches on door & fuzz on a fan blowing toward clean dishes (F).

F 496—Nurse Aide Registry Verification

- Did not check NA Registry prior to hire (E).
  Nurse aide registry verification; facility failed to verify CAN nurse registry before hiring (D).

F 497—Regular In-Service Education

- Facility failed to perform annual performance review for one nurse aide (D)

F 499—Staff Qualifications

- Failed to verify professional licensure (D).

L1093 & 441-58.12(1)—Veterans Affairs Status Verification

- Failed to complete VA benefit verification on multiple residents.
- Failed to submit 3 res to VA.

481-50.7--Additional Reporting Requirements (Iowa)

- Failed to report a major injury to DIA as required **$500 fine**.

AHCA/NCAL *Long Term Care Trend Tracker*

CASPER Citation Report: Combined Health Survey

User:
Login ID: maryjane@iowahealthcare.org
Organization: IOWA HEALTH CARE ASSOCIATION/IOWA CENTER FOR ASSISTED LIVING
Run Date: Wed Jun 28 09:53:05 EDT 2017

Report Selection Criteria:
My Buildings: IOWA HEALTH CARE ASSOCIATION/IOWA CENTER FOR ASSISTED LIVING
Peers: Peers are in the entire nation; No Peer Type restriction; Centers from My Org are not included in peer group; Tags selected: Most Frequent F Tags (State).

		Current Survey	1st Prior Survey	2nd Prior Survey	
Survey Results					
Number of Centers		455 - Iowa	455	455	My Centers
		15,616 - U.S.	15,616	15,616	My Peers
Centers with Standard & Complaint Survey Citations		403	408	416	My Centers
		14,287	14,194	14,054	My Peers
Centers with Standard Survey Citations		379	388	401	My Centers
		14,028	13,871	13,721	My Peers
Centers with Complaint Citations		246	269	251	My Centers
		6,461	7,100	6,937	My Peers
Deficiency Free Providers	IOWA	11.4%	10.3%	8.6%	My Centers
	US	8.5%	9.1%	10.0%	My Peers
Average Number of Citations	IOWA	6.1	6.6	5.9	My Centers
	US	7.8	7.8	7.5	My Peers
Average Number of Standard Survey Citations	Iowa	3.6	3.7	3.8	My Centers
	US	6.0	5.8	5.6	My Peers
Average Number of Complaint Survey Citations	Iowa	2.5	2.8	2.1	My Centers
	US	1.8	2.0	1.9	My Peers
Immediate Jeopardy	IOWA	10.1%	7.9%	4.6%	My Centers
	US	5.6%	5.6%	5.0%	My Peers
Centers with Standard Survey IJ Citations		1.1%	0.2%	0.7%	My Centers
		2.8%	2.4%	2.1%	My Peers
Centers with Complaint Survey IJ Citations	IOWA	9.5%	7.9%	4.4%	My Centers
	US	3.6%	3.9%	3.4%	My Peers
Substandard Quality of Care		12.1%	7.0%	4.4%	My Centers
		6.7%	6.8%	6.3%	My Peers
Centers with Standard Survey SQC Citations		1.5%	0.2%	0.7%	My Centers
		3.6%	3.3%	3.0%	My Peers
Centers with Complaint Survey SQC Citations		11.2%	7.0%	4.2%	My Centers
		4.0%	4.5%	4.2%	My Peers
Deficiencies Greater than or Equal to "G"	IOWA	35.2%	29.5%	25.7%	My Centers
	US	17.8%	18.8%	18.7%	My Peers
Centers with Standard Survey G and Above Citations	IOWA	11.4%	7.5%	8.4%	My Centers
	US	10.0%	10.1%	9.8%	My Peers

Centers with Complaint Survey G and Above Citations	30.8%	26.8%	21.8%	My Centers
	11.2%	12.3%	12.1%	My Peers
Highest Scope and Severity	L	L	L	My Centers
	L	L	L	My Peers
Highest Scope and Severity: Standard Survey	L	J	J	My Centers
	L	L	L	My Peers
Highest Scope and Severity: Complaint Survey	L	L	L	My Centers
	L	L	L	My Peers
Survey Deficiency Score	44	44	44	My Centers
	60	60	60	My Peers
Specific Tags of Interest (% of Centers with citations)				
F225 No employment of persons found guilty of abuse, neglect, mistreating of residents	21.3%	31.1%	12.0%	My Centers
	16.8%	17.2%	17.9%	My Peers
F226 Development and implementation of policies and procedures for prevention of mistreatment, neglect, abuse and misappropriation of property	16.4%	17.6%	9.6%	My Centers
	16.5%	17.1%	16.8%	My Peers
F241 Quality of life: Dignity	10.9%	14.7%	13.5%	My Centers
	19.5%	19.9%	19.9%	My Peers
F279 Comprehensive care plans with measurable objectives and timetables	27.3%	23.3%	7.7%	My Centers
	24.1%	25.2%	24.7%	My Peers
F281 Services must meet professional standards of quality	35.0%	35.3%	34.6%	My Centers
	16.2%	16.3%	16.9%	My Peers
F309 Necessary care and services	20.1%	25.2%	24.0%	My Centers
	33.3%	35.3%	34.6%	My Peers
F312 Resident receives services: Nutrition, grooming, personal/oral hygiene	32.3%	31.9%	32.7%	My Centers
	14.5%	14.8%	13.5%	My Peers
F314 Pressure sores	12.4%	11.0%	12.5%	My Centers
	17.4%	18.1%	17.6%	My Peers
F323 Accidents	51.1%	51.2%	55.3%	My Centers
	38.5%	39.6%	40.2%	My Peers
F329 Unnecessary Medications; Each resident's drug regimen must be free from unnecessary drugs.	14.4%	21.1%	30.0%	My Centers
	24.0%	25.7%	25.6%	My Peers
F353 Sufficient staffing	14.4%	15.7%	11.8%	My Centers
	4.7%	4.7%	4.2%	My Peers
F363 Menus and nutritional adequacy	12.4%	13.0%	19.7%	My Centers
	4.0%	4.4%	4.2%	My Peers
F371 Sanitary conditions: Store, prepare, and serve food under sanitary conditions	33.5%	39.5%	39.9%	My Centers
	42.6%	40.6%	39.9%	My Peers
F441 Infection Control	28.5%	34.1%	33.7%	My Centers

	44.8%	45.0%	43.8%	My Peers
F465 Physical environment must be adequately furnished with sufficient space	8.7%	8.6%	12.3%	My Centers
	14.1%	13.3%	12.8%	My Peers

Report Source: *CMS 2567 Statement of Deficiencies. CASPER data. -- Jun 2017*