Compliance Tips from IHCA's Survey Results Committee

May 2018

Survey composition: 33 annual surveys (1 deficiency free), 34 complaints (17 unsubstantiated), 11 self-reports (3 unsubstantiated), 11 complaint/self-report (2 unsubstantiated) and 1 mandatory reports (0 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 179 total deficiencies.

The following is a breakdown of severity level:

A =	0.00%	D =	64.41%	G =	3.95%
B =	4.52%	E =	20.34%	H =	0.00%
C =	0.56%	F =	3.95%	I =	0.00%
				J =	1.69%
				K =	0.56%
				L=	0.00%

Total # of Reports: 77
Total # of surveys/reports deficiency free or unsubstantiated: 23
Avg. # of deficiencies

- All = 3.28
- Annual = 3.55
- Complaints = 2.60
- Self-reports = 3.80
- Complaint/Self-Reports= 3.60
- Mandatory = 2.00

Total state fines for January Report = $29,750 ($38,000 held in suspension)

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

F 550—Resident Rights/Exercise of Rights

- Staff failed to knock on doors prior to entering (D)
- Resident found sitting in hallway crying and no interactions with staff, facility said it was because he/she had head lice (D)
- Staff performing personal care on resident who was exposed. Other staff knocked on door and entered room without a response (D)

F 554—Resident Self Administration of Medications/Clinically Appropriate

- Certified med aide left Vicodin in med cup with resident at dining room table and did not wait to see if resident consumed medication (D)

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

- Resident stated she didn't like a toileting plan to only toilet every 1 to 1.5 hours (D)

F 558—Reasonable Accommodations of Needs/Preferences

- Call lights not within reach (E)
- Resident was left on toilet one hour and 38 minutes, had call light but did not know how to use it, was evaluated by OT to demonstrate use of call light and OT found resident unable to safely use (D)
- Resident call lights not placed within reach of resident. Another resident complained that agency staff nurses did not respond to call lights, sometime all night (D)

F 577—Right to Survey Results/Advocacy Info

- Facility did not post previous survey results (D)

F 578—Advance Directives/Discontinuation of Treatment

- No indication of resident choice for CPR for two residents (D)

F 580—Notification of Changes Injury/Decline

- Severely demented resident needed extensive assistance with eating and ADLs, care plan mandated weight monitoring, res lost 19 pounds in one month (9% of body weight), family notified but no record physician was notified (D)
- Failure to notify physician about tachycardia for 10 days (D)
- Failed to notify family of condition changes-use of oxygen and temp (B)

F 582—Medicaid/Medicare Coverage

- Failure to complete SNFABN for 2 of 3 residents. #1 appropriate form was signed but did choose an option. #2 not signed (D)
- Failed to provide Medicare ABN notice (B)

F 583—Personal Privacy/Confidentiality of Records

- Staff failed to knock prior to entering room when surveyor performing interview (D)
- Left resident uncovered during care (D)
- Leaving breasts uncovered while leaving resident to get new towels, Resident transferred in lift with breast exposed (D)
- Privacy curtain not pulled during pericare (D)

F 584—Safe/Clean/Comfortable Homelike Environment

- Facility failed to provide enough housekeeping services. Beds stripped and not made, and staff stated that some sheets don't get changed for a week (E)

- Missing mop boards, worn mattresses, chipped countertops (E)
- Multiple scratched and chipped walls, chipped paint on doorways, gouges in kick panels of doors (E)

F 600—Free from Abuse and Neglect

- Facility failed to suspend or prevent staff member from working with a resident he/she was accused of abusing (D)

F 604—Right to be Free from Physical Restraints

- CNA used a gait belt to wrap a gait belt thru the wheel chair wheel and hooked to the hand rail (D)

F 607—Develop/Implement Abuse and Neglect Policies

- Resident stated staff slapped her, DON aware but didn't investigate (F)
- Failure to follow care plan - resident was 2-person transfer with EZ stand and was transferred by a single aide and non-major injury occurred. Per facility policy it says employee must maintain separation and have no contact with the resident alleged to have been abused. Said employee did have contact with resident (D)

F 609—Reporting of Alleged Violations

- Failure to report allegations of abuse on 2 occasions. Both were a resident punching/hitting another resident as reported in the nurse's notes, DON stated since there were no injuries it was not reported (D)
- Failed to report possible abuse to DIA (D)
- Facility failed to report an injury of unknown origin. Family member was witnessed roughly transferring resident and removing gait belt, but claimed staff members fractured resident's rib (D)
- Facility failed to report all allegations of dependent adult abuse (D)

F 610—Investigate/Prevent/Correct Alleged Abuse

- Failed to investigate possible abuse (D)

F 637—Comprehensive Assessment After Significant Change

- Failed to complete a significant change MDS assessment when indicated for 1 resident.that required assistance with most all ADL's (D)

F 641—Accuracy of Assessments

- Failed to complete accurate assessments as directed by CMS for 2 residents The MDS nurse stated the resident does not receive Hospice care and she miscoded the MDS for Hospice and did not include dialysis (D)

F 655—Baseline Care Plan

- No initial baseline care plan, not completed for 10 days (D)
- No care plan developed to accommodate resident who smoked (D)
- No documentation showing baseline care plan summary was provided to resident or family (B)

- No written summary of baseline care plan provided to family (B)
- Baseline care plan completed but not dated (B)

F 656—Develop/Implement Plan of Care

- Not including anticoags and psychotropics on care plans, no hand splints as care planned (E)
- Care Plan did not address wandering for a wandering resident (D)
- Care plan failed to address O2 and it was set wrong (D)
- Facility failed to follow care plan for skin issues by repositioning, heel boots, toileting (D)
- Care Plan did not address how to handle anxiety (D)
- No care plan developed for resident after hospitalization and readmission to the facility (D)
- Staff failed to follow care plan. Resident had requested rail on bed side against wall. No rail on bed. Resident fell (D)

F 657 Care Plan Timing & Revision

- Change in ADLs, healed pressure ulcer, removed catheter, changed discharge plan not updated on care plans (E)
- Facility failed to update three resident care plans to reflect the use of high risk meds and discharge from the CCDI unit (E)
- Failed to update a care plan to reflect current status of 6 residents (E)
- Failure to update comprehensive care plan - lacked a focus of the area of hospice care as resident had changed to hospice (D)
- Staff failed to invite resident to their own care plan (D)
- No comprehensive care plan completed for resident after admission (D)
- Resident care plan not updated after resident had wandering incident (D)

F 658—Services Provided Meet Professional Standards

- Orders were for a Dolphin Bed (rotating water bed) and facility provided a rotating air mattress instead (D)
- Daily weights and ted hose not completed as ordered (D)
- O2 at wrong level, did not prime insulin needle x2 (D)
- Staff failed to practice safety precautions during insulin administration for one resident. The nurse drew up insulin and did not replace the cap and carried the uncovered needle 6 feet and while holding this needle, opened the alcohol pad and wiped the resident's arm and injected the insulin (D)
- Failed to obtain further physician orders to address care related to IV treatment for one resident (D)
- Vitals taken prior to 7AM some at midnight, failed to take BP per Dr. order (D)
- Dr. orders not implemented for Rocephin and resident sent to ER, failed to provide feeding tube fluids as ordered (D)
- Physician order Gentamycin, used out of town pharmacy and not delivered timely, resident ended up being sent to ER (D)

F 659—Qualified Persons

- Care plan interventions not followed: No heel boots on (D)
- Failed to implement care plan interventions such as pressure reduction (D)

F 660—Discharge Planning Process

- Failed to complete effective discharge plan, baseline care plan did not address desire to plan to return home (B)

F 661—Discharge Summary

- Discharge plans for care not dated, failed to document recapitulation of care of the resident's care (D)
- No recapitulation completed on discharge (D)
- No discharge summary in one closed record (D)
- DC Summary did not include a thorough skin assessment and that was the main reason for facility care (B)

F 676—Activities of Daily Living/Maintain Abilities

- Failed to provide residents regular bathing opportunities. One resident had 5 baths in Feb. This resident refused baths on 2 occasions but there was no documentation to indicate staff returned to offer again and the nurse failed to document interventions staff attempted to assist the resident. The care plan failed to inform the staff the resident had a history of non-compliance with bathing and provide or suggest approaches to use when the resident refused their bath. One resident refused all baths in January and February and had 1 bath in March. One resident did not receive a bath for one week on Feb and had 1 bath in March (D)

F 677—ADL Care Provided for Dependent Residents

- Failure to provide bathing opportunities and incontinence care to maintain personal hygiene. Failure to check and change every 2 hours per company policy. Residents missed several shower days for four months. Staff stated that they didn't have enough help (E)
- Residents were not being toileted every 2 hours (D)
- Missing bath records and resident's state didn't get a bath 2X a week (D)
- Residents complain of not getting showers or baths and no documentation why (D)
- Staff did not provide meal assistance to resident who required help to eat and special adaptive equipment. Resident unable to drink without assistance and no help given (D)
- Resident's fingernails not free of brown debris (D)

F 678—Cardio-Pulmonary Resuscitation

- CPR not initiated for resident who requested resuscitation when found pulseless (J) **$6,750 fine in suspension**

F 684—Quality of Life

- Facility failed to updated Dr. that resident was throwing up, couldn't keep food down, do BM's and family intervened and took resident to ER, hospitalized for severe dehydration (G) **$7,250 fine**
- Facility failed to change a catheter by 6 weeks after insertion as ordered by the physician (D)
- Resident did not have ordered neck collar, hand rolls or hand splint as ordered; heel protectors not in place for resident with prior history of heel breakdown; physician not notified regarding resident change in condition (D)
- Failure to take vital signs or do assessment after a fall. Resident has history of multiple falls (D)
- Facility failed to accurately assess and measure pressure ulcers, Open area found by surveyor during observation that was not documented (D)
- Failed to provide a homelike environment by not paying the garbage services for 2 weeks and the facility piled the garbage on top of the dumpsters and on the ground. They also had one resident room that smelled of urine (D)
- Failed to assess out of the ordinary behavior for one resident that was not able to wake up (D)
- Nursing and Dietary didn't address wt. loss (D)
- Lack of assessment for potential impaired skin integrity (D)
- Facility failed fully assess a resident after a fall (D)

F 686—Treatment to Prevent Pressure Ulcers

- Four residents developed pressure ulcers while in the facility (G) **$15,000 fine ($5,000 trebled)**
- The facility failed to assess and provide treatments for 4 residents with pressure ulcers. The facility failed to have systems in place to ensure the residents skin and wounds were being assessed properly and in a timely manner. Failed to schedule adequate staff to ensure treatments for pressure ulcers were being consistently completed. On one resident the plan of care failed to address the residents current pressure ulcers. Two of the dressings were on for one week. The TAR revealed omissions in the treatments and there were no entries in the progress notes indicating the resident refused any treatments Staff could not recall completing treatments for this resident and told the Administrators they were understaffed. Another staff did not recall completing treatments for this resident. Resident seen at wound clinic and was always compliant, the wound clinic sent resident to the hospital and the hospital records noted right buttock wound is so deep that wound nurse could feel bone and resident diagnosed with osteomyelitis. One resident the facility did not have the locations of the actual skin impairments on the care plan and no documentation regarding the open area to the resident's buttocks and did not notify the physician and failed to contain treatment orders. Another resident had areas that failed to have the correct treatment on the TAR and had missed weekly assessment. Another resident failed to have MDS identify the resident had skin impairment and the care plan failed to identify skin impairments. This resident had heel wounds and

right heel was blackened and was unable to be staged and facility required. Hospice nurse obtained orders for treatment and facility failed to complete treatments, and weekly assessments and did not list this resident on the list of pressure sores obtained upon surveyor entrance (K) **$4,500 fine in suspension**

- Resident failed to receive necessary treatments for a pressure ulcer that worsened. Facility was aware there were issues with pressure sores (G) **$5,250 fine**
- Policy read weekly skin assessments and facility went greater than 7 days for assessments (D)
- Care plan lacked documentation of pressure ulcer (D)
- Resident with pressure ulcers on feet, other areas, care plan called for staff to provide treatment to bilateral feet per wound ostomy, and continence nurse treatments orders; nurse failed to reglove between cleaning wounds and applying Betadine; CAN used same side of wash cloth to clean resident's groin and face, failed to wash hands when regloving during peri care (D)
- Lack of interventions for pressure ulcers not healing (D)

F 688—Prevent Decrease in Range of Motion

- Failed to follow walk-to-dine program 3 times a day (D)
- Failure to provide restorative to resident that was to have it 7 days a week and received it 4 times in a 2-month period and resident declined (D)
- Restorative program not implemented as recommended by PT/OT (D)

F 689—Free from Accidents and Hazards

- Facility failed to provide adequate supervision and assistance devices to prevent accidents and injury for one resident who fell out of the facility's wheelchair van. The van driver released the wheelchair from the hooks in the van and the resident unlocked the brakes and backed up, but the lift platform had been already lowered prematurely. Both the driver and resident fell from the van. The resident hit her head, loss consciousness, sustained fractured ribs, and experienced pain. The resident was air lifted to the hospital and admitted to ICU and returned to the facility with rib fractures and pain. The administrator did not have instructions for the lift for over 3 years. The van driver sustained a neck fracture. The administrator provided a list that provided training by a former driver. The facility to provide direct supervision of medication ready to administer. The med cart with a med cup with meds was left unattended (J) **fines: $500; $8,250 in suspension**
- Resident stood on own and fell with a fracture (G) **$9,000 fine in suspension**
- Resident had multiple falls and one required an ER visit. Dr. from ER stated that a follow up with eye specialist "right away". Follow up was not done. Resident expired two days later, although death certificate identified immediate cause as respiratory failure due to breast cancer with metastases to the bone (G) **$6,000 fine**
- Interventions not implemented promptly, and resident had 5 falls due to no intervention with each fall (G) **$4,050 fine**

- Resident suffered arm fracture when staff transferred without use of a gait belt; another resident sustained skin tears when staff transferred resident without the use of sit to stand lift as care planned (G) **$3,000 fine in suspension**
- Sanitizing liquid left unattended in the dining room (E)
- The facility failed to maintain an environment free of hazards by having a 4 ft floor scale in the short hall entrance to the low stimulation unit which takes up half of the hall way and there are 3 resident who independently wander outside of the 400 hall (D)
- Failed to follow care plan interventions to reduce the risk of an accident for one resident (D)
- Resident care plan called for use of pressure alarm in WC and bed. Alarm in place but not turned and resident fell (D)
- Resident slid out of lift sling, striking head on leg of lift and sustained a head laceration and scalp hematoma requiring evaluation and CT scan to rule out significant injury (D)
- Staff shut off alarm prior to assisting the resident to prevent fall (D)
- Medication left in cup at dining room table (D)
- Staff didn't use Hoyer lift, did bear hug and resident had bruise on arm, w/c brakes not on during transfer (D)
- Staff pushed resident over 40 feet without wheelchair pedals in place (D)
- Resident slid out of wheelchair during Hoyer lift transfer as sling was not properly placed and brakes on wheelchair were not locked (D)

F 690—Bowel, Bladder Incontinence, Catheter Care

- Failure to wipe correctly during peri care and resident had urosepsis (D)

F 692—Nutrition/Hydration Maintenance Status

- Physician and family not notified of resident's weight loss and no documentation in medical record (D)
- Failed to initiate interventions with wt. loss with sig wt. loss (D)

F 697—Pain management

- Failed to manage pain (D)

F 698--Dialysis

- Facility failed to assess the resident before and after going to outpatient dialysis treatments (D)

F 700—Bedrails

- Facility failed to document individual need for bedrails for 18 of 18 residents (E)
- Gaps identified in bedrails on one bed (D)

F 725—Sufficient Nurse Staffing

- Facility failed to have sufficient nursing staff. Call light reports ranged from 18-38 minutes. Baths were not being given to residents twice weekly. One resident found to have no bath within 8 days and again within in 7 days (E)
- Call light not answered within 15 minutes per resident interviews (E)
- Failed to ensure staff answered resident and call lights in a timely manner (D)

F 726—Competent Nursing Staff

- Failure to respond to a call light promptly. Call light audit for 2.5 days showed 31 responses were over 15 minutes and of those 10 were over 30 minutes (E)

F 729—Nurse Aide Registry Verification

- CNA Registry not checked for one employee (D)

F 732—Posted Nurse Staffing Information

- Failed to post and have daily nurse staff information available (D)
- Failure to post daily nurse staffing data for fourteen days in a 37-day period. (D)

F 744—Treatment/Services for Dementia

- Not addressed (D)

F 755—Pharmacy Services/Procedures

- Med aide did not keep med cart locked when unattended; controlled medication log book did not reflect correctly narcotics administered for nine residents (E)

F 756—Drug Regimen Review, Report Irregularities

- Pharmacy suggest decrease in medication and physician didn't address for 3 weeks (D)

F 757—Drug Regimen/Freedom from Unnecessary Drugs

- Failed to administer Warfarin and ASA per physician order, lack of INR completed, no assessment of blood in toilet, was given regular baby aspirin and not delayed time release (J) **$9,500 fine in suspension**

F 758—Free from Unnecessary Psychotropic Medications

- Use of PRN anti-anxiety medications beyond 14 days, Use of anti-psychotic for dementia diagnosis (D)
- Failed to have diagnoses for the continued use of antipsychotic meds for 3 residents (D)
- No gradual dose reduction completed for 3 residents (D)
- Facility failed to ensure antipsychotic medications were re-assessed or included a clinical rationale. Provider failed to document clinical rationale for continued medication dose (D)
- Failure to provide non-pharmological interventions prior to giving a hypnotic medication 12 times (D)

F 761—Label/Storage of Drugs and Biologicals

- LPN checked in a bubble pack of narcotics when she was called away and placed the pack in an unlocked drawer which then ended up missing (D)

F 802—Sufficient Dietary Support Personnel

- Facility failed to have sufficient dietary staff with appropriate competencies and skills to carry out functions of food and nutrition. Staff did not feel trained, nurses were working in kitchen that had no training. Food temps and dishwasher checks were not checked as staff did not know they were to be doing that (F)

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

- Pureed and mechanical soft diet portions were incorrect for 18 residents (F)
- Facility failed to follow approved menu for one meal. Dietary spread sheets not available, so staff did not follow it. Weekend meals were sparse (one sandwich and nothing else) (E)
- Meals served did not follow renal diet for 1 resident and mechanical soft diet for 7 residents (E)
- Failed to use correct scoops for pureed meal (D)
- Facility did not puree all items on menu (D)

F 804—Nutritive Value, Palatability, Appearance, Temperatures

- At end of the meal, food temps too low, failed to check temp of juices and residents state food is cold (F)
- Milk was not maintained below 40 degrees during meal service (E)

F 806—Resident Allergies, Preferences, Substitutes

- Resident not getting food preferences. No lettuce and tomato on sandwich that they used to get. Facility stated they can't order those items anymore (D)

F 809—Frequency of Meals/Snacks at Bedtime

- Facility failed to offer HS snack consistently (E)
- Failed to offer HS snacks (D)

F 812—Food Procurement, Storage, Preparation, Sanitization

- Staff did not ensure dishwasher wash and rinse cycles maintained appropriate temperatures as set forth from the manufacturer (F)
- Multiple issues with sanitary conditions in kitchen including dirty appliances, range hoods, carbon build up, worn cutting boards, dirty grease traps with buildup, dusty fans, soiled walls, pipes with heavy lime build up, chipped paints, no cleaning schedule, improper glove use, lack of food labels with dates, outdated food in storage, no refrigerator temp logs (F)
- Refrigerator temps not recorded (F)
- Dietary aide touched the plate surface with their thumbs (E)
- Refrigerator vents dirty (E)
- Cook touched multiple surfaces and food with same gloved hands (E)

- No hairnet in kitchen, wet utensils in drawers, plastic utensils with burn marks, greasy cupboards, dented peach can (E)
- Failed to maintain appropriate cooking and holding temperatures (temps were below 135 degrees F and cold temps were above 41 degrees F (E)
- Failure to serve food under sanitary conditions. Used same glove to touch serving utensils and ready to eat foods (E)
- Crumbs, food splatters, brown substances around kitchen (E)
- Failed to wear hairnets in the food prep area (E)
- Food temperatures too cold, staff touched mouth without regloving (E)
- Failed to maintain appropriate cooking and holding temperatures (temps were below 135 degrees F), specifically pureed food not up to temperature prior to serving (E)
- Dietary staff wore gloves, but touched steam table and other items such as frig door (E)
- Mighty Shakes not dated when thawed (E)
- Dirty pots and pans stored in kitchen, frig dirty (D)

F 825—Specialized Rehab Services

- Failed to provide restorative services as care planned and recommended by therapy (D)

F 842—Resident Records—Identifiable Information

- Failed to provide feeding for tubes as order, used Osmolite 1.2 and not 1.5 (D)

F 868—QAA Committee

- Failed to hold a QAA Committee meeting at least quarterly and the meetings held did not meet the minimum attendance of 5 facility staff members and at least 2 others (C)

F 880—Infection Prevention and Control

- Uncovered clean linen carts with clothes being delivered (E)
- Nurses failed to cleanse scissors during dressing change, clean laundry transported uncovered not following their policy (E)
- Used stock glucometer and didn't disinfect between residents (E)
- Nurse failed to wash hands after removing gloves, nurse wore 2 pairs of gloves and removed one pair after cleaning wound to reveal other pair while completing wound dressing (E)
- Resident items in shower room with no names on them such as deodorants (E)
- Infection control: staff failed to reglove after cleaning wound and before application of Betadine (D)
- Facility failed to follow proper cleaning procedures of glucometer. Nurse cleansed glucometer with alcohol wipe instead of hydrogen peroxide wipe (D)
- Cather bag placed on floor and not in bag (D)
- Infection control of resident in isolation - not washing hands between glove use, touching items in room with dirty gloves, failure to sanitize toilet after use (D)

- Glucometer not disinfected after used (D)
- Resident had wound on coccyx. CNA performed pericare wiping from rectal area toward wound. Staff members long hair also touched wound during pericare (D)
- Nurse did not wash hands between glove changes while performing wound dressing procedure; laid dressing supplies on bed without barrier in place (D)
- Nurse did not perform glucometer sanitizing per facility policy (D)

L 1093—Veteran's Administration Benefits Eligibility

- Not all residents admitted to facility had veteran's status confirmed

Nursing Facility Survey Frequency-May 2018

B	C	D	E	F	G	H	I	J
Name of Facility	City	Date	Annual	Complain	Self-Report	Previous Date	Time Frame Months	
Accura HC of Cherokee	Cherokee	4/16/2018	x	x		2/16/2017	14.1	
Accura HC of Newton East	Newton	4/19/2018	x			2/9/2017	14.5	
Avoca Specialty Care	Avoca	4/26/2018	x	x	x	2/16/2017	14.5	
Briarwood Healthcare Center	Iowa City	4/12/2018	x			2/8/2017	14.3	
Caring Acres	Anita	4/5/2018	x			2/9/2017	14.0	
Creston Specialty Care	Creston	4/12/2018	x			2/2/2017	14.5	
Crestview Specialty Care	West Branch	3/8/2018	x			1/12/2017	14.0	
English Valley Nursing CC	North English	4/12/2018	x			2/2/2017	14.5	
Faith Lutheran Home	Osage	4/5/2018	x			1/12/2017	14.9	
Genesis Senior Living	Des Moines	4/5/2018	x	x		3/2/2017	13.3	
Grand Ji Vante	Ackley	4/26/2018	x			2/23/2017	14.2	
Keota Healthcare Center	Keota	4/19/2018	x			2/9/2017	14.5	
Living Center East	Cedar Rapids	4/26/2018	x			1/26/2017	15.2	
Mercy Living Plus	Oelwein	4/26/2018	x			2/23/2017	14.2	
Mercy Medical Center - Centerville	Centerville	3/22/2018	x			1/19/2017	14.2	
Northgate Care Center	Waukon	4/12/2018	x			1/26/2017	14.7	
Parkview Manor Care Center	Reinbeck	4/5/2018	x			1/12/2017	14.9	
Pearl Valley Rehab -- Perry	Perry	4/19/2018	x			2/2/2017	14.7	
Pleasnt View Care Center	Whiting	4/17/2018	x	x		1/26/2017	14.9	
Prairie Ridge	Orange City	4/23/2018	x			2/23/2017	14.1	
Premier Estates Toledo	Toledo	4/19/2018	x			2/9/2017	14.5	
QHC Humboldt North	Humboldt	4/19/2018	x	x		2/9/2017	14.5	
Regency Park	Carroll	4/12/2018	x		x	1/12/2017	15.2	
Regency Park	Jefferson	4/26/2018	x	x		2/16/2017	14.5	
Riceville Family Care &Therapy	Riceville	4/12/2018	x	x		2/2/2017	14.5	
Rose Haven Nursing	Marengo	4/26/2018	x			2/23/2017	14.2	
Sunny Brook Living Center	Fairfield	4/5/2018	x	x		1/26/2017	14.5	
Sunnycrest Manor	Dubuque	4/5/2018	x		x	2/26/2017	13.4	
The Ambassador - Sidney	Sidney	4/19/2018	x			1/12/2017	15.4	
University Park	Des Moines	4/5/2018	x		x	1/26/2017	14.5	
Westwood Specialty Care	Sioux City	4/19/2018	x			2/2/2017	14.7	
						Average	14.4	months
						Min	13.3	months