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

Compliance Tips from IHCA's Survey Results Committee
November 2019

Total Number of Survey Reports: 33
Survey Composition:

Annual:	**30** Surveys	**2** Deficiency Free
Complaints:	**11** Surveys	**1** Unsubstantiated
Self-Reports:	**1** Survey	**0** Unsubstantiated
Mandatory Reports:	**1** Survey	

State Fines: $9,000
State Fines in suspension: $23,250

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

F 880 – Infection Prevention and Control (14)

F 658 – Services Provided Meet Professional Standards (10)

F 812 – Food Procurement, Storage, Preparation, Sanitization (9)

F 657 – Care Plan Timing & Revision (9)

F 625 – Notice of Bed Hold Policy Before/Upon Transfer (9)

F 623 – Notice Requirements Before Transfer/Discharge (8)

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

F 686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers 1 G Level Tag

F 689 – Free from Accidents and Hazards 2 G Level Tags, 1 J Level Tag

F 692 – Nutrition/Hydration Status Maintenance 1 G Level Tag

Top 10 National F-Tags*

Citation Frequency Report

National Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Active Providers=15605		Total Number of Surveys=56283
F0880	Infection Prevention & Control	5,199	30.3%	9.2%
F0689	Free of Accident Hazards/Supervision/Devices	4,911	24.8%	8.7%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	4,327	26.1%	7.7%
F0656	Develop/Implement Comprehensive Care Plan	3,849	21.9%	6.8%
F0684	Quality of Care	3,601	18.8%	6.4%
F0761	Label/Store Drugs and Biologicals	3,022	18.2%	5.4%
F0657	Care Plan Timing and Revision	2,458	14.4%	4.4%
F0677	ADL Care Provided for Dependent Residents	2,250	11.9%	4.0%
F0758	Free from Unnec Psychotropic Meds/PRN Use	2,202	13.4%	3.9%
F0550	Resident Rights/Exercise of Rights	2,125	12.3%	3.8%

*Additional detailed national, regional, state and facility-specific CMS regulatory data can be found S&C's Quality, Certification, and Oversight Reports (QCOR).

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

F550 – Resident Rights/Exercise of Rights

- Fail to ensure residents were covered during cares. Curtains left open during incontinent cares. Staff left room to get help with cares and left resident fully exposed. D

F558 – Reasonable Accommodations of Needs/Preferences

- Failed to use a bolster cushion (Adaptive Device) for proper positioning for one resident. D

F574 – Required Notices and Contact Information

Staff failed to provide information for residents to formally complain to the state about the care received, state agency office information not found or available in the facility. C

F577 – Right to Survey Results/Advocate Agency Info

- Failed to post prior survey results in prominent place. D

F578 – Request/Refuse/Discontinue Treatment; Formulate Adv Di

- Failure to ensure code status in electronic health record and IPOST for scope of treatment. D
- Resident chart had red dot for no CPR and clinical record indicated CPR. D

- Facility failed to update the advanced directive status. EHR and face sheet reported resident as a DNR. IPOST reported resident chose CPR status. D
- Facility failed to ensure all staff were aware of the residents' health decisions regarding advance directives and failed to document accurate code status. Care plan states resident was full code and required green sticker on door, the order summary reported resident was a DNR. EHR reported resident was a DNR. Advance Directive Acknowledgement form revealed resident requested CPR. Treatment records revealed DNR. Name plate on door had green sticker, signifying CPR. D

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

- Failure to inform physician and family of change in condition. Stroke like symptoms and elevated blood pressure. D

F582 – Medicaid/Medicare Coverage/Liability Notice

- Facility didn't provide the required forms for Medicaid Liability notices and beneficiary appeals when skilled service was no longer covered. D
- Medicaid/Medicare Coverage of residents were not given information on their BNP. SNF resident not provided information on appeal rights under Notice of Medicare Non-Coverage. B

F584 – Safe/Clean/Comfortable/Homelike Environment

- Failure to maintain a clean/sanitary environment. A family interview reports they had to clean a resident's room themselves because there were dirty briefs in the trash and pillows on floor. Resident council meeting reported that Housekeeping does not always complete duties. Room observations revealed multiple soiled toilet risers that remained that way for extended periods of time. D
- Failed to provide a clean, homelike environment for resident equipment including the cleanliness of resident wheelchairs, fall mat, cushions, and wheelchair armrest full of cracks exposing the white fabric underneath the black covering of the armrest. E

F585 – Grievances

- Residents did not know who the grievance official was or how to file a grievance. Admission packet lacked information required regarding the grievance policy. D

F606 – Not Employ/Engage Staff with Adverse Actions

- Several employees had DCI record, but not forwarded to DHS for approval letter. An employee was a rehire with no record check completed. **D $500 FINE IN SUSPENSION**

F609 – Reporting of Alleged Violations

- Several incidents of resident-resident abuse not reported to DIA. A missing item not investigated timely or reported to DIA (Item later found or returned to room). DON did not know abuse policy. D
- Facility failed to report an allegation of a resident missing possession to DIA within 24hrs of it being reported missing. Daughter reported a missing wallet. Administrator reported they had not reported the missing wallet to DIA due to feeling confident they would find it. Wallet was found 10 days after allegation of a missing wallet. D

F623 – Notice Requirements Before Transfer/Discharge

- Facility failed to ensure the ombudsman was notified of a transfer or discharge. Transferred and admitted to hospital. B
- Failure to notify the LTC ombudsman of a transfer/discharge for multiple residents. C
- Transfer/Discharge Notice Records review monthly Ombudsman reports not reported, and no transfer forms completed after review of MDS/Clinical documentation and not following Facility Transfer/Discharge-Outside Policy. B
- Failure to provide notification to Ombudsman about a hospital transfer. B
- The facility failed to notify the Ombudsman's office of Medicaid transfers to the hospital for residents. Director of Social Services explained that she did not submit the names of several residents transferred to the hospital. Stated did not report these because they were Medicaid residents and had a 10-day bed hold so they do not notify the Ombudsman for anyone on Medicaid. E
- Notice to ombudsman for discharges/transfer not done 9/12 months. B
- Facility failed to notify long term care ombudsman of transfer. C
- Facility failed to notify the Ombudsman regarding a transfer to the hospital. B

F625 – Notice of Bed Hold Policy Before/Upon Transfer

- Failure to provide resident or family with bed hold policy upon transfer to hospital. D
- Failure to notify resident or representatives of the bed hold policy upon transfer for multiple residents. C
- Failure to provide bed hold prior to or within 24 hours of transfer to acute care hospital. D
- Fail to provide bed hold prior to/within 24 hours of transfer to acute care hospital. B
- Failure to provide bed hold prior to or within 24 hours of transfer to acute care hospital and therapeutic leave. B
- The facility failed to provide resident or resident's representative with a bed hold upon transfer to the hospital for multiple residents. E
- Bed hold not given for hospitalization. B
- Facility failed to provide a bed hold policy and ensure it was signed and returned within 48-hours. D
- Fail to provide resident/representative with a bed hold with discharge to hospital. B

F637 – Comprehensive Assmt After Significant Change

- Facility failed to complete a significant change MDS within 14 days of discovering a resident had changes in condition. D
- Lack of completed MDS when resident went into Hospice Care. B

F640 – Encoding/Transmitting Resident Assessment

- Failed to complete an MDS discharge assessment and failed to submit an assessment timely. D

F641 – Accuracy of Assessments

- Failure to complete an accurate assessment on a resident who should've been a level II PASRR. D
- MDS documentation stated resident received anticoagulant medication seven days a week and MAR lacked documentation of any given for residents. E

F644 – Coordination of PASRR and Assessments

- Facility failed to notify Ascend promptly when a resident with Mental disorder or intellectual disability experienced a significant change in mental or physical status. Resident was approved for terminal illness for 6 months. Facility failed to submit a new Level I PASRR review after the 6 months expired. D
- Level 2 PASARR required resident to have evaluation for dementia or other organic brain disease. This was not completed. New PASRR not completed when resident had new diagnosis of bipolar. D
- The facility failed to refer resident with a negative Level 1 who was later identified with new or possible serious MD/ID for a level II PASRR eval. The facility also failed to care plan the specialized services that were recommended by Ascend for a level II eval for resident reviewed. Resident had a level I screen outcome with MMI marked "no" but had a dx of major depression and delusional disorder that was being treated with antidepressants. The PASRR notice listed identified specialized services for behavioral health. The care plan documented focus areas but interventions failed to address specifics such as the type of service, who provided the service, where it was provided, when it would begin, and the duration. D
- PASRR not updated with new dx of delusions and depression. D
- Facility failed to submit a PASRR when a resident had a newly diagnosed mental disorder. No diagnosis of mental illness or intellectual diagnosis on original PASRR, currently resident has diagnosis of Anxiety, Depression and Psychotic disorder without submitting a new PASRR. D
- Facility failed to incorporate the PASRR Level II determination into care plan regarding ongoing rehabilitative services. D

F645 – PASARR Screening for MD & ID

- Facility failed to resubmit a PASRR after a change in condition. PASRR submitted with change in medications but lacked the new diagnosis of schizophrenia. B

F655 – Baseline Care Plan

- The facility did not follow therapy recommendations for use of an orthotic foot drop boot listed on the baseline care plan; didn't have policies in place regarding therapy recommendations. Staff observations had boot sitting in corner in room, not being used, not listed on TAR or in Care Plans. D
- Failure to provide resident or rep with a baseline care plan. D
- Facility failed to provide a written summary of the baseline care plan and the medical record did not contain an explanation to identify why the facility did not provide a baseline care plan to the resident/responsible party. D

F656 – Develop/Implement Plan of Care

- Failed to include care plan interventions for incontinence care. D
- Care plan lacked any problem/interventions related to constipation. No documentation regarding any dietary interventions. D
- Care plan interventions not followed (walker not used and a resident's siderails were not padded) D
- Fail to complete a comprehensive care plan and implement care plan interventions. Resident's care plan lacked documentation regarding contractures of the resident's hands, care plan included to place a blue carrot in the resident's right hand at all times, during observation resident's hands rested on his lap with fingers curled inward without the blue carrot positioner or other device in his right hand, and resident did not have blue bunny boots on according to care plan. D

F657 – Care Plan Timing & Revision

- Facility didn't update the care plan to reflect a resident's current status- pressure ulcer, goals or interventions. D
- Failure to review and revise residents' care plans. D
- Facility failed to update Care Plans for multiple residents. Pre-Admission Screening and PASRR, Hospice Services, O2 Therapy, Dialysis and Insulin usage. E
- Failure to update care plan after a fall. D
- Failure to revise plan of care for resident with pressure ulcer. D
- No documented plan in place for resident on fluid restrictions to let nursing know how much fluid they can provide throughout the day. D
- Facility failed to update the care plan for a resident following anticoagulant use ending and following falls. Resident had anticoagulant therapy and when it was discontinued it was not removed from the care plan. Another resident had a fall in the day room. The intervention was one on one with the resident which was not addressed on the care

plan. Later the same resident was observed on the floor in room. Interventions also not included on the care plan. D

- Care plan did not reflect resident's current status-- not updated after fall with fx. D
- Failure to update a care plan for a resident with significant weight loss and change in condition. D

F658 – Services Provided Meet Professional Standards

- Facility failed to obtain orders for O2 therapy. D
- Failure to wear gloves during administration of insulin pen. D
- Failure to follow occupational therapy recommendations. Resident was to wear a splint to right elbow, and it was not on resident. D
- Failure to follow physician orders for wound care, did not pack wound as ordered. D
- Resident had order to wear heel soft booties at all times other than cares. Resident was not wearing them on multiple occasions. Care plan did not indicate to staff to have resident wear heel soft boots. No documentation that resident had refused to wear boots. Nurse used new blood sugar meter without running controls first. D
- Fail to provide treatment/care in accordance with professional standards in regard to implementing ted hose and completing wound care for a skin tear per physician orders. Resident admitted with an order for TEDS on in the AM and off at HS. Observation days later revealed pitting edema and no TED hose on, and resident reported he/she has not had them on since admitted. Order was not on MAR/TAR. Another resident had an order for a daily dressing for a skin tear, but review of the TAR showed the treatment had not been completed every day as ordered. D
- Many incidents of medications being given several hours late. Resident cried in pain due to late meds and reported late due to staffing. Employees also stated staffing as a reason for late meds. D
- Fail to assure physician's orders were followed. Weighs were to be taken but weren't. D
- Staff failed to prime insulin flexpen prior to administration to ensure proper amount of insulin was administered, staff present showed the top drawer of the medication cart contained three medication cups with names on them and pills in them, then showed staff took the three medication cups out of the medication cart and administered the medications in the cups to the residents. Observation revealed three pills in a medication cup sitting on a resident's nightstand. Completed Spiriva and Symbicort one right after another without pausing in between inhalations and not cleansing of the resident's mouth completed following the medication administration. E
- Facility failed to ensure staff did not leave medications unattended during medication administration. Left medications at dining room table with resident without observing resident taking meds. Family reports finding medications on resident bedroom floor in the past. Staff reported finding meds on table left unattended by nurse. D

F661 – Discharge Summary

- Facility failed to complete a recapitulation for a closed record. B
- No discharge summary, recap of stay. B

F676 – Activities of Daily Living (ADLs)/Maintain Abilities

- Failure to identify necessary services to assure a resident's ADLs didn't diminish. D
- Failed to encourage/assist a resident to complete a walk to dine program 2x per day as per care plan or document refusals to participate. Family member said staff didn't follow care plan. No documentation of program being completed as planned. D

F677 – ADL Care Provided for Dependent Residents

- Failure to provide complete incontinent care. D
- ADL's facility failed to bathe residents twice weekly. Lack of documentation/follow through by DON and staff when nothing was charted/documented on Bath list. E
- Failure to provide complete incontinence care. Staff did not wipe the perineal area, buttocks and hips of urines residue. D
- Failure to provide appropriate peri care. Staff glove touched dirty hip, did not change gloves. Staff wiped resident four times with towel, did not change fold in towel. Picked up clean towels with dirty glove, set dirty towel on bed, and picked up clean brief with dirty glove. D
- Facility failed to provide proper incontinence care. Staff failed to change the wipe or wipe surfaces with each contact of resident's skin. Failed to cleanse both hips. D
- Observation revealed resident walked in halls wearing a shirt with a large brown area down the front and brown areas visible around the resident's lips and face, care plan indicated the resident needed assistance in dressing, grooming, and bathing. D
- The facility failed to provide consistent baths weekly for multiple residents, showed no documentation of baths or "N/A" for varying amounts of time in July and Aug - sometimes weeks with no documented bath. D

F679 – Activities Meet Interest/Needs of Each Resident

- Failed to provide activities that met residents' mental and psychosocial well-being. D

F684 – Quality of Care

- Facility failed to assess resident's lack of bowel movements, provide timely intervention with bowel regimen medications to promote bowel movement per facility protocol and nursing professional standards and notify physician of lack of bowel movements. No documentation to support bowel movements and/or abdominal assessments. D
- Failure to assess a resident with a change in condition with stroke like symptoms. Blood pressure was taken but that was all. D

F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers

- Facility failed to ensure a resident didn't develop pressure sores unless the clinical record demonstrated they were unavoidable. D
- Failure to prevent another pressure ulcer and did not use prevlon boots correctly. The two pressures then combined into one large pressure. D
- Facility failed to inform the physician when pressure area became a stage 3 from a stage 2, and when the depth of the area increased. The resident was underweight with recent significant weight loss and the facility did not begin a protein supplement until six days after ordered; facility assessment did not match wound clinic's evaluation of the pressure ulcer. Facility did not initiate a low air mattress until the time the resident had tunneling and was known to refuse position changes. D
- Failure to provide care in accordance with professional standards related to preventing a stage III pressure ulcer from deteriorating. Resident had a stage III pressure ulcer upon admission. Observation revealed no Prevalon boot on per Phys order; also, a delay in ordering a low air loss mattress. Skin assessment upon admission was not completed. Failure to complete Tx/dressing changes per order also noted for resident. Resident's dressing on coccyx was late and order is to change every 3 days and PRN. **G $4,500 FINE IN SUSPENSION**

F688 – Increase/Prevent Decrease in ROM/Mobility

- Fail to ensure residents received appropriate treatment/services to multiple residents. D
- Fail to provide a restorative program to resident with mobility concerns. Therapy recommended for resident to assist with maintaining current level of performance and to prevent decline, but a restorative program was not being completed. D
- Failure to provide restorative services for multiple residents. E

F689 – Free from Accidents and Hazards

- Communication/Update of Adaptive Device List and lack of supervision while under observation failed to provide supervision while toileting as directed by Care Plan. D
- Resident fall with fx, then fell five more times without investigation or root cause analysis being completed. Another resident fx after multiple falls. Interventions not appropriate such as "educated resident" when resident was confused and hallucinating. Multiple employees stated staffing as a reason and referenced leaving a resident alone in the shower. **G $7,250 FINE IN SUSPENSION**
- Failed to ensure wheelchair foot pedals were applied to resident wheelchair and that resident's feet were on the foot pedals while pushing a resident. D
- Staff failed to adequately supervise and prevent a fall for a resident. Resident required use of a gait belt, staff didn't use the belt and left the resident unattended. The resident then fell and sustained multiple rib fractures and a hip fracture. The resident required surgery. Resident passed away due to complications of pneumonia due to or as the consequence of a neck fracture and rib fractures. **G $9,000 FINE**

- Facility failed to provide adequate nursing supervision and assistance devices to prevent accidents. Facility van driver failed to attach all four floor restraint straps/hooks to the wheelchair frame and buckle a shoulder-lap seat belt. Resident fell out of wheelchair and hit metal floor and went into cardiac arrest, CPR was initiated, and the resident was transported to the hospital and later died. Resident was taking anti-coagulant. **J $10,000 FINE IN SUSPENSION**
- Facility failed to ensure staff transported resident in the same manner in order to prevent accidents. Pushed resident in wheelchair without pedals in place. D

F690 – Bowel, Bladder Incontinence, Catheter Care

- Facility didn't ensure incontinent care/catheter care in a manner that prevented infection for multiple residents. E
- Failure to provide adequate incontinence care, not cleaning front perineal area. D
- Staff, when performing perineal care, wiped the anterior perineal area producing a large amount of stool and then used the same wipe to cleanse the area three more times. Staff left urinary catheter drainage bag hooked to a trash can beside the resident's chair and left the room. The trash can contained garbage. E
- Failed to provide catheter care to minimize the occurrence of UTI, staff did not use and alcohol wipe to cleanse the catheter port after draining the catheter bag and before replacing the catheter port back into the holder. Staff did not rinse the catheter bag out and place into something to protect from infections. D
- Failure to ensure incontinent care to prevent infection for several residents. E
- Facility failed to provide catheter care with a suprapubic catheter. Staff provide pericare but failed to cleanse 4-6 inches down the catheter tubing. D

F692 – Nutrition/Hydration Status Maintenance

- Fail to provide needed assistance to prevent weight loss. Resident care plan stated they required cueing at meals and special equipment. In less than one month they lost 11 lbs. Observation revealed no staff staying with the resident while they slept through multiple meals. D
- Resident in recliner sleeping for 6.5 hrs. (pressure ulcer on buttock), not offered fluids, toileting repositioning. Wrong diet was also given. Weight loss of 12.6% and no dietary assessment for over two months. Employees did not assist with meals routinely. **G $500 FINE IN SUSPENSION**
- Resident admitted to the facility following a stroke and newly placed PEG, the resident weighed 111 pounds on admit, six days later the dietician identified the resident's enteral feedings did not meet the resident's required needs and recommended an increase in calories. The recommendation was not acted on until 15 days later, in the interim the resident weight went down to 92 pounds 17.12%. D

F693 – Tube Feeding Management/Restore Eating Skills

- Failure to provide appropriate treatment and services to residents. Resident's head was not raised 30 degrees while receiving nutrition putting resident at risk for developing aspiration pneumonia. D

F695 – Respiratory/Tracheostomy care and Suctioning

- Resident with trach did not have orders for supplies as policy dictated. Also, no Ambu bag as required. During cares the resident stopped breathing and heart stopped, CPR was initiated. LPN reported limited supplies on crash cart, no backboard and no ambu bag available. Surveyor taken to supply closet where ambu bag was present but no backboard or suction machine available. D

F698 – Dialysis

- Lack of Dialysis assessment for residents. MDS identified resident dependent on renal dialysis but Care Plan failed to address these needs. Facilities Dialysis Communication report was available for staff to document with the expectation (pr. DON) to complete assessments prior to and after dialysis. D
- Failed to complete nursing assessments and monitor residents before/after going to outpatient dialysis. Facility had no contract with Dialysis Center and no policy and procedure on assessments for residents who receive outpatient dialysis. D

F700 – Bedrails

- Failure to assess a resident's need for a bed rail, attempt to use alternatives prior to installing a bed rail, or review risks/benefits of bed rails with resident or representative. Failure to obtain consent prior to installation of bed rails for multiple residents. D
- Failure to assess residents for use of bed rails, risk of entrapment, ensure correct dimensions were used on bed rails to prevent entrapment for multiple residents. K
- Failed to do assessment for use of bed rails and did not get consent for use. E
- No side rail assessment or consent. D
- Multiple residents without consents for bedrails D
- Failed to assess residents for use of bed rails and obtain informed consent. D
- Facility failed to ensure nursing assessments for bed rails were completed and consents were obtained. D

F710 – Resident's Care Supervised by a Physician

- Fail to notify and ensure notification to the resident's physician regarding a significant change in a resident. The resident experienced significant weight loss and developed a stage 4 pressure ulcer with MRSA. D

F725 – Sufficient Nurse Staffing

- Facility failed to have adequate staff to care for residents' needs. Resident interviews indicated long call light wait times. Staff interviews report not feeling like they had enough staff to complete their duties. E
- Based on facility assessment, call light reports, timeclock records fall reports, family/resident interviews and staff interviews, failed to provide sufficient staffing to care for residents. No staff on locked dementia unit at several times. E
- Resident put on call light. CNA responded two minutes later but needed to get help. Resident put call light back on approx. 10 minutes later. CNA answered call light at that time but had to go get help; Five minutes later staff entered the room and reported he/she needed to get another staff to help; moments later staff entered room and visited resident about a shower, resident asked if he/she was going out for breakfast or eating in her room, staff did not respond, the resident said it would be easier to eat in the room, staff said it would be OK and he'd feed the resident, at 8:40 staff left the room to get the resident's breakfast, 8:46 HRD delivered the breakfast to resident's room, the resident stated he/she didn't like milk, so the HRD took it and went to get a different drink, 8:48 staff helped the resident eat. DON expected staff to help resident within 15 minutes. D

F728 – Facility Hiring and Use of Nurse

- Multiple CNAs hired but not certified as DON thought certified. Worked past the four months of being uncertified. D

F729 – Nurse Aide Registry Verification, Retraining

- Did not obtain registry verification prior to hire. D

F730 – Nurse Aide Perform Review – 12 Hours /Year In-service

- CCDI training incomplete on staff, no policies/procedures on dementia training. Surveyor referenced facility assessment that indicated CCDI training done. E
- Failure to ensure all CNAs receive annual performance reviews. B

F732 – Posted Nurse Staffing Information

- Facility didn't have the daily staff posting fully completed for seven of eight calendar days in a two-week period. C
- Failure to post required nurse staffing information. D
- Facility failed to ensure the daily nursing staff information was posted. No daily staff posting for two days during survey. B

F756 – Drug Regimen Review, Report Irregular, Act On

- Monthly drug regimen not completed by pharmacist, several 6-7 months late. D

F758 – Free from Unnecessary Psychotropic Meds/PRN Use

- Failure to assure residents prescribed PRN psychotropic meds were limited to 14-days unless the physician evaluated the resident for appropriateness of med. Facility also failed to identify interventions to attempt prior to administrating PRN meds. D
- Residents' charts lacked GDR for multiple residents. E
- Failed to get rationale from provider who declined a GDR. D
- Facility failed to provide non-pharmacological approaches prior to administering a prn psychotropic; failed to provide rationale for usage beyond the 14-days for residents. D
- Unnecessary drugs: PRN lorazepam with no stop date. D
- Failure to ensure PRN orders for antianxiety med was limited to 14-days of utilization. D
- Facility failed to ensure anti-psych medications were re-assessed or included a clinical rational to continue the medication. Record lacked a GDR attempt or medication review for mirtazapine. D

F760 – Residents Are Free of Significant Med Errors

- Facility failed to prime an insulin flex pen prior to administering insulin to ensure the proper amount was administered for a resident. D

F761 – Label/Store Drugs & Biologicals

- Failed to remove expired medications from the Med room and cart. B
- Medication bottles on cart not labeled as to when opened. Center had no policy related to medication storage. D

F801 – Qualified Dietary Staff

- Facility failed to employ a qualified person to serve as the Director of Food and Nutrition services in the absence of a full-time dietician. D

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

- Facility failed to follow the planned menu for pureed diets. No dietician signature on menus. Used wrong serving scoops. D

F812 – Food Procurement, Storage, Preparation, Sanitization

- Kitchen area had brown/red substance on floor and wall; Dietary manager didn't have hairnet when walking through kitchen. D
- Multiple sanitation issues, hairnets worn but not containing hair, no beard guards worn, dust on sprinkler heads, dirty prep areas, crumbs in drawers, gloving not worn while preparing ready to eat foods, lack of proper hand washing and gloving, gloves not worn while preparing ready to eat foods Not following cleaning lists and cleaning lists did not list frequency, labeling and dating of open food item in cooler. E
- Hair was not tucked all the way into a hairnet. Hood had peeling paint. E

- Fail to provide and serve food under sanitary conditions. Dust/dried food/grease found throughout kitchen in/on multiple appliances. Director of Culinary Services stated items needed to be cleaned and there was currently no cleaning schedule. E
- Administrator delivered drinks to residents with ungloved hands, held by the rim. D
- CNA cut bun in half with bare hands, picked up toast with bare hands, hair net was half off of head, front half of hair exposed, hard water stains on dishes etc. worn cutting boards, dirty oven, stainless steel table to right of steam table was in need of being cleansed. Staff obtained temperature of food using thermometer and cleaning with alcohol wipe; used the same alcohol wipe between each food item, and the same alcohol wipe for regular and mechanical soft; the alcohol wipe that was used multiple times also touched the pan lids and the back to the thermometer. E
- Facility failed to provide a sanitary environment when staff did not completely cover their hair with hairnets during food prep/service. One to three inches of hair exposed in back not covered by hair net. E
- Food safety cleanliness, grime, debris, food crumbs throughout the kitchen and storeroom. Unsanitizable surfaces; Veneer on cupboards, walls and floors. Mock survey completed shared these concerns. Deep cleaning lists were identified but no initials/documentation. Label/dating of items identified multiple opened; Thickened Liquids labeled but outdated past manufacturer's use by date. Unidentified food items with no labels or dates in refrigerator labeled for resident use. Food Brought in from the outside policy was in place but not followed. Mock survey earlier in the year had also addressed these issues. E
- Facility failed to label, and date food items stored in the main kitchen walk-in cooler and failed to prepare and serve resident food items in order to reduce the risk of food-borne illnesses. No cover on milk and ice cream transported to resident rooms. Uncovered food trays delivered to resident rooms. Handling glasses of water by the rim of the glass. Touching multiple surfaces with gloved hands and touching food. Dietary staff wearing baseball hat and no hairnet covering facial hair. E

F865 – QAPI Program/Plan, Disclosure/Good Faith Attempt

- Fail to have an effective QA program in place to assist in provision of quality care for residents, review of facility records revealed repeated deficient practices identified during facility's special focus bi-annual surveys completed and current survey. E

F880 – Infection Prevention and Control

- Staff changed gloves but didn't wash hands between cares for resident. D
- Staff didn't change gloves to ensure proper infection control practices to prevent cross contamination and potential infection. D
- Failure to disinfect hands between residents while assisting with eating. Linen cart transported without being covered. E
- Staff did not perform hand hygiene on residents with precautions during incontinent cares. Staff picked up pill with bare hand that had bounced out of medication cup. D

- Fail to complete annual review of infection prevention/control program. Last update was four years prior. Infection control antibiotic stewardship policy had not been updated for two years. D
- Fail to provide appropriate cath care. Clean wipes placed on top of package or on the bed sheets prior to using for peri care and the catheter port was not cleaned. D
- Staff did not change gloves/wash hands between peri-cares and placing barrier cream. Policy had not been reviewed annually as required. D
- Failure to complete hand hygiene when completing a dressing. D
- Failure to maintain a sanitary environment to help prevent transmission of pathogens for multiple residents. D
- Nurse applied gloves without hand hygiene, did not put a barrier on the floor, did not clean the floor following spilling on the floor, did not use clean gloves to get clean gauze out of the package of multiple gauzes. D
- Failed to follow proper infection control measures for resident utilizing oxygen; failed to ensure proper hand washing after personal cares. No date on humidification bottle, nebulizer mask or oxygen tubing to indicate when last replaced. Policy reported all oxygen delivery systems will be dated when changed and initialed. Failed to complete hand hygiene when ambulating resident out of room after personal cares. D
- Facility failed to maintain a catheter drainage bag in a sanitary manner and provide incontinence care in a sanitary manner; Failed to provide incontinence care in a manner to prevent the spread of infection. After cares, used same glove to wipe off soiled toilet seat, with same gloves (that contained stool) proceed to dress resident and transfer to wheelchair. Uncovered catheter drain bag touched the floor. D
- Failed to follow infection control practices in order to prevent/control the onset and spread of infection within the facility by not performing hand hygiene. Wiped resident's mouth with a napkin and without washing hands reached over to assist another resident. Continued to wipe resident's mouth with a towel while assisting other residents and not washing hands or using hand sanitizer throughout meal. Nurse wiped resident's mouth with clothing protector after administering medications and proceeded back to medication cart to preparing other residents' medications without washing/sanitizing hands. D
- Facility failed to ensure staff followed infection control practices. During pressure ulcer treatment observation, a tube of medi-honey was on bedside table with no barrier. Nurse changed gloves between dirty dressing to cleaning wound but did not sanitize hands prior to putting on the clean gloves. D

F883 – Influenza and Pneumococcal Immunizations

- Influenza and Pneumococcal based residents were not offered the pneumococcal immunizations and no policy was in place and lack of documentation that the vaccine was offered. D

F921 – Safe/Functional/Sanitary/Comfortable Environment

- Sit-to-stand contained buildup of dirt, grime and food debris. Toilets revealed stained bowls, soiled floor and walls and floors had water damage. E

C136

- Failure to report two falls to DIA as required. **$500 FINE IN SUSPENSION**

L1093

- Failure to submit resident admissions to VA.
- Fail to submit resident admissions reviewed to Iowa Department of Veterans Affairs.

Nursing Facility Survey Frequency

November 19, 2019: CMS lists 45 Iowa facilities (10.3%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 8.1%. National average is 5.8%.

Provider	City	Survey End Date	Previous Date	Months Between
Calvin Community	Des Moines	10/17/2019	6/7/2018	16.57
Clarksville Skilled N&R	Clarksville	10/24/2019	8/9/2018	14.70
Glen Haven Home	Glenwood	9/19/2019	3/13/2019	6.33
Good Sam - Forest City	Forest City	10/10/2019	7/26/2018	14.70
Great River CC	McGregor	10/17/2019	7/19/2018	15.17
Greene Co Medical	Jefferson	10/1/2019	7/3/2018	15.17
Henry County HC	Mt Pleasant	10/17/2019	8/2/2018	14.70
Heritage Care & Rehabilitation Center	Mason City	9/26/2019	6/28/2018	15.17
Iowa City Rehab & Health Care	Iowa City	10/10/2019	7/26/2019	2.53
Longview Home	Lenox	9/26/2019	7/12/2018	14.70
Methodist Manor	Storm Lake	10/17/2019	7/19/2018	15.17
Monroe Care Center	Albia	10/17/2019	7/26/2018	14.93
New London Specialty	New London	9/26/2019	7/12/2018	14.70
Newaldaya Lifescapes	Cedar Falls	10/3/2019	6/28/2019	3.23
Oakwood Specialty	Albia	10/24/2019	8/2/2019	2.77
Odebolt Specialty	Odebolt	10/17/2019	7/26/2018	14.93
Oelwein HCC	Oelwein	10/24/2019	8/2/2018	14.93
Ossian Senior Hospice	Ossian	10/10/2019	7/12/2018	15.17
Ridgecrest Village	Davenport	10/3/2019	8/2/2018	14.23
Risen Son Christian Village	Council Bluffs	8/22/2019	5/2/2018	15.90
Rowley Memorial	Perry	10/15/2019	7/5/2018	15.57
Savannah Heights	Mt Pleasant	10/3/2019	7/19/2018	14.70
Sibley Specialty Care	Sibley	10/10/2019	7/12/2018	15.17
Solon Nursing Care Center	Solon	10/3/2019	7/12/2018	14.93
The Village	Indianola	10/3/2019	8/2/2018	14.23
Timely Mission	Buffalo Center	10/24/2019	8/2/2018	14.93
Touchstone Healthcare Community	Sioux City	9/19/2019	3/21/2019	6.07
Twilight Acres	Wall Lake	10/24/2019	8/9/2018	14.70
Westview of Indianola	Indianola	10/10/2019	7/19/2018	14.93
Windmill Manor	Coralville	10/3/2019	7/19/2018	14.70
			AVERAGE	**14.30**