Compliance Tips from IHCA's Survey Results Committee

November 2016

The five most frequently cited tags from the 33 annual surveys (5 deficiency free), 65 complaints (26 unsubstantiated), 53 self-reports (17 unsubstantiated), 17 complaint/self-report (7 unsubstantiated) and 2 mandated reports (0 unsubstantiated reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 193 total reported citations.

The following is a breakdown of severity level:

A =	0.00%	D =	65.28%	G =	10.88%
B =	0.52%	E =	19.17%	H =	0.24%
C =	1.04%	F =	2.60%	I =	0.00%
				J =	0.52%
				K =	0.00%
				L=	0.00%

Total # of Reports: 124
Total # of surveys/reports deficiency free or unsubstantiated: 55
Avg. # of deficiencies

- All = 1.56
- Annual = 2.77
- Complaint/Self-Reports= 1.18

Total state fines for November Report = $5,000 ($79,500 held in suspension)

Top 5 Most Frequently Cited Tags for November 2016 Report

F 281—Professional Standards of Quality

- Nursing staff signed medications as given prior to administration, causing medications count to be inaccurate (E)
- Signed physician's orders and medications sheets not available for six of fourteen residents (E)
- Resident's oxygen was not administered continuously as ordered by physician, not on during cares/transfer (D)G-tube feedings administered too early; resident's daily weight not recorded by staff as doctor-ordered (D)
- GT placements not checked prior to medications administration (D)

- Facility staff failed to provide lymphedema wear according to physician's orders (no TED hose applied as ordered) (D)
- Staff failed to check resident's blood pressure each time prior to administration of Hydralazine; there were parameters for when to hold based on resident's blood pressure readings (D)
- Facility staff failed to apply PRN Calmoseptine or Nystatin powder to excoriated, reddened groin as ordered (D)
- Nurse left pills unattended at bedside; did not watch resident take medications (D)
- Services meeting professional standards—multiple medications patches found on resident (old ones had not been removed) (D)
- Staff failed to give Ativan for 1.5 days due to medication not available (D)
- Facility staff failed to obtain physician's orders; oxygen given to resident prior to receiving physician's orders (D)
- Facility failed to follow physician's orders in a timely manner, resident had rash that went undiagnosed as scabies until 2.5 months later (D)
- Facility failed to follow physician's orders; on Aug. 20 resident readmitted to facility, on Aug. 21 resident had not received medication as ordered (D)
- Facility staff incorrectly administered Tylenol T.O.D., not at eight hours as ordered by physician (D)
- Staff failed to apply pressure on lacrimal sack after eye drops administration (D)
- Facility failed to always follow professional standards and physician orders as written; no physician order for compayne, lack of PT/INR being drawn as ordered (D)
- Staff failed to implement daily weights; MAR showed five doses of narcotic given, but eight doses signed out on narcotic sheet; staff failed to implement edems wraps; no narcotic sheet documentation for 48 doses of hydrocodone; staff failed to sign narcotic count forms (E)

F 323—Free of Accident Hazards/Supervision/Devices

- Staff transferred resident without gait belt, staff walked away, resident fell, fractured hip and pelvis (G) **$8,000 fine**
- Resident fell from sit and stand lift waist and leg straps were not secured, only one staff was using the lift (G) **$6,000 fine**
- Staff did not use gait belt per care plan; resident fell during transfer and suffered a fracture (G) **$6,000**
- Resident required two-person lift left unattended in standing position, fell and fractured skull (G) **$5,000 fine**
- Facility staff failed to use a care-planned assistive device when transferring resident in order to prevent injury; resident was a mechanical lift, and two CNAs did a pivot transfer and resident experienced fractured arm (G) **$3,000 fine (in suspension)**
- Staff failed to use wheelchair foot pedals, resident put feet down, fell forward, hit head resulting in a "complex facial laceration" of forehead and left eyelid (G) **$2,000 fine**

- Resident was chewing denture tab; care plan called for two-person assist of resident, but one staff attempted transfer, resident fell with fracture (G)
- Staff transferred resident with slide board instead of Hoyer lift (as indicated in care plan); resident slipped from slide board and dislocated shoulder; also, staff used a standing lift instead of a Hoyer lift and resident heard their shoulder pop (G)
- A strap loop fell of a lift during transfer and was not resecured (D)
- Facility staff failed to use walker with gait belt on resident per care plan (D)
- Staff did not use gait belt as care planned (D)
- Cognitively-impaired resident was repeatedly getting up unattended from wheelchair, on one occasion went to roommate's bedside and touched genitals, facility failed to protect resident (D)
- Facility staff failed to provide safe wheelchair transportation; no use of foot pedals (D)
- Nurse charting room was left unattended and unlocked with various chemicals present; inappropriate surge protector use, lamp and cell phone charger plugged into surge protector (E)
- A resident exited the facility, another resident with wheelchair was near door, staff did not check outside the door for other residents (E)
- Door alarmed activated, staff failed to look out door; 20 minutes later staff found resident outside (E)

F 279—Resident's Comprehensive Plan of Care

- Facility staff did not care plan psychotropic medications and monitored resident for side effects (E)
- Facility staff failed to care plan psychotropic medications and monitor resident for side effects (E)
- Resident's care plan failed to contain possible side effects of psychotropic medications, AD, AA, and AP (E)
- Resident's care plan lacked instructions for resident psychotropic medications use (E)
- Staff failed to develop care plan interventions for use of psychotropic drugs (D)
- Cognitively-impaired resident was repeatedly getting up unattended from wheelchair, on one occasion went to roommate's bedside and touched genitals (D)
- Resident's care plan lacked psychiatric medications addressed (D)
- Facility staff failed to develop care plan goals and interventions for safety for a Hospice patient; patient with poor dietary intake and weight loss had no care plan or interventions developed (D)
- Facility failed to address resident behaviors/interventions in care plans for residents with dementia (D)
- Resident's care plan did not match therapy recommendations for transfers (D)
- Resident's care plan did not address requirement for staff to conduct 15 minute checks for resident's behavioral interventions (D)

- CNA put resident's arm through shirt sleeve, arm fractured, displaced fracture of the humerus; CNA put resident's right arm in sleeve first, DON said left arm should have been put in first due to contracture, was not included in care plan to direct staff on how to dress (D)
- Facility failed to develop a comprehensive care plan; resident had exit seeking behaviors; this was not included in care plan, no Wanderguaard alarm was on resident, who then exited the building (D)
- Facility failed to have complete and comprehensive plan that included interventions for residents nutritional status and diagnosis of diabetes (D)
- Facility failed to develop a plan of care to prevent specific behaviors which could result in an injury; one resident threw water at another resident who then fell; facility failed to implement interventions to prevent one resident from throwing water at another (D)
- Facility failed to update one of six care plans when the resident change of behavior (D)

F241—Quality of Life; Dignity

- Residents awakened before 6 a.m. for blood sugar checks and skin checks (E)
- Staff put resident on bed pan two times during the night without first removing resident's brief (D) **$2,000 fine**
- A staff member talked to a resident in a disrespectful manner, making inappropriate comments (D)
- Facility staff failed to provide a clean wheelchair pad at the time of resident transfer to a wheelchair (D)
- Dignity and respect; staff did not knock before entering resident's room (D)
- Resident asked dietary aide for coffee, dietary aide said she didn't have any **** coffee and told the resident to leave, staff was terminated (D)
- Staff scared a paranoid resident by pounding on her door; staff took resident's wig away to get resident to follow staff (D)
- Facility staff failed to treat each resident with dignity and respect by failing to provide privacy during personal cares, care provided in bathroom with no door separating bathroom from the resident's room (D)
- Staff (CNA) was unkind to resident; told him/her they were "fat and lazy" and that spouse was going to leave him/her; called resident a "bitch" (D)

F 371—Store, prepare and serve food under sanitary conditions

- Facility failed to prepare and serve food under sanitary conditions; visible dust on stainless steel shelves, black substance hanging from air vents, brown flakey ceiling fixture near sprinkler head (F)
- Kitchen had hams with expired dates, multiple opened, undated food items, kitchen needed cleaning (F)
- Safe food procurement and handling practices--no backfill devices on water fixtures, outdated food items in refrigerator, dishwasher was not working (F)
- Staff failed to change gloves when serving food and touching door handles, plates, etc. (E)

- Scoops in ice bins; unlabeled and undated food; worn cutting boards; no thermometer in freezer (E)
- Facility staff failed to ensure sanitary environment in kitchen and properly handle food (E)
- Dirty grill in kitchen (E)
- Facility failed to handle and serve food under sanitary conditions; dietary aide didn't change gloves prior to handling glass plate (E)
- Sanitary conditions—dishwasher was not at the appropriate temperature (D)

F 225— The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately

- Facility failed to report suspected abuse to DIA immediately or separate alleged abuser from other residents (F)
- Facility failed to report an injury of unknown origin to the Department of Inspections and Appeals (F) **$3,500 fine** (in suspension)
- Allegation of abuse not reported to administrator for five days (D) **$500 fine**
- Staff failed to report incidents of resident-to-resident abuse (D) **$500 fine**
- Facility failed to report two occurrences of resident to resident altercations; staff were not aware to report all abuse incidents (D) **$500 fine**
- CNA held down resident's arms after resident was striking out; LPN did not report to DON for two days at which DON reported to DIA; no separation was provided during the two days between the incident and the report to the DON (D)
- Investigate and report allegations of abuse; facility failed to timely report abuse to DIA (D)
- Facility failed to report resident-to-resident abuse in a CCDI unit (D)

Other notable deficiencies and fines

F-157

- Resident on Coumadin fell sustained head injury and facility did not notify physician or family for more than six hours later, CT scan showed multiple head bleeds (G) **$5,000 fine**

F-221

- Facility failed to assure residents were free from resident abuse (D) **$500 fine**

F-223

- Resident with a history of aggressive behavior hit another resident with a book and threw hot coffee in her face (G) **$6,000 fine**
- Freedom from abuse; one resident threw hot coffee on another resident (G) **$1,500 fine**
- Facility did not prevent resident-to-resident abuse; no policy available on resident-to-resident abuse (G) **$2,000 fine**

- Resident touched another resident on breasts, leg and between thighs (G) **$2,000 fine**
- A staff member witnessed another staff member hit a resident in the back of the head during transfer (G) **$500 fine**

F-226

- Facility failed to protect residents from abuse; staff hit resident on back of the head during transfer (D) **$500 fine**
- Employment policies—facility failed to complete criminal background check before hire and expired background check (D) **$500 fine**
- Facility failed to perform criminal history check on one employee prior to hire (D) **$500 fine**

F-309

- Staff failed to properly assess and treat a resident's fall resulting in head injury while on Coumadin and in full code (G) **$8,500 fine**
- Staff could not find contact information for surgeon and therefore he was not notified of wound issues which led to use of wound vac, hospitalization, IU antibiotics; prior to his happening, the facility failed to perform wound treatment as ordered (G) **$8,000 fine**
- Facility staff failed to masses an open wound and develop interventions to promote healing (G) **$8,000 fine (in suspension)**
- Facility failed to assess and develop interventions for device to prevent bruising (G) **$3,500 fine** (in suspension)
- Resident's coccyx ulcer progressed with no record and documentation of change (G) **$500 fine**

F-314

- Resident had no assessment or prevention for a pressure ulcer; a resident was admitted with an open skin area, and the open area was not assessed on admission (G) **$2,000 fine**

F-328

- Facility failed to ensure staff were trained and educated and demonstrated proper use of oxygen administration; resident died (J) **$8,000 fine (in suspension)**

L 488

- An opened and undated bottle of latanprost Optham solution found in Medications cart.

L 687

- No quarterly activity notes

L1097

- Facility failed to do a Veteran's Administration benefits check at admission

Annual Survey Frequency
November Survey Results Meeting

Facility	City	Last Year	This Year	Frequency
Akron Care Center	Akron	11/5/15	10/13/16	48 Weeks
Bishop Drum Retirement Center	Johnston	12/7/15	10/27/16	46 Weeks
Centerville Specialty Care	Centerville	11/5/15	10/20/16	50 Weeks
Correctionville Specialty Care	Correctionville	11/12/15	10/13/16	48 Weeks
Cottage Grove	Cedar Rapids	11/25/15	9/29/16	44 Weeks
Danville Care Center	Danville	10/15/15	10/6/16	50 Weeks
Dave's Place	Keokuk	11/5/15	10/6/16	51 Weeks
Good Samaritan	Villisca	11/12/15	10/6/16	50 Weeks
Hallmark Care Center	Mount Vernon	9/17/15	9/1/16	50 Weeks
Hawkeye Care Center	Cresco	10/15/15	10/6/16	51 Weeks
Hegg Memorial Health Center	Rock Valley	10/29/15	10/20/16	51 Weeks
Heritage House	Atlantic	1/7/16	9/29/16	38 Weeks
Hiawatha Care Center	Hiawatha	10/22/15	10/6/16	50 Weeks
Hillcrest Health Center	Hawarden	10/22/15	10/6/16	50 Weeks
Keosauqua Health Care Center	Keosauqua	11/19/15	9/27/16	45 Weeks
Mechanicsville Specialty Care	Mechanicsville	11/12/15	10/27/16	50 Weeks
Mercy Medical Center	Cedar Rapids	10/29/15	9/8/16	45 Weeks
North Lake Manor	Storm Lake	11/12/15	10/6/16	47 Weeks
Ramsey Village	Des Moines	10/29/15	10/20/16	51 Weeks
Regency Care Center	Norwalk	12/21/15	10/13/16	43 Weeks
Rehab of Hampton	Hampton	11/25/15	9/29/16	44 Weeks
Rose Vista	Woodbine	11/19/15	10/13/16	47 Weeks
Scottish Rite Park	Des Moines	11/25/15	10/19/16	47 Weeks
Sigourney Health Care	Sigourney	11/12/15	10/20/16	49 Weeks
Valley View Community	Greene	11/12/15	10/20/16	49 Weeks
Valley View Village	Des Moines	10/30/15	9/15/16	46 Weeks
Virginia Gay Hospital	Vinton	11/12/15	10/6/16	47 Weeks
Wapello Specialty Care	Wapello	9/24/15	10/13/16	55 Weeks
Wilton Retirement Community	Wilton	10/1/15	10/14/16	54 Weeks
Woodland Terrace	Waverly	11/5/15	9/15/16	45 Weeks

Of the (30) Tabulated Annual Surveys Reviewed in November:

(2) Annual Surveys were later than last year:

Wapello Specialty Care	Wapello	9/24/15	10/13/16	55 Weeks
Wilton Retirement Community	Wilton	10/1/15	10/14/16	54 Weeks

(28) Annual Surveys were earlier than last year:

Earliest Surveys:

Heritage House	Atlantic	1/7/16	9/29/16	38 Weeks

Average Survey Frequency:	**November Survey Meeting**	**48.03 (3 Weeks Early)**
	October Survey Meeting	**47.04 Weeks**
	September Survey Meeting	**46.72 Weeks (5.28 Weeks Early)**
	August Survey Meeting	**47 Weeks (5 Weeks Early)**
	July Survey Meeting	**45.12 Weeks (6.88 Weeks Early)**
	June Survey Meeting	**45.31 Weeks**
	May Survey Meeting	**46.60 Weeks**
	April Survey Meeting	**48.50 Weeks**