



Compliance Tips from IHCA’s Survey Results Committee March 2019

Total Number of Survey Reports: 53

Survey Composition:

Annual:	20 Surveys	4 Deficiency Free
Complaints:	35 Surveys	13 Unsubstantiated
Self-Reports:	13 Surveys	1 Unsubstantiated
Mandatory Reports:	4 Surveys	1 Unsubstantiated

State Fines:	\$4,000
State Fines in suspension:	\$29,750
Trebled Fines:	\$10,500

Most Commonly Cited Iowa Tags:

- F 689 – Free from Accidents and Hazards (9)
- F 656 – Develop/Implement Plan of Care (8)
- F 658 – Services Provided Meet Professional Standards (7)
- F 625 – Notice of Bed Hold Policy Before/Upon Transfer (6)
- F 812 – Food Procurement, Storage, Preparation, Sanitization (6)
- F 880 – Infection Prevention and Control (6)

Tags Resulting in Actual Harm or Higher Citations:

F 689 – Free from Accidents and Hazards: 4 G Level Tags, 3 J Level Tags

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=15578		Total Number of Surveys=8468
F0880	Infection Prevention & Control	594	3.7%	7.0%
F0689	Free of Accident Hazards/Supervision/Devices	536	3.3%	6.3%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	491	3.1%	5.8%
F0656	Develop/Implement Comprehensive Care Plan	466	2.9%	5.5%
F0684	Quality of Care	389	2.4%	4.6%
F0761	Label/Store Drugs and Biologicals	345	2.2%	4.1%
F0657	Care Plan Timing and Revision	297	1.8%	3.5%
F0758	Free from Unnec Psychotropic Meds/PRN Use	294	1.8%	3.5%
F0677	ADL Care Provided for Dependent Residents	255	1.5%	3.0%
F0609	Reporting of Alleged Violations	225	1.4%	2.7%

*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

- Resident stated that staff ripped her glasses off of her face, threw them on bed when resident was unable to swallow medication. Staff stated resident had glasses in hand, staff took them then accidentally dropped them and forgot to pick them up. D
- Fail to ensure each resident received care with dignity, respect, in full recognition of their individuality; staff member refused to provide ordered treatments, was rude. D
- Fail to provide eating assistance in manner that maintained resident's dignity and affirmed individuality. Staff stood next to residents while assisting them to eat. D

F554 – Resident Self-Admin Meds-Clinically Appropriate

- Fail to assess/evaluate to determine resident's capability of self-administering medication (Tums). Care plan lacked documentation of self-administering the medication. Lacked a physician order to self-administer medication. D

F558 – Reasonable Accommodations of Needs/Preferences

- Fail to provide reasonable accommodation of resident needs and preferences. D

F576 – Right to Forms of Communication with Privacy

- Failure to provide residents access to mail services on Saturday. D

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

- Failure to ensure advanced directive was in place for a resident.

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

- Fail to notify physician of change of condition when hospice resident had left sided drooping and skin was gray in color. D
- Fail to notify physician and family in a timely manner of a change of condition. D
- Failure to consult a resident's guardian prior to asking the Physician to discontinue a medication for resident. D

F582 – Medicaid/Medicare Coverage/Liability Notice

- Facility failed to provide residents discharged from skilled level of care with the required forms for Medicare Liability Notices and Benefits Appeals. B

F584 – Safe/Clean/Comfortable/Homelike Environment

- Doors had marring, 2-inch gap between kick guard and bottom of door, baseboard disconnected from wall, doors with chunks missing. E
- Facility failed to provide the residents a homelike and well-maintained environment. Boards in hallway supporting ceiling, no hot water in dirty utility room. Ceilings with multiple holes, missing paint on walls E

F600 – Free from Abuse and Neglect

- Facility failed to protect one resident from resident-to-resident abuse. Lack of follow up interventions after separation. D

F604 – Right to be Free from Physical Restraints

- Failure to assess for side rail use for residents. D

F607- Develop/Implement Abuse/Neglect, etc. Policies

- Employee did not receive 2 hours of DAA training within 6 months of hire. D

F610 – Investigate, Prevent, Correct Alleged Violation

- CNA who witnessed an alleged incident of verbal abuse did not report it to management. Facility did not separate the alleged victim and perpetrator and failed to educate staff on abuse following the alleged incident. D

F620 – Admissions Policy

- Fail to obtain completed admission agreements at time of admission for multiple residents. E

F622 – Transfer and Discharge Requirements

- Clinical record did not show medical information sent to hospital with resident. B
- Facility failed to document they provided adequate information when a resident transferred to another facility. Record lacked documentation that confirmed staff communicated pertinent information to the receiving facility. D

F623 – Notice Requirements Before Transfer/Discharge

- Facility did not notify ombudsman of discharge/transfer to hospital. B
- Failed to notify a resident of an involuntary discharge from the facility. D
- Facility failed to notify Long Term Care Ombudsman of resident transfers. C

F625 – Notice of Bed Hold Policy Before/Upon Transfer

- Facility did not provide notice of bed hold policy to resident or representative. B
- Bed hold policy not provided to resident that was sent to hospital. B
- Fail to provide a copy of bed hold policy at time of transfer to hospital. B
- Failure to provide notice to resident or resident representative of the facility's bed hold policy prior to and upon transfer to the hospital for multiple residents. D
- Fail to provide copy of bed hold policy at time of transfer to hospital. B
- Fail to notify the resident or representative of the facility bed hold policy. B

F636 – Comprehensive Assessments & Timing

- Facility failed to complete a comprehensive and accurate assessment. Miscalc Level II PASRR. B
- Fail to complete comprehensive admission MDS assessment within 14-days of admission. D

F637 – Comprehensive Assessment After Significant Changes

- Fail to complete significant change assessment for resident in closed record review. D

F638 – Quarterly Assessment at Least Every 3 Months

- Facility failed to complete comprehensive assessments in a timely manner. E

F641 – Accuracy of Assessments

- Did not accurately document information in MDS for three residents. B
- Fail to code MDS for 2 of 19 residents related to falls and injections (insulin). B
- Failure to accurately code the MDS assessment. D

F644 – Coordination of PASRR and Assessment

- Failure to submit a new PASRR after a resident had a new diagnosis of delusional disorder, major depressive disorder and unspecified psychosis. D
- Failure to refer a resident for special behavioral services. D
- Failure to repeat a Level 1 PASRR when a resident had a diagnosed mental disorder not documented on the previous PASRR for multiple residents. D

F645 – PASRR Screening for MD & ID

- Fail to complete subsequent form/resubmit to ASCEND for placement/services according to PASRR after limited 60d approval stay requiring reevaluation. D
- Fail to ensure PASRR form was completed/updated when resident had condition change for multiple residents for PASRR. Lack of documentation. E

F655 – Baseline Care Plan

- Failure to provide the resident or resident representative with the Base Line Care Plan for multiple residents. B

F656 – Develop/Implement Plan of Care

- Care plan failed to address the use of anticoagulation medication D
- Care plan didn't establish interventions to address resident's repetitive action of removing lap buddy; for staff to monitor resident when sitting in wheelchair; no interventions giving staff specific directions regarding care needs/behavioral actions of resident. D
- Fail to create comprehensive care plans for at-risk for pressure ulcers. Skin sheets lacked weekly assessments. Progress notes lacked documentation resident had a pressure ulcer. Failed to contain names of specific medications or staff directives for a resident taking an antipsychotic. D
- Fail to develop comprehensive care plan for resident in closed record review. D
- Failure to complete comprehensive care plan for multiple residents. E
- Failure to establish a care plan reflective of assessment that identified resident's need for nursing, medical, mental and psychosocial care for resident. D
- Failure to follow care plan. D
- Fail to develop a comprehensive care plan that addressed the use of psychotropic medication. D

F657 – Care Plan Timing & Revision

- Failure to update POC for significant weight loss and interventions. D
- Failure to ensure POC addressed all care issues for residents. D
- Fail to ensure resident presence; document resident's attendance at care plan conferences. D

F658 – Services Provided Meet Professional Standards

- Fail to don TED hose 13 of 31 days for resident and to apply ointment. D
- Fail to follow physician orders apply prn, resident had dime sized eschar. D
- Fail to follow physician orders. Facility did not do daily pulse or blood pressures as physician ordered due to medication. D
- Fail to provide services that met professional standards of medication administration related to gastrostomy tube. Fail to listen for air bubble to check placement. Fail to flush water before/after instilling Sucralfate. Lacked an order to flush the tube. D
- Failure to follow physician's orders for or clarify the use of alcohol and failed to complete routine renewal of orders for resident. D
- Failure to provide appropriate care in accordance to accepted professional standards of clinical practice for residents. D
- Fail to ensure staff utilized professional standards when administering resident medications. D

F661 – Discharge Summary

- Failed to complete a discharge summary recapitulation of the resident's stay. C

F675 – Quality of Life

- Failure to assess and provide interventions to resolve skin conditions . D

F677 – ADL Care Provided for Dependent Residents

- During incontinent cares staff failed to clean the perineum. D
- Failed to provide complete and proper incontinence care. D
- Failure to assure 3 of 12 residents receive baths per their preference. D
- Fail to ensure complete peri-care provided for resident during personal cares. D
- Fail to ensure resident who was unable to carry out ADLs received necessary services to maintain personal hygiene. Lack of morning cares with incontinence. CP didn't address resident's incontinence. Resident wheeled into room after meal and left in wheelchair. D

F684 – Quality of Care

- Fail to adequately assess a change of condition (closed record). Record lacked follow up assessment related to complaints of itching/initiation of Prednisone. D
- Fail to ensure staff completed a full nursing assessment when a resident had a condition change that warranted an assessment. D
- Failure to provide appropriate treatment of diabetic foot ulcer for a resident. D
- Fail to ensure residents receive treatment/care in accordance to professional standards of practice, person-centered care and offer choices. Cream ordered, not started for 5 days without physician notification. Jar of lidocaine/nifedipine on sink counter, resident reported he applied it himself. Lack of documentation on TAR that cream was applied. Record lacked assessment of skin or refusals of resident to allow skin to be checked. Lack of follow up assessment of skin tear after resident altercation. Another altercation r/t a resident touching other residents' breast per family interview, record lacked documentation of incident and/or assessment of area. D

F686 – Treatment to Prevent Pressure Ulcers

- Fail to prevent pressure ulcer. Prevalon boots not initiated as ordered. D
- Fail to ensure resident with pressure ulcers receives necessary treatment/ services, consistent with standards of practice. Resident with current pressure ulcer, without pressure reduction cushion, treatment dressing not in place. Care plan without direction for pressure reduction cushion. D
- Fail to ensure intervention planned for healing of pressure area was in place. D
- Fail to properly document, provide care, treatments, services consistent with professional standards to prevent new pressure ulcers from developing and care for existing pressure ulcers. Lack of weekly skin assessments. No cushions in place. No request for repositioning. Care plan lacked skin prevention interventions. D

F 689 – Free from Accidents and Hazards

- Resident with Wanderguard exited building and staff were not aware until resident was knocking on door to come back in. Door had alarm that could not be heard throughout unit. Door had been "broken" for the last 8 months. J **(\$4,000 FINE)**
- Fail to provide adequate supervision to prevent an accident causing injury; resident with multiple fall history fell forward out of wheelchair. G
- Facility staff left a resident at edge of bed in the middle of dressing room, exited the room and staff found her on the floor a few moments later. Resident required the assistance of one staff to dress and walk. G **(\$10,500 FINE- (3,500 TREBLED))**

- Fail to ensure residents environment remained as free of accident hazards as possible and each resident received adequate supervision/assistance devices to prevent accidents for multiple residents. G
- Fail to follow care interventions to prevent falls for resident resulting in fractured hip. G **(\$5,250 FINE).**
- Fail to recognize door alarm sounding resulting elopement of residents. J **\$7,000 FINE)**
- Fail to ensure safety; resident fell, and foot was close to register; resident sustained 2nd degree burn. Residents did not receive safe smoking environment. Residents are unsupervised, staff fail to respond to doorbell to assist residents back into facility. G **(\$4,000 FINE)**
- Failure to provide adequate supervision for a resident in order to prevent an unplanned exit (elopement) from the facility. J **(\$6,500 FINE).**
- Fail to ensure the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision and assistive devices to prevent accidents. Resident was known to not wait for staff and not use the call light and staff failed to increase resident monitoring. Resident fell 5 times in a month sustaining 2 fractures. Lack of interventions on care plan other than educated to use call light. (Lewy Body Dementia). G **(\$7,000 FINE).**

F 690 – Bowel, Bladder Incontinence, Catheter Care

- Staff failed to provide proper perineal care to incontinent resident. D
- Failure to provide complete incontinence care for multiple residents. E
- Facility failed to provide proper pericare for residents. D
- Fail to complete proper perineal care for resident, fail to complete thorough bladder assessment. D
- Fail to provide appropriate catheter care. Staff placed the catheter bag, covered with dignity bag and cath tubing on floor during toileting, then placed again on floor after transfer to bed. Staff put on gloves, picked up the dignity bag and drained cath bag with same gloves. D

F 692 – Nutrition/Hydration Status Maintenance

- Failure to prevent weight loss for 1 of 3 residents. D
- Failure to identify a significant weight loss for a resident. D

F 695 – Respiratory/Tracheostomy care and Suctioning

- Staff failed to follow physician orders related to oxygen therapy. 4lpm at night and resident was seen wearing it at 2.5 lpm during the day. D

F 698 – Dialysis

- Failure to complete a nursing assessment on multiple dialysis residents before and after dialysis treatments as required. D
- Fail to provide nursing assessment before/after dialysis treatments. D

F 700 – Bedrails

- Fail to assess bed for risk of entrapment for residents utilizing side rails. D
- Fail to assess each resident for use of bed side rails, review risks/benefits with resident or representative, or obtain informed consent for use of side rails. E

F 725 – Sufficient Nurse Staffing

- Failed to answer call lights in a timely manner. E
- Fail to answer resident call lights in timely manner in order to meet residents' needs. D

F 727 – RN 8 Hrs./7 days/Wk., Full Time DON

- Failure to have RN on duty for 8 hours and used DON when census was 70. D
- Fail to have adequate RN coverage; LPN working 31-hours straight. E

F 730 – Nurse Aide Perform Review – 12Hr /Year In-service

- Fail to ensure CNA's completed 12 hours of in-service for staff reviewed. B
- Failure to perform performance evaluations for 4 of 10 staff. B

F 732 – Posted Nurse Staffing Information

- Failed to display a posting of nursing staffing hours during the survey week. C

F755 – Pharmacy Services/Procedures/Pharmacist/ Records

- Mishandling controlled medications, didn't follow protocol to prevent discrepancies. Ativan vial was borrowed from one resident and used for another. Facility records did not match pharmacy records of Lortab 5/325. Nurses/CMA's not counting off narcotics when keys were handed off. E
- Failure of facility to accurately dispense and account for controlled substances for residents, residents received Tylenol versus Tylenol #3. E
- Facility failed to ensure resident medications were properly stored after received to prevent loss or diversion. Failed to count narcotics at change of shift and failed to secure in double locked area. No count sheet for Tramadol. D

F757 – Drug Regimen- Free From Unnecessary Drugs

- Fail to provide appropriate diagnosis for use of antipsychotic medication. D

F758 – Free from Unnecessary Psychotropic Meds/PRN Use

- Fail to discontinue prn psychotropic after 14 days. Didn't try a nonpharmacologic intervention prior to giving anti-anxiety medication. D
- Failure to assure GDR of antipsychotic medications for 1 of 5 residents. D
- Fail to discontinue as-needed psychotropic med w/in 14 days of new order. D
- Fail to have anti-anxiety medications ordered for limited time of 14-days, failed to provide written rationale for anti-anxiety medication use extended for 6 months. D

F760 – Residents Are Free of Significant Med Errors

- Significant medication error - anticoagulant medication given after it had been discontinued by the physician. D

- Failed to ensure residents are free of significant medication errors - 1 resident's meds given to another resident. D
- Fail to ensure free of significant medication errors; wrong dose of Morphine. D

F761 – Label/Store Drugs & Biologicals

- Failure to date an insulin vial when opened. D

F801 – Qualified Dietary Staff

- Failed to have a CDM on staff. F
- Fail to employ full-time dietician, certified dietary manager, certified food services manager. D

F803 – Menus Meet Res Needs/Prep in Advance /Followed

- Fail to serve menu as written; wrong serving size scoop used for pureed meat. D

F804 – Nutritive Value/Appearance/Palatability/Temp

- Failure to serve meals at proper temperature. E
- Fail to provide hot food items at/above 140 degrees and cold items at or below 41 degrees F. E

F 812 – Food Procurement, Storage, Preparation, Sanitization

- Dietary staff failed to wash hands before moving from dirty to clean task. E
- Failed to ensure that dietary staff wore hair restraints for facial hair. E
- Fail to maintain cleanliness- ice machine, dish wash, cookie sheets in kitchen. F
- Failure to maintain hot food at or above 135 degrees F and cold foods at or below 41 degrees F during observation at meals. E
- Fail to maintain sanitation in dry storage area, serve food in sanitary manner. F
- Fail to handle, prepare, distribute food in manner that prevents foodborne illness to residents. After handling raw chicken employee touch inside bowls of other foods (beans, sweet potatoes) No revision to cleaning procedures/schedules since July 1999. E

F 842 – Resident Records - Identifiable Information

- Fail to accurately document incidents in nurse's notes related to behaviors/burns. D

F 880 – Infection Prevention and Control

- CNA double-gloved while doing cares, did not do hand hygiene. When bed pan was placed and removed nothing was placed under it to provide infection control staff didn't change gloves/hand sanitize when going from dirty to clean task. D
- Fail to follow proper infection control for use of blood glucose meter by putting dirty meter in drawer of med cart. D
- Fail to ensure staff utilize infection control techniques for residents related to removing contaminated gloves, dressing changes, changing of oxygen tubing and humidifier. D
- Fail to ensure staff utilized proper infection control practices during cares/treatment for multiple residents. E
- Clean linens transported in hallway uncovered. D

- Facility failed to practice adequate infection control measures with a urinary catheter. Cath strap grey and dingy and contained the name of another resident on the strap. Staff emptied wash basin into sink after incontinence cares. D

F883 – Influenza and Pneumococcal Immunizations

- Failure to ensure each resident received education related to the influenza vaccine and failed to administer the influenza vaccine in accordance with national recommendations for multiple residents reviewed. E

F943 – Abuse, Neglect, and Exploitation Training

- Fail to ensure CNA received two hours of dependent adult abuse training within six months of hire. D

S128

- Fail to assess residents for latent or active TB infection, complete two-step TB skin test or single Interferon Gamma Release Assay as directed for TB infection.

Nursing Facility Survey Frequency

As of April 2, 2019, CMS lists 80 Iowa facilities (18.3%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 8.5%. National average is 6.6%

2019 - January Totals - LTC Surveys				
Provider	City	Survey End Date	Previous Date	Months Between
ACCURA HEALTHCARE OF BAXTER, LLC	Baxter	01/24/2019	10/26/2017	15.17
ALGONA MANOR CARE CENTER	Algona	01/03/2019	9/14/2017	15.87
CEDAR MANOR NURSING HOME	Tipton	01/16/2019	10/12/2017	15.37
CREST HAVEN CARE CENTER	Creston	12/8/2018	9/14/2017	15.00
CRESTRIDGE CARE CENTER	Maquoketa	01/10/2019	10/5/2017	15.40
DEERFIELD RETIREMENT COMMUNITY INC	Urbandale	01/19/2019	10/19/2017	15.23
HERITAGE HOUSE	Atlantic	01/10/2019	9/28/2017	15.63
KANAWHA COMMUNITY HOME	Kanawha	01/10/2019	9/28/2017	15.63
MANILLA MANOR	Manilla	01/24/2019	10/5/2017	15.87
MAPLE HEIGHTS	Mapleton	01/10/2019	9/14/2017	16.10
MERCY MEDICAL CENTER	Cedar Rapids	01/15/2019	10/5/2017	15.57
NORA SPRINGS CARE CENTER	Nora Springs	01/16/2019	9/28/2017	15.83
PARKVIEW CARE CENTER	Fairfield	12/13/2018	8/4/2016	15.93
PEARL VALLEY REHABILITATION & HEALTHCARE	Washington	01/17/2019	8/14/2017	17.37
QHC MITCHELLVILLE, LLC	Mitchellville	01/24/2019	10/19/2017	15.40
RUTHVEN COMMUNITY CARE CENTER	Ruthven	01/16/2019	10/5/2017	15.60
SUNNY VIEW CARE CENTER	Ankeny	01/16/2019	10/12/2017	15.37
VALLEY VIEW VILLAGE	Des Moines	01/10/2019	9/15/2016	15.63
WESTVIEW CARE CENTER	Britt	01/16/2019	10/5/2017	15.60
WHEATLAND MANOR	Wheatland	01/24/2019	10/12/2017	15.63
			Average =	15.80