Compliance Tips from IHCA's Survey Results Committee

March 2018

Survey composition: 26 annual surveys (7 deficiency free), 33 complaints (9 unsubstantiated), 10 self-reports (4 unsubstantiated), 11 complaint/self-report (1 unsubstantiated) and 3 mandatory reports (0 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 135 total deficiencies.

The following is a breakdown of severity level:

A =	0.00%	D =	70.37%	G =	6.67%
B =	1.48%	E =	16.30%	H =	0.00%
C =	2.22%	F =	0.00%	I =	0.00%
				J =	1.48%
				K =	0.74%
				L=	0.00%

Total # of Reports: 69
Total # of surveys/reports deficiency free or unsubstantiated: 20
Avg. # of deficiencies

- All = 2.76
- Annual = 3.11
- Complaints = 2.45
- Self-reports = 5.33
- Complaint/Self-Reports= 2.55
- Special Focus = 0.00 Mandatory = 2.00
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Total state fines for January Report = $24,000 ($51,250 held in suspension)

Be sure to see the survey frequency report on page 12!

This report includes a combination of old and new F Tag numbers

Deficiencies and Fines (sorted ascending by f-tag number)

F 157—Notification of Changes

- Staff failed to notify POA of resident who showed signs of aspiration and required additional assessment and monitoring, use of oxygen over the course of several hours (E)

F 241—Resident Rights

- Staff was overheard saying to resident "do you want her, I sure as hell don't" This was reported to Administrator and counseling form was done (D)

F 281—Professional Standards of Quality

- Resident had a high INR of 3.5. This was faxed to Dr., but Dr. did not respond until 3 days later. The nurse had initiated a "re-start" of the coumadin before hearing back from the Dr. to re-initiate the Coumadin; therefore, the resident received the Coumadin for 3 days with an elevated INR. When the Dr. did respond, he DID order for the Coumadin to be re-initiated. The Dr. did not order a repeat INR, and the nurse did not ask for an order. Resident #2 had an order for an antibiotic given at 2:59PM on 11/16. The first dose was not given until 8PM on 11/17. The medication was to be given 2 times a day. The resident received only 18 of the 20 doses. The medication was available in the Emergency Kit, but staff did not use it (D)

F 314—Pressure Ulcers

- Resident had pressure ulcers upon admission. The nurse did not document (weekly) if the ulcers had declined or remained stable. She did not document stage or an assessment of the wound bed. These assessments were co-signed by the wound nurse. Staff was using a "barrier" on the open pressure ulcers that was intended for intact skin (per the Medline Wound Consultant). The physician confirmed that these treatments were not appropriate. The wounds were unstageable with slough. Also, the 11/16/17 and 11/24/17 assessment were not entered into the computer until 11/30/17. The MDS did not proper address the wounds. The physician was not properly notified of the deterioration of the wounds (G) **$500 fine**

F 325—Maintain Acceptable parameters of Nutritional Status

- Staff did not offer assistance in the dining to a resident who had had a significant weight loss (5.8% in one month, 12.2% in 3 months, 18.8% 6 months). Resident sat until food was cold and staff did not reheat it. An hour later, resident was removed from the dining room without eating (G) $500 fine

F 441—Infection Control

- Nurse did not wash or sanitize hands between residents during med pass (E)

NEW F TAGS

F 550—Resident Rights/Exercise of Rights

- Raised voice, rough, staff had previous reprimand (D)

F 554—Resident Self Administration of Medications/Clinically Appropriate

- Facility failed to provide ongoing assessment, care planning and current physician order for a resident to self-administer medications. MAR lacked documentation the resident kept the inhaler in the room (D)

F 557—Respect, Dignity/Right to Have Personal Property

- Facility failed to ensure resident had sufficient clothes to wear (B)

F 558—Reasonable Accommodations of Needs/Preferences

- Staff failed to empty gas filled colostomy bag. Bag routinely comes loose and soils resident. Resident left exposed by aide during care and privacy curtain not routinely closed. Another resident found often in urine-soaked bed without position changes (D)
- Accommodations of needs-resident with dementia was taken by taxi service to dr appt--taken to wrong address. Driver stayed with the resident for 1 hour, then took to correct address and was still early. Physician interviewed by surveyor reported they called facility and was notified by staff that the resident did not finish eating due to transportation arrived early. Physician also reported resident had a loving family, attended appts and made sure resident had a coat on but the family did not know of appt until they went to visit the resident and they were not at facility. When family arrived at appt, resident appeared traumatized, was wearing pajamas and a blanket stating, "they lost me." (D)

F 580—Notification of Changes Injury/Decline/Room)

- Facility failed to notify family of a resident fall (D)
- Failed to promptly report a resident's change in condition to family; bruise found on resident's chest and x-ray showed 2 rib fractures and family was not notified for 2 days after the bruise was found (D)
- Facility did not notify the MD or family of significant weight loss (D)
- Notification of changes-family not notified of physician appt as listed in F558 (D)
- Fall with resulting hip fracture. Facility contacted hospice with fall with injury, but did not contact the physician timely when res. Was in pain after fall (D)

F 582—Medicaid/Medicare Coverage

- The facility lacked documentation that residents were offered information that they could appeal the decision to end Medicare services (D)
- ABN's not served within the appropriate time frame or after resident's skilled stay ended (B)

F 583—Personal Privacy/Confidentiality of Records

- Cares provided, and staff left resident uncovered and curtains opened (D)
- Facility failed to observe resident right to privacy by not knocking on the bathroom door before entering (D)

F 584—Safe/Clean/Comfortable Homelike Environment

- Stained and peeling wallpaper (E)
- Environment-dingy floor several resident rooms and bathrooms, floors and doors cracked and gouged. Hskp supervisor reported not enough time to get floors done properly. Dirty sinks, vents, shower chairs, wall by tub, etc (E)

F 600—Free from Abuse and Neglect

- Raised voice, rough, staff had previous reprimand (D)
- A gift card that was meant for resident items was misused by staff (D)

F 602—Free from Misappropriation/Exploitation

- Facility failed to identify personal property reviewed on the personal inventory form; resident reported a lock box was removed from their room that contained $200, an anniversary ring, and personal medical and credit cards (D)

F 604—Right to be Free from Physical Restraints

- Staff member restrained a resident by tying the gown behind the resident's neck, binding the arms. Staff member involved did not have current DAA training documented (D)

F 606—Not Employee/Engage Staff with Adverse Actions

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

F 607—Develop/Implement Abuse and Neglect Policies

- Staff member hired before DHS clearance of criminal hit evaluated (D) **$500 fine**

F 609—Reporting of Alleged Violations

- CNA witnessed another CNA slap a resident 2x's but did not tell anyone until the next day making it greater than 2 hrs. for reporting (D) **$500 fine**
- On 11/4/17 CNA was witnessed by another CNA with a resident at dining room table. CNA slammed hands on table startling resident stating, "I don't have time for your Sh-t, you need to get up and leave the dining room." CNA then pulled resident up by the front of the shirt to a standing position, then pushed the resident in the back and again said, "I don't have time for your Sh-t." CNA finished her shift and DON was not informed until morning, at which point DIA was notified and employee suspended (D)

F 620—Admissions Policy

- Facility failed to have a signed admission agreement on file by responsible party until after the resident was discharged from the facility (D)

F 623—Notice Requirements Before Transfer/Discharge

- Facility failed to provide required 48-hour notice of discontinuation of Medicare services (D)

F 624—Prepare for Safe/Orderly Transfer and Discharge

- Facility did not complete discharge instructions (D)

F 625—Notice of Bed Hold Policy Before/Upon Transfer

- Family/resident not informed on bed hold policy (D)

F 637—Comprehensive Assessment After Significant Change

- No significant change MDS assessment with change of condition (hospice) (D)

F 644—Coordination of PASRR and Assessments

- PASRR ordered psychiatric services and not provided (D)
- Failed to complete a new PASRR assessment with significant change in mental status for 2 residents (D)

F 656—Develop/Implement Plan of Care

- Facility failed to update and follow care plans to reflect a resident's current status to maintain optimum care, based a resident's health condition and facility failed to follow planned interventions for one resident involved in a resident to resident altercation (E)
- Fall with no interventions, falls with lack of investigations (E)
- Facility failed to have interventions on care plan addressing anticoagulant and diuretic therapy (D)
- Facility failed to follow the plan of care. Resident with weight loss did not have consistent weights checked (D)
- Facility did not care plan interventions to address res. Medication condition of partial bowel obstruction (D)
- Actual skin issues with air mattress and cushion added but facility failed to put the items on the care plan (D)
- Facility failed to put treatment in a care plan for tubi-grips (D)
- Resident on Seroquel and no care plan interventions addressing med (D)
- Resident with fx and no interventions on care plan (D)
- facility failed to implement an intervention to help prevent altered skin integrity . Care plan directed to have client wear geri-gloves and non applies (D)

F 658—Services Provided Meet Professional Standards

- Order for oxygen and not on resident (D)
- Failed to have res. Rinse mouth after a breathing treatments resulting in a sore mouth (D)
- Failed to follow physician's orders for 1 of 12 residents regarding every shift oxygen saturations. Missed documentation 10 times each in Dec & Jan. (D)
- Facility failed to follow doctor's orders for tubi-grips (D)
- Nebulizer prepared by LPN; left at bedside in presence of res. Stated R.N. administers after assessment is completed. Failed to implement a Remeron GDR for 3 months after reduction was ordered by physician (D)

F 659—Qualified Persons

- Facility failed to follow the plan of care. Resident who was a 2-person transfer was transferred with one person to the bathroom when legs gave out and staff lowered to floor, knee swollen and transferred to hospital. Resident sustained a spontaneous fracture (D)
- Facility failed to complete psych eval ordered by physician (D)

F 677—ADL Care Provided for Dependent Residents

- Multiple residents received baths only 1x weekly. Some had documentation for only 2x per month because facility did not have enough staff. Resident observed with long, dirty fingernails, unshaven with food particles in beard (E)
- Facility failed to assist residents with timely dining assistance (E)
- Facility failed to maintain nails, shave residents or provide baths as required (E)
- Resident wet, staff applied clean pad with no incontinence cares (D)
- Facility failed to complete morning cares (D)

F 680—Qualifications of Activity Professional

- Resident exited the door in a wheelchair setting off the alarm. Staff turned off the alarm and did not see resident outside. A visitor came in and reported a resident was outside tipped over in the wheelchair. Resident sustained a small hematoma to the head. A second resident got up unattended, fell, and sustained a large subdural hematoma. The resident had his/her floor alarm discontinued in November of 2017 after being fall free for some length of time. Staff told surveyors the floor alarm worked to keep resident from getting up unattended, but when they DC'd it (in an effort to be "alarm free") she began getting up unattended again. She sustained the fall on 2/27/18, 3 months after the alarm was discontinued. (J) **$500 fine plus $6,000 fine in suspension**

F 684—Quality of Life

- Resident with Urinary report showing VRE and not acted upon for 2 days. Resident hospitalized and subsequently passed away (G) **$5,000 fine in suspension**
- Quality of care- Resident with recent history of hip surgery and noted to be alert and oriented reported to CNA she felt as though she was having a stroke. Demonstrated difficulty in speech. CNA reported to LPN approx 9:30a. CNA reported answering call light later approx 12:30pm and resident nodded head up and down when asked if wanted to go to hospital. CNA noted resident having increased trouble speaking and notified LPN. LPN asked CNA to take vital signs but CNA reported LPN advised them to watch resident for now and that LPN did not respond quickly enough and did not call ambulance until 2pm. Physician interviewed stated resident should have been brought to ED sooner. Family reported resident had permanent speech impairment from stroke (G) **$4,000 fine in suspension**
- Facility failed to complete wound care as ordered by physician (E)

- Facility nurse administered Lantus insulin ordered for administration in evening in am. Insulin administered over resident's objection. Nurse notified physician of med error via fax. Physician response not noted by staff until 2 am the next day (D)
- Failure to complete wound assessment sheets/assessment for wounds to feet. Failure to secure podiatry services for res. With toenail growing into skin and verbalizing pain (D)
- Facility failed to assess three bruises (D)
- Facility failed to intervene or notify the physician after a wound worsened. Measurements of the wound showed the area getting larger (D)
- Facility failed to ensure staff reported skin issues to the nurse immediately in order to obtain treatment orders for one of five residents (D)

F 685—Treatment/Devices to Maintain Hearing and Vision

- Facility didn't get antbx started for 4 days after UTI dx. There were multiple faxes not responded or followed-up on by MD (D)

F 686—Treatment to Prevent Pressure Ulcers

- Pressure sore not cleansed prior to applying ointment. Resident observed in bed without intervention or dressing in place over heel ulcer. Resident observed multiple times without dressing on sacral wound (E)
- Wound care for a pressure ulcer was not provided (D)
- Failed to ensure ongoing interventions were implemented for one resident with a pressure sore by not putting on a schedule to lie down during the day (D)
- Wound tx not changed for 3 months and no improvement, when tx changed not completed as ordered, care plan interventions not followed, lack of weekly skin assessments (D)
- Did not have the required members on the QA team for 3 of 6 meetings. Required to have DON, MD, Administrator, Owner or Board member and 2 additional staff. Owner/board member or additional staff not present (C)

F 688—Prevent Decrease in Range of Motion

- Therapy recommended restorative program-not provided or NA (D)
- Increase/prevent decrease in ROM/Mobility-1 of 19 residents, OT made a recommendation for ROM did not reach the nursing dept for 13 days (D)
- Therapy recommended restorative program-not provided or NA (D)

F 689—Free from Accidents and Hazards

- Resident eloped from building. Chair alarm was not in place as it was supposed to be per care plan. Wander guard was not working (staff was aware that it was not working), a second resident eloped from the same facility (AL) (dementia diagnosis) within 3 weeks of the first elopement. The audible alarm did not sound according to staff. A new server for the alarm system had been installed but it had not been programmed (per staff); therefore, the audible system did not sound. (K) **$19,500 fine in suspension**

- Resident eloped out the door. The wander guard alarm sounded but staff failed to verify who went out the door when another resident sitting near the door told her it was a staff member leaving (J) **$12,750 fine**
- Facility failed to provide 1 to 1 monitoring which resulted in a fall with fracture (G) **$7,250 fine**
- Fall outside bathroom, and resident not toileted per care plan, resident fell trying to get out of w/cfx wrist lack of full investigation, resident fell with walker when clothes on the floor and no review of causal factors for fall, resident fell out of w/c and bed and lack of fall prevention interventions on care plan (G) **$5,000 fine in suspension**
- Resident suffered head injury and vertebral fracture after falling out of bed when staff was repositioning resident. There was an air overlay on the bed and resident slipped from bed and hit head on trash can (G) **$3,000 fine in suspension**
- Res. Eloped out door. Door failed to alarm to alert staff of elopement. Res. Suffered. Staff were to check door alarm and res. Bracelet function weekly. Staff were checking door alarm, but not res. Bracelets. Res. Suffered a facial fracture. Facility thought bracelet model was good for 6 months; bracelets only good for 90 days. Res. to have a tabs alarm on during dining. Family member brought to D.R. Staff did secure the tabs alarm. Res. got up from D.R. chair, fell, suffering fracture. Repeated falls from electric recliner and res. using remote (J)
- Failed to ensure safety interventions were in place as planned for one resident; dycem was supposed to be above and under the alarm (D)
- Resident with history of sexual behavior had door sensor alarm and was removed due to new regs looking at alarms being restraints, then resident left room and inappropriately touched 2 female residents (D)
- Resident fell from Hoyer lift with no known reason why and fractured her clavicle (D)
- Facility failed to provide adequate supervision in dining room to prevent altercation as per care plan (D)
- Facility failed to educate a resident's family member on safe transfer technique and facility staff failed to elevate a resident’s feet off the floor during a transfer (D)
- Accidents/supervision/devices, extension cord for Christmas lights in 2 areas, 1 surge protector in resident room with oxygen concentrator and air mattress plugged into it (D)
- Resident found on floor by bed, no investigation or care plan interventions added (D)

F 690—Bowel, Bladder Incontinence, Catheter Care

- During pericare, aide wiped from buttock to vaginal area, rather than front to back (D)
- A leg strap was not utilized to secure a catheter (D)

F 692—Nutrition/Hydration Maintenance Status

- Facility failed to monitor plan for and/or modify interventions to meet a resident's needs with a significant weight loss (G) **$3,750 fine in suspension**
- Resident with significant weight loss and no interventions in place (D)
- Staff failed to follow S.T. recommendations for meal assistance for two residents. Res. Stated food was cold repeatedly to staff. Staff did not offer to heat food or replace the food. Failure to follow S.T. recommendations resulted in res. Having a deep harsh cough during meals (D)

F 695—Respiratory/Tracheostomy Care and Suctioning

- Resident on oxygen and order for o2 stats, not completed or documented (D)

F 725—Sufficient Nurse Staffing

- Facility failed to ensure proper staffing levels to provide adequate call light response times (E) **$500 fine**
- Facility residents, family and staff all reported chronic lack of staff impacting resident care (E)
- Facility failed to answer call lights in a timely fashion (D)

F 727—Registered Nurse 8 Hours per Day, 7 Days per Week, Director of Nursing

- Facility failed to provide the services of a full-time DON and failed to provide RN coverage for at least 8 out of every 24 hours (D)

F 730—Nurse Aide Performance Review/12 Hours In-Service Annually

- 6 of 9 CNAs did not receive 12 hours of training per year (D)

F 755—Pharmacy Services/Procedures

- Facility failed to properly count narcotics in E-kit (E)

F 756—Drug Regimen Review, Report Irregularities

- Pharmacist recommended GDR of Risperdal and Dr. wrote "rejected, stable on current dose" (D)
- Drug regimen review 1 of 14 residents physician did not return pharmacy recommendations (D)

F 757—Drug Regimen/Freedom from Unnecessary Drugs

- No gradual drug dosage reduction attempts for a resident taking Sertraline (D)
- Failed to discontinue a medication as ordered by the physician; administration continued BID for over 4 weeks (D)
- Failed to document interventions prior to PRN Seroquel and IM Haldol being administered (D)
- PRN Haldol administered without documented interventions being tried prior to medication administration (D)

F 758—Free from Unnecessary Psychotropic Medications

- No gradual dose reduction for a resident on Zyprexa (D)

- 2 residents received PRN psychotropic meds beyond 14 days without evaluation by physician (D)

F 760—Residents Free from Significant Medications Errors

- Resident had orders for both Plavix 1x daily and Eloquis bid. MAR shows that Eloquis not administered as ordered for a period of 8 days. At the end of the 8-day period the resident had contracted a deep vein thrombosis to the right hip and lower extremity (G) **$5,500 fine in suspension**

F 761—Label/Storage of Drugs and Biologicals

- Resident kept a bottle of Tylenol PM in room that family brought in unknown to staff (D)

F 803—Menus Meet Residents' Needs/Preparation in Advance/Followed

- Facility failed to serve a planned meal to one residents. Client who wanted to eat in her room did not receive noon meal until 2:00PM (D)
- facility failed to serve diets as ordered for residents on a mechanical soft diet (D)

F 804—Nutritive Value, Palatability, Appearance, Temperatures

- Milk temp too warm at 55-57.6 degrees, room trays temp too cool and resident reported would like hot food (D)

F 809—Frequency of Meals/Snacks at Bedtime

- Group interview revealed bedtime snacks not given on weekends or not always during the week (E)

F 810—Assistive Devices/Eating Utensils

- Facility failed to provide one resident their adaptive equipment during meal times. Staff did not serve clients meal in a bowl-like plate (D)

F 812—Food Procurement, Storage, Preparation, Sanitization

- Dirty items in kitchen, mixer, storage room, ice maker (E)
- Food procurement/storage/sanitary conditions-several food items opened but not dated/labeled and several items not covered. (E)
- Kitchen staff donned gloves to start meal service without washing hands; touched multiple surfaces; changed out gloves twice more during meal service without washing hands between glove changes (E)
- facility failed to always ensure staff prepared and served food under sanitary conditions. Staff did not change gloved hands after touching multiple surfaces (E)
- Kitchen staff touched pie with gloves that had been in contact with multiple surfaces. Cook touched mouth and forehead, the proceeded to touch bread with same gloves which was served to residents. Kitchen aide entered kitchen with fair net, but no beard covering. Multiple food items not labeled and dated when opened (E)

F 838—Facility Assessment

- Facility failed to properly complete facility assessment (D)

F 842—Resident Records—Identifiable Information

- Facility falsified documentation on MAR by circling initials indicating medication had not been given. Medication had not been discontinued per physician order. Nurse tried to alter other nurse's documentation to show medication was not given, but medication continued to be administered for over 4 weeks after order to discontinue the medication (D)

F 868—QAA Committee

- QA-Medical director attended only 2 meetings in last 12 months instead of 4 as required (C)

F 880—Infection Prevention and Control

- Nurse failed to sanitize scissors prior to dressing change. Nurse failed to completed hand hygiene between glove changes with dressing change (E)
- Glucometer not sanitized between residents, did not wash hands prior to putting on gloves, using wet paper towel vs alcohol swab to clean finger prior to lancet use (D)
- Staff handled a soiled lift sling after a transfer with bare hands. Staff did not change a soiled bed pad before placing a clean incontinence pad on the resident (D)
- Failed to sanitize scissors prior to wound dressing change. Failure to change gloves after removing soiled dressing from wound, cleansing and applying clean dressing (D)
- Staff provided peri-care wiping back to front; not cleansing the whole peri-area and not changing washcloth fold with each swipe (D)

F 881—Antibiotics Stewardship Program

- Failed to have an IPCP with an ASP component; no program or policy for ASP (C)

F 883—Influenza and Pneumococcal Immunizations

- Facility failed to provide information on influenza and pneumonia vaccines to residents (D)

C 139—Failure to Report to the Department

- Facility failed to notify DIA of fall resulting in admission to a higher level of care. Major injury determination signed by physician as not a major injury. Physician did not address all the injuries diagnosed in the hospital on the form. Cited due to not addressing injuries of cervical 2 and thoracic 3 fractures **$500 fine**

Annual Survey Frequency
March Survey Results Meeting

Facility	City	Last Year	This Year	Frequency
Brooklyn Community	Brooklyn	11/23/16	2/8/18	63 Weeks
Burlington Care Center	Burlington	12/1/16	1/30/18	60 Weeks
Clarion Wellness	Clarion	12/8/16	2/8/18	61 Weeks
Crestview Nursing & Rehab	Webster City	12/15/16	2/22/18	62 Weeks
Fellowship Village	Inwood	12/22/16	2/22/18	61 Weeks
Good Neighbor Home	Manchester	12/15/16	2/22/18	62 Weeks
Guttenberg Care Center	Guttenberg	121/1/16	2/8/18	62 Weeks
Living Center West	Cedar Rapids	12/8/16	2/8/18	62 Weeks
Maple Crest Manor	Fayette	12/15/16	2/22/18	62 Weeks
Mercy Medical Center-Dubuque	Dyersville	11/23/16	2/8/18	63 Weeks
Mercy Medical Center-Dubuque	Dubuque	12/29/16	2/28/18	61 Weeks
Meth Wick	Cedar Rapids	12/1/16	2/15/18	63 Weeks
Morning Sun Care Center	Morning Sun	1/25/17	2/22/18	56 Weeks
Newton Health Care Center	Newton	12/8/16	2/15/18	62 Weeks
Norwalk Nursing & Rehab Center	Norwalk	12/13/16	2/8/18	60 Weeks
Oakwood Care Center	Clear lake	12/8/16	2/15/18	62 Weeks
Osage Rehab & Healthcare Center	Osage	12/15/16	2/22/18	62 Weeks
Pearl Valley	Estherville	12/27/16	2/8/18	57 Weeks
Prairie Ridge Care & Rehab	Mediapolis	12/8/16	2/8/18	61 Weeks
Southern Hills Specialty care	Osceola	12/22/16	2/22/18	61 Weeks
St. Frances Care Center	Grinnell	11//17/16	1/30/18	63 Weeks
Sunrise Hill Care Center	Traer	12/15/16	2/15/18	61 Weeks
*Touchtone Healthcare Center	Sioux City	8/15/17	2/15/18	26 Weeks
Trinity Center at Luther Park	Des Moines	12/8/16	2/15/18	62 Weeks
Tru Rehab of Grinnell	Grinnell	11/17/16	1/30/18	63 Weeks
Wapello Specialty Care	Wapello	10/13/16	11/28/17	59 Weeks

*Special Focus Facility – Not counted in Totals

Earliest Survey:

Morning Sun Care Center	Morning Sun	1/25/17	2/22/18	56 Weeks
Pearl Valley	Estherville	12/27/16	2/8/18	57 Weeks

Latest Survey:

Brooklyn Community	Brooklyn	11/23/16	2/8/18	63 Weeks
Mercy Medical Center-Dubuque	Dyersville	11/23/16	2/8/18	63 Weeks
Meth Wick	Cedar Rapids	12/1/16	2/15/18	63 Weeks
St. Frances Care Center	Grinnell	11//17/16	1/30/18	63 Weeks
Tru Rehab of Grinnell	Grinnell	11/17/16	1/30/18	63 Weeks

4 Facilities were "Deficiency Free" - (16 %)

Brooklyn Community	Brooklyn
Mercy Medical Center- Dubuque	Dubuque
Morning Sun Care Center	Morning Sun
Wapello Specialty Care	Wapello

Average Survey Frequency:	**2018**		
	March Survey Meeting	**61.24 Weeks**	**(9.24 Weeks Late)**
	February Survey Meeting	**60.00 Weeks**	**(8.00 Weeks Late)**
	January Survey Meeting	**56.44 Weeks**	**(4.44 Weeks Late)**
	2017		
	December Survey Meeting	**56.79 Weeks**	**(4.79 Weeks Late)**
	November Survey Meeting	**57.30 Weeks**	**(5.30 Weeks Late)**
	October Survey Meeting	**55.92 Weeks**	**(3.92 Weeks Late)**
	September Survey Meeting	**55.00 Weeks**	**(3.00 Weeks Late)**
	August Survey Meeting	**55.92 Weeks**	**(3.92 Weeks Late)**
	July Survey Meeting	**56.54 Weeks**	**(4.54 Weeks Late)**
	June Survey Meeting	**54.90 Weeks**	**(2.10 Weeks Late)**
	May Survey Meeting	**54.90 Weeks**	**(2.10 Weeks Late)**
	April Survey Meeting	**52.84 Weeks**	**(0.84 Weeks Late)**