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

Compliance Tips from IHCA's Survey Results Committee
May 2019

Total Number of Survey Reports: 106

Survey Composition:		
Annual:	**36** Surveys	**11** Deficiency Free
Complaints:	**64** Surveys	**41** Unsubstantiated
Self-Reports:	**28** Surveys	**14** Unsubstantiated
Mandatory Reports:	**6** Surveys	**2** Unsubstantiated

State Fines:	$26,750
State Fines in suspension:	$84,750

<u>Most Commonly Cited Iowa Tags:</u>

F 689 – Free from Accidents and Hazards (13)

F 658 – Services Provided Meet Professional Standards (12)

F 684 – Quality of Care (12)

F 880 – Infection Prevention and Control (11)

F 812 – Food Procurement, Storage, Preparation, Sanitization (10)

F 656 – Develop/Implement Plan of Care (9)

F 677 – ADL Care Provided for Dependent Residents (9)

<u>Tags Resulting in Actual Harm or Higher Citations and Fines:</u>

F 678 – *Cardio-Pulmonary Resuscitation (CPR)	**1 K Tag**
F 684 – Quality of Care	**1 G Level Tag, 1 J Tags**
F 686 – Treatment to Prevent Pressure Ulcers	**2 G Level Tags**

F 688 – Increase/Prevent Decrease in ROM/Mobility **1 G Level Tag**

F 689 – Free from Accidents and Hazards **4 G Level Tags, 2 J Level Tags**

F 760 – *Residents Free of Significant Med Errors **1 G Level Tag 1 J Level Tag**

F 806 – Resident Allergies, Preferences and Substitutes **1 J Level Tag**

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=15619		Total Number of Surveys=37236
F0880	Infection Prevention & Control	3,504	21.0%	9.4%
F0689	Free of Accident Hazards/Supervision/Devices	3,215	17.4%	8.6%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	2,901	17.7%	7.8%
F0656	Develop/Implement Comprehensive Care Plan	2,638	15.6%	7.1%
F0684	Quality of Care	2,405	13.2%	6.5%
F0761	Label/Store Drugs and Biologicals	1,987	12.1%	5.3%
F0657	Care Plan Timing and Revision	1,666	9.9%	4.5%
F0758	Free from Unnec Psychotropic Meds/PRN Use	1,552	9.5%	4.2%
F0677	ADL Care Provided for Dependent Residents	1,474	8.2%	4.0%
F0550	Resident Rights/Exercise of Rights	1,395	8.1%	3.7%

*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

- Failure to treat each resident with respect, dignity and care in a manner that promotes quality of life. Staff member reported that a second member was not treating a resident well. The second staff member referred to a resident as psycho and threatened to murder the resident's baby dolls. D
- Failure to treat residents with dignity. A resident asked staff for assistance with toileting but did not receive assistance for twenty minutes and the resident had an accident during that time. Staff was rude to the resident because of the accident. D
- Failure to provide privacy during personal cares. Staff lifted blankets to change Foley and the resident stated, "it's getting kind of personal". Staff covered the resident, then staff tried again, and the resident stated, "ok but just a little bit". The resident reported to the surveyor "everyone stares at me and it gets cold". D

F554 – Resident Self-Administers Meds-Clinically Appropriate

- Failure to provide a resident the right to self-administer their medication at bedside, even though the resident had a physician's order to do so. Resident crying to surveyor

that staff had come in and removed the resident's Vicks Baby rub from her room when surveyors came to facility. Resident had an order to self-administer, no locked drawers/containers in room. No self administration assessment completed. D

F557 – Respect, Dignity/Right to have Personal Property

- Failure to treat residents with dignity and respect. Staff member didn't display kindness and considerate care while working with residents. D

F558 – *Reasonable Accommodations of Needs/Preferences

- Resident was not positioned in bed correctly in order to eat and his tray sat uneaten in front of him for three hours after the meal was served. D

F565 – *Resident/Family Group and Response

- Failure to document and demonstrate a response to grievances filed by residents. Resident council brought issues to the attention of the facility and the issues were not addressed or resolved. B

F576 – Right to Forms of Communication with Privacy

- Failure to deliver mail to residents on Saturdays. D

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

- Failure to document physician's order for residents with advanced directives; Admissions orders and physician's orders failed to contain advanced directives that addressed CPR wishes; however the chart front and spine of the same contained stickers labeled DNR on two residents, another resident's advanced directives at her front of chart directed staff to initiate CPR, but the form contained the resident's POA signature and was dated, but current physician's orders failed to contain advanced directive, all advanced directives were addressed on their care plans. D
- Failure to correctly document resident's Advanced Directive status. Client had elected no CPR, but the chart stated FULL CODE. B

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

- Failure to consult with a resident's physician following an accident resulting in injury which had potential for requiring physician intervention. Resident fell and had a black eye/bleeding nose, but physician was not notified. Resident had a change in neuro status and was sent to the emergency room. D
- Failure to promptly report a resident's change of condition to the physician, failed to notify MD of the resident's condition change related to facial swelling. D

F582 – Medicaid/Medicare Coverage/Liability Notice

- Failure to comply with applicable Federal Regulations regarding Medicare requirements governing billing practices for multiple residents reviewed for beneficiary protection; Forms 10123/10055 were on file but lacked signature/date of notification to resident/resident representative, MDS coordinator reported she called

and left message regarding notices and requested a return call and mailed the forms, but acknowledged failure to document the attempts to call representatives; confirmed resident representative did not sign/date documents and did not make another attempt to contact rep until the next care plan. C

- Failure to provide required forms for Medicare liability notices/beneficiary appeals when skilled services had been exhausted or no longer covered for multiple residents. None of these residents who had skilled services had received the CMS form 10123. An interview with the restorative nurse on 1/29/19 revealed she had never used this form. D
- Failure to ensure compliance with Medicare regulation- 48-hr advance notice not given. B

F584 – Safe/Clean/Comfortable/Homelike Environment

- Failure to provide adequate linens to perform resident cares for several residents. No washcloths or hand towels available when needed. No staff available or scheduled to wash soiled linens. D
- Failure to maintain resident rooms, facility hallways and laundry room in clean, sanitary and homelike atmosphere. No cover on running air conditioner vent, dried brown substance scattered on the resident's bed side dresser, build-up of dust, dirt and debris, jagged edges along baseboard, no baseboard along wall in washing area of laundry, heating element along floor in poor repair. Dust, dirt, debris on vent in ceiling, sink, control unit of dryer, shelf, pipe running along the wall above dryers, wall with paint removed. Holes in walls, laundry cart build-up of large amounts of white/brown substance. Food debris on bedding, red substance on comforter. Fall mat torn, exposes inner foam cushion not subitizable. E
- Failure to provide clean, homelike environment; food crumbs/debris on floor, powder on floor, black substance around toilet base, a white-water stain on floor. D
- Failure to maintain proper resident supplies and homelike atmosphere for multiple residents. No washcloths/towels in several residents' rooms. Resident indicated he/she only sometimes receives clean washcloths; facility lacked clean linens. Group interview confirmed staff do not provide clean washcloths and towels every day. Resident council minutes documented residents' concerns with towel availability. Staff nurse stated not knowing whether linens were passed daily. Staff CNA stated 3rd shift should pass clean linen but do not always do it. Stated rarely sees linen in the resident rooms. E
- Strong odor that won't go away. D

F600 – Free from Abuse and Neglect

- Failure to ensure residents are free from abuse. Multiple residents were engaging in various forms of sexual expression, residents were harassing other residents and making sexual comments towards staff; staff consistently failed to contain information on the handling of resident-to-resident abuse. D
- Failure to provide services free of physical/mental abuse. Resident got agitated and hit staff and staff slapped resident back, then they started yelling at each other. D

F602 – *Free from Misappropriation/Exploitation

- Failure to protect residents from financial exploitation. Several residents reported missing money/items and the facility failed to act investigate and act immediately.

F606- *Not Employ/Engage Staff with Adverse Actions

- Failure to conduct background check on CNA until 5 months after hire. **D $500 FINE**

F607 – *Develop/Implement Abuse/Neglect, etc. Policies

- Failure to thoroughly investigate an injury of unknown origin and to obtain required background check prior to employment. Resident complained of right shoulder pain during bed transfer. Lack of any statement from staff that had transferred resident. Resident reported to surveyor he/she obtained bruise from hitting bed during a fall. Lack of thorough investigation. Staff started work 6 days prior to receiving background check verification. D

F609 – Reporting of Alleged Violations

- Fail to report allegation of abuse to DIA within 24 hours of receipt of allegations. D
- Resident reported a staff member being rude, however staff member that was reported to did not report it to any other staff member or management of the facility for over 4 days. F
- Failure to initiate facility abuse procedures requiring the facility to report an injury of unknown origin to DIA. Record lacked investigation of origin of bruise related to nurse's notes stating resident complained of right shoulder pain and subsequent bruise that occurred during transfer. D

F610 – Investigate, Prevent, Correct Alleged Violation

- Facility did not promptly investigate an allegation of a CNA posting inappropriate pictures of a resident care setting to Snap Chat. D
- Failure to thoroughly investigate injury of unknown origin related to right shoulder pain/bruise injury during transfer to bed. Clinical record lacked documentation that staff member was interviewed who transferred resident to bed. Staff report resident was care planned as two assist with transfers but was only assisted with one. Facility investigation lacked staff interviews. D
- Failure to thoroughly investigate/assess resident for injuries upon suspected abuse being reported. F
- Failure to investigate an allegation of financial exploitation for a resident. D

F622 – Transfer and Discharge Requirements

- Resident was a danger to himself and others and was transferred to the hospital. Involuntary discharge notice was provided but overturned by judge due to facility rep

not attending hearing or presenting evidence. Facility still refused to re-admit even with judge ruling against the involuntary discharge. D

F623 – Notice Requirements Before Transfer/Discharge

- Failure to notify the Ombudsman of hospitalization. Resident had written in chart stated client was admitted to hospital and no documentation of notification of the Ombudsmen. B
- Failure to send a notice of discharge to the Ombudsmen for a resident. Resident was discharged to the hospital with no documentation of the notice sent. The social worker confirmed it was not sent. B

F625 – Notice of Bed Hold Policy Before/Upon Transfer

- Facility failed to provide notice to the resident and/or representative of facility bed hold policy prior to and upon transfer to the hospital. E
- Failure to notify resident or resident rep of the bed hold for hospitalization. B
- Facility failed to provide residents or responsible party designee with bed hold information on multiple occurrences. Residents chart lacked documentation that bed hold option had been offered to resident designee for admission to the hospital. D
- Failure to notify residents of Bed hold upon hospitalization. D
- Facility failed to notify a resident, or their representative of the facility's bed hold policy, including reserve bed payment, during hospitalization. D
- Failure to provide written notice to multiple residents or representatives regarding facility behold policy when a resident is transferred/admitted to a hospital. B
- Failure to document/demonstrate a response to grievances filed by residents. Resident council brought issues to the attention of the facility and the issues were not addressed or resolved. D
- Failure to provide written notice to resident explaining bed hold policy when resident transferred to hospital after a fall and for another resident admitted to hospital. B

F636 – Comprehensive Assessments & Timing

- Failure to complete a comprehensive/accurate assessment using the Rai. Client's care plan stated they had a UTI for the last 120 days which was untrue. B

F641 – Accuracy of Assessments

- Lack of accurate assessments of resident status; one resident had 12.5% weight over six months that was not identified. Another resident had no admission nutritional assessment. D
- Failure to accurately complete quarterly MDS care plan entries; wound record state the pressure ulcer was a stage 3, MDS was coded that resident had one pressure ulcer stage 2. D
- Failure to complete accurate MDS assessments. Care plan entry stated the resident required hospice services when resident didn't, and a care plan entry stated the resident had a feeding tube and MDS assessment stated they didn't. D

- Failure to complete a significant and a quarterly assessment accurately for several residents. Anticoagulant marked on MDS's with no documentation on care plan r/t anticoagulant or monitoring, and record showed residents received Plavix and ASA. Residents had not been on anticoagulants. D

F642 – Coordination/Certification of Assessment

- LPN signature under the RN signature section for the completion of the MDS. B

F644 – Coordination of PASARR and Assessments

- Fail to notify ASCEND of change in condition for resident with Level II PASARR. D
- Failure to submit a request for evaluation for the PASRR for a resident, failed to obtain a psychological assessment for resident as recommended with the PASRR review, admission record documented diagnosis of unspecified psychosis not due to a substance or physiological condition, the residents clinical record lacked a request for another evaluation. PASRR recommended to obtain resident's archived psychiatric record to clarify history and provide to treating physician, chart lacked the resident's psychiatric history and care plan did not include this PASRR. B
- Failure to resubmit follow-up PASRR for several residents. Lack of PASRR updated with new dx of Major Depression and anxiety. Another resident with no update to PASRR d/t change in medications and psychdx from 2016. No updates to Ascend were found - last PASRR's 2013. D
- Failure to identify/reassess change in mental health according to PASARR. Resident with previous negative level I and no updates for diagnoses of psychotic disorder with delusions. D
- Residents with newly diagnosed major depressive disorder, no new PASRR was completed. D
- Multiple residents with new mental health diagnoses/no new PASRR's submitted. D

F655 – Baseline Care Plan

- Facility did not provide residents baseline care plans within 24 hours of admission. D
- Failed to provide the resident and their representative with a summary of the baseline care plan. D
- Facility failed to explain and give a copy of the baseline care plan. Spouse reports remembering a care plan meeting but did not receive a copy of the care plan. D

F656 – Develop/Implement Plan of Care

- Fail to create comprehensive care plans for constipation problem/catheter use. D
- Failure to develop comprehensive care plan for several residents. One resident is severely impaired with BIMS score of 2. This resident is on a pureed diet, has alarms in place, and behaviors all documented in chart but not care planned. Resident receives dialysis M-W-F. Facility lacked documentation regarding interventions carried out and care plan did not direct staff to complete interventions such as vitals including BP and weight/communication with dialysis center before/after dialysis/direct visual

monitoring of site before and after dialysis etc. Care plan did not address transportation arrangements/nutritional needs or restrictions and emergency contact for dialysis concerns. D

- Failed to ensure comprehensive care plan included all services required to ensure residents' medical and nursing needs were met. Care plan did not address diagnosis of diabetes mellitus or use of insulin. Residents' care plan did not address residents' use of anticoagulants or provide direction to staff for bleeding precautions. D
- Failed to ensure care plan was followed. Care plan stated to assist resident with meals, speak loudly and tell resident what they're eating, and CNA assisting did not tell the resident what they were feeding them. Resident who had an order for tubi-grips on upper extremities and heel couch to bed was not done. D
- Failure to develop/implement a comprehensive person-centered care plan with regard to dialysis care/treatment. Resident care plan who went to dialysis lacked documentation of assessing vitals before and after dialysis, assessing the site and coordinating and collaborating with the dialysis facility. D
- Care plan lacked in-depth information on resident's catheter care or management. D
- Fail to personalize care plan regarding resident's use of psychotropic medication. D
- Fail to develop/implement comprehensive person-centered care plan for each resident, consistent with resident rights. Pain- not documented in care plan. D
- Failure to update care plan related to edema. Resident had 2+pitting edema to BLE's and one hand. Care plan lacked documentation of edema and any interventions. Lack of physician notifications of the change in edema. D

F657 – Care Plan Timing & Revision

- Resident care planned for two-person assisted transfers was transferred by one staff member only. D
- Facility did not update care plans for multiple residents as follows: care plan did not include updated dietary preferences; did not address side effects of AS medications and antidepressants; did not address most recent changes in transfer method; did not accurately reflect use of Prevalon boots. E
- Fail to develop resident-centered interventions towards fall prevention for resident. Resident had nine in ten months. Care plan lacked any further interventions during several months of this period. r/t circumstances r/t falls to prevent further falls. D
- Failure to revise care plans for constipation problem; to prevent elopement and exit seeking behaviors and when the resident eloped from the facility. D
- Fail to ensure care plans were updated related to psychotropic medications/falls. D
- Failure to revise a care plan to reflect current needs of residents. Physician discontinued the 2 L fluid restriction for a resident, but it remained on the care plan. D
- Failed to update resident care plans reviewed for diet orders. Client who was on a pureed diet did have care plan updated to reflect. D
- Resident's care plan lacked use of Ted Hose as intervention and resident did not have on the Ted Hose as ordered. D

F658 – Services Provided Meet Professional Standards

- Failure to follow physician's orders for multiple residents- failed to apply meds as ordered for skin infection and complete dressing change; facility failed to administer the correct amount of Jevity as ordered when using feeding pump; D
- Failure to discontinue a medication as ordered with initiation of a new medication. D
- Facility failed to administer medication as ordered by the physician, nurse had applied the cover of the clonidine patch and not the patch itself to the resident. D
- Failure to meet professional standards for services provided. Staff failed to properly administer, and document medication administered. D
- Dialed up dose of insulin without priming the Flexpen needle and holding the needle in subQ tissue for a count of 3 instead of 6 seconds as per recommendations. D
- Failed to follow physician orders for multiple residents. Resident stated staff failed to administer her medication on time. Another resident had an order for peritoneal dialysis between 9 pm and HS and stated was not hooked up until 1 am even though she would have liked it to be completed at 10 pm. Also reported that staff checked BP at 7 pm and administered heart meds at 9 pm which made no sense to resident. A different resident had an order for Trazadone at Hs that was scheduled at 8 pm. Nurse administered multiple medications to resident at 10:45 when they were ordered to be given at 7 am. Different staffer was observed administering a resident multiple medications at 10:07 when they were due at 7 am. Staff nurse confirmed that med pass runs late due to many residents. Staff reported med pass is not completed on time which is frustrating. Staff aide reported resident complaints about med pass not being on time. E
- Failed to obtain a physician order for administration of oxygen for resident. Resident on oxygen via NC- Jan 2019 POS lacked oxygen order. Care plan showed oxygen use. Nurses notes indicate use of 2L. D
- Failed to follow physician orders. CNA did not apply compression wraps as ordered and did not follow the diagram and applied the calf before the ankle. Staff failed to do any massage or range of motion to resident's right hand, failed to complete any massage to the residents left hand. D
- Facility medication record did not identify that resident received the proper dose of Warfarin as ordered by physician. D
- Failed to follow physician's orders. Resident with orders for dressing on toe and foot not completed as ordered by the physician. D
- Failure to follow doctor's orders for dressing changes. D
- Failure to follow physician's orders for resident. Following a fall with wrist injury for a resident, a splint was ordered but not ordered from pharmacy or applied. D

F677 – ADL Care Provided for Dependent Residents

- CNA told surveyor he/she had performed pericare after resident was incontinent of urine. When the surveyor looked in the trash, saw only gloves and a used brief, but no wipes. After questioning, CNA admitted she had not used any wipes for cleansing but had simply changed the brief. D

- Failure to provide bathing for multiple residents. D
- Failure to aid with shaving of a resident. Three days in a row, a dementia resident was noted unshaven. Resident reported each day "I forgot to shave today" when asked. D
- Failed to provide proper incontinence care; incontinence care with toilet paper only; gloves not changed after providing care before applying clean brief; failed to provide repositioning and incontinence care for 5 hours and 27 minutes, when care provided wiped from back to front and side to side. D
- Failure to shave multiple residents and provide nail care for several. Resident with long rough nails asked for assistance was told it depended on whether they had enough staff. Second resident with long rough nails and facial hair showed same results. Resident revealed he likes to be clean shaven. Later, the nails were noted to be trimmed but facial hair remained. Third resident with long rough nails although she stated she prefers them trimmed. Observation revealed another resident had long jagged nails with facial hair although resident stated they like nails/facial hair trimmed. Later, same resident observed in the same condition. E
- Failed to provide shaving for several residents. D
- Failure to provide baths as required. Facility had care planned to give resident a bath 2 times a week, shower record revealed client was not receiving 2X/week. D
- Failed to complete baths. Bathing records revealed staff failed to give/offer resident a bath until Thursday. Resident revealed they did not have a bath for at least a week after admission. D
- Failure to schedule baths or showers for multiple residents. E

F677 – *ADL Care Provided for Dependent Residents

- Failure to schedule baths or showers for multiple residents. E

F678 – *Cardio-Pulmonary Resuscitation (CPR)

- Failure to initiate CPR for a resident who requested CPR. No IPOST- Review of physician's order stated resident had desire for full code status, but the care plan failed to identify resident's wishes for CPR. Resident was found in bed cold and motionless with no pulse and was assumed to be deceased. Staff left to check resident's IPOST for CPR wishes but couldn't find it. So, staff called ambulance and facility LPN; LPN indicated resident was clearly already deceased and CPR was unnecessary. Staff didn't chart anything about the incident; Further survey findings indicated multiple residents did not have IPOSTs in their clinical records and staff could not locate them. Four different residents' records had conflicting stickers in their clinical charts that did not reflect their wishes correctly. **K $10,000 FINE IN SUSPENSION**
- Physician orders for advanced directives had not been correctly documented on resident’s care plan/medical record. Physician’s orders for resident documented the resident had been a full code status the care plan directed staff to treat the resident as follows if found in cardiac/respiratory arrest DO NOT START CPR. One nurse said he/she would look at the outside of chart and care plan for code status, another nurse said he/she would look at outside of chart for sticker, administrator reported he/she

will make sure doctors' order gets changed to a DNR status according to the directives for resuscitation that the family signed. D

F684 – Quality of Care

- Resident had choking history on peanut butter sandwiches. Care plan directed staff to not serve these sandwiches to resident. Resident received a PB sandwich, choked, suffered cardiac arrest. **J $27,000 FINE IN SUSPENSION**
- Failure to identify, assess, and treat skin conditions. Resident had potential/actual impaired skin integrity. Resident did not wish to be repositioned; Resident ended up with multiple Surveyor observed new skin conditions, soiled linen, dry feces on the resident's buttocks, fungal skin infections, serious drainage and foul odor, as well as pressure ulcers, bruises, excoriations. Documentation sheets revealed no weekly skin assessments for ten weeks. Facility skin nurse stated he/she was pulled from regular duties to work the floor and did not have time to complete assessments on resident's skin. Skin nurse also did not know he/she was supposed to complete a skin sheet for new skin issues. **G $7,250 FINE**
- Failure to follow up/assess after resident did not receive insulin, MAR stated staff did not administer resident's scheduled 5 pm Novolog;MAR lacked information regarding resident not receiving the insulin; Earlier MAR stated resident refused scheduled 5 pm Novolog the MAR, documented resident refused but had no other information regarding the refusals. Progress notes revealed facility lacked documentation of any assessments done or of physician notification after resident did not receive insulin. Another resident sent to ER, nurse's notes did not have documentation of assessment of resident or interventions prior to resident being taken to ER. D
- Failure to provide necessary assessments reviewed with a condition change. Facility's skilled charting forms revealed the staff failed to have assessed resident, DON confirmed staff failed to document skilled information. D
- Failure to provide necessary care/treatments for multiple residents for respiratory care/treatment, edema care/treatment and treatment of weight loss. MDS reported Oxygen, SOB with rest. MDS& care plan lacked documentation of respiratory diagnosis or current condition. Care plan lacked mention of BiPaP, did not provide updated/specific guidelines to address resident's increased vulnerable condition related to respiratory condition to include decreased O2 sats, visible SOB, wheezes after resident was sent to ER/admitted to hospital. No update to care plan after resident returned from hospital or documentation on EMAR to support providing Neb treatments/house supplements. House supplement discontinued on EMAR without a physician's order. D
- Failure to complete timely assessments for resident who required wound care and/or had condition change. Resident noted to have late/incomplete/missing skin assessments to multiple skin areas; diagnosed with a UTI in the ER with missing urinary assessments on multiple dates.
- Failed to ensure timely assessments and interventions were completed for areas of altered skin integrity. Resident had care plan to monitor skin with baths/care, report any reddened or open areas, and resident had dark purple bruises on bilateral hands and a tear covered with a dark scab that was not reported. D

- Fail to provide necessary assessments. Resident left on bed pan all night, CNA failed to perform resident rounds through night, bed pan found by day shift staff. DON confirmed staff failed to have completed incident report, no documentation. D
- Fail to identify, assess, provide treatment. Client had red peri area/buttock which was not getting better; was not reported to skin nurse/doctor for further treatment. D
- Resident admitted to facility with area of redness on coccyx noted on assessment. No documented indicated assessment of area occurred- 14 days later assessment indicated the area was open. Resident also suffered a skin tear after admission, no record of wound assessment/treatment documented until week later. D
- Failed to provide appropriate assessments/intervention who had fallen. Resident found on floor and ended up having right femur fracture and left femur fracture and aide moved client's legs before being assessed by a nurse. D
- Failure to meet professional standards of practice involving assessment of resident who fell and sustained significant physical injury. Progress note does not include documentation of head to toe assessment, including range of motion of extremities, shortening/lengthening of egs with internal or external rotation, neck assessment. D

F686 – Treatment to Prevent Pressure Ulcers

- Failure to prevent the development of pressure sores. Surveyor requested skin assessment on residents. Facility identified seven residents with pressure sores; two of these were not identified prior to the surveyor requesting the assessment. Facility identified approx. 30 residents with other skin issues including bruises, skin tears, rashes, or scratches. **G $5,000 FINE IN SUSPENSION**
- Failure to provide interventions to prevent pressure sore from developing, TAR lacked documentation of Prevalon boot being on; observation revealed same. D
- Failure to carry out proper interventions and wound care in order to promote healing, Nurse used the stick end of cotton swab moving it back and forth over wound to remove slough; facility lacked order for wound debridement. Physician stated the wound did not need debridement as it was clean wound and not tunneled. D
- Failed to prevent development of pressure ulcers area after returning from hospital with surgery for a fractured hip. Resident was not thoroughly checked after returning from hospital. **G $4,250 FINE**
- Failure to create and carry out interventions to treat existing pressure ulcers for multiple residents with pressure ulcers. D
- Failure to document, track healing progress, treat as ordered and notify physicians of the development of and progress of pressure ulcers for multiple residents. D

F 688 – Increase/Prevent Decrease in ROM/Mobility

- Failure to complete restorative programs for multiple residents sampled; Care plan failed to reflect resident had restorative program, so resident wasn't receiving restorative exercises as needed. Facility doesn't have anyone overseeing the restorative program but does have a staff member who heads up the program. This staff member indicated the facility owners directed her/him to put the restorative program on hold

so the restorative aides could work on the floor to decrease use of agency staff. **G $4,750 FINE IN SUSPENSION**

- Facility did not ensure accurate assessment/implementation of consistent intervention for care and treatment of resident. Resident did not receive Restorative program for passive, active or use of splint or brace. Care plan reported contractures of hands with direction to apply splints in the morning and removing in afternoon (opposite of physician's order). Care plan directed resident was on dressing, eating and personal hygiene for Restorative programs. MDS had no documentation of resident receiving restorative programs. No splints observed on by surveyor. Resident reported he did not wear splints. Staff verified no splints were on the night before. TAR lacked documentation of splints being on for 10days. No documentation noted from resident refusing splints. D
- Failure to provide restorative services as planned for multiple residents. E
- Resident did not receive restorative services as care planned 3x/ week for 1/2 of January, February and 1/2 of March dues to oversight after discontinuation of Therapy services. D

F 689 – Free from Accidents and Hazards

- CNA washed residents face around eyes with a wash cloth that had just been used to complete pericare. D
- Failure to provide supervision for a resident who utilized an electric wheelchair. No wheelchair safety assessment was ever completed. Facility failed to document that the resident utilized a wheelchair and failed to inform staff that the resident could go out into the community in his electric wheelchair, unaccompanied by staff. The care plan also failed to identify safety concerns with use of the electric wheelchair. Resident continuously disregarded staff warnings to slow down speed of wheelchair. Repeatedly left the building in inclement weather and got stuck outside and had multiple falls. **J $10,000 FINE IN SUSPENSION**
- Fail to ensure safety for residents requiring gait belt transfer, LPN asked resident to stand up so could look at bottom, resident did with no gait belt/leaned on sink in hunched over position, resident was at risk for falls; was to be assist of one and gait belt. D
- Facility failed to provide adequate nursing supervision and assistive devices to protect against hazards for self, others or elements in the environment during transfers and ambulation for 1 resident. No gait belt used with ambulation with Ax1. Staff let go of resident's arm to remove a wheelchair out of their way and resident fell and fractured hip. **G $6,000 FINE IN SUSPENSION**
- Resident with history of wandering exited the building without staff knowledge and was found outside in the snow**. J $8,000 FINE IN SUSPENSION**
- Failed to maintain a safe and secure environment. Unattended Tx cart was noted to be unlocked. Remained unlocked until administrator was informed. Treatment cart was unlocked/unattended at 10 am and was observed again at 1304 unlocked. E

- Failed to complete assessments to determine independent resident smoking safety for residents. Residents' care plans indicate they can go out to smoke independently but no assessment documented. D
- Failed to ensure staff maintained a safe and secure environment. Resident was left on a bedpan all night due to CNA did not make rounds. D
- Failed to complete nursing assessments/monitoring of a resident before/after going to output. Dialysis. Facility lacked documentation that staff carried out the following interventions of assessing vital signs before and after dialysis, provide direct visual monitoring of access site, and coordinate and collaborate with the dialysis facility. D
- Resident transfer was attempted with assist of 1 when CP stated assist of 2 was needed. Resident slid off the bed and sustained a hip fracture. 2. Resident self transferred from his wheelchair in his room and feel, CP stated that resident was not to be in his room alone in his wheelchair and was not followed. 3. Resident was transferred in front of surveyor without gait belt. **G $4,500 FINE**
- Resident failed to be assessed for use of lift chair appropriately and used it wrong resulting in a fall and subdural hematoma. D
- CNA attempted to transfer resident hemiparesis from commode to wheelchair without the required use of a gait belt. Resident fell and suffered a impacted fracture of humeral head. **G $2,750 FINE**
- Fail to adequately supervise/develop/implement interventions to prevent fall injury for resident. Care plan lacked further interventions to prevent falls. **G $7,500 FINE**

F 690 – Bowel, Bladder Incontinence, Catheter Care

- Failed to provide adequate incontinent and catheter care to prevent urinary tract infections. CNA removed urine-soaked socks and replaced with dry ones but did not wash skin. Staff did not wear gloves, do hand hygiene nor wash their hands at any time while assisting with personal cares. D
- Failed to complete catheter cares as ordered. Facility policy stated that catheter cares were to be done every shift, but only one shift was doing them. D
- Failure to provide appropriate treatment to prevent urinary tract infections/restore continence to extent possible. Baseline care plan showed resident incontinent of bowel/bladder- no interventions. Incontinent assessment reports resident is candidate for nursing restorative/rehab or bladder training program. Pericare completed- no cleansing of hips/outer buttocks that had contact with stool. Spouse reports resident didn't have sensation of need to toilet but would go if put on. D

F 692 – Nutrition/Hydration Status Maintenance

- Facility failed to notify physician of a significant weight loss of 17 pounds in six months and failed to implement timely nutritional interventions. D

F 693 – Tube Feeding Management/Restore Eating Skills

- Failure to properly label new bags of tube feeding for multiple residents. D

F 695 – *Respiratory/Tracheostomy care and Suctioning

- Failure to perform tracheostomy care. Staff failed to suction resident as needed. D
- Facility did not ensure oxygen therapy provided according to the individualized need, oxygen order was 4 L/M cannula at bedtime resident was observed on 2.5L/M, no oxygen, oxygen cannula rested on resident not in nostrils, inconsistent statement from staff regarding oxygen orders. D

F 698 – Dialysis

- Failure to consistently complete full nursing assessments, monitor resident before and after going to outpatient dialysis treatments. Lack of pre/post-assessments. D
- Fail to complete assessments/monitoring of residents before/after dialysis. Resident receives dialysis M-W-F didn't have pre/post assessment treatment documented. D
- Failure to complete prior/past dialysis assessments; fail to assess the port site. D
- Facility failed to complete assessments before or after dialysis. Resident chart shows no documentation of assessments pre or post dialysis tx for Jan 2019. D

F 700 – Bedrails

- Failure to ensure physical nursing assessments were completed prior to using side rails and accurate consents for their use not signed. D
- Fail to ensure physical nursing assessments completed prior to using side rails. D
- Facility did not assess residents for appropriate bed rails use, inform resident of benefits and risks or obtain informed consent prior to the use of bed rails. D
- Failure to obtain informed consent for use of bed rails and/or failed to assess safety of bed rails. Facility had doctor's orders for 1/2 bedrails but did not obtain informed consent from the resident and/or her representative for the use of bed rails. E
- Facility failed to assess bed side rails for risk of entrapment. Record showed mobility bar added to be with no side rail assessment was completed. D

F 725 – Sufficient Nurse Staffing

- Staff did not answer call light for 23 minutes. When they did answer, the resident was incontinent with standing and felt "upset" related to the incontinence episode. D
- Failed to answer call lights timely; bathroom call light not answered for 21 minutes. D
- Fail to answer resident call lights in a timely manner in order to meet resident needs. Residents stated usually had to wait over 20 minutes to have call lights answered. E
- Failure to provide adequate staffing. Staff were not answering call lights within 15 minutes and resident often had to wait 30 minutes or longer. D
- Failure to have sufficient nursing staff with appropriate competencies and skills sets to provide nursing and related service to assure resident safety. Resident call lights not answered timely- 40-60 minutes. D

F 729 – Nurse Aide Registry Verification, Retraining

- Facility failed to conduct a registry check on a CNA until 5 months after hire. D

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

- Facility failed to conduct annual performance reviews for multiple CNA's. D
- Failure to complete performance reviews of multiple nurse aides at least once every 12 months. Facility office manager stated performance evaluations weren't completed every 12 months because the corporation has not given the staff raises for quite some time and it's a waste of time to do them. D

F 732 – Posted Nurse Staffing Information

- Failure to post nursing staff data for a minimum of 18 months or as required by state law (whichever is greater). Facility failed to post nursing staff data at the beginning of each shift in a prominent place readily accessible to residents and visitors. D
- Failure to post daily nurse staffing data during survey. B

F755 – Pharmacy Services/Procedures/Pharmacist/ Records

- Failure to ensure staff documented accurately and tracked a controlled substance medication for resident. Tramadol signed out and then lined out as not given with no explanation. No documentation to support why Narcotic count being incorrect. D
- Staff did not conduct an accurate narcotic count and later 2 doses missing; did not accurately document narcotic use for residents; residents missing Fentanyl patches not investigated; narcotics not signed out at time of administration; staff dropped narcotic tablet and did not identify if it was destroyed or destruction witnessed. E

F756 – Drug Regimen Review

- Failed to verify potential and actual medication allergies; medications that triggered a medication alert were not addressed. D

F757 – Drug Regimen- Free from Unnecessary Drugs

- Facility failed to do monthly INR testing for 4 months during the last year. D

F758 – Free from Unnecessary Psychotropic Meds/PRN Use

- Facility did not ensure monitoring of specific target behavior for use of an antipsychotic medication and failed to ensure that a GDR was attempted for the antipsychotic medication for resident. Physician declined dose reduction indicating "poor behavioral control". Record lacked supportive documentation of any resident behaviors that supported continuing need for antipsychotic medication. Record lacked documentation of targeted behavior symptom being monitored for. D
- Failed to ensure drug regimen review was free of unnecessary drugs, extending PRN psychotropic medications past 14 days without documentation of rationale and duration of use. D
- Failure to obtain an order for PRN Lorazepam beyond a 14-day period or document non-pharm interventions for residents. The chart shows indefinite order for Lorazepam 1mg IM q 8 hrs. PRN with no further documentation of physician evaluation. Administration on only had one intervention documented. D

- No GDR completed for resident on psychotropic drug. D
- Failure to provide a rationale for continued use of an antidepressant. Client did not have gradual dose reduction of medication and no rational why. D
- Failure to implement a GDR (Gradual Dose Reduction) or provide documentation of rationale from the prescribing practitioner as to why this would be contradicted for residents on psychotropic medications. D

F760 – *Residents Are Free of Significant Med Errors

- Facility failed to ensure resident was free from significant medication errors. Facility did not administer a resident's Coumadin for one month as required by order. **J $7,000 FINE IN SUSPENSION**
- Failed to ensure that resident remains free from undesired side effects from medications identified as allergens that resulted in pain, nausea, weight loss, overall decline and hospitalization related to Sulfa allergy identified on admission records but not transcribed to MAR and given. G DEFICIENCY WAS NOT INCLUDED.

F761 – Label/Store Drugs & Biologicals

- Facility failed to label medications with an open date and failed to discard expired medications. Expired eye ointment, insulin pens, nitro tabs. E

F801 – Qualified Dietary Staff

- No certified dietary manager in the facility. New dietary manager not enrolled in a program. E
- Failure to employ staff with appropriate competencies to carry out the functions of food and nutrition services. Facility employed a dietician on a part-time basis and designated a person to serve as the director of food and nutrition that lacked the required certification. E
- Facility failed to ensure that the dietary service manager had the required qualifications. Food Service Manager had been employed for 1 month and was enrolled in a 12-month program to become certified. Facility policy states dietary supervisor is required to have completed programs as required by the regulation. D
- facility failed to employ a qualified person to serve as the Director of Food and Nutrition Services in the absence of a full-time dietician. D
- Facility failed to have a CDM currently employed. The dietary manager was registered for the class but not started yet. F

F802 – Sufficient Dietary Support Personnel

- Cook used the wrong portion scoops for pureed food and there was no training documentation showing the cook had been trained on pureed food. E

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

- Residents were served too small of pureed portions compared to what was listed in the menu. E

F804 – Nutritive Value/Appearance/Palatability/Temp

- Food was not served at adequate temps. D
- Facility failed to provide palatable food for multiple meals. Resident reports food as usually cold or lukewarm. Food temps verified with meat at 109 degrees and potatoes at 120 degrees. Test trays tested at 137 degrees. E

F806 – Resident Allergies, Preferences and Substitutes

- Facility served shrimp to a resident with a shellfish allergy. The resident had an anaphylactic reaction and was admitted to ICU for airway protection and sedation. **J $7,000 FINE IN SUSPENSION**

F809 – Therapeutic Diet Prescribed by Physician

- Residents complained that bedtime snacks were not offered. D
- Facility failed to ensure that bedtime snacks are consistently being provided to residents. Residents reported issues voiced during resident council meetings and no improvement noted. Lack of documentation of snacks being offered on multiple days. E

F812 – Food Procurement, Storage, Preparation, Sanitization

- Failure to ensure proper temperature testing of dishwasher performed. Facility was using strips that were not accurately indicating proper temperature of dishwasher. F
- Failure to ensure surfaces in the kitchen were maintained in a sanitary manner; Facility failed to protect food from contamination during meal services. E
- Fail to use gloves when preparing/handling/serving food and properly handwash. ?
- Failure to ensure dietary staff followed proper sanitizing recommendations when disinfecting food prep area in main kitchen. Strip failed to change color to the appropriate level showing the sanitized water to be effective. E
- Meat in the refrigerator was dated as thawed 2 weeks prior. All resident's items in the resident refrigerator lacked dates. E
- Failure to serve food in accordance with professional standards for food service safety, fail to practice proper hand hygiene during lunch meal service. Cook reached into a container with bare hands to obtain butter packets. Facility failed to practice proper hand hygiene during the lunch meal service. E
- Fail to properly handle food during meal and one meal prep. Fail to change gloves. E
- Failure to properly label/date food items in refrigerator areas, maintain equipment in a suitable manner and keep freezer free of ice build-up. Ice cream noted with freezer build up, cutting boards with fuzz noted in grooves, breadsticks and hash brown patties not labeled or dated, donuts not labeled or dated with freezer burn noted. E
- Facility did not ensure consistent sanitary practices in food prep/handling. Staff dropped gloves on floor, picked up, got new pair from box and placed contaminated gloves back in box. Another staffer took contaminated gloves out of box and put them

on. Another staff person with gloved hands touched multiple items/different areas of the kitchen, touched and pulled down her scrub top multiple times. E
- Fail to follow adequate sanitary practices with food distribution in meal. Cook wore gloves and touched multiple handles and scoops and then with the same gloves touched and served pieces of bread. D

F 836 – License/Comply w/Fed/State/Local Law/Prof Std

- Failed to complete a thorough evaluation of needs/services. Facility assessment does not evaluate the resident population and identify resources needed to provide the necessary person-centered care and services residents require. DON stated the facility assessment was completed by the former administrator and it did not include all the resources and services provided to the residents. C

F 842 – Resident Records - Identifiable Information

- Facility failed to follow physician orders, residents received orders; staff failed to administer medications or perform treatments, reviewed MAR and TAR forms. D
- Facility didn't maintain records in accordance with professional standards of practices. Didn't maintain medical records on each resident that were complete, accurately documented, readily accessible and systematically organized. D

F 880 – Infection Prevention and Control

- During pericare, staff cleansed buttock of stool but did not change gloves prior to application of Nystatin cream. When prompted to remove dirty glove, the staff member removed one glove only and applied a new glove without performing hand hygiene. Staff member also touched computer prior to performing hand hygiene. D
- Failure to utilize proper infection control techniques during wound care. Change gloves between performing dressing changes on a resident with several wounds, disinfect scissors between dressing changes. D
- Failure to properly cleanse a wound for resident and properly cleanse a graduate used for urine. After emptying urine from graduate, staff placed graduate under sink faucet, with soap and water she swirled graduate around in sink then poured into toilet. Wound care - staff used same gauze to clean all areas of a wound. Cleansed wounds from outside of wound to inside. D
- Failed to maintain appropriate foley cath cares in prevention of acquiring infections. Foley tubing lying on floor in room, hallway and therapy room. D
- Fail to utilize infection control techniques during resident care/treatment, handwashing not done between glove changes; catheter port not cleansed with alcohol prior to emptying urine; gloves not changed after removing soiled dressing before cleansing wound; glucose monitor placed on bedspread top without barrier. D
- Staff did not complete hand hygiene when changing gloving. D
- Failure to maintain infection control for resident with a Foley catheter. D
- CNA failed to sanitize a wheel chair cushion after resident was incontinent of large amount of urine. D

- Failure to utilize proper infection control techniques for residents with foley cath. Resident aide didn't change gloves/wash hands before emptying catheter bag. D
- Failed to implement and maintain infection control measures for resident. D
- Failed to maintain proper infection control procedures while providing cath cares. LPN did not wash hands prior to leaving room after cleaning up urine or when returning to room. LPN put on a new leg bag and did not use alcohol wipes when emptying or changing the leg bag. D

F881 – Antibiotic Stewardship Program

- Failed to create a comprehensive antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use. D
- Facility did not follow their antibiotic stewardship program policy and procedure for two residents with infections. D

F909 – Resident Bed

- Facility did not provide routine assessment and maintenance of facility bedrails. E

F921 – Safe/Functional/Sanitary/ Comfortable Environment

- Failure to maintain sanitary shower chairs for multiple shower rooms and failed to repair wallpaper in resident's bathroom. D

F947 – Required In-Service Training for Nurse Aides

- Failure to assure nurse aides receive nine in-service hours for a one-year period. D
- Two CNAs did not have 12 hrs. of in-services. D

L1093

- Failure to check for Veteran's Benefit's Eligibility for residents
- Facility failed to check Veteran status for one resident upon admission

L190

- Multiple facility employees did not have records of physical exams prior to hire.

L191

- Multiple employees didn't have records of required physical exams every four years.

Nursing Facility Survey Frequency

As of May 26, 2019, CMS lists 58 Iowa facilities (13.2%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 7.8%. National average is 5.6%.

Provider	City	Survey End Date	Previous Date	Months Between
Accura Healthcare of Baxter	Baxter	1/24/2019	10/26/2017	15.17
Accura Healthcare of Pomeroy	Pomeroy	3/7/2019	11/27/2017	15.50
Bishop Drumm Retirement Center	Johnston	3/7/2019	11/16/2017	15.87
Deerfield Retirement Community	Urbandale	1/19/2019	10/19/2017	15.23
Donnellson Health Care	Donnellson	1/24/2019	10/5/2017	15.87
Glen Haven Home	Glenwood	3/13/2019	9/13/2018	6.03
Golden Age Care Center	Centerville	1/31/2019	10/19/2017	15.63
Good Samaritan Society - Ottumwa	Ottumwa	02/14/2019	11/2/2017	15.63
Good Samaritan Society - Villisca	Villisca	03/06/2019	11/9/2017	16.07
Hiawatha Care Center	Hiawatha	3/14/2019	11/28/2017	15.70
Hillcrest Healthcare	Hawarden	3/21/2019	11/16/2017	16.33
Iowa Lutheran Hospital	Des Moines	3/13/2019	12/28/2017	14.67
Iowa Masonic Health	Bettendorf	3/28/2019	12/28/2017	15.17
Iowa Veterans Home	Marshalltown	02/28/2019	11/9/2017	15.87
Lone Tree Health Care Center	Lone Tree	3/28/2019	12/19/2017	15.47
Montrose Health Center	Montrose	1/31/2019	10/12/2017	15.87
Northbrook Manor Care Center	Cedar Rapids	3/21/2019	12/7/2017	15.63
Northcrest Specialty Care	Waterloo	3/13/2019	11/16/2017	16.07
Parkview Manor	Wellman	2/14/2019	6/28/2018	7.70
Ramsey Village	Des Moines	03/19/2019	11/16/2017	16.27
Regency Care Center	Norwalk	1/3/2019	9/14/2017	15.87

Rehabilitation Center of Hampton	Hampton	2/19/2019	10/26/2017	16.03
Southfield Wellness Community	Webster City	3/28/2019	12/28/2017	15.17
St. Anthony's Regional Hospital	Carroll	2/22/2019	10/26/2017	16.13
Sunrise Retirement Community	Sioux City	3/13/2019	11/2/2017	16.53
The Gardens of Cedar Rapids	Cedar Rapids	1/3/2019	9/28/2017	15.40
The Madison	Fort Madison	3/28/2019	11/9/2017	16.80
Valley View Community	Greene	3/21/2019	11/28/2017	15.93
Wilton Retirement Community	Wilton	3/26/2019	11/28/2017	16.10
Woodland Terrace	Waverly	1/16/2019	9/28/2017	15.83

Average= 15.39