Compliance Tips from IHCA's Survey Results Committee

September 2016

The five most frequently cited tags from the 61 annual surveys (4 deficiency free), 66 complaints (18 unsubstantiated), 24 self-reports (11 unsubstantiated), 20 complaint/self-report (7 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 427 total deficiencies.

The following is a breakdown of severity level:

A =	0.00%	D =	53.86%	G =	9.84%
B =	2.11%	E =	26.46%	H =	0.24%
C =	1.64%	F =	3.98%	I =	0.00%
				J =	1.17%
				K =	0.47%
				L=	0.00%

Total # of Reports: 180
Total # of surveys/reports deficiency free or unsubstantiated: 40
Avg. # of deficiencies

- All = 2.37
- Annual = 5.60
- Complaint/Self-Reports= 4.11

Total state fines for September Report = $61,500 ($92,500 held in suspension)

Top 5 Most Frequently Cited Tags for September 2016 Report

F 323—Free of Accident Hazards/Supervision/Devices

- Resident eloped outside, set off "silent alarm," staff did not respond; resident found on sidewalk by staff reporting to shift, no injuries; staff was not educated on silent alarm activation protocol, other door alarms were not consistently checked, pages that were to receive the silent alarm notifications were sitting in a basket, 2 with dead batteries, they were supposed to be carried by the aides (J) **$8,000 fine**

- Resident given hot coffee resulting in burns on lap; staff left resident in wheelchair unattended and resident fell sustaining fractures, staff did not use wheelchair pedals or platforms when propelling residents; resident eloped in an electric wheelchair and facility had no knowledge of the elopement (resident had history of hallucinations and cognitive issues (J) **$8,000 fine** (held in suspension)
- Facility failed to provide adequate nursing supervision to prevent accidents; resident fell and fractured humorous (G) **$7,000 fine**
- Lack of supervision to prevent accidents failure to intervene (G) **$6,000 fine**
- Facility failed to provide adequate supervision to ensure against hazards when transferring resident from a lift, and failed to assess risk for elopement (G) **$5,000 fine**
- Facility failed to ensure 1 of 11 residents were free from abuse; resident 1 placed hands on breast of resident 2 (G) **$3,500 fine**
- Resident unstable with ambulation; resident fell, was sent to ER; alarm didn't sound, resident had removed pajama top to silence alarm, pajama top was on his/her bed with alarm intact. Pressure alarm added to plan of care as intervention; resident fell again, staff found pajama top with alarm attached draped over bed rail, report didn't state why pressure alarm failed to activate when resident got up (G) **$3,500 fine**
- Resident in shower chair was pushed into cabinets, tore big toenail (G) **$3,000 fine** (in suspension)
- Facility failed to ensure each resident consideration and dignity and freedom from abuse; resident to resident altercation; resident 1 was hitting resident 2 (G) **$2,000 fine** (in suspension)
- Cognitively-impaired resident spilled hot coffee resulting in second-degree burns on abdomen; care plan called for no hot liquids (G) $**2,000 fine**
- Facility failed to protect residents from abuse; resident was wandering into other resident's rooms and hitting them (G) **$1,500 fine**
- Facility must ensure the resident's environment remains free from accidents and hazards; facility failed to ensure 2 of 11 residents received adequate supervision; resident 1 placed hands on breast of resident 2, later resident 1 found in room of resident 2, was asked to leave and continued talking inappropriately about resident 2 (G)
- Facility failed to ensure each resident receives adequate supervision and assistive devices to prevent accidents; resident on floor, no alarms in place per care plan, resident sustained compressed vertebrae (G)
- Resident fell with fracture, staff was not following care plan for ambulating with walker within reach; resident fell forward out of chair with injury and chair was left upright when care plan dictated to keep chair reclined residents left unattended by staff (G)
- Facility policy—residents free from abuse—resident unpleasant and uncooperative, would not leave another resident's room, would not allow the other resident to exit their room, slapped and pulled hair when the other resident attempted to exit their own room; unit manager said not aware of July 2nd incident until July 15 (G) **$5,000 fine**

- Oxygen tanks in locked room, but tanks did not stand in base holder or behind chain (G)
- Resident found with bruises of unknown origin on arm; no documentation; resident asked what happened, resident said “you’re not going to yell at her, right?;” but resident said staff grabbed his/her arm and jerked it. Facility policy called for staff to immediately report abuse to management, did not happen (G) **$4,000 fine**
- Resident with history of falls; resident said “leaned forward” in wheelchair and chair “followed” her as she fell forward; the progress note documented the fall intervention directed staff not to leave resident unattended while in wheelchair (G)
- Facility failed to provide adequate supervision to ensure resident did not hit or bump wheelchair into other residents (G)
- Same staff same resident; 2 falls unusual fracture with no explanation, no gait belt used (G)
- Facility failed to provide adequate supervision to prevent 4 instances of resident to resident abuse (E)
- Doors buzzed when opened but reset when closed without staff intervention; oxygen canisters not secure, Clorox wipes not locked up, Lysol spray in hallway (E)
- No door alarms on main entrance door nor back door service entrance; main entrance had Wanderguard alarm only (E)
- Medication room left unlocked (E)
- Facility failed to secure hazardous chemicals and failed to properly store oxygen canister (E)
- Resident tried to get out of wheelchair, self-locking brakes didn’t work, resident fell was injured (E)
- Unlocked drawer in therapy room had scissors; unlocked drawer in kitchenette with butane lighter and medicated inhaler; unit had cognitively impaired, independent residents (E)
- Fire exit doors not alarmed, and information desk left unattended; resident’s medications left on top of medication cart unattended (E)
- Oxygen containers and concentrators in unlocked closet (E)
- Facility failed to provide adequate supervision for 1 of 4 residents who eloped and was found in another resident’s unit (E)
- Resident’s non-skid strips not in place as per care plan; unlocked housekeeping closet (E)
- Worn gripper strips on floor, broken concrete in multiple areas of concrete walkways (D)
- Facility failed to provide adequate investigation after a fall to determine future care plan interventions (D)
- Resident’s alarm switched off, did not sound when resident fell, also resident left unattended in dining room to eat, on a pureed diet (D)
- CNA did not use gait belt while transferring resident (D)
- Resident fell; no alarm in place per care plan (D)

- Medications room door not pulled shut all the way—door had to be pulled shut due to sticking (D)
- Resident with Wanderguard exited facility, triggered another alarm but staff did not investigate thoroughly; staff member found resident in parking lot with no injuries (E)
- Facility failed to ensure hazardous chemicals were secure and not accessible to residents, failed to secure oxygen tanks in a hallway (E)
- Facility failed to provide accurate nursing supervision in an effort to prevent accidents; resident wheeled outside by CNA resident not able to steer, CNA let go of wheelchair, wheelchair and resident hit curb and resident fell from wheelchair, was injured (D)
- Resident left facility without signing out; CPAP and oxygen converter in power strip, not in wall outlet (D)
- Inadequate supervision to prevent 2 residents in CCDI unit who could not remember to use call lights to prevent falls (D)
- Facility failed to ensure equipment had intact electrical cords to prevent injury; bed control hung off of bed with frayed electrical wires exposed (D)
- Facility failed to provide adequate supervision for 2 of 4 residents; resident 1 crawled in bed with another resident on top of covers; no physical contacts made (D)

F 281—Professional Standards of Quality

- Facility failed to follow physician's orders for 7 of 11 residents; resident did not receive medications as still in bubble pack; treatment orders not administered for 1 week (E)
- Staff failed to follow physician's orders regarding labs, procedures, wound care, consultations, medications,
- Facility failed to follow physician's orders; order for clonozeporn 0.25 mg tablet given at 1.25 mg tablet (D)
- Oxygen not administered per doctor's orders, surveyor observed staff giving wrong dosage of medicine to the wrong resident (D)
- Transcription error—order transcribed as 120.3 ml, was supposed to be 20.3 ml (D)
- Staff failed to follow physician's orders on gastro tube flushing (D)
- Surveyor observed no foot pedals on wheelchair per care plan, nurse treated wrong toe (D)
- Nurse opened capsules with her bare hands during medications pass, eye drop administration completed without holding open the lacrimal sac per manufacturer's recommendations (D)
- Resident's wound cares treatment not always documented with dates of dressing changes (D)
- Aspirin given but no dosages in the order (D)
- Facility failed to follow physician's orders to keep head above bed 30 degrees also not following physician's orders to call physician when blood sugar testing is high (D)

- Facility failed to follow physician's orders concerning taking blood pressure vital sign before administering Losaritan (D)
- Facility failed to follow physician orders and manufacturer's recommendations, facility did not administer medications for ordered parameters (D)
- Tubigrip (elastic hose) not in place on resident per physician's order when observed (D)
- Facility failed to follow physician's orders to discontinue TED hose but they were observes still applied on resident (D)
- MAR directed administration of Allegra and Flonase; review of clinical record did not reveal a physician's order for either of these medications (D)
- Failed to follow physician's orders; motion alarm to be used at all times, surveyor noted no motion alarm, when asked, LPN pointed out resident had a personal alarm but no motion alarm, LPN said facility didn't have motion alarm (D)
- Physician's orders called for non-weight bearing on left leg for 4 weeks; staff was transferring with a pivot disk that required resident to bear some weight on left leg (D)
- Lab work not completed as physician-ordered (D)
- There was no thermometer in medication room refrigerator with urine sample inside (D)
- Oral hypoglycemic administered on 3 days when resident's blood sugar was less than 100 in contraindicative to physician's orders; facility failed to schedule a physician's follow up visit as ordered for urinary tract infection (D)
- Facility failed to administer medications as ordered by physician; resident did not receive medications as ordered, did not get PT and INR as ordered (D)
- Medication error professional services (E)

F 225—Abuse Reporting, Background Checks

- Facility failed to report an allegation of resident-to-resident abuse (D) **$500 fine**
- Facility policy—residents free from abuse—resident unpleasant and uncooperative, would not leave another resident's room, would not allow the other resident to exit their room, slapped and pulled hair when the other resident attempted to exit their own room; unit manager said not aware of July 2nd incident until July 15 (G) Resident found with bruises of unknown origin on arm; no documentation; resident asked what happened, resident said "you're not going to yell at her, right?;" but resident said staff grabbed his/her arm and jerked it. Facility policy called for staff to immediately report abuse to management, did not happen (G)
- Facility failed to report within 24 hours five instances of resident-to-resident allegations of abuse; facility failed to report bruises of unknown origin on resident (E)
- Facility failed to timely report a resident to resident abuse altercation (D)
- Resident-on-resident abuse not reported to DIA (D)
- Facility failed to separate an alleged abuser from victim after allegation of abuse (D)
- Facility failed to report resident-on-resident altercation (D)

- Facility failed to report allegations of abuse for 2 of 2 residents; facility lacked incident reporting for resident hitting and punching another resident (D)
- Facility failed to timely report resident-on-resident abuse (D)
- Facility failed an allegation of abuse to DIA and failed to investigate allegations of resident-to-resident abuse (D)
- Facility failed to report a resident-to-resident altercation one resident hit another resident in the face (D)
- A resident was witnessed inappropriately touching and kissing another resident on a weekend; was not reported to DIA (D)
- Facility failed to separate an alleged abuse perpetrator from the resident until an investigation by DIA was complete; staff member tried to intervene and resident who was trying to exit the building received scratched on forearm, etc. (D)
- Facility failed to report suspected dependent adult abuse to DIA within 24 hours (D)
- Facility failed to report resident-to-resident altercation within 24 hours. Resident #1 sat his/her cookie down in front of resident #2. Resident #2 handed cookie back to resident #1. Resident #1 slapped cookie out of resident #2's hand. Resident #1 bent down to pick up cookie while resident #2 continued slapping resident's #1 arm. DON became aware of incident while reviewing nurse notes, then reported (presumably outside of 24-hour reporting window) (D)
- Facility policy—residents free from abuse—resident unpleasant and uncooperative, would not leave another resident's room, would not allow the other resident to exit their room, slapped and pulled hair when the other resident attempted to exit their own room; unit manager said not aware of July 2nd incident until July 15 (D)
- Facility failed to follow its abuse policy (D)

F 371—Store, prepare and serve food under sanitary conditions

- Surveyor observed hair sticking out from under hair nets (cook) (F)
- Food safety—rubber spatulas with gouges, food with mold in refrigerator, food opened without labelled date, food in freezer not frozen, freezer temperature was 20 degrees Fahrenheit (F)
- Facility failed to prepare, distribute and serve food under sanitary conditions; temperatures not being checked on food being served (F) **$500 fine**
- Refrigerator door had sticky substance, refrigerator contained opened, undated, unsealed, bag of shredded lettuce, staff did not change gloves after touching several items (E)
- Dusty vent, frozen meat sitting in drainage not from that meat, cleaning tables with water and soap; water and sanitizer was what was needed (E)
- Kinchenette with three plastic containers with cereal, all undated; tops of cereal boxes showed dark and yellow dry, debris/dirt; bag of summer sausage undated; dirty, yellow debris in drawers, dirty refrigerator (E)
- Dietary staff failed to date nutritional supplement to ensure use within manufacturer's guidelines (E)

- Thermometers lacking in both refrigerator and freezer; partially eaten Subway sandwich in refrigerator (E)
- Facility distaff failed to label and date opened food in the walk-in cooler (pizzas with ice on them, etc.) (E)
- Facility failed to date and label foods and staff did not wash hands appropriately (E)
- Facility failed to develop and implement hair net policy, staff observed not wearing hairnets (E)
- Food not removed from refrigerator after 3 days; dirty meat dispensing spigots (E)
- Facility failed to maintain refrigerator at or below 41 degrees Fahrenheit (E)
- Dust and debris on shelving, plastic container and pots and pans (E)
- Dietary staff gloved, then touched unsanitized surfaced such as bowls, bread bags, etc. (E)
- Fuzzy black substance on fluorescent light fixtures, dishwasher, stove/oven, fryer, the fuzzy black substance moved when air flowed through vents (E)
- Utility room freezer lacked thermometer (D)

F 441—Infection Control

- Same staff same resident; 2 falls unusual fracture with no explanation, no gait belt used (G)
- Soiled garment found on floor near resident bed (F)
- Facility failed to ensure staff performed proper infection control practices; staff did not change gloves after touching soiled items; nurse placed glucometer on chair armrest with no barrier, staff did not know resident had MRSA and did not use proper precautions (E)
- Failure to provide proper infection control (E)
- No barrier for glucometer placed on medications cart, no hand hygiene after glove removal and resident care (E)
- No blood glucometer barrier; resident's dentures placed by staff on another resident's bed without barrier (E)
- Staff did not gown when providing care to resident with MRSA in coccyx wound; Medi-lift taken from resident rooms without staff sanitizing it, staff did not leave sanitizer on equipment for 3 minutes per manufacturer's recommendations, staff did not reglove after cleaning resident's dentures after touching door knobs, etc. (E)
- Wound care to MRSA resident—scissors from staff's pocket was used multiple times without sanitizing; clean supplies placed on bed without barrier, items dropped on floor and placed on clean items (E)
- Nurse did not change gloves between soiled and clean procedures during a dressing changes (2 examples) (D)
- Staff failed to use barrier between glucose testing supplies and non-sanitized surface for IC purposes (D)
- Facility failed to carry out adequate infection control for utilizing a glucometer (D)
- Staff had handwashing issues during incontinence care and wound care (D)

- Staff failed to wash hands or reglove after incontinence care and before dressing residents (D)
- Nurse failed to disinfect scissors after cutting through soiled dressing, nurse cleansed wound from the outer edge to the center (D)
- Facility failed to properly sanitize glucometer (D)
- Staff failed to change gloves and wash hands to prevent cross contamination (D)

Other notable deficiencies and fines

F-221

- CNA braced a chair behind resident so she could not get up (restraint) (G) **$500 fine**

F-223

- Facility failed to revise care plan for resident on multiple occasions attempted to ambulate independently when it was determined that was unsafe; resident fell with hip fracture, (G) **$5,000 fine**
- Facility failed to ensure residents free from abuse; resident 1 in room of resident 2; resident 1 had hand up shirt of resident 2 and on breast; resident 2 slapped resident 1, resident 1 hit resident 2 (G) **$4,000 fine** (in suspension)
- Facility failed to ensure resident was free from sexual abuse (G) **$3,000 fine**
- Facility failed to provide adequate supervision in order to assure resident-to-resident abuse in CCDI unit is prevented; resident #1 hit multiple other residents (H) **$3,000 fine** (in suspension)
- Facility failed to ensure residents were free from abuse and failed to be treated with consideration and respect; resident hitting other residents and pulling on their Foley tubing (G) **$2,000 fine**
- Facility failed to ensure resident 1 was free from verbal and sexual abuse by nurse who kissed resident (G) **$2,000 fine** (in suspension)
- Facility failed to ensure 3 residents were free from abuse from another resident (G) **$1,500 fine**
- Multiple resident-to-resident abuse reports—resident sexual reports (G) **$500 fine**
- Resident with behavioral problems involved in a dispute between 2 employees while they were upset at each other and became upset at this resident **(G)**

F-224

- Same staff same resident; 2 falls unusual fracture with no explanation, no gait belt used (G) **$15,000 fine**
- Facility failed to plan, direct the nursing care and provide to other residents' safety; resident was hitting other residents and verbally abusing them (G) **$2,000 fine**
- Facility failed to prevent misappropriation of a resident's narcotic medication; 2 residents with hydrocodone medications had altered narcotic sheets and missing pills (D) **$500 fine**

- Facility did not investigate missing doses of Trazadone (D) **$500 fine**
- Staff with a record of suspected impairment while on duty discovered making significant medication errors, 141 pills discovered in sharps container including morphine (K)

F-226

- Facility failed to complete abuse and criminal background checks within 30 days of hire (D) **$1,500 fine**
- Facility failed to complete 1 of 5 criminal background checks prior to hire (D) **$500 fine**
- Staff with a record of suspected impairment while on duty discovered making significant medication errors, 141 pills discovered in sharps container including morphine (L)
- Facility failed to obtain criminal background and dependent adult abuse check prior to hire (E) **$500 fine**
- Facility failed to obtain required background checks prior to employment (D) **$500 fine**

F-241

- Dignity—staff did not tell a resident to "go in their brief" when staff unable to answer call light timely (reported in group interview) (D) **$500 fine**

F-246

- Facility failed to assist resident's return from the dining room after meals, failed to assist resident requiring eating assistance and resident's attendance at required physician's appointments (E)

F-250

- Facility failed to treat resident with dignity, and implement interventions for psychosocial needs concerning resident to resident sexual behaviors (D) **$500 fine**

F-309

- Facility failed to prevent leg ulcers due to continued massive leg edema and resident had uncontrolled pain for over 30 days, resident was hospitalized with pneumonia, had maggots found in wound when admitted (J) **$10,000 fine** (held in suspension)
- Failure of staff to intervene regarding catheter; physicians' notifications not done (G) **$6,000 fine**
- Facility failed to assess and implement interventions for a change in condition after a resident's fall, resident complained of pain and was later diagnosed with a fracture, surveyor noted poor assessment of pain complaint (G) **$500 fine**
- Staff failed to adequately assess resident with head injury and possible neuro problems (G)

F-322

- Restorative eating treatment—restore eating skills—staff lowered HOB during feeding causing aspiration (G) **$2,000 fine**

F-333

- Staff with a record of suspected impairment while on duty discovered making significant medication errors, 141 pills discovered in sharps container including morphine (G)
- Significant medication error; morphine overdose (G) **$5,000 fine**

F-325

- Resident with weight loss of 17 percent in 30 days; dietitian failed to perform an assessment of weight loss or nutritional status (G) **$2,000 fine**
- Facility failed to maintain adequate nutrition status by not revising nutritional interventions or offering food for extended periods of time to prevent further weight loss (G) **$500 fine**

F-329

- Facility did not obtain laboratory testing as ordered by physician; PT/INR not drawn as ordered (E) **$500 fine**
- Facility failed to ensure residents were monitored for non-pharmacological interventions prior to administration of anti-anxiety medication; CMA gave double dose of seizure medication, resident required ER visit (G) **$500 fine**

P464/61.12(5) Electrical requirements

- Facility failed to fire alarm all exit doors, double doors between A and B areas of skyline hall only had Wandergaurd alarms **$3,000 fine**

481-61.6

- No alarm on exit door from assisted living to nursing units

L 190

- Four employees failed to have physicals every four years

L 330

- Facility failed to document disposition of resident medications on discharge

L 435

- Director of Nursing failed to perform annual employee evaluations

L1093

- Facility failed to ensure that residents eligible for Veterans' Administration benefits were ensured on the facility's current residents CCRS form

S 115

- Facility failed to complete two-step TB testing for all employees on hire

S 129

- Inadequate TB screening for all residents on admission