Compliance Tips from IHCA's Survey Results Committee
June 2019

Total Number of Survey Reports: 100

Survey Composition:

Annual:	**66** Surveys	**30** Deficiency Free
Complaints:	**54** Surveys	**30** Unsubstantiated
Self-Reports:	**17** Surveys	**11** Unsubstantiated
Mandatory Reports:	**7** Surveys	**5** Unsubstantiated

State Fines:	**$14,250**
State Fines in suspension:	**$26,250**

Most Commonly Cited Iowa Tags:

F 656 – Develop/Implement Plan of Care (15)

F 812 – Food Procurement, Storage, Preparation, Sanitization (14)

F 880 – Infection Prevention and Control (14)

F 644 – Coordination of PASARR and Assessments (13)

F 689 – Free from Accidents and Hazards (13)

F 623 – Notice Requirements Before Transfer/Discharge (11)

F 625 – Notice of Bed Hold Policy Before/Upon Transfer (10)

F 657 – Care Plan Timing & Revision (10)

F 658 – Services Provided Meet Professional Standards (9)

Tags Resulting in Actual Harm or Higher Citations and Fines:

F 686 – Treatment to Prevent Pressure Ulcers	**1 G Level Tags**

F 689 – Free from Accidents and Hazards **5 G Level Tags**

F 697 – *Pain Management **1 G Level Tag**

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=15567	Total Number of Surveys=24792
F0880	Infection Prevention & Control	2,237	13.6%	9.0%
F0689	Free of Accident Hazards/Supervision/Devices	2,024	11.3%	8.2%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	1,841	11.4%	7.4%
F0656	Develop/Implement Comprehensive Care Plan	1,666	10.0%	6.7%
F0684	Quality of Care	1,467	8.4%	5.9%
F0761	Label/Store Drugs and Biologicals	1,296	8.0%	5.2%
F0657	Care Plan Timing and Revision	1,052	6.4%	4.2%
F0758	Free from Unnec Psychotropic Meds/PRN Use	990	6.1%	4.0%
F0677	ADL Care Provided for Dependent Residents	932	5.3%	3.8%
F0609	Reporting of Alleged Violations	892	5.0%	3.6%

*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

- CNA reprimanded resident who suffers from frequent incontinence after she requested transfer to bed for frequently turning on call light. D
- During am cares staff put a resident's top on, applied socks, and put pants on and pulled them up to midthigh. Resident had an incontinent pad with snap pants on to keep it in place. Staff left the room and left the door wide open to retrieve the sit to stand lift. Resident attempted to pull the pants up higher while staff remained out of the room, staff returned shut the door and placed the sit to stand lift. D
- Resident stated staff member told him/her to go sit down and that he was always complaining. D

F553 – Right to Participate in Planning Care

- Care conference not held for one resident. Family had canceled twice and MDS. D

F554 – Resident Self-Administers Meds-Clinically Appropriate

- Facility failed to assess resident's ability to self-administer medications and inhalers and address this on care plan prior to allowing resident to do so. D

F561 – *Self-Determination

- During group interview a cognitively intact resident stated that the night shift staff frequently partially dress her on non-bath days when they provide cares at 3:00 am, and she doesn't like it, but has not told the staff. D

- Review of cognitively impaired residents found staff awoke them for medication administration prior to 6 am. Care plan did not address residents' preferences regarding staff awakening to take routine medications between the hours of 10 pm and 6 am. Family did not want staff waking up mother to take routine medications prior to 6 am. E

F567 – Protection/Management of Personal Funds

- Failed to assure residents had access to personal funds on weekends. Residents reported they can only get their money when Business Office Manager is there. No policy in place to address accessing money from personal accounts on weekend. B

F568 – Accounting and Records of Personal Funds

- Failed to provide financial records to residents or resident representatives on a quarterly basis; resident fund statements provided upon request but not quarterly. B

F576 – Right to Forms of Communication with Privacy

- Residents did not receive mail on weekends. C
- Facility did not deliver resident mail on Saturday. B

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

- CPR status documented in records did not match resident's expressed wishes for multiple residents. E
- Failure to have accurate advanced directives on the residents' medical records. D
- Discrepancy with code status: Record of resident's care plan indicated the resident requested to be a CPR code status. Electronic health record showed the resident was as a DNR on his face sheet. Record review of the hard chart showed an IPOST indicating the resident chose CPR with full treatment on file. D
- Failed to document code status in a standard location. Staff reported multiple places of the code status location (head of bed, list at nurses' station, spine of chart. One staff reported not being able to locate code status and no code status in the room. D

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

- Facility failed to consult with resident physician following an accident, event or change of condition which may have potential for requiring physician intervention and failed to notify family. Resident had choking episode and required Heimlich maneuver by staff. Physician and family were not notified at time of incident. No follow-up lung assessment completed after incident. Another resident was noted to have STII ulcers on buttocks. Staff documented the assessment, did notify physician (instead fax was written and placed in physician folder for next visit which was two days later). No treatment was initiated until day after physician visit. Another resident with abnormal labs, delay in PCP notification, resident was then admitted to hospital. No family notification of lab results until after admitted to hospital. Another resident with heel blister, chart lacked documentation of blister wound assessment, lacked physician and family notification. No new care plan interventions were added. E

- Failure to report a resident's medication changes to family or responsible party for multiple residents. E

F582 – Medicaid/Medicare Coverage/Liability Notice

- Failure to provide residents required form for Medicare Liability Notices/Beneficiary Appeals when skilled services was exhausted, or services no longer covered. B

F583 – Personal Privacy/Confidentiality of Records

- Failed to maintain privacy during transport to the whirlpool room. Drape covering resident did not extend down far enough, buttocks exposed during transport in hallway. D
- Staff prepared resident for transfer to shower chair, staff removed resident's incontinent pad, and left room to get a pan for under the shower chair, the resident perineal area remained expose while she was out of the room. Staff returned with pan and had to leave again to retrieve lift. Staff then covered the resident, transferred resident via total mechanical lift, the resident's breasts were exposed during transfer and not covered until after in the shower chair. Another resident was observed in bed with no pants, blankets nearby but resident had removed per self and had oxygen tubing in hand, resident was sitting on commode unclothed except for slipper socks, resident had no clothes on from five minutes. D

F584 – Safe/Clean/Comfortable/Homelike Environment

- Facility didn't thoroughly investigate resident complaints of missing leather jacket. D
- No record of missing item in chart. Resident's family had been told the facility would reimburse amount of missing item, but family had not given facility the amount yet. D
- Resident's son stated concern with cleanliness of resident's room. Observation revealed a clock on the wall with a thick layer of dust on clock surface and in corner between wall/dresser, noted a large lint/dirt ball of material hanging from the wall. D
- Failed to ensure safe, clean, comfortable and homelike environment - one resident's wheelchair neck cushion was torn and had holes in it. D
- Food/tissues on resident floor, wheelchair worn and cracked and soiled with food. D

F585 – Grievances

- Failed to ensure residents receive required information regarding their right to file a grievance and ensure the grievance policy included the required information. Multiple residents at group meeting didn't know the name of grievance officer and policy failed to identify resident has right to file a grievance anonymously, the contact information of the grievance official and their right to obtain a written decision.

F606- *Not Employ/Engage Staff with Adverse Actions

- Staff had a criminal history record and the facility's file didn't have a DHS letter of approval to work in the facility. D

F607 – *Develop/Implement Abuse/Neglect, etc. Policies

- Facility failed to conduct a SING check prior to hire date for an employee. D

- Facility staff exceeded the 6 months allowed to complete mandatory dependent adult abuse training. D

F609- Reporting of Alleged Violations

- Facility did not report allegation of theft of resident's cell phone within 24 hours of the allegation. D
- Resident thought her lorazepam was being tampered with, ended up it was loratadine. Several residents had cassettes that had been tampered with that the lorazepam was replaced with loratadine. E
- Resident phone came up missing and staff reported to supervisor, but facility did not do anything about it because administrator said they are not responsible for such valuables and resident had been told about such things. D
- Resident claimed abuse but admin did not report it because it was in the sling. D
- Facility failed to report a missing liquid anti-anxiety medication to DIA for a resident. Possible drug diversion suspected of a staff member. Staff member acting suspiciously, and DON didn't report in a timely manner. D
- Failed to report/investigate an incident involving neglect with injury. Staff transferred resident without gait belt, resident fell into bed. Complained of ankle pain. No incident report of event/investigation/discussion with staff or discipline was given. D

F610 – Investigate, Prevent, Correct Alleged Violation

- Failure to investigate a missing item thoroughly. D
- Facility did not thoroughly investigate the report of abuse. D
- Failed to investigate, separate and report incident involving neglect with injury. Staff transferred resident without gait belt, resident fell and injured ankle. No incident report, investigation was completed. D

F622 – Transfer and Discharge Requirements

- Proper documentation not sent on transfer to hospital. D
- Failure to provide discharge and medical information to the hospital for a resident sent to the hospital. D

F623 – Notice Requirements Before Transfer/Discharge

- Failed to send a notice of discharge to the Ombudsman. Resident was discharged to the hospital; facility had no record of notice being sent to Ombudsman. B
- Bed hold policy not reviewed with two residents prior to hospitalization. D
- Failure to notify ombudsman of resident transfer to hospital. D
- Failure to notify the Ombudsman of a resident's transfer to the hospital. The Social Services Director said he/she notifies the Ombudsman of discharges monthly as he/she obtains the information from nurses. B
- Failed to send a copy of a Notice to Transfer to Office of the State Long Term Care Ombudsman, clinical records lacked documentation of ombudsman notification of hospitalization. D
- Failed to send a copy of Notice to Transfer to the state Ombudsman for residents. D
- Failed to send a copy of Notice to Transfer to state Ombudsman for residents. D

- Ombudsman not notified of transfer to hospital. D
- Failure to notify LTC Ombudsman of resident transfers for multiple residents for hospitalizations. D
- Failed to notify Ombudsman at time of transfer from facility. One resident transferred to the hospital and then expired, another transferred to another LTC facility. Facility was only sending permanent discharges to the State Ombudsman. C
- Facility failed to notify the Ombudsman's office of discharge to hospital. Resident was admitted to hospital twice, with no notice to State Ombudsman's office. C

F625 – Notice of Bed Hold Policy Before/Upon Transfer

- Notice of resident transfer not provided to LTCO. D
- No signed bed hold documentation for several residents after transfer to hospital. D
- Facility failed to notify resident and/or resident's representative of the facility policy for bed hold prior to transfer to the hospital. D
- Failed to notify a resident and/or the resident representative of facility policy for bed hold prior to transfer to the hospital for several residents. D
- Failed to provide multiple residents sampled with bed hold information upon transfer out of the facility. C
- Failed to notify a resident and/or the resident representative of the bed hold option for multiple residents reviewed. D
- No documentation of a bed hold policy for a resident transferred to hospital given to resident or POA. Admin stated they hadn't been doing them for quite some time. E
- Fail to provide bed-hold policy prior to/upon transfer to hospital or another facility. C
- Failure to provide a written bed hold notice policy to residents transferring to the hospital and documenting in nursing record this notice. B
- Facility failed to notify family of the bed hold policy. Resident admitted twice to hospital, without notifying family of bed hold policy. D

F636 – Comprehensive Assessments & Timing

- Facility failed to update multiple residents' care plans when changes occurred. Changes in medications, dietary needs. D

F640 – Encoding/Transmitting Resident Assessment

- Facility failed to transmit MDS data within 14 days after completion. D
- Failed to electronically transmit a completed MDS to the CMS system within 14 days after the facility completed the MDS for resident. D
- Failure to transmit a resident's MDS assessment within the required timeframe of 14 days after completing the assessment. D

F641 – Accuracy of Assessments

- Failure to complete an admission and annual assessment accurately using the RAI for multiple residents. PASRR level not documented for residents. D
- Failure to assess resident's status. Medicare Coordinator incorrectly coded in MDS that a resident with upper and lower extremities impairments did not have them, though the resident did. D

F642 – Coordination/Certification of Assessment

- Failed to complete an accurate MDS for 2 of 14 residents that used anti-coagulants; Plavix coded on MDS as an anticoagulant. D

F644 – Coordination of PASARR and Assessments

- Fail to ensure resident had PASRR required psychiatric evals on regular basis. D
- Facility failed to report all psychiatric diagnoses on Level I screen for one resident. D
- Facility did not refer a resident with a negative Level I screening who was exhibiting obvious signs of mental illness for a Level II evaluation. B
- PASRR was expired and new one had not been done. D
- Facility failed to submit a status change level 1 preadmission screening and resident review when the previous level 1 expired, failed to assure recommended PASRR specialized rehabilitation services were provided, and failed to identify possible serious mental disorder and refer the resident to appropriate state designated authority for PASRR level 2 evaluation and determination. Resident was approved for 60 days, submit status change level 1 several days prior to date; resident clinical record lacked any additional PASRR screening. Resident's specialized services included ongoing psychiatric services; resident's record and care plan lacked any documentation psychiatric services had been implemented. Resident's record lacked documentation to show new PASRR submitted for evaluation that included the dx. of psychosis and use of antipsychotic medication. Resident on a 30-day exemption- clinical record lacked documentation the facility had completed a new status change level 1 PASRR prior to the expiration of the initial PASRR. E
- Failed to reassess resident for PASRR - lacked diagnosis of psychotic disorder on PASRR screen but was listed on Diagnosis/History sheet. B
- Failed to complete a referral for level II PASRR screen after new diagnosis of psychotic disorder received. D
- Failed to refer residents with negative level I results for PASRR who were later identified with newly evident or possible serious Mental Disorder, ID or other related condition. D
- Resident had new psychiatric disorder and new PASRR was not done. D
- New PASRR not completed when new psychiatric diagnosis given with new medications. D
- Diagnosis change to major depressive disorder and new PASRR not done for residents. New psychotic disorder given and new PASRR not done. D
- Failure to refer a resident who had significant change in mental health status and received treatment, for a re-evaluation of a PASRR. D
- Failure to update PASRR recommendations into residents' plan of care for multiple residents. PASRR recommended resident met criteria for mental health diagnosis, but POC lacked documentation for specialized services. D

F645 – PASARR Screening for MD & ID

- Failed to resubmit a PASRR for evaluation/determination. Failed to resubmit a Status Level I change for a resident after the short-term approval 6-month time frame expired from the original PASRR. D
- Fail to ensure each resident is screened for MI, MD, ID, prior to admission and that individuals identified with MD and ID are evaluated and receive care/services in the most integrated setting appropriate to their needs. Fail to complete status change level 1 PASRR for resident prior to expiration of 30 day exempt initial PASRR. D
- PASRR was expired and new one had not been done. D

F655 – Baseline Care Plan

- Resident/resident representatives did not receive summary of baseline care plan. E
- Failure to implement baseline care plan within 48 hours. D
- The baseline care plan lacked documentation that the resident received a copy. D

F656 – Develop/Implement Plan of Care

- Failure to follow plan of care for multiple residents. D
- Diagnosis of depression/anxiety and anti-depressant, anti-anxiety agent used to treat these diagnoses and medication potential side effects were not listed on resident's care plan. D
- Staff did not implement interventions in a comprehensive care plan. D
- Failure to include psychotropic medications and adverse effects in multiple residents' comprehensive care plans. D
- Care plan did not address use of Coumadin and interventions related to use; Plan lacked interventions of monitoring for potential adverse effects of antidepressant. Care plan interventions included to provide heel protectors in bed and recliner, a ROHO cushion to recliner and wheelchair, shoes worn with all transfers. Resident in bed staff pulled covers back to reveal bare feet. Staff used sit to stand and resident was wearing socks during transfer, wheelchair had waffle cushion in it not ROHO, and no heel protectors, place in recliner without heel protectors and not cushion. D
- Failed to personalize the care plan of resident; lacked interventions for monitoring behaviors while using anti-psychotic medication. D
- Failed to develop/implement comprehensive, person-centered care plan focusing on residents receiving Hospice and Dialysis without interventions on the care plan. D
- Failure to develop comprehensive care plan for resident on blood thinner. D
- Care plan not updated to include skin issue. D
- Failure to implement a comprehensive care plan - did not list had denture or glasses, incontinent and lack of interventions for edema. D
- Failure to develop comprehensive, individualized care-planning for resident with diabetes and insulin use, resident with heart failure and diuretic use, and resident with pressure ulcers and high risk for skin impairment. D
- Failure to implement care plan interventions to address signs/symptoms related to Diabetic Mellitus. D
- Failure to update resident's care plan related to edema. Should have had furosemide on the care plan. D
- Resident's care plan didn't address antipsychotic medication and adverse effects. D

- Failure to document assessments of pressure ulcer weekly and to implement interventions for residents with pressure ulcers including floating heels, repositioning, and use of positioning devices. **$6,750 IN SUSPENSION**

F657 – Care Plan Timing & Revision

- Failed to provide documentation of quarterly care plan meetings for residents and documentation of resident/family participation in care plan meetings for residents. E
- Use of anticoagulant, potential side effects and signs and symptoms to assess not listed on care plan for residents. E
- Failure to complete a care conference. D
- Care plan lacked documentation of the following interventions for falls: check oxygen tubing, the nonslip strips on resident's floor, rules sign located on resident's closet. D
- Failure to revise care plans. Didn't include use of side rails, half rails, no signed consents for either, no update in care plan for change from sensi socks to TED hose. MDS did not match care plan. E
- Failure to review and revise residents' care plans for use of anticoagulant medication, resident-centered interventions for fall prevention, resident-centered interventions to address repeated unassisted transfers or standing. D
- Failure to conduct resident care conferences on a quarterly basis for residents. E
- Resident care plan was not updated to reflect a new order of mechanical soft diet. D
- Care plan did not include presence of pressure sore or interventions. D
- Failed to measure participation of residents/residents' representatives at the care conferences. D

F658 – Services Provided Meet Professional Standards

- Failure to ensure timely administration of prescribed medication and obtain physician's orders upon admission for multiple residents. Review indicated residents didn't have signed admission orders in their clinical records. D
- Failed to follow physician's orders; No INR as ordered and continued to give same dose of Coumadin; facility policy directed not to give next dose of Coumadin until order clarified after INR results reviewed, Coumadin order is clarified by physician. D
- Medication ordered on but not given for several days after on two occasions. D
- Staff left medications unattended with resident, CNA noticed and gave resident the pills even though she did not prepare them. Fentanyl patch not removed as ordered but was signed off as done. D
- Failure to follow physician's orders for resident. Staff failed to administer a resident's morning dose of Levemir insulin. D
- Failure to administer medications using professional standards of practice. Staff put medication in a medication cup and placed it in medication chart to use- not appropriate practice. D
- Fail to follow physician's orders. Didn't change resident's dressings twice daily. D
- Facility failed to meet professional standards of care when didn't follow physician orders. Lack of applying ordered treatment to ulcer for two days, also holes in TAR related to treatment not provided as ordered. Lack of weekly skin assessments of

wound. Staff reported it is not unusual to come across dressings that have not been changed as ordered. Weekly labs not being completed as ordered. D

- Facility failed to follow professional standards with a resident with a gastrostomy tube. Multiple medications were crushed and administered together. Chart lacked order from physician to crush and combine oral medications. Nurse instilled air bubble into tube and listened for bubble. Nurse did not check for residual prior to administering medication to ensure correct placement of tube. D

F661 – Discharge Summary
- Failure to complete a recapitulation of one resident's stay. D

F676 – *Activities of Daily Living (ADLs)/ Maintain Abilities
- Resident with multiple functional deficits received therapy, referred for restorative nursing program. Yet no documentation that a restorative program was initiated. D
- Resident not given treatment to keep ADL's intact. No restorative program. D

F677 – ADL Care Provided for Dependent Residents
- Failed to provide care/services to maintain resident's optimal health and well-being for residents unable to carry out activity independently. Baths not completed as scheduled. Resident in bed most of day without staff entering to provide incontinence care. Resident reported not checked/changed. Staff reported they had checked on resident but had not checked if was incontinent. Other staff reported they had provided incontinence cares in the AM but not oral or grooming cares. Surveyors asked staff person if he/she had provided perineal care on resident, staff reported yes. When surveyor went to check garbage can with staff, wet briefs were found but no wipes. Staff then reported they had not given her peri-care. D
- Failed to ensure that residents received baths twice a week due to staff shortages. E
- Failure to reposition a resident in a timely manner. Resident waited approx. 3.5 hrs. for repositioning. D
- According to care plan staff were to reposition resident frequently, from 7:09am-10:48am resident was not repositioned, according to the resident positioning policy the policy directed staff to turn residents at least every 2 hours. D

F678 – *Cardio-Pulmonary Resuscitation (CPR)
- Facility did not have CPR certified staff on duty 24 hours per day despite the fact that multiple residents were identified as full code status. E
- Facility failed to have an employee to provide basic life support on each shift. E

F684 – Quality of Care
- Facility failed to meet professional standards involving medication administration and assessment of wounds, fall events or changes in condition which warrant assessment and intervention. Second tag related to the above incidents with choking episodes, fall with injury, pressure ulcers, abnormal labs, lack of providing treatments as ordered and weekly skin assessments not being completed. Medications noted being passed two hours after time due to be given on multiple occasions. Staff report "late meds are a

pervasive problem and staff are not following med error policy". Staff reported that he/she notified two nurses of resident who was having trouble breathing- "she's not doing good", nurse went to room a little later, and hung an antibiotic and opened the window, did not check vitals, short time later, resident noted in distress, CPR initiated and resident passed. E

- Resident not getting to specialty appointments necessary due to staff being too busy or unavailable. D
- Interventions for skin not in care plan. D
- Eight blood glucose checks not done, six omissions in the sliding scale, one unit of sliding scale insulin administered when not ordered. D
- Failure to follow a resident's care plan regarding use of EZ stand and block under the left foot to promote non-weight bearing on the right leg. D
- Resident care plans not followed or updated according to regulations and with significant changes. D

F686 – Treatment to Prevent Pressure Ulcers

- Resident with heel pressure was to float heels while in bed. One foot on pillows not floating and the other laying directly on bed. D
- Failure to assess pressure ulcers per protocol and implement interventions to promote healing. Resident's pressure ulcer wasn't documented for several weeks and did not receive treatment. D
- Failed to provide necessary treatment and services consistent with professional standards of practice to promote healing and prevent new ulcers from developing. Lack of nurse follow up from staff reporting blisters and ulcers. Staff implemented boots for heels but was not added to care plan. Lack of physician notification of skin issues. Recent resigned nurse reported she left because nurses were not properly taking care of issues professionally, ignored wound care and neglected residents. Lack of wound assessments, physician and family notifications and lacked care plan (pocket care plan) interventions. **G $5,750 FINE IN SUSPENSION**

F 688 – Increase/Prevent Decrease in ROM/Mobility

- Resident who desired restorative nursing program was not receiving services after return from hospitalization and subsequent admission to hospice services. D
- Resident with bilateral upper and lower body mobility deficits was not provided a restorative nursing program to prevent further loss of function. D

F 689 – Free from Accidents and Hazards

- Medication cart was left unlocked/unattended two times during survey in resident care area which housed residents with cognitive impairment but were ambulatory. E
- Care plan called for personal alarm use at all times. Staff failed to move personal alarm to recliner from wheelchair after transfer. Resident fell and sustained hip fracture. **G $4,250 FINE**
- Failed to safely transfer resident who required transfer with mechanical lift. Resident required assistance of two staff for transfer. Resident fell- was not injured. D
- Kitchenette cabinet door under sink unlocked and chemicals present. E

- Resident who smokes left unsupervised while doing so since admission, though MDS states supervision needed. Resident wasn't using smoking apron. CNA pushing resident in wheelchair with foot pedals, but resident's feet not on pedals. D
- Staff attempted to turn resident in bed without assist and the resident sustained a fracture of the right humerus. **G $500 FINE**
- Failure to maintain a safe environment by placing wet floor signs in residents' rooms after mopping. Residents with fall risks had wet floors and no signs. D
- Resident at high risk for falls/multiple falls fell (alarm was not on) complained of knee pain, staff said that was normal. Resident went to ER next day with fractured femur. Surgeon had trouble repairing, resident came back on hospice, passed away a week later. Another resident was to be transferred using Hoyer, when two staff went to move resident from wheelchair there was no sling under resident which brought into question how resident was transferred into chair. **G $6,250 FINE**
- Staff should have placed enough of the Hoyer sling under resident's buttocks to put the resident into a sitting position; the sling was positioned at the lower back and not under buttocks; improper placement of sling forced the resident's chin down and knees to chest, buttocks hung out from the bottom of sling, resident displayed facial grimacing; staff adjusted the bed three times while the resident hung in the sling. Reviewed operator's instruction manual how to set the sling properly. D
- Failed to provide adequate supervision/assistance devices to mitigate a resident's risk for falls and injury. Multiple falls with injury and without care plan updates. Facility staff said they don't fill out incident reports or communicate well to get needed interventions, that administration was not doing investigations for falls. D
- Staff independently transferred a resident care-planned for a 2-person assist. During transfer the resident suffered a large skin tear which required 15 stitches to repair. The wound became infected and required debridement by a wound care nurse.
- Failed to ensure resident safety. PTA turned away from resident to obtain a chair when the resident became tired; resident fell while staff obtaining the chair, sustaining a fracture. **G $3,250 FINE**
- Failure to provide supervision and interventions for accident prevention for residents with repeated unassisted transfers or ambulation and to safely store potentially hazardous items including a box of lancets kept within reach of residents at the nurse's station. **G $10,000 FINE IN SUSPENSION**

F 690 – Bowel, Bladder Incontinence, Catheter Care

- Improper glove use and handwashing during peri-care. D
- Catheter tubing resting on the floor and resident was pushed in wheelchair and moved throughout the building while dragging the tubing on the floor. D
- Staff wiped the form groins and genital area with a disposable wipe multiple times, including over the urinary meatus area without turning the cloth, they rolled the resident and cleaned the rectal area with disposable wipes, the resident had a bowel movement and staff used a new cloth with each wipe, staff changed gloves with no hand hygiene, then placed a new pad and pulled resident pants up. D
- Failed to provide complete peri care; not changing the surface of the washcloth with each wipe, no hand hygiene between glove changes after cleaning BM, went from back

to front when cleaning BM, wiped in circular and back and forth motion without changing the surface of the wash cloth, placed new brief without removing gloves or completing hand hygiene D

- Failure to ensure appropriate, complete incontinence care for multiple residents. Staff failed to provide complete perineal care after incontinence episodes. Failed to toilet resident in reasonable amount of time, resulting in a heavily saturated incontinence product. D
- Did not complete bladder and bowel assessments for incontinent resident. MDS did not have toileting or bladder training since incontinence had been noted. Staff did not wipe a resident from front to back. D

F 692 – Nutrition/Hydration Status Maintenance

- Failure to offer resident on thickened liquids fluids during daily activities to maintain proper hydration. D

F 693 – Tube Feeding Management/Restore Eating Skills

- Failure to provide enteral feeding care that maintained infection control and verified gastric tube placement for a resident. Staff placed syringe on bed, picked it up, rinsed it out, then washed hands- all without wearing gloves. D

F 695 – *Respiratory/Tracheostomy care and Suctioning

- Staff picked nebulizer off the floor prior to resident's first treatment; could not recall if the nebulizer tubing, cup, mask were on the floor when she went into the room. But did not clean any of the equipment prior to treatment. D
- Failure to administer O2 per the physician's order. D

F697 – *Pain Management

- One resident had pain documented by therapy and restorative that his/her feet hurt horribly. Pain scale was ordered twice a day and that morning it was "0" even though therapy and restorative had mentioned the pain to the nurse- no clinical record of pain assessment/intervention. Another resident complained of shoulder pain and again the clinical record showed no pain and staff had reported to physician no concerns. **G $3,750 FINE IN SUSPENSION**

F 698 – Dialysis

- Fail to complete pre/post assessments before/after outpatient dialysis treatment. D
- Failure to complete nursing assessments and monitor resident before/after going to patient dialysis. Multiple dates lacked documentation of resident's last blood sugar, dietary concerns, medications to be taken at dialysis, pain, weight, etc. D
- Failed to consistently complete full nursing assessments and monitoring of a resident's vital signs before and after going to outpatient dialysis treatments. D
- Pre and post assessment of resident who had dialysis not done. D

F 700 – Bedrails

- Facility failed to review risks and benefits with the resident or the resident representative or obtain informed consent of use of side rails. E
- Failed to assess each resident for use of bed side rails, review risks/benefits with the resident or their representative or obtain informed consent for the use of side rails. D
- Facility did not assess each resident for use of side rails and did not obtain consent to use them on several residents. Care plan did not have use of side rails listed. E
- Failure to assess bedside rails for use and obtain consent for resident. D
- Failed to obtain consent for use of side rails by the resident or resident rep and side rail assessment. Fail to assess residents for risk of entrapment; only using bedrails after trying other alternatives and explaining risks/benefits to residents or reps. D

F 725 – Sufficient Nurse Staffing
- Call lights not answered timely; medications not given at scheduled or as needed. E

F726 – Competent Nursing Staff
- Facility failed to provide prompt response for residents use of call light system. Call light response up to 45 min. Daughter reports father had called her because no one would answer his bathroom light; family member came in to help him off the toilet. Staff report "on-call" person refuses to come in at night when they have call offs". E

F727 – RN 8 Hrs./7 days/Wk., Full Time DON
- Failed to use RN services for at least 8 consecutive hours/day, 7 days a week - only 1 hour of RN coverage for 1 day on nursing schedule for week prior to survey. D

F728 – RN 8 Hrs./7 days/Wk., Full Time DON
- Failure to have a licensed professional nurse pass medication to residents. E
- Failure to verify a CNA licensure for a newly hired CNA. D

F 729 – Nurse Aide Registry Verification, Retraining
- CNA registry not checked for eligibility prior to hire. D
- Failure to verify certification for Nurse Aide from direct care worker for multiple Nurse Aides reviewed. D

F 730 – Nurse Aide Perform Review – 12 Hours /Year In-service
- Inhaler and nasal spray not labeled with resident name; Unlocked metal box found in the resident food refrigerator in the med room contained Lorazepam. E
- Facility did not have documentation that any of their CNAs had received the required 12 hours of in-service training within the last year. D
- Facility did not ensure all CNA's had the required 12 hours of in-service training. B
- Failure of nurse aides to complete 12 hours of in-service training on annual basis for multiple staff. B
- Failure to ensure all CNAs completed 12 hours of in-service training every 12 months for a CNA. D

F 732 – Posted Nurse Staffing Information

- Failed to post current daily nurse staffing worksheets for multiple days. B
- Facility did not post daily staffing sheet for several days. D

F741 – Sufficient/Competent Staff-Behavioral Health Needs

- Failed to provide 6 hours of dementia education for staff prior to working on CCDI. B

F744 – *Treatment /Service for Dementia

- Failure to ensure a treatment plan was created for several residents with Dementia, including tracking targeted behaviors, appropriate diagnoses, and developing a comprehensive care plan. B

F755 – Pharmacy Services/Procedures/Pharmacist/ Records

- Staff failed to document the amount of drug actually present in medication bottles. Instead they documented what amount should be present in the bottle. E

F756 – Drug Regimen Review

- Failure to document an appropriate diagnosis for psychotropic medication and to report irregularities to the physician for several residents. D

F757 – Drug Regimen- Free from Unnecessary Drugs

- Lack of documentation of alternatives attempted prior to administration of PRN Lorazepam. Documentation couldn't be located in electronic or physical clinical record regarding the intended length of time for order, rationale for continued use in physician's progress notes to indicate further evaluation for medication use. D
- Failure to adequately monitor for a resident receiving Warfarin for blood clotting. INR had not been completed as ordered. D

F758 – Free from Unnecessary Psychotropic Meds/PRN Use

- PRN Lorazepam order was not reviewed within the 14-day time limit. D
- PRN order for lorazepam did not have rationale and duration. D
- Failure to have primary care physician review use of psychotropic medication within 14 days of start date, that was ordered on an as-needed basis for several residents. Failure to ensure psychotropic medication was addressed individually during a gradual dose reduction review for many residents. Clinical records lacked diagnosis for antidepressant and antipsychotic medication. E
- Resident received order for Sertraline for increased anxiety, clinical record lacked documentation regarding a gradual reduction review of sertraline to the physician. D
- Failed to assure GDR's were attempted for psychoactive medications. D
- Facility did not obtain rationale for continuing prn order Ativan. D

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

- LPN administered one spray of Flonase per nostril instead of two and did not wait 30 seconds between inhalation of next medication. D

F760 – *Residents Are Free of Significant Med Errors

- Failure to ensure residents are free of significant medication errors. Not obtaining blood sugar checks as ordered. Nurse to resident "I will just write down 88 for your blood sugar, and then you won't need your insulin and winked at her". Nurse never came to do resident's blood sugar. Multiple holes on MAR related to blood sugars and insulin administration. D

F761 – Label/Store Drugs & Biologicals
- Expired insulin not discarded. D
- Failed to properly store medications, limit access to authorized personnel. Multiple boxes of insulin were noted in shower room without being locked in a secured cabinet or unit. Multiple unlicensed staff members had access to shower room. D

F801 – Qualified Dietary Staff
- Failed to provide a certified dietary manager or fulltime dietician. Facility couldn't produce a document showing the dietary supervisor passed the required exam. E
- Fail to ensure Dietary Service Manager completed Dietary Manager Certification. E

F803 – Menus Meet Resident Needs/Prep in Advance /Followed
- Residents on regular diet to receive 3/4 cup of spaghetti/meat sauce, staff used 1/2 cup to serve these residents. Pureed diets were served pureed green beans instead of corn (what was on the menu). E
- Residents received wrong scoop size on mechanical soft diet. E

F804 – Nutritive Value/Appearance/Palatability/Temp
- Food temps not adequate and food trays not delivered in a timely manner. E
- Parmesan chicken served at 114.3 degrees and parsley noodles at 96.9 degrees. Resident council stated food is served cold and room trays are always late. E

F812 – Food Procurement, Storage, Preparation, Sanitization
- Cook preparing sandwiches with gloved hands touched multiple surfaces (outer sack, refrigerator handle, etc. and then without changing gloves handled bread. E
- Vent above food prep table was dirty, fire nozzles on suppression hood above stove had black dust particles hanging from them. E
- Accumulation of dust on sprinkler heads, dry storage room cement floor areas with no paint and cannot be sanitized. F
- Failure to distribute food and beverages under sanitary conditions. Dietary Aide placed water glasses on tables by touching the rims. Also continually pushed up eyeglasses and itches nose then continued to serve food. E
- Bangs not secured under hair net, staff removed buns from plastic bag with one hand, touched outside of the bag with the other hand; used both hands to open bun before using tongs to put fish filet on bun, touched dietary cards in between serving residents, delivered desserts to memory care unit dining room without a cover. E
- Pureed food was not done properly. Food not covered that was transported to a different floor. Staff took temps of food and wiped thermometer off in between foods on

own apron. Can of soup set in bowl, then taken out and dumped into the same bowl the can had been sitting in. E

- Coffee creamer, V-8 juice, chocolate ice cream, ranch dressing, chocolate syrup, strawberry syrup and mustard we're all open with no dates on them. E
- Under-cooked chicken, hamburger, and breaded chicken liver. Kitchen temp log showed chicken was 175 degrees. E
- Staff picked something up off the floor, touched trash barrel then passed food trays, didn't wash hands. Staff continued to touch clean items throughout the kitchen. E
- Cook didn't practice proper hand washing technique or glove use during meal. E
- Cutting boards had deep grooves and "fuzz" on the sides of them. Wall in kitchen under air conditioner contained buildup of dust and dirt that was 2 feet by 2 feet. E
- Failed to ensure the kitchen and food storage areas meet professional standards of cleanliness and sanitation. Clutter, food debris on floor in fridge/freezer. Freezer with buildup of frost, non-functioning fan. Tacky substance and food debris on table, carts and ovens. Stove vents with buildup. Floor with dirt, grime and food debris. Floor under sink contained dirty rag and soda can. Dry storage area observed as lack of cleaning. Cleaning schedule with omissions noted in many cleaning activities. E
- Failed to maintain adequate kitchen sanitation and carry out sanitary food handling practices. Dietary staff had one inch of hair exposed from hairnet. Dipped hands in sanitation solution to grab cloth to wipe off blender, without washing hands, staff scooped vegetables into blender to puree for lunch. Staff reached into water sanitation solution located in sink, without washing hands staff picked up a cookie sheet containing garlic bread, used tongs to remove bread. Another staff wore gloves and touched bread for sandwiches. Dust particles on handles of stove, dead flies noted, fire suppression system pipes with dust present, particles hanging down from pipes over the stove griddle. Facility lacked a policy for glove use in kitchen. E
- Facility staff failed to ensure staff covered all hair with a hairnet. Several dietary staff noted with 2-4 inches of hair exposed. E

F825 – Provide/Obtain Specialized Rehab Services

- Failure to provide restorative therapy as ordered for several residents. E

F 839 – Staff Qualifications

- License verification not done for a nurse prior to hire.
- Fail to verify nursing licenses for multiple nurses. Facility utilized staffing agency. D

F 842 – Resident Records - Identifiable Information

- Clinical record had no mention of resident being struck in eye nor was there an incident report. There was not a skin sheet for the wound either. D
- Failed to maintain accurately documented Medication/Treatment records. Lack of documentation of treatments being completed as ordered. Dressings dated with previous days dates. Staff report it's not uncommon to find dressings not changed. D

F 880 – Infection Prevention and Control

- Failure to maintain infection control practices during laundry delivery. Staff mixed a dirty blanket with clean cart of clothes. D
- Facility failed to ensure staff wash or sanitize their hands prior, during and after cares, in which hand washing is indicated by accepted professional practice. During cares staff failed to remove contaminated gloves and wash or sanitize hands in between going from a contaminated task to a clean one during peri-care. During wound treatment staff did not sanitize or wash hands when changing gloves. E
- Nurse contaminated gloves by accidentally touching unclean surface during sterile trach care and did not change gloves. D
- Failure to follow infection control policy. Resident observed in hallway with catheter in a dignity bag, and the dignity bag dragging in the floor. Staff didn't disinfect glucometer machine in between uses. Family member of resident reported staff didn't wear gloves to do treatments and didn't wash hands before treatments. D
- Staff did not have a clean barrier for dressing supplies during dressing change and did not remove glove and complete hand hygiene after removing old dressing, observed 4 inches of catheter tubing sat directly on floor. Staff applied lotion to the residents back and arms without removing gloves, touched the EZ stand lift, neither staff cleansed lift after use. Staff failed to wash hands before feeding residents. D
- Failed to deliver clothes while maintaining infection control and to maintain infection control for care of catheter; laundry staff delivering clothes half covered, dragged clean clothes on floor during delivery and carried clean clothes over their shoulder; catheter bag and tubing touched the floor during transfers for residents. D
- Failed to use appropriate hand hygiene practices during catheter cares. D
- Catheter tubing resting on the floor and resident was mobile in wheelchair and moved throughout the building while dragging the tubing on the floor. D
- During a two-person transfer staff touched catheter bag and neither washed their hands and then took residents water pitcher by the top and held the straw for resident to take a drink. D
- During cares staff did not change gloves after wiping resident then putting clean brief on. Staff did not place barrier between resident and incontinence pad, nor did they cleanse the resident’s buttocks or hips. Another staff did not wash their hands before and after providing care. During wound care scissors were not cleaned prior to being placed back into the cart; did not complete hand hygiene. E
- Nurse didn’t set up treatment supplies for wound vac dressing change on barrier. D
- Following demonstration of incomplete perineal care, staff rolled resident onto soiled incontinent pad before applying a clean brief and dressing the resident. D
- Staff failed to change gloves and perform hand hygiene between tasks. Another staff failed do perform hand hygiene after touching areas considered to be dirty before moving objects considered to be cleaner. D
- Facility failed to perform dressing changes to an open wound in a manner to promote the possible spreading of infection. Nurse pulled scissors from her pocket and cut the dressing without sanitizing the scissors. D

F883 – *Influenza and Pneumococcal Immunizations
- Facility failed to get resident records for flu and pneumonia vaccines. D

- Facility failed to offer pneumococcal vaccination for residents. D

F917– Resident Room Bed /Furniture/Closet
- Facility did not provide a large enough bed for a resident. D

F919 – Resident Call System
- Failed to assure accessible toilet facilities were adequately equipped to allow residents to call for staff assistance; no call light in men and women's bathrooms by nurse's station that were unlocked. E

F947 – Required In-Service Training for Nurse Aides
- Facility failed to ensure staff completed dementia management training. Lacked documentation of multiple staff members without dementia training in past year. B

Nursing Facility Survey Frequency

As of June 26, 2019, CMS lists 63 Iowa facilities (14.4%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 7.6%. National average is 6.3%.

Provider	City	Survey End Date	Previous Date	Months Between
ABCM Rehab Centers of Independence West Campus	Independence	4/18/2019	1/18/2018	15.17
Burlington Care Center	Burlington	5/16/2019	1/30/2018	15.70
Correctionville Specialty Care	Correctionville	4/4/2019	11/16/2017	16.80
Fellowship Village	Inwood	5/30/2019	2/22/2018	15.40
Fonda Specialty Care	Fonda	4/18/2019	11/17/2017	17.23
Garden View Care Center	Shenandoah	4/10/2019	12/19/2017	15.90
Good Samaritan Society Estherville	Estherville	4/25/2019	12/19/2017	16.40
Guttenberg Care Center	Guttenberg	5/9/2019	2/8/2018	15.17
Hegg Memorial	Rock Valley	4/4/2019	11/27/2017	16.43
Keystone Nursing Care Center	Keystone	4/12/2019	1/18/2018	14.97
Little Flower Haven	Earling	5/11/2019	1/9/2018	16.23
Living Center West	Cedar Rapids	5/2/2019	2/8/2018	14.93
Newton Health Care Center	Newton	5/8/2019	2/15/2018	14.90
Oskaloosa Care Center	Oskaloosa	4/18/2019	12/7/2017	16.57
Red Oak Rehab and Care Center	Red Oak	5/8/2019	1/30/2018	15.43
River Hills Village in Keokuk	Keokuk	4/18/2019	12/19/2017	16.17
Sheffield Care Center	Sheffield	4/13/2019	1/9/2018	15.30
Shell Rock Senior Living	Shell Rock	4/10/2019	12/6/2017	16.33
Southern Hills Specialty Care	Osceola	5/16/2019	2/22/2018	14.93
Spurgeon Manor	Dallas Center	5/2/2019	1/18/2018	15.63
Accura Healthcare of Ogden	Ogden	5/2/2019	1/9/2018	15.93
Brooklyn Community Estates	Brooklyn	4/10/2019	2/8/2018	14.20

ManorCare Health Services	Waterloo	5/8/2019	1/30/2018	15.43
Meth-Wick Health Center	Cedar Rapids	5/16/2019	2/15/2018	15.17
QHC Fort Dodge Villa	Fort Dodge	4/10/2019	12/7/2017	16.30
Sunrise Hill Care Center	Traer	5/11/2019	2/15/2018	15.00
West Point Care Center Inc	West Point	5/2/2019	1/18/2018	15.63
Cherokee Specialty Care	Cherokee	5/2/2019	1/18/2018	15.63
Clarion Wellness and Rehab Center	Clarion	4/10/2019	2/8/2018	14.20
Fleur Heights Center for Wellness	Des Moines	3/28/2019	12/19/2017	15.47
The Bridges at Ankeny	Ankeny	4/4/2019	12/7/2017	16.10
Tru Rehab of Grinnell	Grinnell	5/2/2019	1/30/2018	15.23
Highland Ridge Care Center	Williamsburg	4/4/2019	1/9/2018	15.00
Heritage Specialty Care	Cedar Rapids	4/25/2019	1/30/2018	15.00
Wapello Specialty Care	Wapello	4/25/2019	11/28/2017	17.10

Average = 15.39