Compliance Tips from IHCA's Survey Results Committee

November 2017

The five most frequently cited tags from the 40 annual surveys (12 deficiency free), 39 complaints (10 unsubstantiated), 16 self-reports (9 unsubstantiated), 23 complaint/self-report (3 unsubstantiated) and 0 mandatory reports (0 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 171 total deficiencies.

Be sure to see the survey frequency data at the end of this report.

The following is a breakdown of severity level:

A =	0.00%	D =	63.16%	G =	8.77%
B =	0.58%	E =	21.64%	H =	0.00%
C =	1.75%	F =	1.70%	I =	0.00%
				J =	0.00%
				K =	0.00%
				L=	0.00%

Total # of Reports: 91
Total # of surveys/reports deficiency free or unsubstantiated: 29
Avg. # of deficiencies

- All = 1.88
- Annual = 3.15
- Complaints = 3.00
- Self-reports = 2.80
- Complaint/Self-Reports= 3.00
- Mandatory = 7.00
- Special Focus = 0.00

Total state fines for October Report = $10,000 ($46,500 held in suspension)

Deficiencies and Fines (sorted ascending by f-tag number)

F 156—Notice of Eligibility

- Facility failed to provide notice of appeal rights for DC from SNF (D)
- Facility failed to provide the appropriate notices of Medicare coverage coming to an end for 1 of 3 residents reviewed, ABN lacked documentation the facility notified resident of services ending within 48 hours prior to the last day of services (D)

F 157—Notice of Changes to Family, Physician

- Wound treatment not completed on weekend as ordered by physician (D)
- Resident rolled out of bed, staff failed to notify family until next day, facility failed to have policy regarding family notification of such instances (D)
- Facility failed to notify physician concerning a significantly low blood sugar for a resident with diabetes (D)
- Notification of changes- Failure to notify Physician of change of condition (D)

F 167—Examination of Survey Results

- Right to survey results-Readily Accessible Survey results were kept at nurses station and not posted (C)

F 204—Orientation for Transfer or Discharge

- Preparation for Safe/Orderly Transfer/Discharge--Staff provided improper orders to resident and medication at time of discharge (D)

F 223—Freedom from Abuse

- Facility failed to ensure residents were free of abuse for 4 of 7 residents. Resident being sexually inappropriate with other residents and staff with inappropriate touch and removing of their clothes (E)
- A bib was placed over a resident's mouth and pushed head back to encourage swallowing of the medication. Other staff felt this was abusive (D)
- Facility failed to ensure all residents remained free from abuse. Resident #1 hit another resident and hurt their eye (D)

F 225—Reporting to the Department

- 2 cognitively impaired residents had a tug of war with the table cloth and then kicked each other under the table making contact. Facility failed to report this within 24 hrs. to DIA (D)
- Facility failed to report allegations of abuse to the department. Facility did not make an incident report when one resident inappropriately touched another resident (D)
- Failed to report a bib was placed over a resident's mouth and pushed head back to encourage swallowing of the medication. Other staff felt this was abusive (D)
- A report of suspected abuse was not reported to the facility or DIA within the time requirements (D)

- Facility failed to report nurse taking narcotic medications from resident medication cards in a timely manner. Facility failed to report a resident to resident altercation in a timely manner (D) **$500 fine**
- Resident with bruises to hip and inner thigh that were not investigated as unknown injuries (D)
- A report of abuse was not made to DIA when medication were missing, thought to be a theft (D)
- Control utilization record for Fentanyl 50 micrograms per hour patches change every 72 hours, staff applied a new Fentanyl patch but did not dispose of the old patch that staff previously applied because the patch was missing; staff observed dietary staff rubbing shoulders of resident and suspected he/she took fentanyl patch (D)

F 226—Staff Treatment of Residents

- Facility failed to ensure staff had a minimum of 2 hours mandatory adult abuse training completed within 6 months of hire. Employee had 2hour training for adult/child but not 2 hours of adult (D)

F 241—Dignity and Respect of Individuality

- Staff member was heard using foul language and being disrespectful to a resident in her room (D)
- Resident's catheter bag was laying on floor under bed with no privacy bag (D)
- Resident reported that staff were rude to her and turned her call light off 3 times without helping her with her needs (D)
- Resident complained of rough treatment during evening care and when he complained the staff member called him a "shit" (D)

F 246—Accommodation of Needs

- Facility failed to provide water at the bedside as requested for 1 of 21 residents (D)
- Facility failed to ensure 1 of 11 residents reviewed received services to accommodate the resident’s needs and preferences. Resident waiting in day room after lunch for over 2 hours to be toileted with no call light within reach and soiled herself waiting (D)

F 248—Activities Program

- Facility failed to ensure residents received individualized , meaningful activity programs and failed to document routine quarterly activity assessments for 6 of 10 residents (E)

F 250—Social Services

- Facility failed to complete and document routine social service assessment for 3 of 7 reviewed. Clinical record lacked a social service note (C)
- Provision of Medically related Social services-Failure to do initial ongoing assessment of resident psych-social services on multiple residents (C)

F 252—Safe, Clean, Homelike Environment

- Safe/Clean Comfortable homelike environment-The Bathing area needed to have repairs and multiple items cleaned up (E)
- Separated wallpaper & solid corners/ cracked vinyl in shower rooms (E)
- Shower room with dirty floor and scattered debris soiled clothing barrel overflowing with no lid (D)
- Safe/Clean Comfortable homelike environment-Marred doors cracked tiles, build-up of dirt around cove base (C)
- 24 door casings and jams in need of repair or replacement (E)

F 276 – Quarterly Review of Assessments

- Missed quarterly MDS assessment (D)

F 279—Comprehensive Care Plans

- Heel protectors and geri sleeves not on per care plan (D)
- Care Plan did not address behaviors symptoms as described by multiple staff members, Care plan for resident with VRE contained no VRE precautions (D)
- Care plans not updated to address how to handle 2 residents when they have behavior issues and staff observed using an EZ Stand lift for a resident care planned to be assist of 1-2 (D)
- Develop comprehensive Care Plans-Facility failed to Care plan aggressive behavior for one resident- Resident witnessed hitting staff and another resident (D)
- Facility failed to implement interventions to prevent resident's fall, care plan called for all 4 bed rails to be up, they were not, resident rolled out of bed and was injured; call light was not within reach, nor care planned floor mats in front of bed; another resident fell in bathroom and was injured; should have had assistance (D)
- Resident requested to be left alone in tub to soak, care plan did not address residents wish for bathing & privacy (D)
- No revisions were made to a care plan to address the causes and contributing factors that lead to the development of pressure areas (D)

F 281—Professional Standards of Quality

- Failure to instruct resident to rinse mouth after inhaler administration, no POS for 6 months for multiple residents, and failure to provide lacremal pressure after administering eye drop (E)
- Resident given 3 liters O2, admission orders called for 2 liters; resident who needed a brace for fracture did not receive one, staff said facility didn't have "much luck" in obtaining one; Treatment Administration Sheet didn't list order for new catheter (E)
- Services Provided meet professional Standards- Failure to follow physicians orders- Failure to run Oxygen at proper liter flow (D)
- Wound dressing not on as ordered (D)

- Facility failed to follow physician order for 2 of 21 residents. Facility did not follow physician order of calling blood sugars that were out of range (D)
- Services meet professional Standards-Failure of Staff to follow medication administration and physician's orders (D)
- Facility failed to follow physician orders. Client had order for device for hands due to contractions but on device was being used (D)
- Facility failed to implement and follow physician orders for 1 of 5 residents, Order to weigh patient daily and chart did not contain any weights, and facility scale was broken (D)
- Staff did not restrict fluids and provide follow up lab work for a resident as ordered (D)
- Services meet professional Standards-Failure of Staff to check a pulse and blood pressure to assure standards met prior to administration of a medication (D)

F 282—Qualifications of Staff

- Staff failed to follow care plan interventions for heel protectors and keeping chair controls out of reach (E)
- CNA transferred resident with assist of 1 and care plan stated assist of 2
- Resident began yelling in pain approximately 2 hours later and was diagnosed with a thigh bone fracture. Physician gave diagnosis of Spontaneous fracture unrelated to the transfer (D)
- Pushed resident without WC pedals (D)
- Facility did not apply pressure relieving boots and other pressure relieving aides as ordered by physician (D)
- Services by Qualified Person per Care Plan-Failure by staff to follow CP of having preventive heel boots on a resident while in bed (D)

F 285—PASRR

- Facility failed to incorporate PASRR recommendations in a resident's care plan for 4 of 7 residents (E)
- Facility failed to care plan or implement PASSR recommendations (D)
- PASRR requirements for MI/MR-Failure to do timely review and authorization request for additional services and placement and did not get updated (D)
- Facility failed to facilitate the recommendations of the PASRR (D)

F 309—Highest Practicable Well-Being

- Facility failed to notify physician of serious change in resident condition related to almost pound weight gain with diagnosis of CHF and complaints of pain related to bilateral fractures of distal femurs after allegedly being "eased to the floor" when legs gave out during transfer (G) **$3,000 fine in suspension**
- Facility failed to provide appropriate assessment and intervention for a resident after a significant change in condition. Resident found on floor and told nurse who said to transfer client back to wheelchair. Resident could not move leg and cried in pain but staff moved resident anyway. Resident was transferred to hospital and had a hip fracture (G) **$2,000 fine in suspension**

- Nurses failed to provide surgical wound care over the weekend. Resident had a dressing dated Friday when seen by the MD on Monday (D)
- Provide Care/Services for highest Well Being-Failure to provide an adequate assessment to promote highest well-being. Failure of Staff to document further assessment of a wound after surveyor review (D)
- Facility failed to provide adequate assessment and timely intervention for a change in condition. Client requested pain medication for pain in her bottom at a "10" and clinical record lacked assessment of severe pain, or mention of bruising (D)
- Facility failed to ensure timely intervention of a resident's pain for 1 of 5 residents. Patient waited up to 6 hours for pain medication (D)
- Provide Care/Services for highest Well Being-Failure to provide an adequate assessment to promote highest well-being. Failure of Staff to update care plan to offload a heel (D)
- Facility did not properly assess a resident for injuries after a fall (D)
- Order by physician to contact when BS was less than 80 were not followed. No physician notification when record indicated a low blood sugar. Resident experienced a low sugar and was not assessed by nursing staff (D)
- Provide Care/Services for Highest well-being- Failure of Staff to assess dialysis site on daily basis. Failure to note site on care plan (D)
- Facility failed to provide complete and timely assessments and interventions. Patient had a fall-- went to knee and had shoulder pain right away but no incident report was filled out (D)

F 311—Resident Treatment to Improve/Maintain ADLs

- Facility failed to provide restorative nursing as recommended by PT (D)

F 312—Quality of Care; Activities of Daily Living

- Deep tissue injury developed from pressure (G) **$2,000 fine in suspension**
- Oral cares were not provided to residents with am cares. Residents' faces were not washed during cares. Staff did not replace dead hearing aid batteries with cares. Bathe not provided as required (E)
- Facility failed to ensure residents received baths as planned for 6 residents out of 70; resident did not receive 2 baths per week as care planned (E)
- Facility failed to provide toileting assistance timely and also failed to provide complete incontinent care (E)
- Incomplete incontinence cares, weeks with less than 2 baths, family concerns about incontinence cares leading to skin issues, use of washcloth without rotating sides (D)
- CNA removed stool with toilet paper and did not cleanse resident afterwards when performing incontinent cares (D)
- Facility failed to provide complete incontinent care for 3 of 6 residents. Staff did not cleanse outer back or front of thigh (D)
- ADL care for dependent Residents- Failure by Staff to shave Resident to chin hair (D)

- ADL Care for dependent Resident-Failure to reposition a resident every two hours (D)
- Staff did not perform oral cares for 4 residents during surveyor observations. CNA failed to change washcloth surfaces during incontinence cares (D)
- ADL Care for Dependent Residents- Failure to provide incontinence care to prevent infection and to complete incontinence care for hygiene. Improper peri-care done (D)

F 314—Pressure Ulcers

- Heels not floated, 5 days no treatment, up in chair greater than 3 hrs., shoes on feet instead of blue pressure boots, no treatment on open area observed by surveyor (G) **$6,000 fine (trebled) in suspension**
- Resident with a declining pressure area had a roho cushion that was continuously flat, causing pressure area to worsen. Heel protector/boots were not in place on several observations during the survey. Wound developed on ankle (G) **$2,500 fine in suspension**
- Deep tissue injury developed from pressure (G) **$2,000 fine in suspension**
- Resident developed heel ulcer when none was present on admission (G) **$2,000 fine in suspension**
- A resident at risk for pressure areas developed an area on a heel after a hip fracture repair. Staff stated that all pressure reducing efforts were not always in place to avoid skin breakdown. Another resident who developed a pressure area had a pressure reducing mattress, but did not always have a pressure reducing cushion for their chair (G) **$2,000 fine in suspension**
- Facility failed to notify physician of in regards to deteriorating pressure ulcer for one resident, care plan called for heel protectors to be in place when resident is in bed resident had fluid-filled blisters on heel and "soft heels"; surveyor noticed heel boots not in place when resident was in bed; other instances of resident open areas (G) **$500 fine**
- Coccyx wound reopened, nurse noted heal was "spongy" various open areas on resident, staff were to reposition resident often and float heels which was not done, facility did not provide the DIA survey team with an initial care plan for the resident; heal protectors worn and didn't prevent resident's heals from touching mattress (G)
- Resident with new pressure ulcers up greater than 4 hours 2 days in a row, had no air mattress on bed, a crank bed that makes repositioning difficult, and staff complaints of short staffing leading to inability to reposition residents as necessary (D)
- A resident at risk for and had developed a pressure area receive a positioning cushion instead of a pressure reducing cushion and pressure area worsened, made the wound deterioration avoidable (D)
- Pressure ulcers: MDS indicated resident at risk for developing pressure ulcers, was a two-person transfer, care plan called for interventions (repositioning, pillows, etc.) resident was a "big person" had wound on coccyx that grew' surveyor noted resident in wheelchair without pillows (D)

F 315—Incontinence Care

- Staff did not perform catheter care in proper manner (D)
- Facility failed to provide catheter care that minimized risk of infection, staff noted scab at tip of resident's penis (D)

F 318—Range of Motion to Prevent Decline

- Facility failed to ensure 6 of 6 residents reviewed received ongoing restorative exercises as prescribed, care plan failed to include documentation of restorative services, e.g. walk to dining room (E)
- No upper body exercises were provided to a resident after a CVA as directed (2 examples) (D)

F 323—Free of Accident Hazards/Supervision/Devices

- Facility failed to ensure that each resident received adequate supervision to prevent accidents and injuries during a mechanical lift transfer. Client was care planned for staff to use a bariatric mechanical lift and bariatric sling and in their room was a large sling. Resident was transferred to bed and staff was moving legs and had pressure on leg which left an area that blistered and had a hematoma under it (G) **$12,000 fine in suspension**
- Facility failed to implement falls interventions for two residents, and failed to secure exit doors for 10 cognitively-impaired independently mobile residents; middle rail on bed exceeded 4.75 inches, failed to have any padding to prevent injury during seizures, one bed rail had 7.5 inch opening, resident rolled out of bed due to rails not being in locked position (G) **$11,000 fine in suspension**
- Resident fell from EZ lift when agency staff member improperly hooked sling to lift and started transfer without a second staff member present (G) **$6,000 fine ($2,000 trebled)**
- State Surveyor believed not enough interventions were being implemented in a timely manner to prevent falls but instead were being implemented "after-the-fact" (G) **$5,000 fine in suspension**
- Facility failure to properly assess and report resident's declining condition led to an improper transfer and subsequent fall with bilateral fractures (G)
- Free of accident Hazards/supervision-Hot water temperature was too high at 122-132,chemicals stored inappropriately due to not being behind locked door, and other items required behind a locked door (E)
- Resident with multiple falls and interim care plan that did not contain the updated interventions, resident with falls that resulted in fractures and intervention of 1:1 not followed (D)
- Facility failed to provide adequate supervision to prevent falls. Resident had order for gripper socks and fell and socks were not properly on feet (D)
- Free of accident Hazards/supervision- Failure of staff to safely transfer a resident requiring a gait belt transfer (D)
- Failed to apply WC pedals when pushing residents (D)
- Facility failed to ensure adequate nursing supervision maintained for one of six residents. Client did not have an alarm on as was care planned and got up out of wheel chair and fell (D)

- Multiple resident falls without interventions or interventions that were already to be in place (D)
- No dycem was placed in a residents recliner to prevent sliding from chair as per care plan (D)

F 329— Avoiding the administration of unnecessary drugs

- Facility failed to provide non-pharmacological interventions prior to administering an anti-anxiety medication (E)
- Facility did not attempt non-pharmacologic interventions before administering antianxiety agent (D)
- Facility failed to attempt non-pharmacological interventions prior to giving as needed medications for anxiety and pain (D)
- Alternative approaches to the administration of PRN anxiety medications, were not documented. No non-pharmacological approaches prior to use of medications documented (D)
- A resident was prescribed Seroquel for insomnia. No evaluation of sleep habits or assessment existed for the use of that medication. A GDR had not been addressed for the use of Risperidone as required (D)
- Drug Regimen is free from unnecessary Drugs-Failure to provide non-Pharmacological interventions prior to use of an anti-anxiety med on a PRN basis (D)
- Drug Regimen is free from unnecessary Drugs-Failure to assure adequate indications for use of psychoactive prior to use and failure to assure gradual dose reductions attempts are done when indicated (D)

F 332—Medication Error

- Facility failed to ensure the medication error rate was less than 5%. Staff did not wait a full minute between second puff of inhaler, and the label of the pharmacy did not match the label on the bottle (D)

F 333—Free of Significant Medication Errors

- A resident was sent to ER for an evaluation. Physician ordered medications discontinued to evaluate surgery options. Surgery was not done and resident was started on other medications and some medication was not restarted as ordered. Failure to give prescribed medications may have contributed to the resident experiencing a stroke (G)

F 353—Sufficient Nurse Staffing

- Sufficient Staff per care plans-Failure to answer call lights within 15 minutes. Multiple residents and family members reported long wait times (E) **$1,500 fine ($500 trebled)**
- Insufficient staff to provide baths to 6 residents as care planned, call lights not answered for up to 45 minutes, medications missed, not enough help during meal time (E)
- Facility failed to answer resident call lights in a timely manner in order to meet resident's needs (E)

- Sufficient Staff per care plans-Failure to answer call lights within 15 minutes. Multiple residents reported long wait times (E)
- Call light response times exceeded the requirement as verified thru group interview and observation (D)

F 363—Menus, Nutritional Adequacy

- Dietary staff did not serve the correct portion of pureed bread to 6 residents (E)
- Pureed diet: staff used 3 potato wedges (3 oz.) rather than the 4 oz. of mashed potatoes per diet order (E)
- Facility failed to follow the menu for 1 of 1 meals served. Wrong sized scoop used for pureed diet (E)

F 364—Food Temps

- Facility failed to follow policy when food prepared for puree diets. Staff failed to use appropriate liquid of nutritive value or color (D)

F 365—Food: Meeting Individual Needs

- Facility failed to serve food prepared in an ordered texture for 7 of 7 residents. Residents with an order for mechanical soft diet was served regular diet (E)

F 371—Food Preparation-Sanitary Conditions

- Facility failed to maintain and monitor sanitizing solutions in the dish machine and cleaning buckets to reduce the risk of contamination and food-borne illness (F)
- Ice machine was dirty (E)
- Food Procure/Store/Prepare Serve- Sanitary Failure to maintain dish machine temperatures or perform sanitation checks to reduce risk of food borne illness Failure to maintain 120 degrees for wash and rinse cycles (E)
- Cold foods (turkey sandwich) temped too warm 48.8 degrees, should be less than 40 degrees (E)
- Steam pans that had "severe area of discoloration of brown and yellow" (E)
- 4 of 4 dietary staff touched the top of plates with their thumbs (E)
- Multiple opened undated items in the kitchen (E)
- Worn refrigerator shelves & chipped paint on Hobart mixer (E)
- A bowl of food in walk-in cooler was not identified or dated; a container in cooler had no cover, bacon wrapped in paper towels not labeled. Stove drip pan was soiled (E)
- Dietary director walked through kitchen without hairnet, cinnamon rolls sat uncovered (E)
- Food Procure/Store/Prepare Serve- Sanitary Failure to follow cleaning Schedules for floor, stove hood, and cutting board services (E)

F 425—Pharmacy Services

- 4 tablets of Hydrocodone were unaccounted for and 10 tablets were not documented as given on the MAR and therefore no assessment of pain. Another

resident had 4 missing tablets of Oxycodone. Narc counts not completed as per facility policy (D)

- The proper count of Fentanyl patches was not maintained, as patches were missing. Other medications, (morphine & tramadol) were also noted to be missing (D)
- Pharmaceutical SVC-Accurate Procedures- Failure to appropriately store in a secure area- Narcotics received from the Pharmacy (D)

F 428—Drug Regimen Review by Pharmacist

- The physician did not address the need for continued use of each individual psychotropic medication (D)

F 431—Labelling of Drugs and Biologicals

- Facility failed to ensure a staff reconciled controlled medications each time medication cart keys were exchanged from one nurse to another (E)
- 2 doses of scheduled drugs missing at end of evening shift for one resident. Charge nurses suspected of taking medications and was suspended (D)
- Narcotic count sheet has discrepancies (D)
- Vials of Ativan were missing from the med room refrigerator. Staff did not always count the refrigerator narcotic medications (D)
- Drug records/Label/Store drugs and biologicals- failure to discard expired medication-Novolog after 28 days of opening vial (D)

F 441—Infection Control

- Staff failed to cleanse a wall with BM spatters as per infection control policies. Staff placed a soiled scissors on a resident's blanket without a barrier. Staff pushed uncovered laundry carts through the facility (E)
- Insulin injections administered with gloved hands that were used to open the door prior to administration, failure to sanitize glucometer before or after use,
- Failure to sanitize scissors pulled from pocket before or after use (D)
- Staff failed to wash hands between glove changes during incontinence cares (D)
- Improper glove use during pericare (D)
- Facility failed to ensure staff followed proper infection control practices during cares. Soiled linen was dropped on the floor and staff did not clean area on the floor (D)
- Staff performed care then used same soiled gloves to put resident's pants and socks off and folded them, placed a pillow between resident's legs and then regloved (D)
- Staff did not wash hand prior to or between glove changes when changing a dressing. CNA did not wash hands between glove changes (D)
- Isolation laundry was not properly sanitized during the machine wash (no chemical sanitizing). A resident with MRSA was not placed in isolation (D)

F 465—Other Environmental Conditions

- Door knob not secured at service entrance, door loose and bent, dirty shower (F)

- Miscolored and torn accordion doors, black tape wrap around the bottom of multiple dining room chairs (E)
- Marred wood on cupboards worn finish & rust on stainless tables & steam table, black debris on stainless table wheels (E)

F 469—Maintain Effective Pest Control Program

- Maintain Effective Pest control system-Flies in the kitchen-and various other areas of the facility without proper pest control intervention by contractor (E)

F 497—Regular In-Service Education

- Nurse aide review: 4 of 10 CNAs did not attend 12 mandatory in-service annually (D)

F 514—Clinical Records

- Some falls not in the medical record but documented on incident report sheet only which was described as "not part of the medical record" by staff (D)
- Facility failed to ensure medical records accurate and complete. There was no incident report filled out on a resident fall (D)
- Facility failed to document disposition of resident's medications and belongings after death. (B)

N 101

- Failure to notify DIA of major injuries for 2 residents with falls and fractures **$500 fine**

L 257

- Facility failed to submit 1 of 5 residents, known to have military affiliation, to the Iowa Department of Veteran affairs to Identify eligibility to receive Veterans Affairs benefits

L 580

- Required food service program for dietary managers would not be started until Sept. 2017; Dietary Consultants failed to sign and approve 4 week meal plans for all clients

Annual Survey Frequency
November Survey Results Meeting

Facility	City	Last Year	This Year	Frequency
Accura Healthcare of Baxter	Baxter	10/6/16	10/26/17	55 Weeks
Accura Healthcare of Cresco	Cresco	10/6/16	10/19/17	54 Weeks
Algona Manor Care Center	Algona	9/14/17	10/27/17	58 Weeks
Atlantic Specialty Care	Atlantic	8/25/16	10/12/17	59 Weeks
Carlisle Center for Wellness	Carlisle	9/22/16	10/26/17	57 Weeks

Cedar Manor	Tipton	9/22/16	10/12/17	55 Weeks
Colonial Manor	Columbus Junct.	9/22/16	10/12/17	55 Weeks
Crest Haven Care Center	Creston	7/21/16	9/14/17	59 Weeks
Crestridge Care Center	Maquoketa	8/4/16	10/5/17	61 Weeks
Deerfield Community	Urbandale	9/15/16	10/19/17	57 Weeks
Denver Sunset Home	Denver	8/25/16	10/5/17	59 Weeks
Donnellson Health Center	Donnellson	8/18/16	10/5/17	59 Weeks
Evans Memorial Home	Cresco	9/22/16	10/19/17	56 Weeks
Golden Age	Centerville	9/22/16	10/19/17	56 Weeks
Good Samaritan Society	Holstein	9/9/16	10/12/17	56 Weeks
Good Samaritan Society	Red Oak	8/18/16	10/12/17	60 Weeks
Grandview Healthcare	Oelwein	8/31/16	10/12/17	58 Weeks
Heritage House	Atlantic	9/29/16	9/28/17	52 Weeks
Lexington Square	Keokuk	8/11/16	9/15/17	57 Weeks
Luther Manor	Dubuque	9/29/16	10/19/17	55 Weeks
Manilla Manor	Manilla	8/25/16	10//5/17	58 Weeks
Marian Home	Fort Dodge	8/18/16	10/9/17	62 Weeks
Mercy Medical Center	Cedar Rapids	9/8/16	10/5/17	56 Weeks
Montrose Health Center	Montrose	8/25/16	10/12/17	59 Weeks
On with Life	Glenwood	9/8/16	10/19/17	58 Weeks
Panora Specialty Care	Panora	8/18/16	10/9/17	60 Weeks
Parkview Manor	Wellman	12/15/16	10/19/17	44 Weeks
Pearl valley	Gowrie	9/15/16	10/19/17	57 Weeks
Pearl Valley Rehab & HC	Washington	6/23/16	8/14/17	60 Weeks
QHC	Mitchellville	9/1/16	10/19/17	59 Weeks
Ravenwood Specialty care	Waterloo	10/13/16	10/26/17	54 Weeks
Rehabilitation Center	Hampton	9/29/16	10/26/17	56 Weeks
Ruthven Community Care Center	Ruthven	8/11/16	10/5/17	60 Weeks
St Luke Lutheran	Spencer	8/31 16	10/19/17	59 Weeks
St Anthony's Hospital	Carroll	9/8/16	10/26/17	59 Weeks
Sunny View Care Center	Ankeny	8/31/16	10/12/17	58 Weeks
Sunrise Terrace N & R	Winfield	8/31/16	10/12/17	58 Weeks
Thomas Rest Haven	Coon Rapids	9/8/16	10/26/17	59 Weeks
Westview Care Center	Britt	8/4/16	10/5/17	61 Weeks
Wheatland Manor	Wheatland	9/8/16	10/12/17	57 Weeks

Of the (40) Tabulated Annual Surveys Reviewed in November:
1 Survey was earlier than last year
1 of the Surveys was the same week as last year
38 Surveys were later than last year

Earliest Surveys:

Parkview Manor	Wellman	12/15/16	10/19/17	44 Weeks
Heritage House	Atlantic	9/29/16	9/28/17	52 Weeks

Latest Surveys:

Marian Home	Fort Dodge	8/18/16	10/9/17	62 Weeks
Crestridge Care Center	Maquoketa	8/4/16	10/5/17	61 Weeks
Westview Care Center	Britt	8/4/16	10/5/17	61 Weeks

11 Facilities were "Deficiency Free" - (27.5 %)

Accura Healthcare of Cresco	Cresco
Denver Sunset Home	Denver
Evans Memorial Home	Cresco
Goldern Age	Centerville
Good Samaritan Society	Holstein

Grandview Healthcare	Oelwein
On with Life	Glenwood
Rehabilitation Center	Hampton
Sunrise Terrace	Winfield
Thomas Rest Haven	Coon Rapids
Wheatland Manor	Wheatland

Average Survey Frequency:

2017

November Survey Meeting	**57.30 Weeks**	**(5.30 Weeks Late)**
October Survey Meeting	**55.92 Weeks**	**(3.92 Weeks Late)**
September Survey Meeting	**55.00 Weeks**	**(3.00 Weeks Late)**
August Survey Meeting	**55.92 Weeks**	**(3.92 Weeks Late)**
July Survey Meeting	**56.54 Weeks**	**(4.54 Weeks Late)**
June Survey Meeting	**54.90 Weeks**	**(2.10 Weeks Late)**
May Survey Meeting	**54.90 Weeks**	**(2.10 Weeks Late)**
April Survey Meeting	**52.84 Weeks**	**(0.84 Weeks Late)**
March Survey Meeting	**51.21 Weeks**	**(0.79 Weeks Early)**
February Survey Meeting	**50.88 Weeks**	**(1.12 Weeks Early)**
January Survey Meeting	**49.69Weeks**	**(2.30 Weeks Early)**

2016

December Survey Meeting	**48.52 Weeks**	**(3.48 Weeks Early)**