Compliance Tips from IHCA's Survey Results Committee

March 2016

The five most frequently cited tags from the 55 annual surveys (10 deficiency free), 35 complaints (17 unsubstantiated), 24 self-reports (9 unsubstantiated), and 22 complaint/self-report (6 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 269 total deficiencies.

The following is a breakdown of severity level:

A =	0%	D =	57.99%	G =	8.18%
B =	4.46%	E =	22.30%	H =	0.0%
C =	2.60%	F =	2.23%	I =	0%
				J =	1.49%
				K =	0.37%
				L=	0.37%

Total # of Reports: 115
Total # of surveys/reports deficiency free or unsubstantiated: 42
Avg. # of deficiencies

- All = 2.40
- Annual = 3.67
- Complaint/Self-Reports= 2.36

Total state fines for December Report = $147,500 ($63,000 held in suspension)

Top 5 Most Frequently Cited Tags for March 2016 Report

F 323—Free of Accident Hazards/Supervision/Devices The Facility must ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents

- Facility failed to provide adequate supervision related to resident-on-resident abuse (L).

- Front door not alarmed, facility was full of mobile residents, resident went out to smoke but there was no sign-in, sign-out procedure (K).
- Resident eloped, nurse turned off alarm that activated without checking why, eloped resident fell in facility's driveway and was injured (J) **$15,500 fine** (in suspension).
- Resident eloped from facility after several angry outbursts in facility—staff were unaware of elopement, local business called to say resident was there, no wanderguard bracelet in place (J) **$3,000 fine** (in suspension).
- Facility failed to intervene with physically aggressive resident, one resident suffered a scalp hematoma when staff ambulated without a wheelchair per care plan, resident fell, another resident burned when staff left hot coffee on table unattended (G) **$15,000 fine**.
- Facility failed to ensure resident's safety, resident found on floor in bathroom, care plan lacked evidence of interventions were implemented immediately to prevent a fall, resident had fallen and died while staff passed medications, another resident became "twisted" during transfer, with a "crack" heard, resident diagnosed with fracture (G) **$10,000 fine** (in suspension).
- Facility failed to administer the current medication as ordered by physician and as a result developed dehydration and wound infection and required hospitalization, physician ordered Vanco, pharmacy sent wrong medication, patient subsequently died (G) **$10,000 fine.**
- Private duty caregiver let go of gait belt, resident fell and suffered subdural hematoma (G) **$8,000 fine**.
- Resident told surveyor they were struck several times by another resident, facility failed to implement interventions (G) **$6,000 fine** ($2,000 trebled).
- Staff lowered side rail to perform cares, moved to other side of bed without raising rail, resident rolled from bed and fell, fractured hip (G) **$5,000 fine.**
- Facility failed to provide adequate supervision to protect resident from hazards, resident fell while attempting to move rinse bar in the toilet out of the way, resident complained of pain after all, resident had fractured (G) **$5,000 fine.**
- Facility failed to provide adequate supervision to ensure against hazards to self, personal alarm not hooked up and staff left unattended in wheelchair instead of placing in bed, another alarm was not correctly placed on resident (G) **$5,000 fine.**
- Staff failed to use a gait belt, resident fell and fractured bone (G) **$5,000 fine.**
- Facility failed to prevent resident from going in and out of other resident's room, tried to elope through front door, opened other resident's personal hygiene bottles and tried to drink them, resident eloped and ran in street, staff had to call 911, care plan and task list failed to identify need for increased staff supervision in an effort to monitor resident (G) **$2,000 fine.**
- Resident with a child in the same facility was non-compliant with facility requirements for care of the child, parent resident was confused and continued to provide cares unsafely, became extremely upset when redirected, resident had history of incidents with other residents, resident slapped and grabbed child causing bruising, child had Down's syndrome, none of the incidents with the resident were reported to DIA (G) **$2,000 fine**.

- Staff left resident in whirlpool chair lift in high position without safety belt attached, resident fell, was injured resident repeatedly fell over wheelchair foot pedals, were to be removed when the resident was alone, surveyor observed they weren't (G) **$500 fine.**
- Resident from sit-to-stand lift and was injured because staff repositioning lift caused lift to hit resident (G).
- Resident left walker, fell backward, sustained head injury, fall assessment not complete (G).
- Resident's surgical boot not secure and came off; fell and was injured interventions not in place (G).
- Unlocked closet with unsecured cleaning chemical (G).
- Staff let go of resident's gait belt during transfer, resident fell, fractured hip (G).
- Kitchen and dining room doors propped open with wooden shims (E).
- Chipped, jagged tile in shower room (E).
- Unsecured oxygen tanks, key left in door lock to oxygen tank storage room (E).
- Emergency exit door to CCDI unit could not be opened with key pad (E).
- Unlocked housekeeping cart with unsecured chemicals present, facility's exterior doors not alarmed, (E).
- Resident fell from shower chair while staff member was trying to dry after bathing, no seat belt in place, resident sustained injury (D) **$500 fine**.
- Multiple electric cords on floor in pathway of resident ambulation (D)**.**
- Unlocked and unsupervised medication care in hallway (D).
- Staff failed to lock bed wheels while staff was attempting to reposition resident in bed D).
- Staff failed to use gait belt during transfer (D).
- Planned alarm was not in place, fall with a skin tear, other instances where alarms didn't sound (D).
- Staff ambulated a resident that was to have a walker without one (D).
- Nebulizer and clock radio plugged into surge protector in resident's room (D).
- Staff failed to use gait belt for one resident who fell and was injured, failed to use personal alarm for resident as care planned, fell and was injured (D).
- Staff failed to utilize wheelchair foot rests during transfer, resident's bed not in lowest position as care planned (D).
- Fall interventions such as bed in low position and pad alarm not used (D).
- CNA didn't put resident's feet in foot supports, pushed wheelchair 80 feet (D).

F 312--A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene

- Resident complained during group interview that call light response slow and resident had to sit on toilet for long periods of time, observed by DIA surveyor , surveyor observed a 24 minute response time (E).
- During pericare, staff failed to cleanse entire hip and buttocks area that had contact with urine and feces (E).

- Staff failed to complete incontinence care on two residents, resident urinated while standing, urine ran down leg and soaked slippers, slippers not cleaned (E).
- Staff cleansed peri area, wiping down the middle of groin without changing/flipping wipe (E).
- CNA didn't completely cleanse all stool from perineal area, failed to retract penis foreskin to cleanse during pericare (E).
- Staff failed to provide two baths a weeks for six of 15 residents (E).
- Staff failed to clean entire buttocks and hip during pericare (D).
- Resident had bowel movement in wheelchair, staff transferred resident to bathroom in wheelchair without cleaning wheelchair (D).
- No oral care provided for one resident (D).
- Staff failed to provide adequate cleansing during incontinence care, staff failed to cleanse left groin, genital area and outer hips (D).
- Facility failed to offer fluids or toileting, surveyor observed resident in wheelchair with no assistance offered from 12:55 to 4 p.m. (D).
- Incomplete incontinence care, staff failed to cleanse all areas of groin, in contact with incontinence pad (D).
- Incomplete incontinence care, all stool not wiped from buttocks (D)
- Staff failed to completely cleanse after incontinence episode and application of clean brief (D).
- Staff failed to perform complete incontinence care on three residents, failed to clean left hip and buttock, cleansed bottom in a back and forth motion, cleansed perineal area wiping groin and penis with the same surface of the washcloth, rinsed and dried in the same manner (D).
- Staff failed to provide complete incontinence care, failed to cleanse entire buttocks (D).
- Staff didn't provide assistance with eating, resident's hands shook so that they could not get food to their mouth (D).
- Staff failed to cleanse all areas (hips, lower back, and abdomen) during incontinence care for two residents (D).
- Baths and showers not given twice a week (D).

F 281-- Professional Standards of Quality

- Medications crushed for gastro tube administration weren't properly crushed and mixed with liquid (D).
- Dressing change to PICC line not completed as physician-ordered, knee dressing not changed as physician-ordered (D).
- Staff failed to remove a leg immobilizer when resident was in bed, per physician's order (D).
- Staff failed to get an order for a leg bag before implementing it (D).
- Staff didn't change Foley catheter as required, did not use leg strap as ordered (D).
- Facility failed to attempt gradual dose reduction for one resident, failed to follow physician's order for specialized diets for two residents (D).

- Facility failed to provide services meeting professional standards, pill found in resident's room (D).
- Facility failed to follow professional standards and physician's orders for medications, staff failed to apply pressure to lacrimal sack during eye drop administration, failed to clean gastro tube during crushed medications administration (D).
- Nurse did not prime new insulin pen as directed by manufacturer prior to drawing dose and injecting (D).
- Nurse didn't shake nasal spray dispenser prior to application, didn't apply pressure to lacrimal sack during eye drops administration (D).
- Nurse administered incorrect strength of product during tube feeding (D).
- Nurse crushed an extended release tablet (C).
- Staff failed to follow physician's orders for heal protectors, no intake record for resident on fluid restriction (D).
- Facility failed to properly administer eye drops, staff failed to place finger on lacrimal sack, missing medications, so not given (D).
- Staff failed to apply TED hose as physician ordered, a CNA unhooked a feeding tube, performed cares, then plugged tube back in, it should have been a nurse doing it, nurse failed to hold lacrimal sack open during administration of eye drops (D).
- Nurse left medications on dining room table, for nurse to "take later," Nurse withheld pain medication from resident for several days, without notifying physician (D).
- Facility failed to properly administer eye drops, staff failed to place finger on lacrimal sack (D).

F 441—Infection control

- Staff failed to clean urine off floor after resident urinated while standing, failed to sanitize scratched plastic coating on toilet seat lid (E).
- Staff failed to properly sanitize glucometer by leaving alcohol on for two minutes (E).
- Staff failed to change gloves after working with infected wounds prior to touching three objects in room (D).
- Staff placed soiled linens on floor (D).
- Nurse wiped glucometer with alcohol but didn't wait the allotted time, didn't follow facility's policies and procedures (D).
- Staff placed urinal on floor next to resident's bed without a barrier, urinal not cleaned before storage (D).
- CNA picked up tube of barrier cream with soiled gloves while performing pericare (D).
- Staff failed to change gloves and wash hands when moving from dirty to clean procedure or when touching other objects in the room during procedure to empty catheter bag (D).
- Staff failed to wash hands and change gloves during pericare (D).

- Staff improperly changed gloves during pericare and failed to cleanse surface of urine-soaked chair (D).
- Nurse removed items used during wound care for resident in contact isolation out of resident's room after care was performed, nurse used scissors from pocket to remove a dressing without cleansing or disinfecting before use, CNA dropped a contaminated perineal wipe onto a bedside table (D).
- Facility failed to ensure staff followed infection control policy, catheter bag lying on floor, nasal cannula lying on floor (D).
- Staff failed to wash hands and reglove between providing incontinent care for two residents (D).
- Inadequate pericare, staff failed to wash hands after pericare (D).
- Facility failed to ensure staff followed the proper infection control techniques, contaminated washcloth placed in resident's sink, glucometer placed directly on medication cart, after use without sanitizing it (D).
- LPN performed pericare and didn't change gloves before touching wheelchair, gait belt, etc. (D).
- Fan blowing on resident had dust and grime on it, Prafo boots in dirty laundry basket, then placed on floor, then put back on resident, and the other boot on the resident's dresser (D).

F 371 Sanitary conditions

- Hair not properly covered during meal service, improper glove use during food service (F).
- Opened, undated food in refrigerator, sanitizing solution ppm not to manufacturer's recommendations (F).
- Dietary staff failed to wash hands when moving from dirty to clean end of dishwasher (F).
- Facility failed to seal and date food items when opened, failed to ensure three-compartment sink used to wash dishes appropriate amount of sanitizer solution, failed to ensure ground chicken reached safe temperature of 165 degrees for a minimum of 15 seconds to reduce risk of food-borne illness (F).
- Staff walked through kitchen to get hair net, hair was uncovered (E).
- Dietary staff making sandwiches grabbed bread with ungloved hand (E).
- Facility failed to maintain a clean and sanitary food preparation area, dust, dirt and rust along air register (E).
- Food splatters on wall, dirty power cords, pizza oven covered with fuzz, dirty meat slicer (E).
- Food in refrigerator not labeled with when date opened, sanitizer solution used to wipe kitchen counters didn't meet concentration PH test (E).
- Oven dirty with grease buildup, floors under stove heavily soiled with brown reside (E).
- Dirty microwave oven, dirty exhaust hood, dirty convection oven, kitchen staff not wearing aprons (E).

- Staff sanitized food thermometer, then pulled up pants, wiped hands on pants, didn't hand wash before food preparation (E).
- Drinking glasses filled from a sink where staff wash hands, sink also had eye wash station, staff didn't reglove while preparing food items and then touching other surfaces, staff didn't wash hands after touching garbage can lid (E).
- Puree food temperature only 109 degrees (D).
- Dirt on fans, grime on floor, splatters on walls, dirty microwave (E).

Other G Level or Higher Notable Deficiencies and Other Fines

F 309

- Resident rolled by two CNAs, knee struck floor and suffered abrasion with fracture, no nursing assessment conducted or documented until 14 hours after injury (D) **$2,000 fine.**
- Facility failed to conduct ongoing assessment and appropriate interventions for resident with low blood sugar (G) **$2,000 fine.**
- Facility failed to assess three residents prior to hospitalization, failed to assess and implement interventions for residents with skin concerns, clinical record lacked evidence of assessments concerning hydration, resident developed heel ulcers from feet touching, record lacked evidence of nursing assessment, diabetic medicine administered but blood sugar was in the 700s (G) **$10,000 fine.**

F 314

- Facility failed to ensure interventions were implemented to promote health, resident had physician's order for wound care nurse, this service was not provided, wound documentation lacked records of wound size measurements (G) **$10,000 fine** (in suspension).
- Facility failed to complete documentation of assessment of pressure ulcers, did not get orders for wound care for four days, skin documentation form showed no new skin areas, but seven new areas noted unaware of interventions using heal boot, did not identify a turning position program (G) **$2,000 fine**.

F 223

- Facility failed to prevent resident to resident abuse, failed to develop interventions to protect resident from being abused, admitted known sex offender allow sex offender to enter resident's room (J) **$10,0000 fine**.

F 224

- Know sex offender allowed to self-propel in wheelchair, facility failed to implement strategies to prevent resident-to-resident abuse, care plan didn't include any strategies to prevent abuse (J).

F 225

- Resident told aide five men came into room to have intercourse with her, facility staff thought it was a result of placement of catheter, but facility policy was to immediately report any allegation of abuse (D) **$500 fine.**
- Bruise of unknown origin, failed to report to DIA within 24 hours (D) **$500 fine.**

481-50.7(1)a(3)

- Facility failed to notify DIA of accident causing major injury, neck fracture, physician signed off on as major injury **$500 fine.**

481-50.7(5)

- Resident expressed suicidal ideations, had multiple wounds on wrists, resident sent to hospital for treatment, no report to DIA for two days **$500 fine.**

481-59.5(1)

- TB tests not done prior to hire.

481-58.10(3)b

- Employee physicals not completed every four years.

L1093

- Veterans' Administrations submissions to completed as required.

481-58.14(2)

- Physical exam prior to admission not completed.