**Compliance Tips from IHCA's Survey Results Committee**
**November 2018**

**Total Number of Survey Reports:** 62

**Survey Composition:**

| | | |
|---|---|---|
| **Annual:** | 21 Surveys | 3 Deficiency Free |
| **Complaints:** | 40 Surveys | 17 Unsubstantiated |
| **Self-Reports:** | 16 Surveys | 5 Unsubstantiated |
| **Mandatory Reports:** | 5 | |

| | |
|---|---|
| **State Fines:** | $16,150 |
| **State Fines in suspension:** | $46,000 |

**Most Commonly Cited Iowa Tags (Ascending Order):**

**F 656 – Develop/Implement Plan of Care**

**F 623 – Notice Requirements Before Transfer/Discharge**

**F 625 – Notice of Bed Hold Policy Before/Upon Transfer**

**F 684 – Quality of Care**

**F 880 – Infection Prevention and Control**

**F 658 – Services Provided Meet Professional Standards**

**F 689 – Free from Accidents and Hazards** **5 G Level Tags**

**Tags Resulting in Actual Harm or Higher Citations:**

***F 600 – Free from Abuse and Neglect** **1 J Level Tag**

***F 609 – Reporting of Alleged Violations** **1 L Level Tag**

***F 686 – Treatment to Prevent Pressure Ulcers** **2 G Level Tags**

***F 760 – Residents are free From Significant Med Errors** **1 J Level Tag**

***F 802 – Sufficient Dietary Support Personnel** **1 L Level Tag**

**Top 10 National F-Tags***

| 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=15741 | | Total Number of Surveys=68665 |
| F0880 | Infection Prevention & Control | 5,555 | 32.4% | 8.1% |
| F0689 | Free of Accident Hazards/Supervision/Devices | 4,958 | 25.2% | 7.2% |
| F0812 | Food Procurement, Store/Prepare/Serve Sanitary | 4,283 | 25.9% | 6.2% |
| F0656 | Develop/Implement Comprehensive Care Plan | 4,192 | 23.8% | 6.1% |
| F0684 | Quality of Care | 3,659 | 19.3% | 5.3% |
| F0761 | Label/Store Drugs and Biologicals | 2,798 | 17.0% | 4.1% |
| F0657 | Care Plan Timing and Revision | 2,718 | 15.8% | 4.0% |
| F0686 | Treatment/Svcs to Prevent/Heal Pressure Ulcer | 2,356 | 12.8% | 3.4% |
| F0758 | Free from Unnec Psychotropic Meds/PRN Use | 2,275 | 13.9% | 3.3% |
| F0677 | ADL Care Provided for Dependent Residents | 2,235 | 12.1% | 3.3% |

*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)

**F 550 - Resident Rights/Exercise of Rights**

- Did not respect resident right to choose when and how to bathe. Resident was screaming in the shower and CNA continued with shower. (D)
- Failure to treat residents with dignity and respect. Nurse yelled at resident telling him he can get his own pop and staff doesn't have time to do this. Resident felt afraid of nurse and didn't want to ask her for anything. Resident was receiving wound care and told nurse that she was grabbing her leg too hard. Nurse told her that she had back pain and everyone had something to deal with. This staff was found to be rude to other residents as well as was eventually terminated. (D)
- Failure to maintain dignity. Privacy curtain not pulled during incontinence care. (D)

**F 557 – Respect, Dignity/Right to have Personal Property**

- Two staff members treated residents in ways that were disrespectful including raising voice to resident that caused mental anguish. The staff members, including the former administrator and a CNA, were rude, used inappropriate language and insulted residents. (E) **$500 Fine**

**F 567 – Protection/Management of Personal Funds**

- Facility did not provide access to resident trust funds on weekends. (B)
- The facility failed to ensure that the residents had access to personal funds held by the facility during hours in which the facility front office was closed. The office manager stated residents could not get personal funds on weekends or holidays but only when the office was open. and did not know that they needed to allow access during non-office hours. Resident #25 reported they never tried to get funds from the office on weekends because the lights were not on. (D)
- Failed to maintain resident funds in an interest-bearing account. (B)

**F 578- Advance Directives/Discontinuation of Treatment**

- Failed to always follow resident request for DNR (D)
- Facility failed to ensure the clinical record consistently reflected the resident's choices for resuscitation. The resident had a doctor order for DNR but the care plan directed staff to perform CPR.(D)
- Resident record had conflicting advanced directives ranging from neither red nor green notification in the chart to orders and MAR as full code to Care Plan and IPOST as DNR. (D)

**F 580 - Notification of Changes Injury/Decline**

- Failed to always notify family and physician of resident incident (D)
- Failed to notify the physician of a significant weight change (D)
- The facility failed to notify the family of resident's regarding changes in condition in 2/6 resident's records reviewed. Resident #4 received a new order for 2 medications and the facility failed to notify emergency contact #1 or identify attempt. Resident #5 developed a pressure area to the left heel on 5/4/18 and the POA was not aware of the area until June. (D)
- Failure to notify residents change of condition to physician and family. Pressure wound in left heel was found to have maggots in it. DON and nurse documented nothing about it as DON told nurse she would take care of it.(D)
- Failed to notify the family of a change in condition, did not notify family of weight loss and initiation of supplements
- Lack of ongoing documentation for open skin areas, resident with a critically low blood sugar and physician was not notified and resident subsequently passed away (was a full code), failure to administer IV Antbxs and not notify the physician of such. (D)

**F 582 - Medicaid/Medicare Coverage**

- Notice of Medicare Non-Coverage not provided.(B)
- The facility failed to comply with all applicable Federal Regulations regarding Medicare requirements governing billing practices for 3/3 residents reviewed for beneficiary notification protection. Review of documentation for resident #30 and

#38 revealed the resident received Medicare benefits for skilled services and although the Notice of Medicare Provider Non-Coverage documents were provided to the resident's representatives, they were not provided within the required 48-hour notice. Resident #195 did not have the requires appeal notice in their record. (C)

- The facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice for 2/3 residents reviewed. The Administrator reported that resident #8 and resident #41 did not receive the Centers for Medicare and Medicaid Services form 10055 when skilled services stopped.
- Facility failed to give notification of Medicare non-coverage for 2 (D)

**F 583 - Personal Privacy/Confidentiality of Records**

Blinds left open when staff doing peri care, also with another observation resident was left uncovered from waist down when staff went to wash hands (D)

**F 584 – Safe/Clean/Comfortable Homelike Environment**

- Facility had wet dark ceiling tiles and dirty dusty air vents in hallways. (E)

- Dirty unmarked nail clippers, soiled floor tiles, razors full of whiskers, cracked and brown ceiling tiles, bag of soiled linen on floor, toilet riser leg shorter than others, gauges and peeling doors, peeling paint, etc. (E)

**F 600 – Free from Abuse and Neglect**

- Facility failed to ensure resident had the right had the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, or involuntary seclusion. Administrator threw the resident against the wall and basically manhandled him, the administrator also got in a family member’s face and pushed the shoulder of the family member. CNA stated administrator grabbed her butt twice. (J) **$4,750 FINE**

**F 604 – Right to be Free from Physical Restraints**

- Facility failed to ensure residents were free from restraints and provide re-evaluation of the need for restraints. Two residents had a removable seatbelt in their wheel chair and when each resident was asked to remove it, they residents did not respond and were unable to remove the seat belt. Two staff stated that they knew the resident could not remove the seat belt and the MDS Coordinator did not know. (D)

**F 607 – Develop/Implement Abuse and Neglect Policies**

- The facility failed to follow policies and procedures and investigate allegations of abuse in a timely manner. Concerns were noted involving an incident involving two residents with resident #1 touching resident #2 on the breast. Staff A reported that a resident reported she witnessed this event. This was documented in the chart of resident #1 but staff A forgot to report it to the

charge nurse. At least 4 days elapsed before Staff B heard about the incident and reported it to the DON. (D)

- Facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. The administrator pinned the resident against the wall and held it there by the upper body for about 5 minutes. Administrator pushed resident against the wall. (D)
- Failure to separate and report an allegation of abuse. An alleged incident occurred at 3:52PM and C.N.A. did not report to nurse until 10PM. C.N.A. said she had "a lot of people to put to bed" and did not have time to report. The nurse left a note for the D.O.N. to see the next morning. The incident involved a C.N.A. witnessing another C.N.A. hitting a resident in the mouth after the resident bit her when trying to remove dentures. (D)
- Failed to do a criminal history and abuse check on staff prior to hire. (D) **$500 FINE**
- Late dependent adult abuse training for multiple residents and missing DHS approval for employee with criminal background. (E)

**F 609 – Reporting of Alleged Violations**

- Facility failed to report the allegation of abuse. (F)
- Facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property , are reported immediately but no later than 2 hours after the allegation is made. The administrator had an incident with a resident and the charge nurse failed to report it to management. (L) **$4,750 FINE**

**F 622 – Transfer and Discharge Requirements**

- Failure to provide discharge and medical information to a receiving healthcare institution at time of discharge for residents who transferred to the hospital. (D)

**F 623 – Notice Requirements Before Transfer/Discharge**

- Facility failed to notify Ombudsman of resident transfers to hospital. (B)
- Facility did not notify Ombudsman's office of resident discharges. (B)
- Failure to notify state LTC Ombudsman of the hospitalization of residents. (B)
- Facility failed to notify the Long-Term Care Ombudsmen of residents who transferred to the hospital (C)
- Failed to notify the Long-Term Care Ombudsman of resident transfer/discharge to the hospital as required (B)
- Facility failed to notify ombudsman of transfers for hospitalization. (B)
- Facility did not give notice of transfer to the Ombudsman for residents who transferred out of the building (C)
- Facility failed to send a copy of a Notice to Transfer to a representative of the Office of the State Long Term Care Ombudsman (B)
- Failing to notify the ombudsman of facility discharges (C)

- Facility failed to notify the Ombudsman of resident transfers for 3 of 4 residents transferred to the hospital. The residents were transferred to the ER and subsequently admitted to the hospital. (B)

**F 625 – Notice of Bed Hold Policy Before/Upon Transfer**

- Failed to give resident a written notice of the bed hold policy when hospitalized (E)
- No bed hold notice given upon resident transfer to hospital. (B)
- Failure to provide resident with bed hold policy prior to transfer. (B)
- Failure to notify resident or rep of a bed-hold as required when residents were discharged/transferred from the facility. (C)
- Failure to provide copy of bed-hold policy at time of transfer to hospital. (B)
- Failure to give bed-hold policy to 2 residents when resident was transferred to hospital (C)
- Failed to notify a resident and/or the resident's representative of the facility policy for bed hold prior to transfer to the hospital (B)
- Facility failed to notify families and/or residents of bed-hold policies upon discharge to hospitals (B)
- Failure to provide resident a copy of the bed-hold policy (D)
- Failure to provide the bed hold policy at the time of transfer for 4 of 4 residents transferred to the hospital. (C)

**F 637 – Comprehensive Assessment After Significant Change**

- Facility failed to do an assessment following a significant change of condition, a significant decline in ADL status. There was nothing noted in the clinical record addressing the change. (D)

**F 641 – Accuracy of Assessments**

- Failure to accurately complete resident assessment for 3 of 14 sampled. MDS stated resident was on a ventilator and resident had never been on one, as facility doesn't accept them. MDS stated resident did not receive hospice but care plan sated resident received hospice services. PASRR screening in MDS stated resident did not trigger for Level II but was found the screening stated resident was positive for a Level II.(D)

**F 644 – Coordination of PASARR and Assessments**

- No Level II PASARR completed when resident was started on new anti-anxiety meds and had a confirmed diagnosis of PTSD.(E)
- Failure to complete a follow-up PASARR for a resident with significant psychotropic med changes and new diagnoses. (D)
- Resident with newly diagnosed psychosis was not provided a new Level 1 PASRR.(D)

- Failure to re-do PASRR reviews on residents that were admitted with negative Level 1 reviews who were later identified with new mental health disorders. There were 4 residents involved. (E)

**F 645 – PASARR Screening for MD & ID**

- Failure to complete a follow-up PASSAR on a resident that stayed past their 90-day short stay approval. (D)

**F 655 – Baseline Care Plan**

- Failed to provide the resident and the resident's representative with a copy of the initial care plan, lacked documentation had been offered the plan of care (D)
- Baseline care plans were not documented for one resident within 48 hours of admission.(D)
- Facility failed to ensure the resident or resident's decision maker was informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.(D)
- Failure to provide family with a copy of baseline care plan. (C)
- Facility failed to provide the resident and representative with a summary of the baseline care plan (C)
- Failed to provide the resident representative with a summary of the resident's baseline care plan (D)
- New admission residents and/or families did not receive a copy of their baseline care plans within 48-hrs of admission.(C)

**F 656 – Develop/Implement Plan of Care**

- Failed to create complete care plans, resident did not have anti-anxiety addressed on the care plan, resident did not have anti-depressants, anti-anxiety, or anti-coagulant medication addressed on the care plan, resident did not have respiratory distress, swelling, or anti-coagulant addressed on the care plan. (D)
- Failure to develop and update a comprehensive care plan to monitor side effects for psychotropic meds. (D)
- Failure to develop and implement a person-centered care plan. Did not include use of Coumadin or interventions related to use of medication (C)
- Failure to develop a comprehensive care plan for five of fourteen sampled. Lack of dialysis information, lack of interventions for compression stockings, care plan failed to document recommendations from PASRR Level II, and care plan didn't address ROM for restorative program. (E)
- Facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and psychosocial needs. Resident had BIMS of "10" and did not have behaviors identified. Resident who had an order for a pressure reduction mattress to the bed, and the care plan did not address repositioning . (D)

- The comprehensive care plan did not address side effects of psychotropic medications, specifically 2 antidepressants and 1 antipsychotic (D)
- Policy and care plan directed staff to keep resident's cigarettes and lighters at the nurses' station but resident kept it with him/her instead. (D)
- Failure to address elopement risk and frequent UTIs in the care plan. This was on a resident that was talking about leaving, wanting to go home, going to the door and trying to follow visitors out the door. (D)

**F 657 – Care Plan Timing & Revision**

- Resident care plan did not reflect changes in level of independence. (D)
- Failure to update a comprehensive care plan. (D)
- Care plan lacking isolation precaution interventions, care stated full code and IPOST was DNR, dialysis days wrong on care plan. (E)

**F 658 – Services Provided Meet Professional Standards**

- Failed to follow physician's orders for treating constipation (D)
- Failure to weigh a resident on six different occasions per care plan **(D) $4,000 FINE**
- Physician order called for Prevalon heel protector to promote healing of heel ulcer. Boot not in place for 2 days during survey. (D)
- Nurse did not sign off administration of anti-anxiety med on MAR so MAR and PRN sheets did not match. (D)
- Failure to ensure staff provided indwelling catheter care based on professional standards. (D)
- Facility failed to provide services that et professional standards of quality. Resident with an order for sliding scale insulin had several doses missed and charting empty. Resident had no blood sugar readings as ordered.(E)
- Failure to adhere to professional standards of medication administration and order transcription. Sinemet given during a meal instead of prior. Physician transcription error for medication that was to be given BID was documented TID and not changed on the medication cart. (D)
- Failure to administer medications per physician's order. Blood sugars were to be reported to physician if below 70 or above 300 and four times it was above 300 with no notification sent to physician. (D)
- Facility failed to notify the physician of 2 significant weight changes and failed to follow the physician's order for 1 resident. Staff did not rinse the resident's mouth after nebulizing treatment (per order), and di. notify the physician when the resident had a significant weight gain accompanied by shortness of breath and leg pain. (D)
- Air mattress ordered but not on bed, skin treatment order not initiated (E)
- Failure to follow physician orders to wear partial denture. (D)

**F 660 – Discharge Planning Process**

- Full care plan did not include discharge planning in it. (D)

**F 661 – Discharge Summary**

- Failed to complete a discharge summary, closed record review. Chart lacked documentation of the discharge summary, discharge instructions, and location or disposition of the resident's belongings. (D)

**F 676 – Activities of Daily Living/Maintain Abilities**

- Resident had a fall in June, then a decline in ambulatory status. No restorative program documented from June to July when resident declined. A therapy screen was done in June, but no therapy recommended. Resident continued to decline.(D)

**F 677 – ADL Care Provided for Dependent Residents**

- Resident documentation showed resident refused to bath twice weekly. (B)
- Facility failed to ensure residents had necessary supplies to maintain good hygiene and personal care. Resident group meeting revealed residents did not have adequate washcloth supplies and used paper towels for cleaning. Staff did not always have a supply of gloves. Facility runs out of dressings for wounds, so they make due with what they have. (E)
- Staff failed to properly cleanse the front peineal area of an incontinent resident not offer handwashing to the resident after she participated in the pericare (D)
- Failure to provide proper incontinent care. Not cleaning buttock completely. (D)

**F 684 – Quality of Care**

- Facility did not initiate neuro checks when facial bruising appeared after a fall. (D)Resident with back pain and positive lab report indicating UTI at 8:15 pm received orders for ATB at 9:12 am the next day but did not start medication until later that evening despite having temp of 100 degrees at 4 pm. DON said order was not noted until 12:40 pm and should have been noted earlier. (D)
- Failure to keep a resident safe after a fall. (D)
- The facility failed to complete assessments for a resident with abnormal vital signs. Resident #25 had diagnoses of A-fib and HTN. The resident complained of dizziness, balance problems, and a headache. A progress note documented a blood pressure of 205/110. No physician notification, assessment, or follow up of any kind occurred. (D)
- The facility failed to provide timely and accurate nursing supervision for skin changes in 1/3 current and 2 closed records reviewed. Resident #1 received an order for Nystatin powder apply 1 application twice daily on 8/31/18 which was clarified to be for 7 days on 9/3/18. Observation on 8/31/18 revealed the entire groin was bright red with peeling skin. CNA's Staff C and Staff E both reported that the resident returned from the hospital on 7/31/18 with reddened skin in the groin area. RN Staff A did not recall a report of reddened skin. Nurse Staff G stated the resident returned from the hospital with screaming red skin. She called the physician and was instructed by his nurse to use preventative cream.

She stated the hospice nurse was aware as well. She was not sure if it had been documented or not. (D)

- Failure to assess a resident after having gone limp in the sit to stand. Resident complained of right arm pain and was later diagnosed with a right proximal fracture from going limp in the sit to stand.
- Facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Staff did not notify physician of change in condition, when resident not responding 911 was called and when the ambulance arrived the client had quit breathing, resident died in the ER. Client had 11lb weight loss and no evidence the facility assessed the resident based on weight findings. Staff did not administer pain medication. Resident was burned by pouring hot coffee on himself; but didn't know why coffee pot on table. **(J) $10,000 FINE**
- Failed to provide adequate assessment for a change of condition, Staff failed to assess a change in cognition, causing the resident to fall and sustain a fracture **(D) $3,000 FINE**
- 1. Resident with critically low blood sugar lacking follow-up or physician notification and resident given a sandwich to eat of which he/she was allergic to the contents. Resident was a full code but subsequently passed away at the hospital ER. 2. Resident with skin treatments not initiated as ordered, appearing to physician as not having brief changed or pericare in "several days". Areas had become worseneed.3. The resident was not properly assessed with worsening respiratory status and passed away in route to hospital 12-hrs after initial issues. 4. Resident with an unconscious episode that was not documented. **(K) $10,000 FINE**
- Failure to provide complete and timely assessment and intervention with a change in condition. (D)

**F 686 – Treatment to Prevent Pressure Ulcers**

- Facility failed to ensure residents remain free from facility acquired pressure ulcers for 1/3 current and 2 closed records reviewed. Resident #5 noted to have a pressure ulcer on 5/4/18. The care plan for resident #5 directed staff to monitor and document location, size, and treatment for skin injury. Report abnormalities failure to heal, signs and symptoms of infections. Complete weekly treatment documentation to measurement, type of exudate, type of tissue, and other notable changes or observations. Heel protectors at all times was added to the care plan on 5/4/18. H+P indicated a left intertrochanteric femoral fx from a fall. A physician order from 5/4/18 stated to check heels every day/update the clinic weekly, continue to wear heel protectors and encourage bilateral lower extremity elevation while sitting except at meals. On 6/1/18 an order for Betadine to be applied to left heel wound bid was received. Weekly assessments completed: 5/4/18 2.5x2.0 cm, 5/10/18 2.5x2.0 cm, 5/17/18 2.5x2.0 cm, 5/24/18 3.5x1.6 cm, 6/1/18 3.3x2.1 cm, 6/7/18 3.2x2.1 cm, and 6/14/18 2x0.9 cm. (D)

- Facility failed to reposition a dependent resident in a wheelchair for over 7 hours. A new pressure sore was found on coccyx. (D)
- Facility failed to ensure that a resident received care, , consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. TAR failed to contain signatures that identified staff completed the treatment 6 time out of 25 refusal. Resident did not have a reassure reduction cushion in place. Resident had no dressing in place on coccyx that should have been. Care plan did not have repositioning measures. (G)
- Failure to provide necessary treatment consistent with professional standards for residents with pressure ulcers. Resident found with maggots in wound bed, DON called mobile wound solutions when the podiatrist was the one treating. He was notified. (D)
- Resident had open area (pressure) - physician ordered treatment but it was not put on the TAR in August and September. When resident was toileted during survey, staff was unaware of location of open skin, but when resident was wiped there was blood on the cloth. There was no dressing in place (9/5/18). The wound at this time had declined from a St II to a St III. The diameter of the wound had increased**. (G) $4,400 FINE**
- Failure to complete ordered wound treatments for multiple residents (E)

**F 688 – Prevent Decrease in Range of Motion**

- Facility failed to provide a restorative program for one of four residents. (D)
- Failure to initiate a restorative program for range of motion for a resident with contractures. (D)

**F 689 – Free from Accidents and Hazards**

- Facility failed to always provide nursing supervision to ensure interventions followed. (D)
- Failed to follow care plan intervention, transferred a resident with assist of 1 and should have been assist of 2 according to the care plan, Resident required T-scope brace on at all times was removed causing his incision to open and required a trip to the ER after a fall to have surgical wound irrigated, debridement and wound closure. (D)
- Facility failed to follow safe practices when transferring residents requiring gait belt transfers assistance, transferring residents without a gait belt. (D)
- No analysis of multiple falls to determine root cause for subsequent interventions to prevent further falls. (D)
- Failure to prevent a fall for resident at high risk for falls; Resident was left unattended. (G)
- Failure to adequately supervise nicotine dependent residents that use oxygen; One instance resulted resident with minor facial burns due to smoking while using a nasal cannula. (D)

- Facility failed to provide adequate supervision and assistance when staff transferred one of three residents which resulted in a laceration. **(G) $500 FINE**
- Failure to ensure safety of one resident that was to use the Hoyer, but staff used the sit to stand and sustained a fracture of the right proximal humeral shaft. There was not communication to the staff that the resident should be using the Hoyer and not the sit to stand. **(G) $2,250 FINE**
- Facility failed to ensure that the resident environment remained as free of accident hazards as possible. Resident should have stand by assistance and got up several times by themselves and fell. Facility failed to investigate the cause of resident's skin tear. Residents care plan did not contain any toileting interventions. A pot of hot coffee left on residents table and they poured on themselves. **(G) $6,500 FINE**
- Failure to maintain a safe and secure environment. Resident exited out the door into a secure courtyard. Alarm was going off, but no staff were present in the commons area where the door is. Maintenance found resident outside as he was doing door checks. No injuries occurred. (D)
- Resident sustained a fall in her room, landing on her shoulder. The staff assisting her was not using a gait belt - the resident's legs gave out and she fell. (D)
- Failed to ensure each resident received adequate supervision and assistive devices to prevent accidents. The resident was non-ambulatory and required extensive assist of 2 staff for transfers was frequently incontinent of bowel and bladder. Resident was on an outing and taken to the toilet and assisted by activity director and RN. The resident's knees gave out and was slowly lowered to the floor, complained of pain but did not holler out in extreme pain, a full assessment was not done as not able to due to the resident's position, resident did move bilateral legs with minimal pain. Was assisted up with assist of three including maintenance man, activity director and a Hoyer sling into wheelchair, wheeled in her wheelchair to the shelter house and ate lunch. At 1pm returned to facility and at 7:30pm was transferred to the hospital with left distal tibia and fibula fractures. Therapy alert noted resident was a Hoyer lift for all transfers and was on the care plan, at time of incident the facility did not have a policy in place for residents requiring Hoyer transfers and going out of facility for activities (G)
- Staff transferred residents with 1 instead of 2, left residents standing alone when getting supplies (D)
- Failure to have call light in place. Resident was not able to reach call light. (D)

**F 690 – Bowel, Bladder Incontinence, Catheter Care**

- Improper catheter care including failing to cleanse away from catheter, improper glove use, washing catheter bag in bathroom sink, failure to clean connections and ports with disinfectant. Resident had UTI's in December, February, March, July and September. Second resident with catheter had multiple UTI's as well. (D)

- Failure to provide complete incontinence care and failure to assess and intervene for a resident with signs and symptoms of UTI with presence of catheter who later was admitted to the hospital and was septic. (D)
- Staff provided care to a resident who had had numerous UTI's. While observing, the surveyor noted the staff cleansed the front of the peri area, the anal area, and then, without changing gloves, cleansed the catheter tubing and insertion site. Staff cleansed another resident from back to front, did not turn cloth to a clean area. This resident had experienced UTI's. (D)
- Failure to change gloves properly during incontinent cares, catheter cares, skin treatments (D)

**F 692 – Nutrition/Hydration Status Maintenance**

- Failed to identify and assess a significant weight loss timely and notify the physician and family (D)
- Failure to offer therapeutic diets as ordered and assistance with eating to prevent weight loss; Resulted in significant weight loss in two residents. **(G) $500 FINE**
- Failed to follow a primary care provider order for diet evaluation for possible modification (D)
- Resident had a significant weight loss in one month (14.38%) - the physician ordered Boost supplement. The facility did not notify the family of the order and did not implement the supplement for 2 weeks. (D)
- Resident was to receive extra protein in her diet and it is not documented in the medical record as being completed. (D)

**F 695 – Respiratory/Tracheostomy Care and Suctioning**

- Failed to follow proper cleaning procedures for a Bi-Pap and C-Pap machine. Bi-Pap was found to have murky tea colored water in the reservoir and the filter had a black ring on the inside. (D)

**F 697 – Pain Management**

- Resident who described pain as a "10" had no documentation of pain med being administered on multiple occasions. (D)
- Facility failed to ensure the pain management is provided to residents who require such services, consistent with professional standards of practice. Resident did not have her narcotic pain pill reordered timely and went without the medication which caused significant pain. (D)
- A resident complained of leg pain (10/10). She told the surveyor she was not coming to the dining room due to the pain. She stated she had been experiencing the pain for a month, and staff had not assessed her legs or the pain. Chart review showed an order 7/12/18 for muscle rub. The order had never been transcribed onto the TAR and had never been initiated. (D)

**F 698 – Dialysis**

- Facility failed to consistently complete full nursing assessments and monitoring of a resident before and after going to output. Dialysis treatments. (D)
- Facility failed to have a contract with agreement with outpatient dialysis facility and failed to do a complete assessment before and after outpatient dialysis.(D)
- Clinical record lacked any assessments or monitoring pre or post dialysis (D)

**F 700 – Bedrails**

- Failed to complete a siderail assessment and obtain signed consent for siderails (D)

**F 725 – Sufficient Nurse Staffing**

- Residents waiting 30-60 mins for call lights to be answered. CNA staff frequently on phones, making personal calls in front of residents (E)
- Call lights not being answered timely - deficiency based on residents' statements that call lights were not being answered.(D)
- Facility failed to ensure sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, metal, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Client hit call light and waited 30 minutes for staff to respond. (E)
- Failure to answer call lights timely for 3 residents. Call light log showed response times from 17 minutes to 1 hour and 39 minutes. This record was printed for a 30-day period. One resident complained it took 2 hours for staff to respond when he complained of an earache two weeks prior. (D)
- Failing to answer call lights within 15 minutes while surveyors in the facility. (D)

**F 727 – RN 8 Hrs/7 days/Wk, Full Time DON**

- Facility failed to have RN on duty 8 hours a day 7 days a week. (D)

**F 729 – Nurse Aide Registry, Verification**

- Facility failed to document registry verification for 1/4 CNA's prior to employment. The personnel file lacked documentation of registry verification prior to hire. (D)
- Facility failed to check nurse aide registry for one aide prior to hiring. (D)
- Failed to verify certification prior to hire for nursing assistants (D)
- Direct care registry was not verified for 3 CNAs prior to hire. (D)

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

- Failure to provide mandatory 12-hrs of nurse aide in-services for four CNAs. (D)
- Three CNA's did not have 12 hours of annual in-service training. (D)
- CNAs failed to receive 12 hours of in-service education annually. (D)

**F 732– Posted Nurse Staffing Information**

- Facility failed to post daily nursing staff sheets for 33 of the requested dates. (B)

**F 756 – Drug Regimen Review, Report Irregular, Act On**

- Facility failed to complete gradual dose reduction reviews for antidepressants. Policy failed to include monitoring of antidepressant for multiple use or any irregularities. (D)

**F 757 – Drug Regimen is Free from Unnecessary Drugs**

- Failure to use nonpharmaceutical interventions prior to administration of psychotropic medications. (D)

**F 758 – Free from Unnecessary Psychotropic Meds/PRN Use**

- Failed to provide non-pharmacological interventions prior to administration of Xanax and failed to review the as needed Xanax for use within 14 days of the original order (D)
- PRN psychotropic drugs were administered beyond the 14-day limit without rationale from the physician to continue treatment with these drugs. (B)
- Failure to have primary physician review use of psychotropic med within 14 days of the start date, that was ordered on an as-needed basis for 3/3 residents reviewed. (D)
- Failure to have residents free from unnecessary antipsychotics. Resident's spouse stated she was having more anxiety at night, couldn't go to sleep and wanted medications reviewed. Zyprexa was ordered. There was no charting in the notes to support the need of Zyprexa. (D)
- A PRN order for Lorazepam was taken for more than 14 days. When the physician reviewed it, he declined to discontinue it but did not document a rationale for continuing. (D)
- Facility did not follow thru on recommended GDR from pharmacist and gave prn psychotropic meds without documenting any other interventions first. (D)
- Failed to have proper diagnosis for psychoactive medications. Listed as dementia without behaviors - not a proper diagnosis. (D)

**F 759 – Freedom from Medication Error Rate of 5% or More**

- Insulin doses administered for 2 residents were not correct. In both cases the nurse did not follow manufacturer's instructions to prime the pen prior to dialing dose. (D)

**F 760 – Residents are free From Significant Med Errors**

- The facility failed to ensure residents remain free from any significant medication errors. Resident #1 had an order from 7/31/18 for Fentanyl patch 25 mcg change every 3rd day. The progress notes on 9/5/18 noted that the resident was hard to arouse, oxygen saturation at 80% with oxygen on at 2L. Facility called 911 and resident was admitted to the ICU. Three patches were noted to be on the resident that were not removed per order. Narcan used for Fentanyl

overdose in ICU. There was a previous episode in which multiple patches were noted to be on the resident at one time.

- Facility failed to ensure that residents are free of any significant medication error for 3 of 4 residents reviewed. Facility did not perform INR's or administer Coumadin as ordered. Resident died of Cerebral Infarction and ARNP felt like that was due to resident not given coumadin and INR not checked. **(J) $10,000 FINE**
- Failed to administer ordered IV Antbxs, resident given 13 meds by error (D)

**F 761 – Label/Store Drugs/Biologicals**

- Unlocked med carts. Trays of meds left on top of cart. (E)

**F 800 – Provided Diet Meets Needs of Each Resident**

- Failed to follow pureed diet procedure to provide residents with daily nutritional needs, food left after six puree diet residents served lunch.(E)

**F 801 – Qualified Dietary Staff**

- Dietary manager did was not certified. (E)

**F 802 – Sufficient Dietary Support Personnel**

- Failure to employ sufficient staff with the appropriate competencies and skills to carry out food and nutrition services; resulted in an IJ to residents' health and safety; Lack of staff to assist with cooking, serving, cleaning; Meals served late to residents; missing ingredients for multiple meals; Missing dietary logs; Menus not followed; untrained staff- need education; residents not getting prescribed meals; temperature log missing; dishwashing/sanitizer log missing entries. Dietary office littered with garbage (used hair nets, chewed gum, black particles all over floor); Food condiments place on open storage next to chemical cleaning spray. (F)

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

- Failure to follow menu as written for mechanical soft diet. Did not serve bread to one resident as ordered. (B)
- Failure to follow menus as written. Residents were to get one serving of country fried steak. The cook cut each steak into 2 pieces and served each resident 1/2 steak. (D)
- Multiple residents did not receive drinks at breakfast per the menu. (B)

**F 804 – Nutritive Value/Appearance/Palatability/Temp**

- Residents complained of tough, dry meat and food that was cold. During survey the team found meat to be very dry, difficult to chew and not palatable. (E)
- Failure to serve and maintain food temps for all entrees served to residents during lunch meal; failure to ensure resident room trays delivered in a timely manner. (E)

- Facility failed to provide hot food items at or above 140 degrees and cold items at or below 41 degrees. (D)
- Cold food served was not within temperature guidelines. Ham salad was temped at 57 degrees by end of food service. (D)
- Meat left the kitchen at 188 degrees. By the time the meat was served, it temped at 130 degrees. (D)
- Hot food measured less than 135 degrees and milk above 41 degrees. (D)

**F 810 – Assistive Devices - Eating Equipment/Utensils**

- Failure to provide adaptive dining equipment (E)

**F 812 – Food Procurement, Storage, Preparation, Sanitization**

- Failure to ensure dishwasher was functioning properly, fridge temps were completed; failure to ensure dry storage area was clean and food boxes were off of floor; failure to log residents' food temps (F)
- Large amount of dust build-up on exhaust fans above food preparation table. Ice machine had large amount of lime build up. (E)
- Failure to perform proper hand hygiene when assisting residents with meals. (E)
- Facility failed to ensure opened resident food items were properly dated to prevent potential food borne illness. (D)
- The cook served meat using tongs, then laid the handle of the tongs on the cutting board, placing the handle of the tongs on the cutting surface. Also, the cook used a disposable spoon to scrape the food from a container, then laid the spoon on the soiled counter and repeatedly used it on subsequent servings. (E)
- Touching dirty surfaces with gloved hands and not changing gloves in the kitchen, failing to properly wash hands in the kitchen after touching dirty surfaces. (E)

**F 838 – Facility Assessment**

- No facility assessment completed. (D)

**F 842 – Resident Records - Identifiable Information**

- The facility failed to document incidents and changes in skin integrity in the medical record for 3/3 open and 2 closed records reviewed. Resident #1 received an order for Nystatin powder apply 1 application twice daily on 8/31/18 which was clarified to be for 7 days on 9/3/18. Observation on 8/31/18 revealed the entire groin was bright red with peeling skin. CNA's Staff C and Staff E both reported that the resident returned from the hospital on 7/31/18 with reddened skin in the groin area. RN Staff A did not recall a report of reddened skin. Nurse Staff G stated the resident returned from the hospital with screaming red skin. She called the physician and was instructed by his nurse to use preventative cream. She stated the hospice nurse was aware as well. She was not sure if it had been documented or not. On IR dated 5/13/18 resident #4 punched his spouse Resident #5 3 times with a closed fist in the chest/shoulder area which

resulted in a bruise. The facility did not document the incident in the medical record for either resident involved. (D)

- Failure to ensure complete and accurate records of discontinued or destroyed medication. One lorazepam was missing. (D)
- Facility failed to maintain medical records in accordance with accepted professional standards and practices. Review of TAR showed staff did not sign they completed the treatment. (D)
- During chart review, surveyors found a resident's chart without H & P, admission orders, and recertification orders. The facility stated they were unable to locate them. (D)

**F 867 – QAPI/QAA Improvement Activities**

- The facility QAPI committee did not meet monthly per their policy. They also failed to show analysis of information that was gathered, in spite of an identified problem with falls, pressure ulcers, etc. There was no root cause analysis to determine the cause of the problems. (D)

**F 868 – QAA Committee**

- Facility failed to show attendance of facility medical director at a minimum of quarterly (C)
- Repeated deficiencies on the same issues over 5 inspections that are not properly being addressed in the Quality Assurance program. (E)

**F 880 – Infection Prevention and Control**

- During catheter care, CNA placed graduate of urine on floor without a barrier. (D)
- Nurse failed to wipe rubber stopper of insulin pen with alcohol as required by manufacturer's instructions prior to attaching the needle. (D)
- Failure to practice effective hand hygiene during incontinent cares, and while emptying a catheter drainage bag; failed to ensure sanitary oxygen tubing. (E)
- Facility failed to ensure staff followed infection control practices. Nurse used same gloved hand to apply cream to different skin folds on body without changing gloves for each different fold. (D)
- One resident did not get a clean pitcher when pitchers were exchanged. The resident stated it had not been exchanged the last 2 mornings. (D)
- Failure to cleanse contaminated surfaces after providing incontinence cares. Staff did not disinfect wheelchair cushion that was wet with urine prior to putting resident back in chair. Staff did not contact housekeeping to disinfect the floor that had urine on it as well. Staff held soiled linens against her uniform, un-bagged, and took them to laundry. (D)
- Failed to ensure staff maintain infection control practices after direct resident contact and prior to food service. CNA served a tray of food after being in a resident room where she did not wash her hands. (D)
- Surveyors identified concerns with infection related to peri care, wound care, and medication administration. (1) Staff placed a soiled nebulizer mask on a resident

without cleaning it (2) staff administered a nebulizing treatment after picking the mask and tubing off the floor (3) resident used an alcohol wipe on two different fingers and also did not put the glucometer machine on a barrier (4) staff used the same alcohol wiped used to swab the insulin vile to wipe the resident's skin prior to the insulin injection (5) nurses did not complete hand hygiene before or after completing med administration and before using computer (6) C.N.A.s did not change gloves or wash hands between providing peri care and applying barrier cream. (D)

- Many infection control issues throughout the annual survey. (E)
- Maintain infection control practices. Rolled the cleaned resident on the soiled bed. (D)

**F 881 – Antibiotic Stewardship Program**

- Facility had not implemented an Antibiotic Stewardship Program (D)
- The facility did not address Antibiotic Stewardship in their Infection Control Program, and lacked policies and protocols to monitor antibiotic use (D)

**F 925 – Maintains Effective Pest Control Program**

- Facility had large number of flies and other bugs. (D)

**F 926 – Smoking Policies**

- Facility failure to provide a safe smoking environment (D)

**L 1093**

- All residents were not screened for VA status.

## Nursing Facility Survey Frequency - November 2018

- As of Nov. 26, 2018 CMS, lists 70 Iowa facilities or 16% of all facilities in the state as being past 15 months since last annual survey. Region 7 average rate is 10%. National average is 8.1.%.

| FFY 18 - September Totals - LTC Surveys | | | | |
|---|---|---|---|---|
| **Provider Name** | **City** | **Survey End Date** | **Previous Date** | **Months Between** |
| Accura Healthcare Newton West | Newton | 9/6/2018 | 6/22/2017 | 14.70 |
| Accura Healthcare of Spirit Lake | Spirit Lake | 9/27/2018 | 6/22/2017 | 15.40 |
| Afton CC | Afton | 9/20/2018 | 6/22/2017 | 15.17 |
| Dubuque Specialty | Dubuque | 9/20/2018 | 6/22/2017 | 15.17 |
| Elm Heights CC | Shenandoah | 9/13/2018 | 6/1/2017 | 15.63 |
| Elmwood CC | Onawa | 9/20/2018 | 6/8/2017 | 15.63 |
| Franklin General Hospital | Hampton | 9/13/2018 | 6/28/2017 | 14.73 |
| Glen Haven Home | Glenwood | 9/13/2018 | 3/15/2018 | 6.07 |
| Grand Meadows | Asbury | 9/27/2018 | 7/6/2017 | 14.93 |
| Granger N & R | Granger | 9/27/2018 | 6/22/2017 | 15.40 |
| Great River - Klein Center | W Burlington | 9/13/2018 | 6/15/2017 | 15.17 |
| Hillcrest Home | Sumner | 9/6/2018 | 6/15/2017 | 14.93 |
| Manly Specialty | Manly | 9/27/2018 | 6/22/2017 | 15.40 |
| Maple Manor Village | Aplington | 9/20/2018 | 6/15/2017 | 15.40 |
| Mercy Living North | Clinton | 9/27/2018 | 6/22/2017 | 15.40 |
| Mill Valley | Bellevue | 9/6/2018 | 6/28/2017 | 14.50 |
| Pearl Valley - Lake Park | Lake Park | 9/13/2018 | 5/8/2017 | 16.43 |
| Pearl Valley – Sutherland | Sutherland | 9/13/2018 | 6/8/2017 | 15.40 |
| Pioneer Valley Living & Rehab | Sergeant Bluff | 9/20/2018 | 6/15/2017 | 15.40 |
| Ridgewood Specialty Care | Ottumwa | 9/13/2018 | 6/28/2017 | 14.73 |
| Rock Rapids | Rock Rapids | 9/6/2018 | 5/28/2017 | 15.53 |
| Sunny Hill CC | Traer | 9/13/2018 | 6/28/2017 | 14.73 |

| | | | | |
|---|---|---|---|---|
| The Cottages | Pella | 9/17/2018 | 6/15/2017 | 15.30 |
| Titonka | Titonka | 9/20/2018 | 6/15/2017 | 15.40 |
| Touchstone HCC | Sioux City | 9/26/2018 | 2/15/2018 | 7.43 |
| Valley Vue | Armstrong | 9/20/2018 | 6/15/2017 | 15.40 |
| Westmont HCC | Logan | 9/27/2018 | 6/15/2017 | 15.63 |
| | | | AVERAGE | 15.26 |

Highlighted Not included in average