Iowa Health Care Association
Iowa Center for Assisted Living
Iowa Center for Home Care

Compliance Tips from IHCA's Survey Results Committee March 2021

Total Number of Survey Reports: 104

Survey Composition:
Annual: 6 Surveys 1 Deficiency Free
Complaints: 70 Surveys 10 Unsubstantiated
Self-Reports: 13 Surveys 2 Unsubstantiated
Mandatory Reports: 1 Surveys 0 Unsubstantiated
COVID-19 Infection Control Survey: 14 Surveys 2 Deficiency Free
State Fines: $124,750
State Fines in suspension: $114,000

Most Commonly Cited Iowa Tags:
F880 – Infection Prevention and Control (7)
F689 – Free from Accidents and Hazards (6)
F684 – Quality of Care (6)
F580 – Notify of Changes (Injury/Decline/Room, Etc. (5)

Tags Resulting in Actual Harm or Higher Citations and Fines:

F 684 – Quality of Care	**2 J Level Tags and 1 L Level Tag**
F 686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers	**2 G Level Tags**
F 689 – Free from Accidents and Hazards	**4 G 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=15342	Total Number of Surveys=20024
F0884	Reporting - National Health Safety Network	1,816	6.4%	9.1%
F0880	Infection Prevention & Control	1,675	8.9%	8.4%
F0689	Free of Accident Hazards/Supervision/Devices	378	2.1%	1.9%
F0684	Quality of Care	312	1.8%	1.6%
F0580	Notify of Changes (Injury/Decline/Room, etc.)	249	1.4%	1.2%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	238	1.3%	1.2%
F0609	Reporting of Alleged Violations	200	1.1%	1.0%
F0677	ADL Care Provided for Dependent Residents	188	1.1%	0.9%
F0842	Resident Records - Identifiable Information	188	1.1%	0.9%
F0656	Develop/Implement Comprehensive Care Plan	178	1.0%	0.9%

*Additional detailed national, regional, state and facility-specific CMS regulatory data can be found S&C's Quality, Certification, and Oversight Reports (QCOR).

<u>Deficiencies and Fines</u> (sorted ascending by F-tag number)

F550 – Resident Rights/Exercise of Rights

- Staff members failed to respect resident's dignity when 2 CNA's spoke in Spanish to each other when performing resident care. D
- Facility failed to assure resident received appropriate care to maintain/enhance quality of life for 3 of 5 residents. Resident admitted to hospital was unkempt and smelled of urine. Had significant raw wound under left breast extending to side of her back. Wound had foul odor measured 9.75 by 3.5 inches. No bath in almost two weeks. No history re assisting resident with toilet use or personal hygiene. Another resident discharged to AL and LA found resident had foul odor and found when they went to assist with bathing that resident had fecal matter under breasts and over back. Skin had broken down and was red for about six inch area under breasts. Wounds weeping with yellowish green liquid. Third resident multiple instances of not getting a bath for weeks at a time. Long growths of hair across her chin. D **$10,000.**

F558 – Reasonable Accommodations of Needs/ Preferences

- Facility failed to permit compassionate care visitation during a residents significant decline in condition that resulted in the death of resident. Resident resistant to cares, wouldn't eat unless fed, dropping oxygen levels, hospice asked for wife and was told wife of resident in the covid unit (not with resident) late that day resident passed. Wife and husband had previously been in same room but after wife got covid they would not let her visit before he passed away. Permission came 5 minutes after he died. D
- Facility failed to assure resident received appropriate care to maintain/enhance quality of life for 3 of 5 residents. Resident admitted to hospital was unkempt and smelled of urine. Had significant raw wound under left breast extending to side of

her back. Wound had foul odor measured 9.75 by 3.5 inches. No bath in almost two weeks. No history re assisting resident with toilet use or personal hygiene. Another resident discharged to AL and LA found resident had foul odor and found when they went to assist with bathing that resident had fecal matter under breasts and over back. Skin had broken down and was red for about six inch area under breasts. Wounds weeping with yellowish green liquid. Third resident multiple instances of not getting a bath for weeks at a time. Long growths of hair across her chin.

F569 – Notice and Conveyance of Personal Funds

- Facility failed to return funds from the resident's trust fund account within 30days of residents death. D

F578 – Request/Refuse/Discontinue Treatment; Formulate Adv Di

- Facility failed to ensure proper code status was on residents IPOST. CPR/DNR form did not match IPOST. D

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

- Facility failed to notify the resident representative when there was a significant change in the residents physical mental or psychosocial status. Resident found on the floor and would not initially let staff let her up. Yelled obscenities at staff refused vital signs. Isolated in her room and refused food. yelled whenever staff came in. No documentation of notification of fall or order change to DC Benadryl to family. E
- Facility failed to notify family of changes in condition. Multiple resident responsible parties reporting lack of notification related to changes in condition. E
- Facility did not notify the physician and family of a significant weight gain over a 6-month period. D
- Facility did not notify family of resident's fall and transfer to the hospital due to potential head injury and did not notify another resident's family after a 3x4 cm pressure ulcer was detected. D
- Facility staff failed to promptly report a resident skin concerns and new physician orders to family and responsible parties for 2 residents. D

F584 – Safe/Clean/Comfortable/Homelike Environment

- Facility failed to provide a clean shower room. Hall shower with black scuff marks on floor, broken particle boards, buildup of black material around base boards. E
- Staff member failed to provide clean linen after a pillow fell on the floor and then was returned to the resident's bed. D

F600 – Free from Abuse and Neglect

- Staff member, upset at other staff members, cursed at a resident and staff members while providing resident care. Employee terminated. D

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

- Failed to complete background check within 30 days prior to date of hire for one staff. D **$500**.

F609 – Reporting of Alleged Violations

- Facility failed to investigate allegation of misappropriation of resident property, failed to report the allegation to DIA, failed to report reasonable suspicion of a crime to local law enforcement. Missing gold necklace reported by responsible party. D **$500**.

F610 – Investigate/Prevent/Correct Alleged Violation

- Facility failed to separate the alleged perpetrator from the victim. Staff member was moved to another part of facility after allegation, but did have contact with resident by delivering meal to his room without another staff member present. D
- Facility failed to conduct a thorough investigation of an incident of alleged abuse. D

F620 – Admissions Policy

- Facility required payments as a condition of admission and continued stay, a violation of Medicare regulations for skilled care recipients. D

F624 – Preparation for Safe/Orderly Transfer/ Discharge

- Facility failed to do proper discharge planning and resident education. No documentation of family education regarding resident care needs or medications. D
- Failed to provide and document sufficient preparation for transfer or discharge of resident. Facility had agreed to take resident but when resident arrived said they could not and informed family to take her to ER, said they couldn't regulate the drug the resident was on. No records from facility re resident or resident family had provided sufficient preparation to ensure safe or orderly discharge. Facility reported resident had started running up and down hallways and biting upon arrival. Facility did not inform ER that resident was coming and also sent resident in spouse's car. D

F625 –Notice of Bed Hold Policy Before/Upon Transfer

- Facility failed to provide bed hold policy for resident. D

F656 – Develop/Implement Comprehensive Care Plan

- Facility failed to ensure the comprehensive care plan developed and updated for a resident. Care plan did not have order for Eliquis as was facility practice to include all black box warning medications with side effects to monitor for on the care plans. D
- Facility failed to follow physician orders for resident Lortab was not given tramadol given in error at bedtime
- Care plan not updated to show specific goals or directives relating to respiratory function for resident on oxygen. E

F657 – Care Plan Timing and Revision

- Facility failed to update residents care plan. Did not address ambulatory status after a fractured hip, did not address newly developed pressure ulcers from 2 weeks ago,

did not address her transfer status after a fractured pelvis, no reference to fall resulting in fracture. D

- Facility failed to add a care plan intervention after a significant weight gain was identified. D

F658 – Services Provided Meet Professional Standards

- Services did not meet professional services. Lacked documentation that they followed orders to do treatments as ordered by physician multiple dates and times. D
- Facility failed to assure residents were free of significant medication errors. Did not follow insulin pen manufacturer's guidelines of holding the pen in the skin for an additional 6 seconds after injection medication. D
- Facility failed to follow physician orders for 3 of 3 residents. In one case failed to document weight daily. Failed to give updated dose of medication. Another resident identified oxygen therapy use of 02 via nasal prongs at 2-5 units continuously no documentation of OID sats. no weights and vitals. Didn't have triad for resident and failed to notify resident physician to treat with alternative. Signed on MAR as doing treatment when not available. E
- Facility failed to follow physician orders for resident Lortab was not given tramadol given in error at bedtime. D

F661 – Discharge Summary

- Facility failed to document the disposition of medications upon discharge from facility or death. E

F677 – ADL Care Provided for Dependent Residents

- Facility failed to document that baths/showers had been provided and failed to provide proper incontinence care. E
- Facility failed to provide routine oral care. D
- Failed to make sure 5 of 5 residents received grooming and personal hygiene. Resident had not received bath or shower in nearly a month and reported that she had not refused a bed bath either. Similar circumstances for other residents. On resident had caked fecal matter on her and reddened skin. E

F684 – Quality of Care

- Facility failed to document adequate assessments. Resident transferred to ER with complaints of hip pain, no assessment or documentation of what occurred prior to transfer & no assessment of resident upon return to facility after repair of fracture. Resident deceased within 3 days of admission, no documentation of care plan or an assessment of resident prior to death. No documentation of resident having a fall or assessment post fall. Lack of proper wound assessments. Lack of follow up assessment of reddened eyes after x1month when resident was requesting eye drops. E

- Facility failed to adequately assess and intervene for a resident who had 2 unwitnessed falls that ultimately led to a dislocated hip and the need for a hospitalized, sedated, hip reduction. D
- Facility failed to identify a significant change in a resident's condition after the resident fell and sustained a major injury. The resident required transfer to hospital and admission to ICU. D
- Facility failed to report and treat a rapid resident decline including emesis, lack of bowel sounds, lethargy and respiratory distress. Physician was notified by fax that was not signed until 4 days until after resident died. J **$10,000**.
- Failed to meet professional standards of care for 1 resident. Failed to follow physician orders, failed to transcribe orders properly, failed to ensure follow up appointments were attended (should have attended weekly visits upon hospital discharge but not attended for period of at least a month until admitted into hospital again). Resident developed bone infection as a result that required hospitalization. J **$17,750**.
- Facility failed to do assessments and failed to timely intervene after a change in condition for 6 of 7 residents. Resident w/ covid had no assessment after a change in condition including difficulty breathing. He was sent to ER in severe distress and very dehydrated. Another resident with history of urosepsis and elevated temperatures with orders to monitor closely and his temp taken only one day before being hospitalized with acute kidney failure, hypernatremia, hyperkalemia and sepsis. Another with a blood sugar of 51 was given insulin and document refusal of breakfast and no blood sugar check or follow up until lunch at a blood sugar check of 35 and sent to hospital for hypoglycemia. Similar issues. No follow up to physicians. Lack of documentation of basic vitals in all. L

F686 – Trmt/Services to Prevent/Heal Pressure Ulcers

- Facility failed to ensure residents with pressures sores received that necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Lack of thorough weekly assessments. Progress notes failed to reflect weekly assessments of pressure ulcer. Physician reported ulcer was avoidable if treated correctly. Physician had no knowledge of ulcer. Lacked assessment of site, measurements, staging. D
- Facility failed to prevent acquired pressure ulcers forming and failed to document assessments/measurements weekly. Lack of interventions to reduce risk prior to development of ulcer, no wheelchair cushion in place for resident with known coccyx ulcer, document wound treatments per standing order with no mention of hydrocolloid dressing included in signed standard orders. Incomplete EHR weekly wound documentation tool. G **$8,500**.
- Facility failed to ensure residents did not receive facility acquired pressure ulcers and resident did not received assessment and measurement of an ulcer when first

discovered. Lack of following wound nurse recommendations r/t equipment. Lack of assessment and notification of changes to wound nurse. G **$6,000**.
- Resident admitted on 8/20/2020 without pressure ulcers. On 8/21/2020 skin impairment was noted on buttocks. There was no physician notification or weekly assessment of area. On 9/7/2020 resident was transferred to hospital where a Stage 4 pressure ulcer measuring 3-4 cm was noted. D
- Lack of complete documentation of pressure ulcer status for 4 residents. E

F689 – Free from Accidents and Hazards

- Resident elopement- facility failed to identify the resident's window as a potential exit. Resident had lots of exit seeking behaviors and no safety awareness. Interventions include wander guard. Resident found out in parking lot groaning and laying on side. He was given comfort care and hospice care along with pain management. Had some lacerations and bruising, complained of pain. Had a neck fracture. Resident used his over bed table to climb up and out window. heard faint calling out 20 minute after last checked on him. They found window open and screen popped about and secure care band in garbage and found him lying in parking lot. No coat gloves or hat and 22 degrees. history of attempts to elope. G $**5,250**.
- Failed to ensure environment remained free of accident hazards. Resident had history of trying to self transfer from the bed. Staff found resident face down between bed and heater with burn on her arm from baseboard heater. G
- Facility failed to prevent falls resulting in fractures & failed to prevent fall out of a wheelchair. Lack of documentation in risk management re: staff no using gait belt. Lack of assessments after falls with complaints of pain. G **$9,000**.
- Facility failed to provide a safe transfer. During transfer with hoyer sling, leg straps not crisscrossed and resident fell out. G **$5,000**.
- Resident exited the facility to parking lot and was found about 5 minutes later by staff coming to facility. Multiple staff members indicated that they did not hear the alarm sound when the resident exited and thus did not respond. D
- Facility failed to provide adequate supervision to prevent resident from falling and sustaining injury. Resident fell 8 times within 12 days. G **$14,250.**

F690 – Bowel/Bladder/Incontinence, Catheter, UTI

- Facility failed to provide that appropriate care and services to prevent urinary tract infections. Did not follow policy of using sterile kits and containers during bladder irrigations. D
- CNA improperly performed pericare by repeatedly using the same wipe without changing to a clean cloth surface. D
- Facility failed to provide complete incontinence are for two of five residents. Failed to provide catheter care to prevent infection. Failed to change glove when soiled and failed to perform hand hygiene during incontinence care. D

F692 – Nutrition/Hydration Status Maintenance

- Failed to ensure appropriate nutrition hydration for 2 of 4 residents. Assessments documented poor food and fluid intake but no interventions. 9.5% weight loss no family or physician notifications and no interventions. Presented at ER severely dehydrated. Second resident with 9.5% weight loss in 6 weeks no notifications. Did not adequately assist resident who needed assistance eating. brought him food he could not eat. Resident lost 13.8% in 6 months. G

F695 – Respiratory/Tracheostomy Care and Suctioning

- Facility failed to have adequate tracheostomy suctioning equipment on hand for resident who was experiencing respiratory distress. Resident, via sign language, requested call to 911 when a proper suctioning tube could not be immediately found and then suction machine failed to work. Resident required transfer to emergency room. D

F726 – Competent Nursing Staff

- Facility failed to ensure a licensed nurse had competency and skill sets necessary to care for and suction a tracheostomy. Resident having trouble breaching staff not trained on tracheostomy care and suctioning and called NP to get orders to have resident sent to the hospital. Used nebulizer treatment with facemask instead of trach collar as ordered. DON told staff of improper use of mask for nebulizer treatment. Resident wanted to go home but not possible and resident did not understand why. Dr. Order facility should monitor weight daily monitor for edema. No documentation of family notification. D

F755 – Pharmacy Svcs/Procedures/Pharmacist/Records

- Facility failed to ensure narcotics were destroyed with two staff to witness destruction for two of seven residents prescribed controlled substances. D

F758 – Free from Unnec Psychotropic Meds/PRN Use

- Facility failed to provide interventions consistently before providing PRN psychotropic drugs. Failed to obtain doctors order for 14 day limit for anti-anxiety medication. D

F760 – Residents Are Free of Significant Med Errors

- Facility failed to follow physician orders. After return from hospital, Eliquis not given as ordered x2days. Wrong dose of Amiodarone given upon return from hospital. Treatments order to be changed qd not being changed x3days. G **$8,250**
- Facility failed to properly transcribe order for Novolog which resulted in resident receiving ten units at 4 am and ten more at 5:30 am. Resident became unresponsive and required transfer to ER. J
- Significant Med errors for two of five residents resulting in immediate jeopardy. One resident received antidiabetic meds and facility didn't monitor resident's meal intakes resulting in hypoglycemia and resident had to be discharged to hospital with very low blood sugar. Facility failed to acquire meds the resident needed. History of

resident having very low blood sugar. Resident came from hospital for too high blood sugar was discharged with orders of insulin but facility couldn't get orders timely from hospital. family had insulin for resident, but facility said would get from hospital. Resident had glucose reading so high it wouldn't register and had to go back to hospital. Family gave insulin pens with resident name but nursing home would not use. J

F761 – Label/Store Drugs & Biologicals

- Facility failed to keep all controlled drugs locked and safe. Two doses of Ativan uncounted for. Multiple signatures missing on controlled drug sheets. Keys for controlled medication storage were left unattended. E

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

- Facility failed to ensure that menus were followed by not providing pureed bread for residents on puree diet. E

F812 – Food Procurement, Storage, Preparation, Sanitization

- Facility staff did not follow glove policy when touching food and used single use gloves for more than one task. Staff did not wash hands before putting new gloves on. D
- Kitchen range hood was dusty. Staff member pushed up mask while serving food and did not perform hand hygiene. E

F835 – Administration

- Facility failed to be administered in a manner that enabled effective and efficient use of resources. Disruption of telephone services due to unpaid bills and disregard of required Medicare billing practices. F

F842 – Resident Records – Identifiable Information

- Facility failed to maintain accurate and complete record for two of three residents. Resident had fax with order for o2, facility could not locate and did not have in clinical record. Another resident had nursing assessment with wounds on lower extremities and clinical record lacked assessment of wounds (over 25 wounds). Record lacked fax to physician re orders for wound treatment. lacked evaluation of wounds by wound nurse. D

F880 – Infection Prevention and Control

- Facility failed to follow up with staff regarding omission of screening and follow facility policy which prohibits staff from screening themselves. E
- Facility failed to follow proper infection control precautions and guidelines. Staff failed to provide hand hygiene during cares. Lack of changing gloves after peri-care and prior to placing a clean brief on resident, and touched clean linen, side rails with same gloves. D
- Facility failed to follow proper infection control practices, failed to comply with proper screening process for those who entered. Resident not placed in proper

quarantine after returned from hospital, lack of changing gloves after incontinence care until just prior to leaving room. F

- Facility failed to do annual review of its infection control program, failed to follow CDC infection control practices, failed to Failed to properly don and doff PPE. Failed to create an individual plan to cohort residents during an outbreak. 10 covid negative residents resided in rooms with covid positive residents. Failure to perform hand hygiene after doffing soiled PPE. Staff pulling masks down below chin. E
- Facility should conduct annual review of infection control program and update as necessary. Staff did not perform hand hygiene appropriately or change gloves when wound care was provided. D
- Facility should conduct annual review of infection control program. Failed to ensure gloves changed when soiled and hand hygiene performed appropriately during incontinence care. D
- Failed to increase assessments for covid positive resident to 3 times a day. Failed to provide appropriate infection control for 1 resident with catheter, failed to use appropriate infection control during monitoring of blood sugar for another, failed to use appropriate infection control when existing covid units and failed to get TB testing for 4 of 5 new staff. F

F886 COVID-19 Testing Residents and Staff

- Facility failed to test COVID19 twice weekly as per HHS, failed to prevent a positive COVID staff person to have contact with residents. E

F921 – Safe/Function/Sanitary/Comfortable Environment

- Cobwebs and dust on range hood, dead insects in kitchen, dirty kitchen heating vents. E

F925 – Maintains Effective Pest Control

- Failed to control rodents and exterminate them in timely manner. E

Nursing Facility Survey Frequency

As of April 7, 2021: CMS lists 298 Iowa facilities (69.1%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 63.2%. National average is 71.4%.

Provider	City	Survey End Date	Previous Date	Months Between
Accura HealthCare of Pomeroy	Pomeroy	1/7/2021	3/7/2019	22.40
Chautauqua Guest Home #2	Charles City	1/7/2021	4/4/2019	21.47
Fonda Specialty Care	Fonda	1/28/2021	4/18/2019	21.70
Heritage Specialty Care	Cedar Rapids	1/28/2021	4/25/2019	21.47
Highland Ridge Care Center	Williamsburg	1/7/2021	4/4/2019	21.47
Friendship Home	Audubon	1/7/2021	6/15/2019	19.07
Colonial Manor of Amana	Amana	1/14/2021	6/15/2019	19.30
Sunrise Hill Care Center	Traer	1/20/2021	5/11/2019	20.67
Lone Tree Health Care Center	Lone Tree	12/28/2020	3/28/2019	21.37
			AVERAGE	**17.78**