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

Compliance Tips from IHCA's Survey Results Committee
October 2019

Total Number of Survey Reports: 103

Survey Composition:

Annual:	**68** Surveys	**8** Deficiency Free
Complaints:	**25** Surveys	**0** Unsubstantiated
Self-Reports:	**4** Surveys	**0** Unsubstantiated
Mandatory Reports:	**0** Surveys	

State Fines: **$8,000**
State Fines in suspension: **$61,000**

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

F 880 – Infection Prevention and Control (28)

F 812 – Food Procurement, Storage, Preparation, Sanitization (24)

F 689 – Free from Accidents and Hazards (22)

F 657 – Care Plan Timing & Revision (20)

F 658 – Services Provided Meet Professional Standards (18)

F 625 – Notice of Bed Hold Policy Before/Upon Transfer (16)

F 758 – Free from Unnecessary Psychotropic Meds/PRN Use (14)

F 644 – Coordination of PASRR and Assessments (14)

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

F 678 – Cardio-Pulmonary Resuscitation (CPR) **2 J Level Tags**

F 684 – Quality of Care **1 G Level Tag, 1 J Level Tag**

F 688 – Increase/Prevent Decrease in ROM/Mobility **1 G Level Tag**

F 689 – Free from Accidents and Hazards **4 G Level Tags, 1 J Level Tag**

F 692 – Nutrition/Hydration Status Maintenance **1 G 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=15595		Total Number of Surveys=51061
F0880	Infection Prevention & Control	4,745	27.8%	9.3%
F0689	Free of Accident Hazards/Supervision/Devices	4,466	22.9%	8.7%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	3,946	23.9%	7.7%
F0656	Develop/Implement Comprehensive Care Plan	3,545	20.3%	6.9%
F0684	Quality of Care	3,276	17.3%	6.4%
F0761	Label/Store Drugs and Biologicals	2,768	16.8%	5.4%
F0657	Care Plan Timing and Revision	2,244	13.2%	4.4%
F0677	ADL Care Provided for Dependent Residents	2,050	11.0%	4.0%
F0758	Free from Unnec Psychotropic Meds/PRN Use	2,024	12.4%	4.0%
F0550	Resident Rights/Exercise of Rights	1,944	11.3%	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

- Staff didn't respect dignity of resident who did not want to be transferred into a van to go to dialysis. Resident was dragging her foot on the ground while being wheeled by staff into the van. Staff was heard telling the resident he/she had to go to dialysis or resident would die. D
- Staff failed to ask all residents served a meal if they would like to use a clothing protector during lunch prior to placing a clothing protector on each resident. B
- CNA was reported by another staff member who witnessed verbal abuse toward a severely cognitively impaired resident with Alzheimer's disease. Another staff witnessed the same interaction and saw the CNA throw a coat at the resident. D
- Facility failed to provide catheter drainage bag covers to ensure dignity. D
- Fail to assure residents were treated with dignity; Failed to close door during incontinence cares. D
- Facility failed to consider resident preferences regarding medication administration. Resident reported not receiving bedtime medications until after midnight. Receiving AM meds after breakfast with order to give them at 0600 on empty stomach. D

- Facility failed to treat residents with dignity and respect. Blue disposable incontinent pads noted on wheelchair cushions during meals. D

F561 – Self Determination
- Facility did not adequately communicate resident's desire to have whole meats rather than ground meat ordered by his physician so discussion could be had about risks. D.

F565 – Resident/Family Group and Response
- Resident council reported cold food when it should be hot. Facility failed to follow-up on residents' concerns regarding food. E

F577 – Right to Survey Results/Advocate Agency Info
- Facility failed to have past survey results posted. B

F578 – Request/Refuse/Discontinue Treatment; Formulate Advance Directive
- Resident changed code status and the change was not reflected in the chart. D
- Failed to accurately communicate advanced directive choices to resident. D
- Failed to ensure advanced directives for health care were consistently documented. Lack of care plan update regarding Advance Directive for DNR status. D

F580 – Notify of Changes (Injury/Decline/Room, Etc.)
- Failed to notify physician of significant weight loss. D
- Fail to notify physician of a resident's decline. Resident had elevated temperature. D
- Facility failed to report a change in condition or incident to the family and/or physician. Resident choked on food during meal, no documentation of family / physician notification. Lack of documentation of family/physician notification regarding significant weight loss. D

F582 – Medicaid/Medicare Coverage/Liability Notice
- Failure to adequately inform residents of right to appeal the decision or discontinuation of skilled services for multiple residents. B
- Facility failed to adequately inform residents of their appeal rights following discharge from skilled services. Form 10055 did not have an option selected on sheet to whether resident wanted to continue or discontinue services for PT/OT/ST. For another resident the top portion of form 10055 did not include reason services were discontinued and referenced "rehab" verses the specific type of therapy. D
- Facility failed to ensure required documentation was completed for the ABN notices. Lacked documentation of the family's choice of options related to the ABN notice. B

F583 – Personal Privacy/Confidentiality of Records
- Facility failed to assure privacy during care. Leaving resident exposed during cares, while waiting for more supplies. D
- Failed to ensure portion of medical records remained secure in location not accessible to unauthorized people. Hard charts at nurse stations in cupboard not secured. C

F584 – Safe/Clean/Comfortable/Homelike Environment

- Broken, separated, protruded baseboard. D
- Sticky wash basins and emesis basins found in several resident rooms. C
- Room had visible black debris on the floors, air conditioning units contained black mold on and around the vents. E
- Wallpaper peeling in hallway; existing wallpaper had black substance. D

F585 – Grievances

- Facility failed to post grievance procedure. B
- Failed to inform staff staff/residents of grievance policy; how to file a grievance; Failed to follow complaint procedure posted in main area regarding forms to use in filling out. B
- Facility failed to respond to grievances in a timely manner. Lack of prompt response from Resident Council concerns related to call light response times. D

F600 – Free from Abuse and Neglect

- Staff member lost their temper with a dementia resident, struck resident in the face with their glasses. The staff member then reported own behavior to charge nurse. D

F604 – Right to be Free from Physical Restraints

- Resident with a seatbelt and no assessment for its use. D

F606 – Not Employ/Engage Staff with Adverse Actions

- Facility did not complete a pre-employment criminal, child abuse and dependent adult abuse background checks on a new employee in housekeeping. **D $500 FINE**

F607 – Develop/Implement Abuse/Neglect, etc. Policies

- Failure to have staff complete DAA training in 6 months of hire. D
- Facility failed to have staff complete the 2-hour Mandatory Reporter Certification for Child and Dependent Adult. D

F608 – Reporting of Reasonable Suspicion of a Crime

- Facility failed to report an allegation of abuse to the DIA. Resident combative with staff, spit in staff's face. Staff reportedly threatened to slap resident if resident did it again. Staff denied. D

F609 – Reporting of Alleged Violations

- CCDI unit resident went in another resident's room and that resident hit him/her on the head. This was not reported. D

F610 – Investigate/Prevent/Correct Alleged Violation

- Did not thoroughly investigate a resident to resident altercation. D
- Failed to separate an alleged perpetrator form an alleged victim following an allegation of abuse. E
- Failed to identify a reported concern as an allegation of neglect and investigate per facility policy. Resident indicated he/she didn't feel well, was pale in color, struggled

speaking, threw up in basin at bedside. CNA didn't check on resident throughout this process, despite knowing condition. DON was made aware of the CNA's behavior by other staff but did not report it as an allegation of neglect. D

F622 – Transfer and Discharge Requirements

- Resident presented to the ER with complaints of anger/homicidal threats, with audio and visual hallucinations. Documented that hospital staff was informed by nursing home staff that resident would not be accepted back as he/she had been discharged on an emergent basis for behavioral issues. Administrator gave written notice that the facility had issued an emergency involuntary discharge because of behavior to protect the health, safety, and well-being of other residents and staff. D
- Failure to complete a transfer form for a resident who transferred to the hospital. B
- Facility failed to allow residents to return to the facility after an emergency transfer to hospital. One resident exhibited suicidal behaviors, but physician and family were not notified. There was no documentation by physician of the need for emergency transfer. Second resident was presented with an involuntary discharge when becoming combative during peri-care. Both residents were discharged in violation of facility admission agreement. D
- Facility failed to document the standardized assessment data form had been sent with the resident for a hospital transfer for same-day surgery. B
- Facility failed to document circumstances leading up to an emergency transfer of a resident to hospital and failed to document accurate, timely information pertaining to discharge of resident for hospitalization. ER transfer of resident, transfer sheet and EMR lacked documentation of circumstances leading up to the transfer. D

F623 – Notice Requirements Before Transfer/Discharge

- Facility failed to notify the Ombudsman of two residents transferred to the hospital. B
- Failure to notify LTC ombudsman of a transfer to the hospital for a resident. B
- Failed to notify Ombudsman of 2 residents who were transferred to the hospital. D
- Failed to notify the long-term care ombudsman of facility-initiated discharges B
- Failure to notify the LTC Ombudsman of a resident transfer to the hospital. B
- Failed to notify ombudsman of a resident transfer. B
- Facility failed to notify the Long Term Care Ombudsman of discharge/transfer to the hospital. No Ombudsman's notices were completed since January. D
- Failure to notify the Ombudsman of residents' transfers to the hospital. D
- Failed to notify the Long Term Care Ombudsman of resident transfer for hospitalization. D
- Facility failed to notify the Ombudsman of hospitalization. B
- Facility failed to notify the State Ombudsman of a resident's transfer to hospital. B

F625 – Notice of Bed Hold Policy Before/Upon Transfer

- Failed to notify resident/resident representative of bed hold policy, documentation of notification of resident or their representative regarding the bed hold policy was absent from resident's health record. B

- Resident clinical record lacked documentation to show notice of bed hold policy was provided. D
- Failed to provide bed hold notice to residents who were transferred to hospital. D
- Facility did not provide a bed hold policy upon resident transfer to hospital. D
- Failed to provide notification of bed hold policy for facility-initiated discharges. B
- Failure to provide multiple residents with bed hold policy notifications upon leaving the facility. B
- Lack of bed notice to multiple residents. B
- Failure to provide resident with bed hold upon transfer to hospital. B
- Facility failed to provide bed hold policy at the time of hospital transfer. B
- Facility failed to provide a bed hold notice to resident transferred to the hospital. B
- Facility failed to provide notice to the resident and/or representative of the facility's bed-hold policy prior to and upon transfer to the hospital. D
- Facility failed to notify a resident or his/her representative of the facility's bed hold policy, including reserve bed payment during hospitalization. D
- Facility failed to assure the resident or representative received information regarding the bed hold prior to transfer to the hospital. D
- Facility failed to provide notice to the resident or representative of the facility's bed hold policy prior to and upon transfer to the hospital. B
- Failed to provide a copy of bed hold policy at the time of transfer to the hospital. D
- The facility failed to offer bed hold when resident transferred to hospital. B

F636 – Comprehensive Assessments & Timing
- Anticoagulant not being taken but listed on MDS as taken daily. D
- Staff failed to accurately code the MDS for a resident who required oxygen. D
- Facility did not complete an annual MDS Comprehensive assessment on resident. D

F637 – Comprehensive Assmt After Significant Change
- Failed to complete a significant change assessment when resident had a decline in ADLs. D
- Facility failed to complete a Significant Change Assessment on a resident who had an improvement in ADL's. D
- Facility did not submit a significant change assessment after admission to hospice care for a resident. D

F638 – Quarterly Assessment At Least Every 3 Months
- Resident did not have quarterly MDS completed as required. D

F640 – Encoding/Transmitting Resident Assessment
- Failure to submit a discharge MDS in a timely manner per federal regulations. B

F641 – Accuracy of Assessments
- Improper MDS documentation regarding restorative nursing. D
- Failure to ensure an accurate MDS for resident. MDS lacked information- that resident currently received dialysis and used tobacco. D

- Facility failed to accurately document the use of an indwelling Foley catheter with a diagnosis to support the use for multiple residents with catheters. B
- Facility failed to document psychosocial conditions accurately on MDS assessment. Inaccurate coding on MDS related to Level II status - PASRR was a short stay approval no mention of Level II on PASRR. D

F644 – Coordination of PASRR and Assessments

- Facility failed to refer a resident to appropriate state-designated authority for a Level 1 PASRR evaluation and determination for status change review. Initial PASRR was approved for resident admission for up to 60 days (Convalescent Approval). Follow up PASRR was not completed after the stay was extended past 60 days. D
- Facility did not implement or incorporate into the care plan, recommendations from PASRR level 2's (psychiatrist visits). E
- Improper diagnoses on PASRRs. D
- Failure to refer resident with a negative Level I PASRR for Level II evaluation and determination. D
- Facility did not submit a new PASRR with new psychiatric diagnoses. D
- Staff did not submit a new Level I PASRR assessment when resident had new mental health diagnosis. D
- Facility did not submit a new Level 1 PASRR assessment with a new diagnosis of bipolar disorder. D
- Failed to notify ASCEND regarding a mental health status change for resident. D
- Facility failed to resubmit a PASRR for a resident with a significant change in mental status. Resident was started on Latuda and Lexapro in which previous PASRR listed on psychoactive medications. No new PASRR was submitted for change in status. D
- Facility failed to submit a new PASRR for a resident who was started on psychoactive medications for hallucinations, and anxiety disorder. Prior PASRR showed no mental illness and received no medications related to mental illness. D
- Failed to submit a Level II PASRR evaluation for resident with new mental health diagnosis. B
- Fail to refer resident to appropriate state-designated authority for Level 1 PASRR eval for a Level II review who was identified with newly evident mental disorder. Resident transported to a psychiatric hospital, returned with no new PASRR. D
- Failed to refer residents with negative Level I result for PASRR, who were later identified with newly evident or possible serious Mental Disorder, intellectual disability or other related condition to appropriate state designate authorities for Level II PASRR evaluation/determination. Record lacked documentation of referral for Level II with diagnosis of Schizoaffective disorder was added to residents' diagnosis list. D
- Failure to submit a PASRR when resident had a newly diagnosed mental disorder. D

F655 – Baseline Care Plan

- Failed to provide a summary of the baseline care plan to newly admitted residents. D
- Failed to create baseline care plan within 48 hrs. or involve resident and family. D
- Failed to provide resident or representative a summary of baseline care plan. D

- Facility failed to provide a written summary of the baseline care plan to the resident or residents representative for new admissions. D

F656 – Develop/Implement Plan of Care

- Facility failed to ensure that the care plan was being followed, care plan directed staff to use colored plates to help with independence in dining due to visual problems, observation reveal resident was served breakfast on white Styrofoam bowls and a white ceramic bowl. D
- Fall intervention not in Care Plan. D
- Failure to develop a comprehensive care plan for a resident. Care plan lacked detail that resident could smoke and have smoking supplies. D
- Failure to follow care plan. D
- OT daily treatment note stated educated staff to keep wheelchair unlocked at table to avoid patient pushing self away from table and tipping chair, risk for injury care plan did not have intervention to direct staff not to lock the brakes on wheelchair to prevent tipping, observations revealed staff pushed resident up to the table and locked brakes. D
- Failed to develop a care plan for new diagnosis. Care plan lacked documentation of aspiration pneumonia and difficulty swallowing. D
- Facility failed to develop and implement a care plan to address a resident's fall risk. Resident experienced a fall with a hip fracture. D
- Care plan lacked specific interventions and management for resident with ulcers and other skin conditions, and another resident with infectious skin condition. D
- Care plan lacked documentation of resident's cath or ostomy interventions to minimize risks. D
- Failure to provide a person-centered care plan for several residents reviewed for medication prescribed to treat edema, behaviors, or seizure activity and what to look for in effectiveness or adverse reactions/side effects. D
- Care plan lacked interventions regarding the use of anticoagulant therapy. D
- Care plan lacked interventions for inappropriate sexual behavior demonstrated by resident. D
- Failed to develop/implement a comprehensive person-centered care plan. Lack of documentation on care plan related to heel-lift boot and surgical boot. Care plan lacked a focus, goal or interventions for frequent incontinent of bowel and urine. No mention of wanderguard alarm device on care plan. E

F657 – Care Plan Timing & Revision

- Facility to review and revise the plan of care, IPOST documented a CPR, resident's room door revealed a green star beside the name, IPOST located in resident's hospice care notebook documented a DNR, care plan directed resident requested CPR. During observation resident had half side rails up on both sides of the bed, admission summary noted the resident did not use side rails and side rail use was not indicated, baseline care plan failed to identify a problem focus area or directive to address the use of half side rails by the resident. Resident's care plan and the CNA RIS did not match regarding resident ability to transfer self. D

- Facility failed to update the comprehensive care plan. No care plan update regarding oxygen and BIPAP usage. No documentation on care plan regarding Olanzapine administration and side effects. D
- Death of resident's spouse, pressure ulcer, weight loss not addressed on Care Plan. D
- Fluid restriction, foley catheter, weight loss, AAROM, and side rails not addressed on care plans. E
- Resident preference for use of gait belt to support legs/restorative program not on care plan. Care documentation of only one care conference in last year. E
- Facility did not provide advance notice of care plan meetings to resident. D
- Failure to update a care plan for resident. D
- No care plan revisions for a resident with repeated episodes of diarrhea and for 2 residents with repeated falls. E
- Care plan lacked interventions regarding monitoring of side effect of antidepressant. Another care plan did not accurately address the history of a resident with MRSA. D
- Care plans did not include need for hand bar assistive devices on bed for several residents. D
- Care plan lacked additional information regarding the resident's current wound. D
- Failure to revise a resident's care plan. Care plan didn't document specific adverse side effects to watch for. D
- Failure to update care plans. No documentation of alarm use. D
- Facility did not revise resident care plan which transfer abilities decreased and more assistance was required. D
- Failure to update care plan for resident who required supervision when smoking. D
- Facility failed to update and revise the comprehensive care plan related to inappropriate behaviors. D
- Failed to revise care plan for resident with pressure ulcer. D
- Facility failed to revise the comprehensive care plan to reflect history of constipation and use of laxative medications. MiraLAX not mentioned on care plan. D
- Facility failed to revise resident care plan to correctly reflect the needs of residents. Care plans lacked documentation regarding side rail usage, change in ADL assistance/transfer status. No update to care plan once G-tube was removed. E
- Facility failed to develop and revise a comprehensive care plan. No mention of bed mobility devices on care plan. Lack of documentation on care plan regarding dx of Bell's Palsy and effects on resident. D

F658 – Services Provided Meet Professional Standards

- CMA administered narcotics with no documented assessment or direction by nurse. DON stated that he/she expected nurse to complete assessment and direct CMA on dosage prior to administration of an as needed narcotic. Facility policy directed staff CMAs can administer narcotics per their scope of practice, further directed CMA must have approval of the charge nurse to give any narcotics and must co-sign if CMA administers the medication. D
- Physician order summary report instructed staff to obtain blood glucose test strip, one strip in vitro bid related to diabetes mellitus and to notify medical director if blood sugar is less than 60 or over 400. Review of MAR resident BS at bedtime was 483, at

breakfast 413, clinical record lacked any documentation that medical director was notified. The physician order summary report instructed staff to administer Carvedilol related to HTN and hold if systolic blood pressure less than 100 or heart rate less than 60, according to the MAR the resident's blood pressure and heart rate documentation failed to be done. D

- PICC line not care-planned, no orders for flushing but flushed by the nurse, the resident reported no cares to her PICC line for a week. D
- Facility failed to give medication that was delivered for five days. D
- Resident did not have geri-sleeves as care-planned and fluid restriction not listed in care plan. D
- Facility failed to clarify antibiotic orders and gave longer than necessary. D
- Failure to obtain a physician's ordered urinalysis for a discharged resident. D
- CNA applied a physician ordered barrier protectant to open areas on buttock rather than licensed nurse conducting the treatment. D
- Nursing staff did not check for tube placement or residual feeding prior to initiating next tube feeding. D
- Multiple residents were not provided with physician ordered medications due to lack of availability from pharmacy. E
- Nurse did not follow physician orders, did not apply the edemawear stockings, did not follow physician did not have prafo boots. Clonazepam was not administered per physician orders medication was not available. D
- Failure to document an order for oxygen in the MAR. D
- Resident with VRE in urine- Urine specimen collected monthly with MD order to evaluate if urine continued to have bacteria present, once clear, discontinue contact precautions. Monthly urine was collected, lab results showed collection contaminants present. New order obtained from MD to recollect urine specimen via straight cath, five-day delay before specimen was collected. Staff RN informed staff LPN there were collection contaminants present and another specimen needed to be collected. Staff LPN collected a 3rd urine specimen via straight cath. Did not have MD order for this procedure. Another resident had order for continuous enteral tube feedings. Enteral feeding pump failed to operate. Backup enteral feeding pump was used, and it also failed to operate. The nurses began to provide resident with bolus enteral feedings without MD order for approximately a week. MD noted this during a facility medical visit in the resident's progress notes but did not provide an order. Nursing staff texted the MD several days later for an order. E
- Nurses failed to clean top of an insulin pen prior to attaching the needle. Nurses failed to prime insulin pens prior to dialing up the dose to be administered. D
- Facility failed to assure each resident received physician ordered pain treatment. CNA applied biofreeze and no documentation on Medication Sheet of it being applied. Lack of assessment of pain by nurse. D
- Narco tabs ordered q6h prn pain were administered three times at 5-hour intervals; staff administered Jevity via pump at 295 cc per hour, when physician ordered rate was 95 cc per hour. D

- Facility failed to administer medications as ordered. Parkinson's medications not delivered as scheduled to manage Parkinson's. AM medications not delivered until after 9am (not according to med pass schedule). D
- Pharmacy failed to fill an inhaler order in a timely manner and resident did not have medication as ordered by physician for four days. D

F659 – Qualified Persons
- Failed to follow care plan interventions. Clip alarm in w/c not attached to the resident as per care plan. D

F660 – Discharge Planning Process
- Failed to develop an effective discharge plan for resident planning to go home. Lack of documentation by social worker regarding discharge planning. Care plan lacked goals for care and treatment needs the resident will need when goes home. D

F675 – Quality of Life
- Facility failed to include problems, goals, interventions on care plan. Care plan lacked directives to staff in relation to the use of antipsychotic medications and did not list possible side effects. D

F676 – Activities of Daily Living (ADLs)/Maintain Abilities
- Facility failed to complete restorative programs as written for multiple residents. E

F677 – ADL Care Provided for Dependent Residents
- Multiple residents with multiple days/weeks of facial hair growth that want to be shave and require staff assistance to perform the task. E
- Staff provided peri care from back to front rather than front to back. D
- Failure to provide adequate perineal care. Staff didn't follow outlined procedure for cleansing the perineum and buttocks. D
- Failure to provide incontinence care for resident that needs perineal care. Staff didn't clean frontal area of resident after toileting. D
- Failure to properly provide incontinence care. NONE
- Failed to aid with grooming for resident who was unable to carry out activities of daily living. Resident with growth on hair and black build up under fingernails. D
- Facility failed to assure appropriate incontinent care and failed to assure residents received baths as planned. Barrier applied without changing gloves or washing hands. Lack of documentation to support baths completed as planned. Failed to clean all areas exposed to incontinence brief. D
- Facility failed to provide bathing services twice a week for three residents who could not bathe independently. D
- Facility failed to provide proper incontinence care. Failed to cleanse all areas that came in contact with the wet brief. D
- Failed to provide bathing assistance at least weekly and/or per resident preference. Lack of documentation to support resident's refusal of bath or attempts encouraging to bath on several occasions for multiple residents. E

F678 – Cardio-Pulmonary Resuscitation (CPR)

- Failure to do CPR on a resident who expired after a cardiopulmonary arrest. Admission record identified resident as full code status; Staff indicated they didn't know the facility CPR policy. Also didn't know the residents' code status, so waited to initiate CPR until after staff called the DON, resident's physician, and other staff members. Twenty mins passed between finding resident without a pulse and administering CPR. Staff indicated when CPR was finally administered, the resident had already expired. Resident was transferred to the Emergency Department and declared dead. **J $10,000 FINE IN SUSPENSION**
- Resident had a change of condition, was showing signs of declining health status. The nurse was called to the resident's room by staff who noted the resident was pale/ashen in color and in an ineffective breathing pattern. Nurse left CNA/CMA at the bedside to check vitals while nurse called the MD for an order to transfer the resident to hospital. The nurse verified the resident's code status as FULL CODE. The nurse called 911. Paramedics arrived at facility within 6 minutes of call for transport to the ER. Nurse led Paramedics to resident's room. CMA exited the room, informed nurse the resident quit breathing while they were assessing vital signs. Nurse assessed the resident had no pulse, was not breathing. Paramedic informed after the event, the nurse had told them in the hallway, the resident had passed away and was a DO NOT RESUSCITATE, therefore, EMS did not initiated CPR either. The nurse pronounced the resident dead. **J $10,000 FINE IN SUSPENSION**

F679 – Activities Meet Interest/Needs of Each Resident

- Facility failed to provide adequate activities for residents. During survey it was noted no activities on locked unit except reading of the newspaper. Residents sitting at table with no activity going on. D
- Failed to provide and accurately document involvement of activities. Residents reported activities were not appropriate for cognitively impaired residents. D

F684 – Quality of Care

- Facility did not address positioning of resident whose head hung at 90 degrees. D
- Resident had decline in ADLs, restorative program was not initiated as planned by PT/OT. G
- Failure to provide adequate wound care assessment for resident with a skin tear. D
- Fail to follow physician's orders regarding application of compression socks for resident. D
- Facility failed to transcribe physician's order for TED hose onto treatment record and resident did not have TED hose in place as ordered. D
- Resident had multiple bruises to arms, hands, cheek and thigh and clinical record failed to reflect how these injuries occurred. In a previous fall, facility failed to follow its own neuro check policy post fall incident. D
- Failure to complete an ongoing assessment for resident when condition changed. Resident had injury of unknown origin and staff failed to report resident's pain. D

- Resident had a change of condition, showing signs of declining health significantly over period of 7 hours. Staff continued to update nurse on resident's status. Nurse documented one entry throughout change of condition until resident expired. D
- CMA was identified as providing care outside of the scope of practice including administering injectable medications, completing skilled nursing assessments, taking and transcribing physician's orders. E
- Facility failed to provide adequate assessment/timely intervention which resulted in immediate jeopardy to resident health and safety. Open lesion on ear from radiation treatment. Returned from Dr visit without a dressing or noted treatment orders, delay in verifying lack of orders or dressing, resident was later sent to hospital for evaluation of maggots in wound. **J $9,250 FINE IN SUSPENSION**
- Facility failed to ensure a resident received treatment and care in accordance with professional standards by not following physician orders related to bowel medication administration and Oxygen use or assess his response to the as needed Oxygen. D
- Failed to ensure resident received treatment/care in accordance with professional standards by not having current physician order that directed oxygen administration. CNA's turning O2 concentrators on and off and putting O2 level on incorrect liters. D
- Facility failed to provide ongoing assessment with appropriate interventions for a resident who presented with a low blood sugar reading prior to sending to the ER. D

F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers

- A resident with a pressure ulcer that had been in the facility greater than two months had not received a nutritional assessment to address the pressure ulcer. D
- Documentation was not completed to the surveyor's satisfaction on pressure ulcer. D
- Resident was at risk for developing pressure ulcers, care plan directed staff to implement a ROHO, ROHO was not in place and resident developed a wound. D
- Nurse failed to use barrier on which to place supplies during treatment of a pressure ulcer and did not wash hands and re-glove after removing dirty dressing. D
- Facility failed to initiate and carry out treatments to care for a pressure ulcer. Treatment not completed as ordered r/t Calmoseptine application. D

F688 – Increase/Prevent Decrease in ROM/Mobility

- Facility failed to complete restorative programs as written for multiple residents. E
- Facility failed to implement restorative program as recommended by PT/OT. D
- Failure to assure planned restorative programs were carried out for multiple residents. E
- Restorative nursing services were not provided as care planned. D
- Failure to document restorative program recommended by OT for upper and lower range of motion for a resident. NONE
- Fail to provide restorative exercises as planned. Record lacked documentation of providing exercises with a documented physical decline few months later. Resident reports "not very often" regarding when he receives exercises. **G $500 FINE IN SUSPENSION**

F689 – Free from Accidents and Hazards

- Staff failed to properly lower residents in a mechanical lift by using the emergency release button instead of lowering button of the lift. E
- Multiple exit doors did not alarm upon initial tour of building. E
- Resident was to be 1:1 and was not supervised and hit other residents with a vase causing injuries. D
- Care plan stated to use a stand lift and staff transferred by standing with assist of two. Resident lost balance being held up by staff members when the surveyor had to intervene and move bed in place. D
- Resident care planned for 2-person lift transfer told CNA she could stand with walker and assist of one. CNA did not confirm this information with care plan. When second CNA entered room with lift, resident was startled, started to fall backwards. CNA assisted resident to floor without injury. D
- Resident care-planned for assist of two for ambulation was being assisted from bathroom to bed by only one CNA. Resident suddenly fell backwards and sustained a wrist fracture which required surgical repair. G
- Staff did not utilize a gait belt. D
- Failure to provide safe transfers. Staff failed to hold into gait belt throughout perineal care. Resident held onto grab bar for assist. D
- Facility didn't adequately provide supervision for resident with history of falls. Resident fell in bathroom, was on floor and injured back/leg; wheelchair alarm was off. Staff reported alarm was accidentally disabled during toileting earlier that day. Alarm was always supposed to be on. Ambulance was called, resident transferred to ER**. G $3,750 FINE**
- Failed to use a gait belt for resident transfer. D
- Facility failed to ensure the environment remained free from hazards. Observations revealed bath door propped open with chair with unsecured shampoo, conditioner and box or razors. Noted x2 packs of cigarettes and a lighter on a resident's bedside table. E
- Facility failed to complete pre-dialysis and post-dialysis assessments for one resident receiving dialysis services. D
- Resident reported they had exited the building and found a cell phone. During staff interviews, a CNA stated door alarm had sounded, was responded to and staff looked out but did not see anyone and silenced the alarm. The resident was not identified as outside the building. D
- Resident's care plan not followed regarding staff to transfer resident from the w/c while in room unattended. Staff left resident in w/c with brakes applied, unattended. Resident fell, sustaining fractured femur requiring surgical repair of hip. **G $24,750 FINE IN SUSPENSION TREBLED**
- Facility failed to ensure resident received adequate supervision to protect against hazards in the environment. Therapy let go of gait belt to apply brakes while ambulating resident. Resident fell and stained a fracture. **G $3,750 FINE**
- Failed to ensure safe transfer assistance. Record lacked an assessment for safety for smoking. Care plan did not mention resident being a smoker. Walking resident without gait belt. D

- Resident with history of poor safety awareness and multiple episodes of leaving facility property without notice or supervision was allowed to sit outside to smoke unsupervised. Resident was noted to leave the property and self-propel in wheelchair to Casey's (0.4 miles from facility) without telling facility staff. Resident also knew door alarm code and could leave facility undetected. **J $6,000 FINE IN SUSPENSION**
- Facility failed to use a gait belt when transferring a resident. Facility staff was observed transporting residents in wheelchairs without the use of foot pedals. D
- Facility failed to implement planned interventions for fall prevention. Scoop mattress not in place as care planned. D
- Facility failed to keep medication carts locked when not in use and unattended by staff and failed to ensure an alarm was on a resident that had a history of falls. D
- Failed to transport residents safely in their wheelchair. Pushed residents without pedals in place. D
- Facility failed to ensure fall interventions were in place. Door left open on resident with fall history. Resident unable to state how to call for assistance. D

F690 – Bowel, Bladder Incontinence, Catheter Care

- Staff held catheter up in the air behind resident's back, observation noted resident's catheter bag in privacy bag hanging from garbage container, observed privacy bag sitting on floor with catheter tubing and clip to attached catheter laying on the floor. D
- Residents were observed with incomplete peri care provided, lack of toileting per care plan, use of two briefs at once; complaints from families about all above. D
- Fail to complete formal bladder assessment to attempt to decrease resident's incontinence. D
- Staff member providing cath care did not perform hand hygiene before gloving and emptying catheter bag. During procedure, tip of catheter bag drain touched unsterile urine collection graduate. Another staff member performed perineal care without using a clean wipe or side of cloth when changing skin areas to be cleansed. D
- Progress notes lacked assessment or resident's complaints related to a urinary tract infection or how the UA was obtained. D
- Failure to provide appropriate cath cares. Staff used same cloth to clean site of cath opening to clean tubing, failed to pull back foreskin or cleanse urethra opening. D
- When providing pericarp staff member spilled urine on floor soaking the paper barrier protecting graduate, failed to change gloves and wash hands appropriately, cleansed catheter tubing with alcohol wipes without changing gloves, allowed drainage tube to touch wet floor barrier. D
- Fail to follow facility protocol for antibiotic use for resident with indwelling catheter. D
- Staff failed to follow the resident's care plan for toileting needs before meals, after meals, at bedtime and as needed. D
- Failed to assess use of catheter. Lacked order for cath. No appropriate diagnosis for catheter. D
- Facility failed to complete appropriate incontinence care on a resident requiring staff assistance with incontinence care. Washed backside of perineal area prior to completing the front and did not change gloves. D

F692 – Nutrition/Hydration Status Maintenance

- Resident with greater than 7.5% weight loss in 90 days and no nutritional assessment or interventions documented. D
- Failed to ensure a resident who demonstrated need for dining assistance received assistance to eat; failed to provided/document administration of a nutritional intervention who experienced a significant weight loss of 18.22% in 6-months. (hospice resident). Lack of documentation of order to give magic cup and administration of magic cup. Tray was delivered in room to this resident, left on table with no assistance offered. Daughter reported resident needs assist and staff do not offer her enough assist. **G $500 FINE IN SUSPENSION**

F693 – *Tube Feeding Management/Restore Eating Skills

- Facility failed to check gastrostomy tube placement prior to use or check for residual or correct placement prior to use, physician order directed staff to check for residual prior to medication administration. D
- Nursing staff did not check for tube placement or residual feeding prior to initiating next tube feeding. D

F695 – *Respiratory/Tracheostomy care and Suctioning

- Failure to change oxygen tubing weekly as per treatment sheet. B
- Resident had orders for oxygen at 3 liters; Surveyor observed concentrator control set at 3.5 liters. D
- Multiple residents' oxygen tubing and nasal cannulas were not covered, labeled and dated to assure clean, non-contaminated respiratory equipment. Facility did not follow their policy requiring signage for oxygen use. Noted signage does not present on multiple resident room doors indicating oxygen usage. E

F697 – *Pain Management

- MAR revealed ten times in June, eight times in July, resident's pain rated 5 or higher and the staff failed to administer a PRN pain medication, care plan staff are to notify doctor if pain medication is ineffective, observe for any reports/indication of pain. D

F698 – Dialysis

- Care plan lacked dialysis plan for resident that included when resident went to dialysis or when to provide treatment. D
- Facility failed to conduct pre and post dialysis assessments for a resident. D
- No pre and post dialysis assessment. D
- Failure to consistently complete a nursing assessment, monitor residents after they returned from outpatient dialysis for multiple residents receiving dialysis services. E
- Failure to ensure ongoing assessment of residents undergoing dialysis. D
- Facility failed to complete assessments before and after dialysis. Lack of assessments re: pre and post assessments. D

F700 – Bedrails

- Facility failed to complete assessments to determine continued usage of side rails or consents to use side rails, resident's chart lacked documentation of side rail assessment,

care plan lacked documentation of side rails, another resident lacked assessment and consent for side rail usage. D
- Facility failed to assess for proper side rail usage. D
- Fail to assess need for bedrails, obtain informed consent for use for multiple residents. D
- Failed to explain risks/benefits of use of side rails. No side rails consents obtained. D
- Resident using side rails on bed did not have signed informed consent in medical record. D
- Facility failed to assure residents were assessed for risk of entrapment from bed rails, risks/benefits of bed rails were reviewed, and consents obtained. Lack of side rail assessments and consents for side rails. D
- Facility failed to assess bed rails and/or obtain consent for use. E

F712 – Physician Visits-Frequency/Timeliness/Alternate NPPs
- Fail to assure residents were seen by a physician at least every 30-days for the first 90-days after admission and at least every 60-days thereafter. E

F725 – Sufficient Nurse Staffing
- Multiple residents with call lights greater than 15 minutes per resident report, staff report, and call light log. E
- Residents were told they could not be bathed due to staff shortages. D
- Staff failed to answer call lights in a reasonable time for multiple residents. E
- Facility failed to respond to call lights in a timely manner (within 15 minutes). D
- Facility failed to ensure call lights and needs were met in a timely manner. D
- Facility failed to provide sufficient number of nursing personnel to meet the needs of each resident in a timely manner for dining assistance, bathing assistance and timely response to call lights. E
- Facility failed to respond to call lights in a timely manner. E

F729 – Nurse Aide Registry Verification, Retraining
- Fail to check CNA registry status of CNAs before assigning to resident care tasks. D
- Fail to document registration verification for CNAs prior to employment for multiple staff. D

F730 – Nurse Aide Perform Review – 12 Hours /Year In-service
- Facility failed to ensure that all CNAs completed 12 hours of in-service training every 12 months. B
- A CNA only received 30 minutes of in-service training in the previous 14 months. D
- Failed to document required 12-monthly in-services completed for multiple CNAs. C

F732 – Posted Nurse Staffing Information
- Failure to ensure staff information was updated daily and placed in a prominent place for residents; Should also have stated staff and shifts. C
- Facility failed to post accurate nurse staffing data in a prominent location visible to residents/visitors as well as retain posting information for 18 months. Lack of posting

information for multiple days, incomplete info on census line. Staff unable to provide previous postings requested. C

F755 – Pharmacy Svcs /Procedures/Pharmacist/Records

- Discharge records of residents did not provide documentation of disposition of all medications. D
- Facility failed to provide pharmaceutical services to meet residents' needs. Failed to supply chewable aspirin, calcium carbonate as ordered. Medications had not yet been delivered by the pharmacy. D

F756 – Drug Regimen Review, Report Irregular, Act On

- Failed to complete drug regimen review, during record review documentation revealed physician has not responded to the pharmacy irregularity report recommendation. D
- Facility failed to assure that residents are free from unnecessary medications. Lack of physician rationale for declining GDR for Fluoxetine. D

F757 – Drug Regimen- Free from Unnecessary Drugs

- Facility failed to offer alternative interventions prior to administration of as needed anti-anxiety medications. Lack of documentation of attempted non-pharmacological interventions prior to administering antianxiety. D

F758 – Free from Unnecessary Psychotropic Meds/PRN Use

- Facility failed to ensure a GDR was attempted; clinical record failed to reveal physician or primary care provider response to suggested decrease in dosage. PRN Ativan was ordered for more than 14 days. D
- Fail to complete GDR review for the psychotropic medication, chart lacked documentation regarding a GDR review for Cymbalta, according to pharmacist- due to medication being used to treat fibromyalgia, medicine did not require GDR. D
- Physician failed to provide proper clinical rationale for denial of GDR for resident. D
- Resident on an antidepressant with no diagnosis of depression. D
- Staff failed to document non-pharm issues prior to administering prn anti-anxiety. D
- Failure to have physician evaluate a 14-day prn order for use of a psychotropic drug; Failed to complete GDR's or rationales for one resident on psychotropic med. D
- Failure to attempt a gradual dose reduction for a resident on Citalopram. D
- Failed to complete GDR for resident on olanzapine. D
- Failure to prevent use of unnecessary meds. One resident prescribed Nuedexta for excessive crying and laughing. Resident had no diagnosis or documented behaviors to indicate it was necessary. D
- Fail to ensure Lorazepam re-assessed, include rationale to continue medication. D
- Facility failed to ensure the MD completed GDR for a psychotropic medication. D
- Facility failed to ensure orders for PRN psychotropic drugs were limited to 14 days unless physician documented a rationale for continuing and a duration for use. Lack of documentation of rationale for continuing the use of PRN Ativan. D
- Facility failed to ensure dosage reduction attempted. Lack of physician rationale to not reduce as per pharmacist's request. D

F759 – Free of Medication Error Rates of 5% or More

- Failed to ensure medication error rate was not greater than 5 percent, observation of administration of 32 medications identified two medication errors, administered Colace instead of peri-Colace and wrong dose of albuterol. D
- Nurse administered wrong dose of stool softener, did not have resident rinse their mouth after inhaler. D

F760 – Residents Are Free of Significant Med Errors

- Staff made multiple medication dosage errors for resident taking Coumadin. D
- Resident received wrong Gabapentin dose prior to being sent to ER for concern related to foot pain. While at the ER, resident's BP dropped to 85/55. Facility failed to document the error in resident's clinical record, did not report incident to ER at time of transfer. D

F761 – Label/Store Drugs & Biologicals

- Facility failed to adequately supervise, administer, handle, label and store narcotic and non-narcotic medications. D
- Inadequate temps for medication refrigerator. Temps ranged 50-51 degrees. D
- Expired emergency drug kit, no refrigerator temp log in med room, improper temp for storage of Pneumococcal vaccine, lack of blood glucose monitor quality checks. E
- Expired E-kit medications. D
- Two medication carts contained open bottles of Valproate Sodium Solution without a documented open date. D
- Failure to endure outdated medications were not available to use in medication storage room. D
- Staff left medication in med cup on unlocked medication cart unsupervised. E
- Facility failed to ensure they did not administer outdated/expired insulin. D
- Failed to store schedule II-Iv medications in a separately locked, permanently affixed compartment, inaccessible to unauthorized staff. Scheduled Tramadol was not kept in a separately locked compartment within medication cart and was not counted at end of each shift. D

F801 – Qualified Dietary Staff

- Facility failed to employ a qualified person to serve as a director of food and nutrition services in the absence of a full-time dietician. C
- Facility failed to ensure the dietary manager had the required qualifications in the absence of a full-time dietician. D

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

- Improper scoop sizes used for pureed food. D
- Facility failed to follow the menu for several meals while surveyors were in the building by replacing various items with others in those meals. F
- Failure to provide full portions of food to multiple residents receiving pureed diets. D
- Failure to assure residents on ground/pureed diet received appropriate portions for multiple residents. E

- Failure to follow menu for residents receiving pureed diets. D
- Fail to serve appropriate portions of food items for pureed menus as directed by physician. Staff did not check conversion chart for proper scoop sizes. Staff reported they did not know how to use conversion char, does measurements in their head. E

F804 – Nutrive Value/Appear, Palatable/Prefer Temp
- Fail to serve/ prepare pureed food in palatable manner for multiple residents on pureed diets. D
- Failure to serve food at the proper temperature. E
- Residents reported food is too cold once served to those who are served last. E
- Facility failed to serve food at an appetizing temperature. Hot food temps were below 140 degrees. E

F805 – Food in Form to Meet Individual Needs
- Failure to follow menu for multiple residents on mechanical soft diets. D
- Facility failed to assure residents received therapeutic diets as ordered. Served potato with skins on for a resident on mechanical soft diet. D

F809 – Frequency of Meals/Snacks at Bedtime
- Breakfast served late at 0830 and greater than 14 hrs. occurred between meals. D
- Facility failed to start serving meals at posted time during three observations. E

F812 – Food Procurement, Storage, Preparation, Sanitization
- Failed to serve food in accordance with professional standards for service safety. Failed to change gloves. Touched food and other surfaces while plating foods with gloved hands. E
- Staff members observed with hair out of their hairnet in the kitchen. B
- Holding cups by the rim; Marred cutting board, dusty stove hood, improper touching of items with gloved hands. E
- Undated and expired food. Warm milk during meal service. F
- Wet and soiled pans stored on a rack. C
- Dusty kitchen fan, wet pans stored in rack, scratched Teflon. E
- Failure to maintain ice machine /water dispenser in a sanitary manner. Buildup of lime, rust on tube/spout of dispenser. E
- Dust, debris, molding on cabinets; brown stains, dirt on sink bottom. Black gunk in seals near beverage freezer. E
- Staff serving food dropped butter pat on floor, retrieved it and continued serving food without performing hand hygiene. Other staff members observed washing hands without using towel turn off water. E
- Ice machine had black mold-like material. D
- Cutting boards had deep grooves and fuzz, buildup of brown substance. Dietary staff had hair hanging out of hairnets. E
- Kitchen staff member contaminated food prep counter by dropping cloth on floor and picking it up and returning to food prep without washing hands. D

- Kitchen was unsanitary; dishwashing process was ineffective. Residents' personal refrigerators were not cleaned, temps not monitored; Dietary staff hair peeking out of hairnets. F
- Fridge has unlabeled food; stove top/food prep area had moderate amount of gray dust particles; fan over stove had dust particles. Fail to use proper glove techniques when serving food; Staff didn't check temperatures of milk before serving. E
- White splatter all over kitchen equipment- AccuTemp Steamer and Vulcan oven warmer. E
- Failure to maintain sanitary kitchen conditions. Black dirt stains and crumbs near base boards and cabinet by exits. Broken glass under stove in kitchen. Splatters running down fridge; Cleaning logs incomplete. E
- Refrigerator temperature was not maintained at below 41 degrees. E
- Facility failed to serve food at safe temperatures and failed to maintain dishwasher water temperatures at 120˚F or higher. F
- Facility failed to label/date opened foods and store them covered in the kitchen. Facility failed to date Mighty Shakes with the expiration date. E
- Failed to serve food under sanitary conditions for a meal. Staff used fingernail to hold potato in place while cutting. Some residents had eaten the potato skin. D
- Facility failed to ensure meat was at a safe temperature after grinding it for the mechanical soft diets. Ground meat tested at 148 degrees. D
- Fail to have santizable cutting boards and upright freezer in need of defrosting. E
- Facility failed to store, prepare, distribute and serve food in accordance with professional standards in food service safely. Boxed food items on floor in storage room, open container of undated frozen food in double freezer. E
- Facility failed to store and prepare food under sanitary conditions. Food particles and residue noted on stove front panels and microwave. E

F825 – Provide/Obtain Specialized Rehab Services

- Failed to start restorative nursing program after discharge from physical therapy services as recommended by PT. D

F842 – Resident Records - Identifiable Information

- Facility failed to document resident complaints about eye drops causing discomfort. Resident felt she was given the wrong eye drops. D
- Facility failed to document the circumstances surrounding the death of a resident, release of the body and disposition status of medications/belongings. D
- Facility failed to document a medication error in a resident's medical record nor was it documented on an incident report. D

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

- QAPI-failure to identify and evaluate services provided for residents. Administrator was unsure what QAPI meant went surveyor asked. D

F868 – QAA Committee

- Failure to have the Director of Nursing, Physician and three other staff members in attendance at the QA meeting at least quarterly. D

F880 – Infection Prevention and Control

- The laundry cart was left uncovered in the hallway. D
- Failure to change oxygen tubing weekly as per treatment sheet. D
- Nurse did not wash hands between glove change, used gloved hand to wipe cream dispenser, and picked up ace wrap off the floor used it on the resident. D
- Improper glove changing, improper handwashing, open linen carts in hallway. E
- Improper gloving and handwashing during incontinent cares. D
- Failure to ensure staff changed gloves between cares, wash hands to prevent infection spreading. Staff assembled equipment on surface that wasn't clean or wash hands. D
- Infection control; Staff failed to change gloves and wash hands appropriately between care and while touching equipment. D
- Laundry staff passed clean clothing without a cover in place over clean items; same staff member dropped socks on floor and picked them up and took them to the resident's room; nurse performing wound care changed gloves during procedure and did not wash hands prior to redonning gloves. E
- Facility's infection control surveillance system failed to include data collection tool and use of nationally recognized surveillance criteria to track/analyze facility infections. D
- Failure to use infection control techniques during catheter care for a resident. No barrier underneath the cath bag. D
- Failure to maintain standard precautions while administering meds vis gastrostomy tube. D
- Nursing staff failed to appropriately sanitize a glucometer and wash hands/use glove appropriately. D
- Failure to properly handle cath during cares. Used same gloves to handle multiple items/equipment. D
- Staff failed to wear gloves while performing incontinence cares; failed to follow infection control measures for residents with urinary cath; Failed to launder clothing properly. E
- Soiled clothing/laundry found at bottom of stairwell; Housekeeper didn't perform hand hygiene while doing laundry; no goggle or face shield for laundry workers. D
- Staff didn't change soiled bed linens in timely manner. D
- Failure to follow appropriate G-tube practices. Syringe not changed daily, dated or stored on a clean surface. D
- Facility staff did not properly label, date and cover oxygen tubing when not in use. D
- Observation of residents with indwelling foley catheters found catheter tubing, drainage bags and dignity bags were noted to touch the floor. D
- Failed to maintain adequate infection control measures. Staff emptied the catheter bag into graduate and without changing the gloves staff cleansed resident’s suprapubic catheter. Staff then dumped the graduate in toilet and a brown spot was noted on seat of toilet. Staff did not sanitize toilet. Toenails clipped by podiatrist in living room with

other residents present. Toenail clippings had been left on the floor for five hours while observed by surveyor. D

- Facility failed to complete appropriate hand hygiene while providing cares. Resident completed perineal care on front side of resident without completing hand hygiene or removing gloves, staff comforted resident with hand by rubbing the residents face and arms. D
- Facility failed to assure appropriate infection control practices. Changed residents soiled clothing, changed gloves but did not wash hands. Removed gloves when completed, did not wash hands prior to applying barrier cream. Wound treatment, nurse did not complete hand hygiene after removing gloves on pressure ulcer. While wrapping site with gauze, it fell to the floor, nurse picked it up, proceeded to wrap foot. Nurse helped resident use inhaler, then dropped inhaler on floor prior to picking it up, placing in the box (did not clean inhaler after picking up off the floor). E
- Facility failed to assure appropriate infection control practices. Applying barrier cream to peri area after incontinence cares without changing gloves. D
- Staff cleansed wounds with saline, removed dirty gloves and donned new gloves but didn't perform hygiene. D
- Facility failed to use proper infection control practices during wound dressing change and failed to complete infection control logs. Lack of washing hands when changing gloves from dirty to clean. D
- Failed to assure proper handling of medications to prevent contamination during a medication administration and failed to provide appropriate disinfectant/cleaning of resident room after exposure to incontinence actions. Failed to wash hands after administering nasal spray. Lack of sanitizing floor after urine spillage. E
- Facility failed to provide a sanitary environment to help prevent the transmission of pathogens. Catheter bag cover dragging on the floor. D
- Facility failed to maintain standard precautions during dressing changes and perineal care. Did wash hips and buttocks during incontinence cares. Nurse did not change gloves from one wound site to the next. D

F881 – Antibiotic Stewardship Program

- Facility did not have an antibiotic stewardship program. E
- Facility failed to establish and infection prevention and control program that included an antibiotic stewardship program with antibiotic use protocols and a system to monitor antibiotic use. D
- Facility failed to maintain records of infections and antimicrobial use, maintain records of corrective actions taken regarding actual versus colonized infections and antibiotic use form. Lack of location of resident infections, the infecting organism, the treatment or response to the treatment. E

F883 – Influenza and Pneumococcal Immunizations

- Staff did not provide education/consent to resident prior to administering immunization. NONE
- Facility lacked documentation of education/consents for resident with influenza vaccinations. B

- Facility failed to offer influenza or pneumonia vaccination to a resident. Lack of documentation of vaccinations in record. D

F909 – Resident Bed
- Failed to conduct regulator inspection of all bed frames, mattresses and bed rails as part of a regular maintenance program to identify areas for possible entrapment. E

F921 – Safe/Functional/Sanitary/Comfortable Environment
- Dirty carpet, missing radiator cover, torn screen, rotted window frame, cracked floor tiles, garbage under a resident's bed. E

F926 – Smoking Policies
- Facility failed to provide proper smoking area away from building, provide smoking aprons, fire extinguisher, fire blanket, proper supervision for residents using area. D

L1093
- Failure to submit residents' admissions to the VA.
- Facility failed to check Veteran's status for 4 residents within 30 days of admission.

L191
- Failure to test staff with the 2-step TB test. First step completed for staff, but not second step.

L257
- Facility failed to check the veteran status on a resident.

Nursing Facility Survey Frequency

As of October 28, 2019, CMS lists 54 Iowa facilities (12.3%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 7.9%. National average is 5.7%.

FFY 19 - October Totals - LTC Surveys				
Provider	**City**	**Survey End Date**	**Previous Date**	**Months Between**
Accura Healthcare of Ames	Ames	9/12/2019	6/14/2018	15.17
Accura Healthcare of Bancroft	Bancroft	8/28/2019	6/28/2018	14.20
Accura Healthcare of Manning	Manning	8/8/2019	5/12/2016	39.43
Accura Healthcare of Milford	Milford	8/22/2019	12/4/2018	8.70
Accura Healthcare of Pleasantville	Pleasantville	9/5/2019	6/28/2018	14.47
Accura Healthcare of Sioux City	Sioux City	8/22/2019	5/17/2018	15.40
Bedford Specialty Care - Amended Survey	Bedford	8/1/2019	5/10/2018	14.93
Black Hawk Life	Lake View	9/18/2019	6/21/2018	15.13
Bloomfield Care Center	Bloomfield	8/28/2019	5/24/2018	15.37
Casa De Paz	Sioux City	9/10/2019	6/21/2018	14.87
Clarence Nursing Home	Clarence	9/5/2019	7/3/2018	14.30
Community Care Center	Stuart	9/12/2019	6/21/2018	14.93
Community Memorial Health Center	Hartley	9/12/2019	6/7/2018	15.40
Eagle Point Health Care Center	Clinton	9/12/2019	6/14/2018	15.17
Edgewater A Wesley Active Life Community	West Des Moines	8/15/2019	5/31/2018	14.70
Edgewood Convalescent Home	Edgewood	9/5/2019	7/3/2018	14.30
Eldora Specialty	Eldora	8/8/2019	5/17/2018	14.93
Elkader Care Center	Elkader	8/28/2019	6/21/2018	14.43
Embassy Rehab & Care Center	Sergeant Bluff	9/18/2019	6/28/2018	14.90
Fort Dodge Health & Rehab	Fort Dodge	8/15/2019	5/10/2018	15.40
Good Samaritan Society - Davenport	Davenport	8/28/2019	5/17/2018	15.60
Good Samaritan Society - Fontanelle	Fontanelle	8/15/2019	5/3/2018	15.63
Good Samaritan Society - LeMars	Lemars	9/5/2019	6/14/2018	14.93
Good Samaritan Society - West Union	West Union	8/15/2019	5/10/2018	15.40
Grandview Heights Inc.	Marshalltown	9/19/2019	6/14/2018	15.40
Griswold Rehabilitation & Health Care Center	Griswold	8/15/2019	5/3/2018	15.63
Heartland Care Center	Marcus	8/20/2019	5/3/2018	15.80
Heritage Care Center	Iowa Falls	8/28/2019	5/17/2018	15.60
Hubbard Care Center	Hubbard	8/15/2019	5/10/2018	15.40
Kennybrook Village	Grimes	8/29/2019	7/19/2018	13.53
Lake Mills Care Center	Lake Mills	8/28/2019	5/31/2018	15.13
Lakeside Lutheran Home	Emmetsburg	9/26/2019	7/12/2018	14.70
Lamoni Specialty Care	Lamoni	8/28/2019	5/24/2018	15.37
Lenox Care Center	Lenox	8/23/2019	6/7/2018	14.73
Lutheran Living Senior Campus	Muscatine	08/01/2019	4/26/2018	15.40
Manorcare Health Services - Cedar Rapids	Cedar Rapids	09/04/2019	6/21/2018	14.67

Manorcare Health Services - Utica Ridge	Davenport	09/26/2019	6/28/2018	15.17
Manorcare Health Services - West Des Moines	West Des Moines	08/28/2019	5/17/2018	15.60
MercyOne Senior Care	Oelwein	8/1/2019	4/26/2018	15.40
Monticello Nursing & Rehab Center	Monticello	8/22/2019	5/10/2018	15.63
New Hampton Nursing & Rehab.	New Hampton	6/20/2019	3/8/2018	15.63
On With Life	Ankeny	9/26/2019	7/3/2018	15.00
Pleasant View Care Center	Whiting	8/1/2019	4/17/2018	15.70
Pleasantview Home	Kalona	8/15/2019	5/10/2018	15.40
Premier Estates Muscatine	Muscatine	9/19/2019	6/19/2018	15.23
QHC Humboldt North	Humboldt	8/1/2019	4/19/2018	15.63
QHC Humboldt South	Humboldt	8/19/2019	8/30/2018	11.80
Regency Park Nursing & Rehab. Center	Jefferson	8/1/2019	4/26/2018	15.40
Riverview Manor Healthcare	Pleasant Valley	8/15/2019	5/31/2018	14.70
St. Luke's Helen G. Nassif (Formerly Living Center East)	Cedar Rapids	7/18/2019	4/26/2018	14.93
State Center Specialty Care	State Center	9/12/2019	7/3/2018	14.53
Sunnycrest Nursing Center	Dysart	8/22/2019	5/14/2018	15.50
The Alverno Senior Care Community	Clinton	8/15/2019	5/3/2018	15.63
The Ambassador Sidney	Sidney	8/8/2019	4/19/2018	15.87
The Suites at Western Home	Cedar Falls	9/12/2019	6/7/2018	15.40
The Village at Legacy Pointe	Waukee	9/5/2019	6/28/2018	14.47
Thornton Manor Nursing and Care Center	Lansing	8/22/2019	5/24/2018	15.17
Tripoli Nursing & Rehab	Tripoli	8/8/2019	5/3/2018	15.40
Union Park Health Services	Des Moines	8/28/2019	5/24/2018	15.37
Vista Woods Care Center	Ottumwa	8/22/2019	6/7/2018	14.70
Wesley Park Centre	Newton	9/5/2019	6/14/2018	14.93
West Bend Health and Rehabilitation	West Bend	9/19/2019	6/21/2018	15.17
West Ridge Specialty Care	Knoxville	9/12/2019	6/14/2018	15.17
Westwood Specialty Care	Sioux City	8/1/2019	4/19/2018	15.63
Willow Dale Wellness Village	Battle Creek	9/5/2019	6/14/2018	14.93
Winslow House Care Center	Marion	8/8/2019	5/24/2018	14.70
Zearing Health Care	Zearing	8/30/2019	6/7/2018	14.97
			AVERAGE	**15.13**