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

Compliance Tips from IHCA's Survey Results Committee
November 2020

Total Number of Survey Reports: 28

Survey Composition:

Annual:	1 Surveys	0 Deficiency Free
Complaints:	13 Surveys	3 Unsubstantiated
Self-Reports:	4 Surveys	1 Unsubstantiated
Mandatory Reports:	1 Surveys	1 Unsubstantiated
COVID-19 Infection Control Survey:	10 Surveys	1 Deficiency Free

State Fines: $0
State Fines in suspension: $ 43,000

Most Commonly Cited Iowa Tags:

F 880 – Infection Prevention and Control (6)

F 689 – Free from Accidents and Hazards (6)

F677 – ADL Care Provided for Dependent Residents (4)

F658 – Services Provided Meet Professional Standards (3)

F 656 – Develop/Implement Plan of Care (3)

Tags Resulting in Actual Harm or Higher Citations and Fines:

F 686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers	**1 G Level Tag**
F 689 – Free from Accidents and Hazards	**3 J Level Tags**
F 690 – Bowel/Bladder/Incontinence, Catheter, UTI	**1 G Level Tag**
F692 – Nutrition/Hydration Status Maintenance	**1 G Level Tag**
F760 – Residents are Free of Significant Med Errors	**1 J Level Tag**
F 880 – Infection Prevention and Control	**2 K Level Tags**

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=15457		Total Number of Surveys=84604
F0880	Infection Prevention & Control	7,625	33.8%	9.0%
F0884	Reporting - National Health Safety Network	3,107	9.7%	3.7%
F0689	Free of Accident Hazards/Supervision/Devices	2,165	11.5%	2.6%
F0684	Quality of Care	1,589	8.4%	1.9%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	1,440	8.6%	1.7%
F0656	Develop/Implement Comprehensive Care Plan	1,313	7.5%	1.6%
F0609	Reporting of Alleged Violations	1,023	5.6%	1.2%
F0761	Label/Store Drugs and Biologicals	995	6.0%	1.2%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	965	5.3%	1.1%
F0677	ADL Care Provided for Dependent Residents	877	4.7%	1.0%

*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)

F553 – Right to Participate in Planning Care

- Facility failed to include three of three residents in care planning process. Residents were not aware of and not invited to attend care planning meeting. Facility did not do quarterly or annual care conferences. D

F559 – Choose/Be Notified of Room/Roommate Change

- Facility failed to notify and document a room change for a resident. Facility did not have a policy for room and roommate changes. D

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

- Facility failed to notify the Physician when residents underwent a significant change in status for 2 of 3 residents Reviewed. D $20,500
- Failed to consult resident's physician and family about a fall. Staff stated that it was after 9pm and not an emergency so they didn't call. No communication was left to contact family next day. D

F583 – Personal Privacy/Confidentiality of Records

- Facility failed to protect the right to confidentially and privacy for 1 of 19 residents. D

F584 – Safe/Clean/Comfortable/Homelike Environment

- Facility failed to maintain a safe, clean, comfortable, and homelike environment.- Center Hall Shower baseboard contained a buildup of a black/brown substance. The 2 vents contained a buildup of dust, dirt and debris. The electric fan positioned on the floor contained a buildup of dust, dirt and debris. E
- Resident had very dirty window with dead flies, fecal matter from birds, etc. and indicated would like a clean window to look out. The windowsills on interior window in dining room had spider webs and dead flies. D

- Failed to provide an environment free of insects. Ecolab had been there and stated that floor tiles and some baseboards needed fix to prevent breeding sites. Cockroaches and bugs flying across the room have been seen by residents and staff. E

F602 – Free from Misappropriation/Exploitation

- Facility failed to investigate two instances of alleged misappropriation of property- resident had two missing apple watches over the year and facility failed to identify either. No follow up documentation or investigation. D

F609 – Reporting of Alleged Violations

- Facility failed to immediately report to the Department of inspections and Appeals an elopement at the facility for 1 resident. D **$9,000**
- Allegation of abuse not reported timely. Staff threatened resident and did to report until 5 months later. D

F610 – Investigate/Prevent/Correct Alleged Violation

- Facility failed to verify they took appropriate corrective action related to alleged abuse and failed to protect and separate the alleged victim from the alleged perpetrator during an ongoing investigation. D

F641 – Accuracy of Assessments

- Staff failed to accurate complete resident assessments for two residents. In one case the BIMS score numbers on section c totaled 11 but MDS documented as 99. The same MDS failed to show documentation in section G relating to functional status of activities of daily living. Second resident lacked documentation of a BIMS score, section C relating to cognitive patterns and section D relating to Mood. D

F656 – Develop/Implement Plan of Care

- Facility failed to complete and update comprehensive care plans for 4 of 9 residents reviewed. E
- Failure to complete comprehensive care plans - no mention of coagulation therapy on MDS. D
- Interventions not identified for resident on anti-anxiety medications needing non pharmacological interventions first, hospice services for comfort care and presence of a cast look for swelling in care plans. D

F658 – Services Provided Meet Professional Standards

- Facility failed to meet professional standards of care by not notifying a Nurse Manager of the inability to access the facilities Electronic Health Records resulting in medications and treatments both being administered without access to the resident Medication Administration Records Treatment for 41 or 47 residents. E
- Facility failed to send medication list to appointment at VA and did not send medication to appt with resident and resident missed medication. D

- Failed to ensure resident received medications as ordered. Resident received Mucinex instead of Nudexa. D

F677 – ADL Care Provided for Dependent Residents

- Facility failed to provide necessary services to maintain personal grooming and hygiene of 5 of 5 residents reviewed for bathing. D
- Facility failed to maintain oral/personal hygiene for resident- aide gave resident a comb but did not offer to provide personal hygiene or deodorant or oral care. D
- Failure to provide necessary services for good nutrition, grooming and hygiene. Tube of toothpaste dated 3 months old. During incontinent care they failed to cleanse both hips. Toothbrush never used on resident after multiple observations - it was still dry. Oral hygiene care not provided for resident with dentures. Oral hygiene items not labeled with resident name. Resident was to be turned from side to side and through observations resident was continually on back. Gloves not changed at appropriate times. Dentures not cleaned. Hair not brushed. E
- Failure to offer showers for three of seven residents. One resident received a shower three times in a month, two others had one shower in a month. Staff member helped toilet a resident and used dirty gloves to pull up residents' pants and put a blanket over resident once in chair. E

F684 – Quality of Care

- Failed to intervene during a change of condition. Resident had very dry tongue with raised brown patches. PCP faxed but no further actions taken. 5 days later resident very lethargic, labored breathing and course lung sounds. Resident went to ER and had dx of dehydration, hypernatremia and hypovolemia. D
- failed to complete neurological assessments after an unwitnessed fall. Subarachnoid hemorrhage found two months later. D

F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers

- Facility failed to provide consistent and adequate wound care to prevent the development and worsening of pressure sores and failed to provide sufficient wound assessments and documentation for 1 of 1 residents reviewed. G
- Failed to prevent a pressure ulcer from worsening. Treatments ordered and no measurements done for 2 weeks. Care plan did not state that resident had an acutal pressure area and interventions. D

F688 – Increase/Prevent Decrease in ROM/Mobility

- Facility failed to provide restorative care for resident. D

F689 – Free from Accidents and Hazards

- Facility failed to ensure each resident received adequate supervision to prevent elopement for 2 residents who exited the facility unsupervised, which resulted in an immediate jeopardy to residents health and safety. The facility failed to follow the plan of care for a resident which sustained a fall with a fracture while in a EZ lift. J

- Facility failed to provide adequate supervision to high risk/cognitively impaired resident which resulted In elopement. At time wander device alarm was unplugged and backup door alarm silenced. Resident followed group after a holiday party (12/28/19) out the door and another resident told nurse aide he saw a resident in the front circle going toward the street. Resident wearing t shirt and long pants. No injuries noted on assessment. J **$6,750**
- Failure to provide adequate nursing supervision to prevent hazards. Door to COVID hall was not locked and not alarmed. Resident was found outside. Key was hanging on a door hook instead of behind the nurses station. Resident was a high elopement risk. D
- Failed to provide adequate supervision of residents. Care plan did not identify updated interventions for a resident that was physically aggressive. Same resident that there was a self report on continued to have self reports due to staff not watching the resident. D
- Resident had a fall while being transferred with a Lumex lift. Staff failed to follow the care plan and manufacturer's instructions when using the lift. CNA failed to apply a gait belt to the resident prior to the transfer, failed to lock the wheels of the lift, and did not have a second staff member present to assist with the transfer. The transfer was recorded on an in room video surveillance camera. D
- Resident exited the facility without staff knowledge because wander device door alarm unit was unplugged and the back up door alarm had been silenced due to a recent family gathering in the facility to allow people to exit without sounding the alarm. J **$6,760**

F690 – Bowel/Bladder/Incontinence, Catheter, UTI

- Facility failed to provide the required nursing services for urinary catheter care to prevent complications for 4 of 4 residents reviewed for catheter cares. The facility failed to obtain catheter orders for routine catheter care, failed to assess and intervene when abnormal signs/symptoms of urinary function presented, and failed to properly insert a catheter which caused a torn urethra that required surgical repair. G

F692 – Nutrition/Hydration Status Maintenance

- Facility failed to provide sufficient fluids to 4 of 6 residents reviewed. D
- Facility failed to address significant weight loss for a resident - resident lost 10.7 pounds over a week. Did not receive supplements and had appetite pattern of 50-75%. D

F730 – Nurse Aide Perform Review- 12 Hr/Year In-Service

- Facility failed to do yearly performance evaluation for 4 of 4 sampled staff. D

F755 – Pharmacy Svcs/Procedures/Pharmacist/Records

- Facility failed to ensure medication carts and treatment cart were secured and locked while unattended in resident care areas. D

F758 – Free from Unnec Psychotorpic Meds/ PRN Use

- Failure to document 3 non-pharmacological interventions prior to giving a resident anti-anxiety medications. D

F812 – Food Procurement, Storage, Preparation, Sanitization

- Facility failed to store food correctly- opened undated bottles of coffee, syrup ice cream sauce and sugar among others. Uncovered rolls. Walk in fridge had an odor and pantry had opened undated items. Dirty dishes on cart outside kitchen, various other undated items. Staff used bare hands to insert bacon into bag in microwave and insert toast in toaster. D

F842 – Resident Records- Identifiable Information

- Facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for 6 of 9 residents reviewed. E
- Failed to document residents clinical record- notes did not show resident was out of facility for appointment or time he left and returned. D
- Failure to document an incident in the resident's medical record. There was a resident to resident situation that was not documented. D

F880 – Infection Prevention and Control

- Facility failed to implement a comprehensive infection control program to mitigate the risk of spread of infection during a covid-19 outbreak. Failed to isolate residents for a minimum of 10 days. K
- Facility failed to implement effective infection control measures in attempts to mitigate the transmission of Covid-19 virus amongst their residents and failed to follow physician's orders to place 1 Covid-19 symptomatic residents into droplet isolation and failed to follow policy and procedures for screening of employees prior to their shift and at the end of their shift. F
- Facility failed to screen employees consistently before reporting for work (more than 66 times) as designated screener not present. Facility had process for staff to call up to get screened if no one present to screen. Failed to properly screen visitors. Failed to change dressings properly- placed items on stand with no barrier, used hands to get ointment on instead of tongue blades and applicators, failed to wash hands between cleansing wound and applying treatment. E
- Facility let staff take own temperature and was allowed to work with COVID symptoms (multiple staff had loss of taste smell and multiple other symptoms but continued to work). Multiple staff tested positive and one resident passed away. Some staff not taking temperatures. Staff cleaning residents face without shield or goggles. Multiple Staff wearing mask below nose or chin, goggles on head. K

- Failure to follow infection control procedures. Glucometer placed on bedside table without a barrier then placed in the med cart without cleaning it. Wipes placed on bed without barrier then used on resident then did not change gloves and did not wipe from front to back. D
- Report by family using in room video surveillance camera that at least 3 CNA's entered room to provide care to resident who were improperly wearing masks that did not fully cover faces and noses of the employees. E

F885 – Infection Prevention and Control

- Facility failed to inform all residents, their representatives, and families by 5 PM the next calendar day following the occurrence of a single confirmed covid-19 infection. Confirmation of a positive Covid-19 test for resident #3 was reported to the facility 8/7/20. E
- Facility did not notify the responsible party of a positive COVID patient by 5 pm the next calendar day. D

Nursing Facility Survey Frequency

As of November 18, 2020: CMS lists 178 Iowa facilities (41.3%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 37.5%. National average is 45.9%.

FFY 2020- November Totals - LTC Surveys				
Provider	**City**	**Survey End Date**	**Previous Date**	**Months Between**
Wilton Retirement Community	Wilton	9/24/2020	3/26/2019	18.27