Compliance Tips from IHCA's Survey Results Committee

October 2018

Total Number of Survey Reports: 85

Survey composition:

Annual	22 surveys	4 deficiency free
Complaints	45 surveys	24 unsubstantiated
Self-Reports	7 surveys	3 unsubstantiated
Mandatory Reports	none	

State Fines **$26,000**
State Fines in Suspension **$ 7,250**

Most Commonly Cited Iowa Tags in order of Frequency:

4 G's and I I Level Tags

F 689 – Free of Accidents/ Hazards/Supervision
F 880 – Infection Control
F 623 – Notice Requirements Before Transfers/Discharge
F 690 - Bowel/Bladder Incontinence, Catheter, UTI
F 656 - Develop/Implement Comprehensive Care Plan
F 658 – Services Did Not Meet Professional Standards
F 578 - Advance Directives/Discontinuation of Treatment
F 644 - Coordination of PASARR and Assessments
F 725 - Sufficient Nursing Staff
F 625 – Notice of Bedhold Policy Before Transfer

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=15696		Total Number of Surveys=49204
F0880	Infection Prevention & Control	4,661	27.7%	9.5%
F0689	Free of Accident Hazards/Supervision/Devices	4,128	21.6%	8.4%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	3,611	21.9%	7.3%
F0656	Develop/Implement Comprehensive Care Plan	3,459	19.9%	7.0%
F0684	Quality of Care	3,073	16.6%	6.2%
F0761	Label/Store Drugs and Biologicals	2,341	14.3%	4.8%
F0657	Care Plan Timing and Revision	2,265	13.3%	4.6%
F0686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	1,968	10.9%	4.0%
F0758	Free from Unnec Psychotropic Meds/PRN Use	1,901	11.6%	3.9%
F0677	ADL Care Provided for Dependent Residents	1,874	10.3%	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)

F 550 - Resident Rights/Exercise of Rights

- Resident had a dress on backwards, staff reported it was easier to dress her despite the fact resident disapproved. Resident reported she did not like that. Dress had also been worn two days in a row and had strong urine odor. (D)
- Staff failed to provide cares in a dignified manner without showing frustration toward the resident. (D)

F 559 – Choice/Be Notified of Room/Roommate Change

- Facility did not provide resident written notice prior to changing resident's room (B)

F 567 – Protection/Management of Personal Funds

- Residents did not have access to personal funds on the weekend. (D)

F 578—Advance Directives/Discontinuation of Treatment

- Resident did not have a signed advanced directive. Another resident's electronic health record stated DNR, while the hard chart revealed Full Code written in large letters on the front of the chart. LPN then found the advanced directives indicating DNR in the hospice record. (D)
- Two residents with PRN psychotropic meds were extended more than 14 days without rationale. One resident received PRN medication without documentation of interventions attempted prior to administration. (D)
- Facility failed to accurately address CPR status for 2 residents. (D)
- Facility failed to ensure advanced directives for health care were documented and readily available for 3 residents. (D)
- Failure to have a code status on one resident who stated he wished to be a DNR, but there was no paper work in the facility to support that wish. (D)
- Resident had conflicting CPR information in the chart. Order and signed documents stated DNR, sticker on the chart indicated Full Code. The code status was ordered by the court. (D)
- Physician indicated a resident is DNR, and sticker on chart indicates DNR, but there was no signed advanced directive in the chart. (B)

F 580 - Notification of Changes Injury/Decline

- Failure to notify the resident's physician of a condition change that included temp, shortness of breath and oxygen saturation of 85%. Resident not transferred to ER for over 24 hours after symptoms occurred. Facility failed to report yellow slough in the wound bed, bright reddened skin surrounding the wounds down leg to physician. (D)
- Facility did not perform blood sugars as ordered (ordered QID and some days were not completed at all) and did not call the physician or family several days when the blood sugar exceeded 300 (some days were over 500). No blood sugar parameters listed for physician notification. (D)
- Resident had a decline in condition including decreased oral intake, fatigue, and refused medications but the physician was not notified. Family requested

transfer to ER. The family states they were not contacted regarding the condition change. (D)

F 582 - Medicaid/Medicare Coverage

- Failure to provide Medicare Notice of Non-Coverage for 3 residents. (B)
- Three residents did not receive Medicare Liability and Beneficiary Appeals Notices prior to discharge from SNF. (B)
- Facility failed to ensure 3 residents received the Notice of Medicare Non-Coverage Form on discharge of Medicare Part A Skilled Services. (B)

F 583 - Personal Privacy/Confidentiality of Records

- Surveyor observed an unlocked room used for meetings and training had 4 file cabinets with closed/discharged medical records that were unlocked. (C)

F 584 - Safe/Clean/Comfortable Homelike Environment

- Resident environment not in good repair - multiple paint chips on doors and walls, missing and chipped floor tiles, baseboard heater with cover removed exposing sharp coils. (E)
- Missing wood trim around window air conditioner leaving mitered sharp edge exposed. (E)
- Doorframe scraped and discolored. Gouges on handrail and a cabinet. Drawers of a cabinet had dust, debris and stains. (E)
- Resident, with BIMS score of 15, complained she did not have a working toilet for 4-5 days in July. Also, the resident stated she watched an aide dump the bedpan in the sink. (B)

F 600 – Free from Abuse and Neglect

- Failure to implement appropriate interventions to protect one resident from touching in a sexually inappropriate manner in two separate incidents. (D)
- Resident reported that a male C.N.A. on 3rd shift had turned her call light off without caring for her, when she put it on again he came in and was "rude". She felt afraid to put it on again, so she laid in urine all night which made her cold. (D) **$500 Fine**

F 607 - Develop/Implement Abuse and Neglect Policies

- Four agency staff did not have complete background checks. One agency employee had criminal record that was not cleared by DHS for nursing facility employment. (L) **$500 Fine**

F 609 - Reporting of Alleged Violations

- Facility failed to ensure all allegations of abuse are reported to the DIA in accordance with state law including drug diversion. (D)
- Facility failed to report an allegation of possible abuse for one resident. (D)
- Failure to immediately report an allegation of resident abuse to DIA. (D)

F 610 – Investigate/Prevent/Correct Alleged Violation

- Failure to ensure the separation of one resident from another after a resident-to-resident incident, and failure to conduct thorough investigations related to that incident. (D)

F 622 - Transfer and Discharge Requirements

- No documentation of a transfer sheet for two residents sent to hospital. (D)

F 623 – Notice Requirements Before Transfer/Discharge

- Ombudsman office was not notified of hospital transfers for 4 residents. (C)
- No documentation of notice to ombudsman of resident transfer to the hospital. (B)
- Failed to send ombudsman notice of a hospital transfer. (D)
- Failed to notify the Ombudsman of hospital transfers and facility discharges. (B)
- Failed to notify the Ombudsman of any resident discharges. (D)
- Facility failed to notify the Ombudsman of hospital discharges for 2 residents. (B)
- Failure to notify the Ombudsman when residents were transferred from the facility to the hospital. (D)
- Lack of notice to ombudsman regarding hospital transfers. (D)
- Ombudsman was not notified of hospital transfers for 4 residents. (C)

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

- Facility failed to notify 2 residents of the right to hold bed and failed to provide facility bed hold policy. (D)
- Resident/family member did not receive) bedhold policy for 3 residents transferred to hospital. (D)
- Bedhold policies not given (or not documented) for 4 residents transferred to the hospital. (E)
- Facility failed to notify a resident or the resident's representative of bed hold rights prior to transfer to the hospital. (B)
- Facility failed to give notice of bed hold policy to 1 resident. (D)
- Failure to notify residents or the resident's representative of the facility bed hold policy, including reserve bed payment, during their hospitalization. Facility lacked a bed hold policy form for three hospitalizations. (E)

F 641 – Accuracy of Assessments

- MDS had errors related to medications ordered by physician and did not identify that resident was on hospice care. (D)
- Failed to complete annual and quarterly assessments accurately for the use of anticoagulants. (E)

F 644 – Coordination of PASARR and Assessments

- After admission, two residents received diagnoses of delusional disorder and unspecified psychotic disorder. Neither were referred to ASCEND for another PASARR. (D)
- Original PASRR did not include diagnosis of anxiety, psychotic and personality disorders. Facility did not notify ASCEND of inconsistency. Another resident

PASARR did not include diagnosis of dementia, cognitive communication deficit, major depressive disorder and anxiety disorder. Facility did not notify ASCEND of inconsistencies. (D)

- Original PASRR did not include diagnosis of bipolar disorder. Resident also had a period of suicide watch. ASCEND not notified. (D)
- Failed to refer residents with a newly evident qualifying mental illness diagnoses for PASARR Level 2 screening. (D)
- Facility failed to refer resident with a newly evident or possible serious mental disorder for PASARR review upon a significant change in mental health status. (D)
- Facility failed to repeal a Level 1 preadmission screening and resident review when a resident admitted to the facility with a diagnosed mental disorder not documented on the previous PASARR. (D)
- Failure to submit a level II PASARR after a diagnosis of schizophrenia. (D)

F 645 - PASARR Screening for MD & ID

- Original PASRR incorrect as submitted by hospital. Facility did not correct. (D)
- Failure to complete a new PASARR evaluation after the PASARR notice of short-term nursing facility approval had expired. (D)

F 656 - Develop/Implement Plan of Care

- Care plan lacked documentation of trach and need for trach care; resident taking anti-depressants and anti-anxiety meds had no care plan interventions related to those diagnoses. (D)
- Resident's care plan did not contain reference to side effects of Ativan, Oxycodone and Fentanyl. (D)
- One resident did not have care plan addressing smoking needs. Resident was outside independently smoking and left the facility to purchase cigarettes. Resident’s care plan stated resident needed assistance. Resident was found outside alone, had trouble speaking and was observed to be confused. Not care plan intervention for this activity. (D)
- Care plan did not reflect information regarding hospice and how to prevent recurrent UTI’s. (D)
- Failed to provide plan goals and interventions addressing behaviors, use of psychotropic medications and possible side effects or elopement risk on the resident's care plan. (D)
- Facility failed to develop a comprehensive care plan that addressed resident's behaviors and individual needs. (D)
- Failure to address ROM in 2 resident's care plans. Cushions were not placed under the resident as documented on care plan. (D)
- Resident's care plan did not address poor dentition. (D)

F 657 - Care Plan Timing & Revision

- Resident reported care plan was incorrect and indicated they had not been invited to care plan meetings. No documentation of resident's attendance or refusal to attend. (D)

- Facility failed to update two resident care plans related to falls. The care plan failed to address interventions listed on the Nursing Documentation and Fall Assessment Form put in place after 2 recent falls. (D)

F 658 - Services Provided Meet Professional Standards

- Resident with diagnosis of anxiety and depression was not given ordered prn medications despite documentation that resident was upset and crying and requesting medications. (D)
- Nurse administering medicated cream to a resident out of a small plastic cup, used a gloved finger to remove from cup and it fell onto resident's sleeve. The nurse then wiped it off and placed it onto resident's wrist. (D)
- Wound treatment order not documented as completed. Progress notes revealed staff did not complete the order treatment to resident's leg. Staff failed to clarify date and time of follow-up physician appointment for family. Facility failed to identify weight gain and notify physician. (D)
- Facility failed to ensure physician orders were followed. (D).
- Facility failed to follow physician orders as directed for 2 residents.
- Failure to follow physician's orders on 4 residents. Resident #1 was to receive Hydrocodone after meals and med was given before meals. Resident #2 did not was not ambulated per physician order. Resident #3 did not have the Metoprolol held as ordered for low blood pressure. Resident #4 did not have a treatment completed per order, although it was signed off. (E)
- Facility did not report blood sugars of over 300 to physician - nurse stated "she usually runs over 300". Only one notification to physician in July, and that was when machine read too high to record. (D)
- Failure to follow physician's order regarding placing a tubi grip on in the am and off at HS. Resident had 1 - 2 plus edema when observed by the surveyor. (D)

F 661 - Discharge Summary

- No documentation of disposition of meds and belongings upon discharge for 1 resident. (B)

F 675 – Quality of Life

- Facility failed to identify and address a significant increase in resident mood indicators, failed to implement interventions to prevent resident physical pursuit of targeted staff members, and failed to coordinate a multi-disciplinary approach that addressed the behaviors of this resident. (D)

F 676 – Activities of Daily Living/Maintain Abilities

- Failure to provide ROM as documented on the established restorative plan of care. (D)
- Oral care not performed twice daily on resident with dentures. When dentures were removed in am, prior to breakfast, large amounts of food were found on dentures and in resident's mouth. (D)

F 677 - ADL Care Provided for Dependent Residents

- Residents with long facial hair; 10-day gap on bathing records for resident; 14-day gap on bathing records for another resident; (E)

- Facility did not provide two baths per week for all residents (D)
- Resident did not receive assistance with eating and did not have eyeglasses on during the meal as care planned. Additionally, another 6 residents on the dementia unit were served breakfast with a ham slice that was not cut into bite size portions. (D)
- Failed to provide toileting in a timely manner. Care plan intervention called for toileting prior to each meal. (D)
- Incomplete incontinent care as follows: staff did not wash hands or re-glove between cleaning fecal material and wiping abdomen; failed to cleanse the groin; and did not change gloves and wash hands after removing dirty brief. (D)

F679 – Activities Meet Interest/Needs of Each Resident

- Care plan stated that resident would watch Spanish channels on TV or watch Spanish movies. Resident's TV was broken and non-functioning. (D)
- Failed to assure residents were invited and assisted to activities of their choice, activity record lacked documentation of the residents attending or if residents were invited and refused. (D)

F 684 - Quality of Care

- Resident who fell and sustained a cervical and skull fracture did not receive proper neuro assessments beyond the initial assessment at the time of the fall. (D)
- Ongoing skin and behavioral assessments not completed by nursing staff. (D)
- 1 resident did not have documented assessment of non-pressure skin related issue. Resident had orders for topical medication and dressing change. Resident confirmed there was a skin issue. No assessment documentation or care plan interventions. (D)
- Failure to assess a resident with a condition change. Hospice resident had been in bed all day, was having difficulty swallowing, and had a color change. Staff began crushing her medications. Nursing facility staff failed to do an assessment but deferred it for 3 days until the hospice nurse arrived. (D)
- Staff did not intervene when resident had a significant change in condition. Resident was not eating or drinking, was unable to take medications, was unable to ambulate, and was very sleepy. Assessment or care plan interventions not completed. No physician notification. (D)

F 686 - Treatment to Prevent Pressure Ulcers

- Facility failed to complete weekly skin measurements for 3 residents. (D)

F 688 - Prevent Decrease in Range of Motion

- Resident did not receive restorative services as care planned. (D)
- Restorative nursing services not provided as care planned (E)

F 689 - Free from Accidents and Hazards

- Facility failed to implement interventions to prevent reoccurrence of resident aggressive behaviors. Resident pinned a staff member against the wall, set a dresser drawer on another resident who was in bed and threw a trash can at a staff member. Later this resident exposed himself and touched another resident

inappropriately. Care plan did not include appropriate interventions for resident behaviors. (D)

- One resident fell 23 times in 5 months (many unwitnessed falls) resulting in fractured toe, abrasions, and multiple ED visits. Same resident using an e-cig independently in the dementia unit. One staff member reported resident was to be monitored every 15 minutes and another staff member said there were no 15-minute checks. The physician reported being concerned about nursing supervision for this resident and 3 others stating he was receiving between 4-8 notification faxes of falls daily. The physician reported the residents seldom had anything to drink and dehydration was an issue and met with the DON to express his concerns. Family member reported being concerned about resident falls. A 2nd resident fell 7 times in 3 months eventually fracturing the left femoral neck. Surveyor observed wheel chair 3 different times with foot pedals in place despite care plan intervention to take foot pedals off. Third resident fell multiple times. Surveyor observed bruise and abrasion on forehead. Staff reported that resident fell when a CNA was pushing resident in wheelchair. Incident report did not indicate employee involvement. DON reported foot pedals were not on wheelchair at the time. (G) **$8,000 Fine**
- Resident with chewing/swallowing difficulties observed being left unattended in room to eat meal. No injuries. (D)
- Surveyor observed a resident being pushed without foot pedals on 1 occasion. LPN reported was not aware of policy that residents being pushed in w/c must have foot pedals. (D)
- Oxygen tanks not secured in storage room. (D)
- Failed to provide adequate supervision and assistance when staff transferred resident without the use of a gait belt resulting in a fall and a hip fracture. Following the hip fracture, the patient's condition deteriorated despite medical management and resident subsequently died. Death certificate listed cause of death sepsis due to or as a consequence of hip fracture due to accidental fall. (G) **$6750 Fine**
- Failed to ensure safety interventions were implemented to prevent further injury following incident that created a large bruise. Bruise assessment form included an immediate nursing intervention was to measure the area. Care plan did not include interventions to assess injury or prevent further occurrences. (D)
- Physical Therapy Assistant used an electric heating pad with a menthol and aspirin combination cream causing a burn on the resident's posterior left upper leg. This is beyond PTA's scope of practice. (D)
- Failed to ensure staff utilized assistive devices as planned for resident. Care Plan called for staff assist of one with ambulation. Staff, failing to use gait belt, stood resident at the end of the bed and left the resident unsupported while retrieving the garbage can. Resident fell suffering displaced right femoral fracture with mild angulation. A policy titled use of gait belt on senior care revealed gait belts are to be used for all transfers and ambulation activities (G)
- Facility failed to follow door alarm procedures to ensure each resident receives adequate supervision to prevent elopement. Resident exited the nursing facility by pushing on the panic bar of the door. Staff member was seen on security video footage responding to alarm but did not go outside the facility to see if there had been an elopement. (J) **$3750 Fine**

- Facility failed to ensure sufficient supervision to assure residents were free from disruptive, intrusive and threatening behavior by another resident. (E)
- Facility failed to ensure staff completed all resident transfers utilizing a gait belt to prevent accidents. (D)
- Failure to summon a nurse after a resident's fall to complete an assessment prior to moving the resident. (D)
- Resident sustained a severe ankle skin tear which resulted in significant blood loss during a Hoyer transfer when resident's ankle struck the battery pack. (D)
- Locks on bed wheels did not work. Bed rolled away from the wall during incontinence care and resident fell from bed. (D)
- A resident exited the building 2 times in 16 days. Resident had a BIMS score of 9 and had schizophrenia. Staff was not wearing the pager that would have alerted him to the wander guard sounding. (G) **$6250 Fine**
- Failure to ensure fall interventions planned were implemented to prevent accidents for residents. Falls in shower area. Nonskid bath strips were not present and gait belts were not being used. (G) **$7500 Fine**

F 690 - Bowel, Bladder Incontinence, Catheter Care

- Resident sleeping in recliner with catheter bag and tubing resting on floor. (D)
- Staff member did not cleanse frontal perineal area of resident with UTI during incontinent care. (D)
- Resident with UTI had no record of catheter care x 2 months. (D)
- Resident with history of UTI's had catheter bag touching floor. During catheter care the CNA placed bag on floor prior to emptying. (D)
- Care plan did not reflect that the resident had fecal impaction, nausea and vomiting. (D)
- Facility failed to provide appropriate care to prevent urinary tract infections. Staff did not change gloves after wiping BM and then cleaned peri-area with soiled gloves. (D)
- Facility failed to identify interventions to prevent dehydration for 2 residents. Both residents were physician ordered to receive specific amount of water while awake. Physician reported 3 residents on the unit had confirmed lab tests of dehydration and also observed the residents seldom had anything to drink. Physician stated met with DON 3-4 months previously and reported concerns. DON responded this led to compulsive drinking and bathroom frequency. Physician's office nurse confirmed this conversation and reported DON replied they didn't leave water out for residents to drink because there would be more incontinence and wet beds and they don't have the staff for that. Care plans did not address risk for dehydration or contain interventions ordered by physician. Surveyor observed water was not in reach of resident. (D)
- Diet order included order to give 1800ml fluid per 24 hours. Care plan lacked interventions related to recommended fluid needs for resident. Fluid record documented the consumed 570-840cc's per day for 7 days. Resident became unresponsive and required hospitalization. Discharge summary documented etiology as most likely mild dehydration. (D)
- Facility failed to implement nutritional interventions for 4 residents with weight loss. (D)

F 693 - Tube Feeding/Management/Restore Eating Skills

- No physician's orders to crush meds and mix together for administration. Nurse did not check tube placement prior to med administration and mixed all crushed tablets together for administration. Facility medication policy did not allow cocktailing or mixing of medications. (D)

F 695 – Respiratory/Tracheostomy Care and Suctioning

- No documentation of trach care on treatment records (D)

F 697 - Pain Management

- Resident with diagnosis of generalized osteoarthritis, osteoporosis and contractures reported to surveyor pain rating of 5 of 10 and desired pain to be below 3. She was observed 2 other days reporting pain and not having pillow under legs/heels as on care plan. (D)

F 698 – Dialysis

- Facility failed to consistently complete full nursing assessments and monitor a resident before and after outpatient dialysis treatments. (D)
- Facility failed to ensure resident receiving dialysis was monitored before and after dialysis treatment as required. There were no pre or post dialysis assessments completed for the resident during the month of August. (D0
- Failure to consistently complete full nursing assessments and monitoring of a resident before and after going to outpatient dialysis treatments.

F 700 – Bedrails

- Failed to ensure the correct dimensions were used on the bed rails to prevent entrapment. Six beds were out of compliance and created substantial risk for resident entrapment. (K)

F 725 - Sufficient Nurse Staffing

- Lack of timely response to call lights. One resident light on for 53 minutes. Multiple family and resident complaints to survey team. (E)
- Call lights not answered in a timely manner. (E)
- Facility failed to answer resident call lights in a timely manner to meet the resident needs. (D)
- Complaints about call lights response from the resident council and resident/family interviews were confirmed by surveyor observation. (D)
- An aide went into a resident’s room twice, cancelled the call light, and did not assist the resident to the bathroom. The resident reported to the surveyor it is not unusual for staff to turn off the light and not return for an hour. (D)
- Failure to answer call lights in a timely manner. One resident stated she waited an hour and 40 minutes to get her call light answered. Call light print out for one resident showed resident waited 47 minutes for call light to be answered. (D)
- Failure to answer call lights in a timely manner. One resident stated she waited for 1 1/2 hours to have her call light answered to use the bathroom. One resident complained of waiting an hour for a pain pill. Resident council minutes indicated complaints regarding call lights. (D)

F 729 - Nurse Aide Registry, Verification

- Facility failed to obtain registry verification prior to allowing individuals to serve as a nurse aide for 2 files reviewed. (D)

F755 – Pharmacy Services/Procedures/Records

- Facility failed to implement procedure to ensure staff accurately acquired, received, dispensed, and administered controlled medication. (E)

F 758 – Free from Unnecessary Psychotropic Meds/PRN Use

- GDR's did not address the need for continued use of psychotropic drugs. (D)
- Pharmacist request for GDR on Haldol was faxed to physician and not returned. Another resident received PRN alprazolam 3 times without interventions attempted prior to administration and also exceeded 14 days. (D)
- Failed to assure as needed prn psychotropic meds were only used for 14 days unless the physician documented rationale for continuing the medication. (D)
- Facility failed to ensure residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. (D)
- Facility failed to assure as needed psychotropic medications were only ordered for 14 days unless the physician documented rationale for continuing the medication. (D)
- Facility failed to limit as needed PRN psychotropic medication to 14 days. (D)
- PRN Ativan order exceeded 14 days and failed to include the physician's anticipated duration. The pharmacist recommended a gradual dose reduction on Ativan. The physician declined but did not document any clinical contraindication for the recommended GDR. (D)

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

- Prilosec given during meal rather than 30 minutes prior to meal. Resident with orders for Fentanyl 37.5/hour patches had 25 and 12 mg patches in place. (D)
- Failure to administer medications for residents within an hour of their scheduled times. (D)

F 761 - Label/Store Drugs/Biologicals

- Door to medication room was open and both carts stored there were also unlocked and unattended. (D)
- Surveyor observed resident with 2 pills on overbed table and an open, unlocked drawer with pill bottles in it. Resident was unable to state what the pills were and what they were for. RN arrived and gave resident 2 pills in applesauce. She was asked about the pills int he drawer and stated did not know. Resident let the RN have the pills and the meds were Furosemide & Gabapentin, which the RN had already administered. Resident then was interviewed and stated drawer could not be locked and did not know how long he had the meds or how many he had taken. (D)
- Nurse failed to lock med cart and controlled substance compartment when cart was out of the nurse's sight. (D)

F791 – Routine/Emergency Dental Services

- Facility failed to follow through with making a dentist appointment for a resident with poor dentition (D)

F 801 – Qualified Dietary Staff

- Failure to employ a qualified dietary staff member to serve as director of food and nutrition in the absence of a fulltime dietician. Facility enrolled Dietary Manager into Dietary Manager Exam prep course at community college. (C)

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

- Resident complained that she was not served the food she requested but was often served oatmeal and eggs. (D)
- During meal service 2 residents did not receive pureed corn or bread as stated on the menu. (D)
- Facility failed to serve correct portion size for three residents on a pureed diet. (D)
- Wrong scoop size used for pureed pork for 5 residents. (E)

F 804 - Nutritive Value/Appearance/Palatability/Temp

- Food was brought to dining room in insulated container and placed in front of a resident who required assistance. Fourteen minutes later, the employee began feeding residents. Food temps were low at 98, 99 and 96 degrees. Cook stated if no staff is available to assist food can get cold. The next day temps were also low at 123 and 121 degrees. Resident group reported food is not always hot. (B)
- Facility failed to serve food at palatable temperature. (E)
- Numerous residents complained about hot food being cold during breakfast. Sausage temped at 106.7 degrees. (E)

F 805 – Food in form to Meet Individual Needs

- During meal service 2 residents did not receive mechanically altered diet as ordered. (D)

F 809 - Frequency of Meals/Snacks at Bedtime

- Residents complained meals are consistently served late. Breakfast was to be served at 7:00 and service did not begin until 8:40. There was more than the allotted 14 hours between supper and breakfast. (E)

F811 – Feeding Assistant Training/Supervision

- Facility used paid nutritional assistants to feed residents with swallowing issues. (D)

F 812 - Food Procurement, Storage, Preparation, Sanitization

- Stove had black residue on burners, splatters on refrigerator doors, sandwiches in refrigerator without dates, undated quart of chicken salad, food in refrigerator was labeled with expired dates, staff serving hamburger buns and cornbread with gloved hands touched glasses during food service, and towels saturated with coffee were laying under coffee machine. (F)
- Five containers of food in refrigerator not labeled or dated. (E)

- Dietary staff did not have hair, mustaches and beards fully covered. (E)
- Kitchen sanitation handwashing sink contained a soiled cloth, mixing bowls lying face down on a buildup of white substance on shelves, caulk between counter and wall was cracked, brown and unsanitizable., front and sides of oven had dried on drippings, and microwave was dirty. Cleaning schedule not being followed. (E)
- Failed to assure appropriate full hair coverage for dietary staff, i.e. hairnet tdid not cover bangs. (E)

F 838 – Facility Assessment

- Facility failed to thoroughly assess the needs of its resident population and required resources to provide the care and services the residents needed. The assessment had no indication of the number of residents who required the use of mechanical lifts or other devices, or pertinent facts about the condition of residents. (C)

F 839 - Staff Qualifications

- Facility failed to verify licensure prior to hire for 2 staff members. (D)

F 880 - Infection Prevention and Control

- Nurse performing wound care took scissors out of pocket to remove dirty dressing and did not disinfect scissors before using to cut clean dressing. Catheter tubing laying on floor (D)
- Staff member placed graduate to collect urine from urostomy tube on the floor without a barrier in place. After collection removed gloves prior to emptying urine in toilet, rinsed graduate in sink and then did not disinfect equipment prior to storage. (D)
- Laundry cart with clean clothes was uncovered in hallway. (D)
- CNA observed leaving room with an opened trash bag with a linen incontinent pad sticking out the top. (D)
- During peri-cares CNAs did not cleanse entire peri area and did not wash hands after removing gloves. Another resident did not receive full peri care and CNA did not wash hands between glove changes or at the end of care. (D)
- Infection control logs incomplete. DON unaware they should be tracking infections. Incomplete peri care. Did not wash hands between glove changes. Resident had catheter covered with dignity bag hanging under wheelchair and dragging on the floor. During transfer, CNA placed dignity bag on floor and after transfer hung it on the bed frame. Same resident had 2 hospitalizations for UTI & sepsis. (D)
- During peri cares, CNA did not change gloves after cleansing and before handling clean items. (D)
- Failed to utilize proper infection control technique during cares. Applied bacitracin to two wounds infected with MRSA with the same gloved finger. Hand sanitation was not completed with glove changes. Did not sanitize hands between giving cares to residents. (D)
- Facility failed to ensure staff washed or sanitized their hands after each direct resident contact for which hand washing is indicated by accepted professional

practice, and failed to utilize sanitary procedures when using a blood glucose device. (D)

- Three residents had catheter bags on the floor with no protective barrier. Failure to use contact precautions for a resident with shingles. Staff was unsure how to implement contact precautions. (E)
- Nursed failed to clean scissors between cutting off dirty dressing and cutting Kerlix for new dressing. (D)

F 883 – Influenza and Pneumococcal Immunizations

- Facility was unable to locate a signed refusal form for either flu or pneumonia immunizations for one resident.

L 257 & 1093

- Failure to complete the veteran's eligibility check on 3 residents.
- Facility failed to report the veteran status for one resident.

Nursing Facility Survey Frequency - October 2018

As of October 29, 2018 CMS, lists 61 Iowa facilities or 13.9% of all facilities in the state as being past 15 months since last annual survey. Region 7 average rate is 12.4%. National average is 8.3%.

Provider Name	City	Survey End Date	Previous Date	Months
Accordius St Mary	Davenport	8/16/2018	6/8/2017	14.5
Accura Healthcare Carroll	Carroll	8/23/2018	5/7/2017	15.8
Bethany Home	Dubuque	8/9/2018	5/24/2017	14.7
Careage Hills	Cherokee	8/16/2018	5/24/2017	15.0
Clarksville Skilled N&R	Clarksville	8/9/2018	6/1/2017	14.5
Crystal Heights	Oskaloosa	8/29/2018	6/15/2017	14.7
Eventide Lutheran Home	Denison	8/16/2018	6/8/2017	14.5
Henry County HC	Mt. Pleasant	8/2/2018	6/8/2017	14.0
Manor House CC	Sigourney	8/9/2018	5/24/2017	14.7
Manorcare - Davenport	Davenport	8/30/2018	6/8/2017	14.9
Mercy Health Services	Mason City	8/16/2018	6/1/2017	14.7
Nelson Manor	Newton	8/29/2018	5/24/2017	15.4
Oakwood Specialty Care	Centerville	8/2/2018	5/18/2017	14.7
Oelwein HCC	Oelwein	8/2/2018	5/24/2017	14.5
Palo Alto Co Hosp	Emmetsburg	8/9/2018	5/11/2017	15.2
Parkridge Specialty	Pleasant Hill	8/23/2018	5/24/2017	15.2
Pleasant Acres	Hull	8/16/2018	5/11/2017	15.4
QHC Humboldt South	Humboldt	8/30/2018	5/24/2017	15.4
Ridgecrest Village	Davenport	8/2/2018	5/18/2017	14.7
Shady Oaks	Lake City	8/23/2018	5/18/2017	15.4
Southridge Specialty	Marshalltown	8/23/2018	5/18/2017	15.4
Story Co Hosp LTC	Nevada	8/23/2018	5/24/2017	15.2
Sunny Knoll	Rockwell City	8/30/2018	5/18/2017	15.6
The Village	Indianola	8/2/2018	6/1/2017	14.2
The Vinton Home	Vinton	8/29/2018	7/13/2017	13.7
Timely Mission NH	Buffalo Center	8/2/2018	5/11/2017	14.9
Twilight Acres	Wall Lake	8/9/2018	5/4/2017	15.4
West Ridge CC	Cedar Rapids	8/23/2018	5/11/2017	15.6
Westbridge Care & Rehab	Winterset	8/2/2018	5/18/2017	14.7
Westhaven Community	Boone	8/9/2018	6/8/2017	14.2
Westridge Quality Care	Clarinda	8/9/2018	5/11/2017	15.2
Westview Acres	Leon	8/29/2018	6/1/2017	15.1
			Average	**14.9**