Compliance Tips from IHCA's Survey Results Committee

March 2017

Total state fines for March Report = $9,000 ($85,500 held in suspension)

Be sure to read the Annual Survey Frequency March Survey Results on the last page!

Top 5 Most Frequently Cited Tags for March 2017 Report

F 323--Free of Accident Hazards/Supervision/Devices

- Facility failed to provide adequate nursing supervision to prevent accidents; residents continued to self-transfer and not used call light **$30,000 fine** in suspension (K)
- Facility failed to develop new care plan with interventions when resident had 3 falls, most recent causing subdural hematoma **$9,000 fine** in suspension (G)
- Alarm didn't sound when resident rolled out of bed; bed was not in low position per care plan, resident sustained head injury and died **$8,000 fine** (G)
- Resident had multiple falls and staff noncompliant with alarm use and transfer protocols **$5,000 fine** (G)
- Facility failed to ensure devices were working (alarms) didn't sound, resident fell with hip fracture, alarm batteries were dead and another alarm was turned off **$3,000 fine** in suspension (G)
- Facility failed to provide adequate supervision to prevent falls, fall from SH chairs and staff did not use chair safety belt (G)
- Resident arose from bed, bed alarm did not sound, resident fell and had head injury, care plan not updated (G)
- Care plan stated "do not leave resident alone while he/she is in wheelchair" staff were not aware of this directive, staff witnessed this resident groping another resident; another resident was witnessed by staff touching another resident inappropriately (G)
- Care plan-use of alarm-resident fell but no alarm was in place, resident had reddened area from all (D)
- Resident hit another resident on back of head (D)
- Leg strap not used during a stand-lift transfer (D)
- Staff failed to use safety belt on tub chair (D)
- Facility failed to ensure resident safety and prevention of injury during transfer by a mechanical lift; resident slipped out of lift and onto bed then to floor resulting in 4 skin tear injuries (D)

- Facility failed to ensure resident was supervised; resident smoked and drank in his room, when staff intervened, resident became aggressive and staff called the police, resident was independent (D)
- Resident being transferred was lowered to floor (D)
- Care plan and falls intervention; one stated slipper socks and the other stated gripper socks (D)
- 2 ounce scoop used, should have been 4 ounce scoop (D)

F 312—ADL Care for Dependent Residents

- Facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; resident did not receive adequate pericare, nail care, resident wet and smeared BM on buttocks (E)
- Baths not given twice weekly (E)
- Staff failed to turn washcloth over to clean side during pericare (E)
- Facility failed to provide grooming (shaving) for 5 residents (E)
- Incomplete pericare, staff didn't cleanse entire soiled area (D)
- Facility failed to provide 2 baths per week for 5 of 11 residents; baths were not completed for lack of baths (E)
- Facility failed to provide baths at "intervals that met hygiene requirements" some resident had gone over 2 weeks without bathing, staff said they had been "short staffed" (E)
- Staff did not complete total pericare to all areas—multiple residents (D)
- Care plan stated to toilet resident before and after meals; surveyor observed this was not done, resident sat for a long period of time on the toilet (D)
- Staff failed to provide complete pericare, staff didn't use a clean face of the washcloth when wiping and cleansed back to front (D)
- Catheters were not properly cleaned and sterilized (D)
- Staff failed to toilet resident ever hour as care planned (D)
- Pericare—staff did not clean outer buttocks; staff transferred resident holding arm (D)
- Resident took knife from meals to cut off Wanderguard, resident had abrasions and bruises from attempt to cut Wanderguard (D)

F279— Comprehensive Care Plans

- Facility staff failed to document resident's pressure areas, weight loss (E)
- No care plan in place for F-323 resident who struck several staff and inappropriately touched other residents (D)
- Facility failed to update care plan to include speech therapy recommendations (D)
- No care plan revisions for resident with delusional thinking; i.e. another resident was his/her spouse leading to sexual activity (D)
- Care plan not updated to prevent additional accidents, no Dycem placed in wheelchair per care plan, no update in care plan for use of Dycem (D)

- Care plan did not address side effects of use of anti-depressant medications; alarms not in place for resident per care plan (D)
- Facility did not provide care plan for side effects of psychotropic medications; side effects not monitored (D)
- Facility failed to develop and implement a comprehensive care plan in place for residents to safely smoke in place from Oct. 31, 2016 to Feb. 1, 2017 (D)
- Facility failed to develop a comprehensive care plan that included measurable objectives and timetable; resident order for baby spoon and CNA gave resident a regular sized spoon (D)
- Staff failed to maintain all residents' assessments completed within the past 15 months and use the assessment results to develop care plan (D)

F 281—Professional Standards of Quality

- Facility failed to provide services that met professional standards of quality—resident did not receive PRN medications as ordered (E)
- Improper eye drop administration; staff failed to respect resident's right to self-administer medications (E)
- Facility staff failed to address psychiatric and anticoagulant medications on care plan (E)
- No record of Miralax administration to resident by staff on MAR; MAR did not match dosage in bubble pack; MAR was not correct dosage as ordered by physician (D)
- Facility failed to ensure physician's orders were followed for vitamin D3 administered daily, daily weights not taken (D)
- Facility failed to properly maintain and administer injectable Lantus insulin; staff administered insulin beyond expiration date (D)
- Facility failed to follow physician's order and failed to administer the correct dosage of medication; order for blood work monthly not completed in January, dosage incorrect of calcium vitamin discontinued but still given to resident (D)
- GARs existed on TAR for wounds for treatments missing, multiple examples (D)
- Facility failed to provide services in accordance with each resident's written plan of care; resident not repositioned according to plan of care, resident not checked or repositioned or changed per plan of care (D)
- Facility failed to follow care plan for ambulation and pressure boots (D)
- Facility failed to weigh residents as ordered (B)

F 371—Food Sanitation and Safety

- "Ready to eat" foods were touched by staff with bare hands, crumbs on food storage shelves, ice machine lacked backflow device (F)
- Cutting boards with grooves, fuzz, unsanitizable, juice machine with no backflow device (F)
- Dirty kitchen floor, no cleaning schedule posted, dirty oven, dirty griddle, dietary employees not properly trained (F)
- Grease on oven and microwave, dirty blender, etc. (F)

- Worn rubber areas on carts (not sanitizable), food residue on cart wheels, frost buildup in freezer (F)
- Facility failed to assure that the kitchen shelving, utensils, drawers, and kitchen area floor was clean and free of debris (F)
- Facility staff failed to label and date open bags of food in freezer (E)
- CNAs touched bread and other foods with bare hands (D)
- Director of nursing touched doughnuts and served with bare hands (D)

F 309—Quality of Care

- Facility failed to provide necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being; resident experienced symptoms of a stroke that facility failed to act in a timely manner, resident had bruises on their faces, facility failed to assess of document; resident with open skin area not assessed not open area measured, resident with cancer and pain medications not given in a timely manner; resident fell with fractured humerous and facility failed to document an ongoing assessment (G)
- Staff used sliding scale type was not available in facility for administration (D)
- CNA witnessed a resident slide from a wheelchair ; staff did not immediately report fall to the charge nurse; resident had no complaints of pain nor injury (D)
- Facility failed to provide timely and complete assessment and interventions for a resident with a change in condition; resident did not have a full assessment conducted after a chocking incident and resident admitted to hospital for pneumonia (D)
- Resident with diareahh had weight loss, physician not notified for over a month (D)
- Resident had scratches on back, staff failed to conduct timely investigation (D)
- Facility failed to provide services to promote healing and prevent decline for vascular heal ulcers; no weekly assessments completed and heals not off loaded (D)

Other notable deficiencies and fines

F-223

- Facility failed to ensure 2 residents remained free from abuse, 2 instances of resident-to-resident sexual contact **$6,000 fine** in suspension (G)
- Staff failed to prevent resident from sexually fondling a cognitively-impaired resident on multiple occasions and failed to report as required **$2,000 fine** in suspension (J)
- CNA snap-chatted a photo of feces in gloved hand and revealed a resident's buttocks, all staff didn't follow a "no cellphone" policy **$2,000 fine** (G)
- Resident-to-resident altercations; both residents had a history of combative behaviors with staff and other residents, one resident hit the other resident on the face, giving him a bloody nose **$2,000 fine** (G)
- Facility failed to prevent resident-to-resident abuse; nurse charted the incident, administrator told nurse to strike it out **$500 fine** (G)

- Bruise on wrist; resident said a CNA grabbed his arm, facility investigation unable to determine how bruise occurred **$500 fine** (G)
- Staff was repositioning resident in chair, resident bumped head (G)
- Resident-to-resident abuse, verbal yelling and physical hit, no evaluation by psychiatrist for a month (G)

F-224

- Facility failed to prevent occurrences of resident-to-resident sexual abuse and monitor for change (G)

F-225

- Facility failed to report possible resident abuse within 24 hours **$500 fine** (D)

F-226

- Facility failed to conduct criminal background checks and abuse checks prior to hire **$500** fine (D)

F-314

- Staff failed to timely assess and provide appropriate care to pressure ulcers and failed to provide timely interventions to prevent development of avoidable ulcers on multiple areas of the resident's body **$30,000 fine** (K)
- Facility failed to obtain treatment for over a week for a PU , had interventions in place for 3 months to prevent reoccurrence; doors in facility had multiple gouges and worn areas **$2,000 fine** in suspension (G)
- Staff failed to reposition residents every 2 hours per care plan, position devices not in place (heel floats) **$2,000 fine** in suspension (G)

F-314

- Facility staff failed to use interventions to prevent pressure ulcers and in accurate documentation (G)
- Interventions to prevent pressure sores were not implemented; boots for heels, float heels, repositioning (not done), pressure reduction mattress (not installed **$2,000 fine** in suspension (G)

F-318

- Facility failed to provide restorative nursing care per care plan; incomplete dates and minutes **$500 fine** (D)

F-353

- 13 residents complained of poor response time to call lights leading to episodes of incontinence, multiple staffing concerns about staff sleeping, using computer, not responding to resident's needs **$4,000 fine** in suspension (G)
- Resident had lacerations on wrist from knife, was transported to emergency room, resident his staff in head, staff hit panic button but another staff didn't respond for 15 minutes **$500 fine** (E)

- No timely call light response **$500 fine** (D)

F-354

- Facility failed to use the services of a registered nurse for 8 consecutive hours a day, 7 days per week **$5,000 fine** in suspension (D)

F-367

- Facility failed to provide a hot breakfast on a resident's dialysis days, fed resident "what they could find" because "kitchen wasn't opened yet" fed resident Oreos and fruity pebbles **$500 fine** (D)

N-101

- Facility failed to report a major injury **$500 fine**
- Facility failed to notify DIA of an accident causing major injury within 24 hours

481-58.28(3)E and 481-58.20(4) A & B

- Failure to adequately supervise to prevent injuries (pressure sores) **$2,000 fine** in suspension

481-58.19(2)B

- Pressure sores **$2,000 fine** in suspension

481-50.7(1)(2)

- Failure to report major injury that resulted in resident admission to a higher level of care **$500 fine** in suspension

L-1093

- Facility staff failed to submit for Veterans Affairs benefits for 2 of 4 residents