Compliance Tips from IHCA's Survey Results Committee

May 2016

The five most frequently cited tags from the 53 annual surveys (4 deficiency free), 44 complaints (15 unsubstantiated), 23 self-reports (6 unsubstantiated), and 11 complaint/self-report (2 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 317 total deficiencies.

The following is a breakdown of severity level:

A =	0%	D =	56.78%	G =	4.73%
B =	3.15%	E =	28.10%	H =	0.0%
C =	1.58%	F =	2.84%	I =	0%
				J =	0.95%
				K =	1.56%
				L=	0.32%

Total # of Reports: 110
Total # of surveys/reports deficiency free or unsubstantiated: 23
Avg. # of deficiencies

- All = 2.88
- Annual = 4.47
- Complaint/Self-Reports= 2.91

Total state fines for December Report = $99,000 ($62,500) held in suspension)

Top 5 Most Frequently Cited Tags for May 2016 Report

F 323—Free of Accident Hazards/Supervision/Devices

- Severely impaired resident required two-staff transfer, needed extensive supervision, and bed alarm when in bed, resident frequently left walker in hall, fell on way to dining room, fractured femur (D) **$5,000 trebled to $15,000**
- Resident elope, fell in busy street eight blocks from facility, was injured, was only wearing Wanderguard bracelet, resident had repeatedly attempted elopement family reported Wandergaurd alarm often malfunctioned (J) **$8,000 fine**

- Resident was lowered to floor, fracture was determined, but resident was not seen by physician until the next day (G) **$5,000 fine**
- Resident fell in dining room, alarm didn't sound, femur fracture, second resident, alarm didn't sound (G) **$5,000 fine**
- Resident fell from lift with heel injury (G) **$2,000 fine**
- Resident fell with femur fracture, alarms not in place, no documentation alarms sounded (G)
- Staff failed to use gait belt per care when transferring resident, fall with injury (G)
- No care plan for a supervised only visitor who had potential to bring a gun; staff not aware of visitor restrictions (E)
- Exit and stairwell doors not alarmed (E)
- Unlocked cupboard in secured unit (E)
- Faulty door lock on a room with hazardous chemicals (E)
- Inappropriate contact between two residents (one cognitive impaired) no care plan developed for interventions, staff said not enough help to supervise residents (E)
- Facility failed to provide enough supervision to prevent numerous resident to resident altercations (E)
- Facility failed to secure alcohol and chemicals (E)
- Leaky toilet, shower door not locked, unsecured oxygen tanks, aerosol cans on hot griddle and cooking surfaces (E)
- Facility lacked front door alarm, resident eloped unobserved, facility lacked elopement policy (E)
- Door to assisted living (alarmed) was propped open and alarms were nonfunctioning (E)
- Chemicals in unlocked cabinets in beauty shop and unlocked utility room (E)
- Medication cart unlocked and unattended, unlocked cupboard under sink contained Virex (D)
- Facility failed to implement measures to prevent injuries m(D)
- Resident's care plan called for walker and gait belt during transfers, resident got up without assistance and fell in bathroom (D)
- Resident's floor alarm didn't activate, resident stood, fell, staff turned alarm off to toilet, didn't turn back on after toileting (D)
- Staff left resident in bedroom unattended with no alarm when resident was care planned for alarm at all times (D)
- Staff pushed resident in wheelchair without chair pedals (D)
- Surveyor observed an unsafe transfer and lift by jerking and pulling and lifting over side rails (D)
- Oxygen tanks not secured in storage closet (D)
- Staff pushed resident in wheelchair without foot pedals, resident caught foot and was injured (D) $**500 fine**
- Resident removed alarm and fell (D)
- Staff failed to use gait belt on a resident that required assistance of one (D)
- Water temperature 124 degrees, resident fell (D)
- Gait belt no used during transfer from bed to chair (D)

- Non-metallic surge protector in use (D)
- Care plan called for two-person lift; staff attempted one-person lift, resident fell, no injury

F 281—Professional Standards of Quality

- Resident to receive Solequel PRN, MARs lacked documentation (E)
- Failed to follow physician's orders, staff were giving in excess of allotted fluid amount (E)
- Lacked signed physician's orders for two medications (D)
- Empty MAR boxes, one medication given three days longer than ordered; bug spray, scissor, disinfectant, peroxide, etc. unlocked, (E)
- CBC not drawn as ordered (D)
- Nurse failed to check status and perform CPR (D)
- Staff failed to properly prime insulin pen (D)
- Nurse crushed three medications together and administered simultaneously through G tube contrary to standard protocols (D)
- Resident fell, no assessment done afterwards (D)
- Facility failed to follow physician's orders and clarify for complete order (D)
- Hydrocodone administered without physician's order (D)
- Nurse left medications with resident, and failed to prime insulin needle (D)
- Oxygen not given per physician's orders, staff didn't put pressure on lacrimal sac per eye drop medication administration (D)
- Six doses of medications due to non-availability of pharmacy services, facility didn't notify physician (D)
- Nurse didn't administer correct form of nitro as physician ordered (D)
- Ted hose not in place during day per physician's order, Blood pressure not documented for use of Metoprolol (D)
- Medications administration, treatment not completed (D)
- Staff failed to hold lacrimal sac for one minute after eye drop administration (D)
- Physician's order for calcium with each requested does (D)
- Directions on medication cart didn't match current order on MAR, no physician's order for Baza cream being administered as a skin treatment (D)
- Staff failed to provide barrier cream per care plan (D)
- Facility failed to watch a resident swallow their medications, two medications were missing when cup was found (D)

F 441—Infection Prevention & Control

- Staff didn't remove gloves after blood glucose test, staff touched med cart/key and timer before removing gloves (E)
- Staff failed to properly sanitize glucometer (E)
- During medications pass, nurse shook hands with resident and didn't wash hands afterwards before returning to medications pass (E)
- Staff unable to oralize or demonstrate how to clean whirlpool tub (E)
- Staff didn't wash hands after providing cares for resident in contact isolation (E)

- Failed to disinfect glucometer between two residents, staff didn't keep sanitizer on machine for two minutes per manufacturer's recommendation (E)
- Staff didn't change gloves after cleaning stool and then pulled up clothes with no glove change in between soiled and clan dressing change, multiple glove changes issues (E)
- Blood and drainage tinged dressings left in garbage bag in resident's room
- Nurse administered six residents eye drops without washing hands (E)
- Cross-contamination during IV med pass (E)
- Resident's slacks wet with urine as was buttocks and chair cushion; cushion wasn't sanitized after incontinence episode (D)
- Poor infection control with a dressing change, nurse didn't change gloves after a dressing change (D)
- Improper use of gloves, CNA dropped bottle of hand sanitizer on floor, placed it back in pocket without cleaning in it (D)
- Staff failed to properly use gloves, measuring tools and handwashing during dressing change for two residents (D)
- Nurse failed to wear gloves in isolation unit (D)
- Nurse didn't change gloves properly after completing GT feeding, and then started dressing change; nurse applied A & D ointment with gloved hand moving from rectal area to vaginal area (D)
- Staff removed a wet incontinence pad without wearing gloves, then handed a clean pad and touched resident without washing hands, also didn't clean wheelchair seat when it was wet with urine, and didn't change resident's wet with urine pants (D)
- Resident's room sign had "contact precautions" sign, staff used EZ lift to transfer resident, , but didn't disinfect lift after moving resident with infection (D)
- Staff removed gloves, but didn't wash hands before leaving room (D)
- Issues with pericare (D)
- Staff placed soiled scissors in bed with no barrier, staff used soiled scissors to cute new dressing, multiple episodes (D)
- Staff failed to disinfect glucometer between use (D)
- Improper suprapublic catheter care given, staff didn't follow policy (D)
- Catheter tubing not cleaned during care, pad not changes, staff didn't clean lift after transfer, resident had C-Diff (D)
- Poor handwashing, and no isolation sign on door of resident needing isolation sign (D)

F 371—Sanitary conditions

- Dirty stove hoods (F)
- No "opened" date on food items or were unlabeled (F)
- Dust on stove, staff obtained drinking water from handwashing sink, dust con kitchen shelves, staff touched food distribution scoop handles with gloved hands, then touched food with same gloved hands without changing gloves (F)
- Failure to have sanitary kitchen and equipment, no backflow device on ice machine (F)

- Baking sheets with heavy carbon buildup, Teflon cookware with scratches, opened undated food containers (F)
- Staff failed to maintain adequate kitchen sanitation and food handling, dirty kitchen, not regloving appropriately (F)
- Facial hair not covered on dietary aides, no hand washing between handling dirty items and putting on gloves to handle clean items (F)
- Food items in refrigerator opened and undated, milk, cheese and other undated items (E)
- Ground beef thawing in sink (E)
- Outdated food stored in refrigerator, beauty shop sink lacked back flow device (E)
- Dirty kitchen, storage are without handles.(E)
- Food containers opened and undated, dietary director had 10 inch braid b was not wearing hair net. (E)
- Dietary staff touched food and non-food items with gloved hands (E)
- Dirty kitchen floor, dirty oven, doors, dusty vents, etc. (E)
- Sanitary issues in kitchen (E)
- Facility failed to date food containers, staff touched ready-to-eat foods with bare hands, scoops left in cans of food with handle down (E)
- Dirty pots, pans and utensils (E)
- Maintenance staff touched phone and then plate when serving food, milk temperature at 45.6 degrees, dust on knife rack (E)
- Worn dish racks, “grime” on sugar and flour containers, loose cupboard hinges, chipped shelves in refrigerator, uncovered food when transporting through hall (D)
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F 309—Quality of Care

- No code status orders, and CPR not started, resident died, no assessment at time of incident (K) **$8,000 fine**
- Facility failed to access and intervene with resident who had open wound areas on hand, not addressed (G) **$8,000 fine**
- Facility failed to assess resident after fall, and failed to have appropriate interventions (G)
- No weekly skim assessments for wounds (G) **$3,000 fine**
- No initial care plan developed on admission(D)
- Facility failed to provide weekly skin assessments completed for a resident with multiple skin issues, no documentation of surveyor-observed skin issues (D)
- Skin sheets not available for bruises identified in the medical record (D)
- Resident complained of leg pain; symptoms evident, not reported to nurse by CNA (D)
- Resident not given Milk of Magnesia as physician ordered (D)
- Skin interventions not implemented per care plan, no float heels, physician not updated on wound changes (D)

- No assessment of resident after sitting on toilet for an extended period of time (D)
- Physician's orders to increase diuretic medications, due to edema, , lacked documentation that staff assessed fluid retention (D)
- Concerning resident with history of bowel issues, care plan called for Ducolax and Milk of Magnesia, resident had bowel movement on Feb. 2, the next one was February 7, Milk of Magnesia not given until Feb. 22, than a suppository was required (D)
- Facility failed to follow bowel management program; no PRN medication given if resident had no bowel movements (D)
- Facility failed to provide thorough assessment upon a change in resident's condition (D)
- Pressure ulcers not assessed and documented (D)

Other notable deficiencies and fines

F 204—Residents rights

- Resident discharged to apartment (assisted living) without discharge planning due to inappropriate touching of other residents (J) **$8,000 fine**

F 223—Free from abuse

- Resident grabbed and held other residents and staff without appropriate staff interventions (J) [Hospital-based facility, fine unknown]
- Resident was inappropriately touching other residents and in public areas (K) **$10,000 fine**
- Failed to prevent abuse from one resident to another (K)

F 224--Reporting to the department

- Over 20 examples of resident to resident conflicts, some resulting in injury, residents tipped over in wheelchairs by other residents, resident found with pants down by another resident, punching, kicking, etc. (E) **$3,500 fine**
- Facility failed to develop and implement policies and interventions to prevent resident to resident abuse (K) [Hospital-based facility, fine unknown]
- Misappropriations of medications, Tramadol missing, facility didn't have system to check incoming medications **(D) $500 fine**
- Failed to have policy on how to contravene when residents show inappropriate sexual behaviors

F 225--Facility failed to report to the department

- Numerous instances of resident to resident abuse, some resulting in injury, medications left at bedside, when found by staff, methadone and Ativan were missing and didn't report (E)
- Facility failed to report to DIA allegation of staff to resident abuse (D) **$500 fine**
- Facility didn't report allegation of abuse and separate accused staff member from resident until investigation was complete (D) **$500 fine**

F 226--Staff Treatment of Residents

- Employee hired with hit on child abuse without DHS evaluation/approval (D) **$1,500 fine**

- Facility failed to complete criminal background or dependent adult abuse check for one employee (D) **$500 fine**
- Facility failed to perform criminal background and abuse check prior to hire (E) **$500 fine**
- Criminal and abuse checks completed after hire (D) **$500 fine**
- Failed to complete background checks for abuse or criminal history prior to hire for two employees (D) **$500 fine**
- Facility failed to do criminal and abuse background checks on two employees prior to hire (D) **$500 fine.**
- Background check not completed prior to hire (D) **$500 fine**

F 314

- Facility failed to provide interventions per care plan, including floating heels and use of gripper socks (G) **$2,000 fine**
- Treatment to prevent pressure sore on heel not done, heel pressure area with no repositioning program in place (G) **$2,000 fine**
- Failure to implement interventions to prevent a heel decub from developing, resident had skin issues in the past (G) **$2,000 fine**
- Skin sheets not always completely weekly (G) **$2,000 fine**
- Resident developed pressure ulcer on heel after hip fracture (G) **$2,000 fine**

F 329--Unnecessary medications

- INRs not reviewed prior to administering Coumadin; not administered per physician's orders (G) **$2,000 fine**

F 353—Resident's right

- Call light showed multiple instances of call lights not answered in 15 minutes (D) **$500 fine**

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- Two fire doors had no alarm system in place

C 148

- Facility failed to notify DIA of suicide attempt **$500 fine**

L 352

- Facility failed to do incident reports for resident to resident altercations

L1093

- Facility failed to check VA benefit status on new admit
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- Four residents didn't have Veterans Administration screening on admission