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

Compliance Tips from IHCA's Survey Results Committee
September 2019

Total Number of Survey Reports: 64

Survey Composition:

Annual:	**30** Surveys	**2** Deficiency Free
Complaints:	**33** Surveys	**11** Unsubstantiated
Self-Reports:	**17** Surveys	**5** Unsubstantiated
Mandatory Reports:	**3** Surveys	**1** Unsubstantiated

State Fines: **$31,250**
State Fines in suspension: **$51,000**

Most Commonly Cited Iowa Tags:

F 689 – Free from Accidents and Hazards (18)

F 812 – Food Procurement, Storage, Preparation, Sanitization (15)

F 880 – Infection Prevention and Control (12)

F656 – Develop/Implement Plan of Care (11)

F 644 – Coordination of PASRR and Assessments (10)

Tags Resulting in Actual Harm or Higher Citations and Fines:

F600 – Free from Abuse and Neglect	**1 J Level Tag**
F 684 – Quality of Care	**2 J Level Tags**
F689 – Free from Accidents and Hazards	**4 G Level Tags**
F757 – Drug Regimen- Free from Unnecessary Drugs	**1 J Level Tag**

F 760 – Residents Are Free of Significant Med Errors **1 J Level Tag**

Top 10 National F-Tags*

Citation Frequency Report

National Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Active Providers=15593		Total Number of Surveys=46858
F0880	Infection Prevention & Control	4,350	25.6%	9.3%
F0689	Free of Accident Hazards/Supervision/Devices	4,110	21.3%	8.8%
F0812	Food Procurement, Store/Prepare/Serve Sanitary	3,601	21.9%	7.7%
F0656	Develop/Implement Comprehensive Care Plan	3,276	18.9%	7.0%
F0684	Quality of Care	2,981	15.9%	6.4%
F0761	Label/Store Drugs and Biologicals	2,532	15.4%	5.4%
F0657	Care Plan Timing and Revision	2,055	12.2%	4.4%
F0758	Free from Unnec Psychotropic Meds/PRN Use	1,881	11.5%	4.0%
F0677	ADL Care Provided for Dependent Residents	1,869	10.1%	4.0%
F0550	Resident Rights/Exercise of Rights	1,777	10.4%	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

- Failure to provide privacy during cares, failure to show respect by slamming med cart shut and talking to resident in a tone of anger. D
- Facility failed to provide a dignity cover bag for catheter drainage bag for resident. Resident was observed at lunch time with catheter bag hanging under the wheelchair without cover. Days later the resident was observed at breakfast with no catheter cover bag. The resident was observed at lunch with no catheter cover bag. CNA indicated the facility does not have a catheter cover bag for the resident. D
- RN spoke to residents in front of other residents, staff, and surveyors in an "abrupt, blunt, loud, undignified" manner to multiple residents. This nurse also did not knock on doors when being observed by the surveyor. E
- Facility failed to assure all residents are treated with dignity and respect. Staff was walking the resident to the dining room for dinner and when she got close to the chair she abruptly pulled on her arm and the gait belt to sit her down. D

F555 – Right to Choose/Be Informed of Attending Physician

- Failure to complete a self-administration of medication assessment for a resident. Eye drops were at bedside. D

F578 – Request/Refuse/Discontinue Treatment; Formulate Advance Directive

- Failed to ensure all staff were aware of residents' health decisions regarding advanced directives; Failed to document an accurate code status for residents. D

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

- Failed to promptly report a resident's change of condition to the physician, family, resident representative. Review of care plan failed to reveal any documentation that addressed the resident's respiratory status and/or oxygen utilization. Resident's doctor was not notified of decreased oxygen level and decreased appetite. Resident got up on own and got oxygen tubing caught up in feet and fell on left side. Staff assessed resident and got him/her up in W/C but did not document assessment. Resident eventually sent to ER and had fractured left hip. E
- Resident was transferred to the hospital without family notification. D
- Failed to notify physician of an increase in non-pressure wound. Superficial pink area on buttocks increased from 0.2cm to 0.7cm in 2-week time frame; no documentation of physician notification. D
- Fail to document physician and family notification for a significant weight change. D

F582 – Medicaid/Medicare Coverage/Liability Notice

- ABN notices not provided to residents as required. B
- Fail to adequately inform residents of the right to appeal decision for discontinuation of skilled services. Fail to issue a form 10123 NOMNC upon notice of discontinuation of SNF services. B
- Failed to provide CMS form 10123 titled Notice of Medicare Non-Coverage to resident before the end of Medicare covered services. B
- Facility failed to comply with all applicable Federal Regulations regarding Medicare requirements governing billing practices for beneficiary notification. Failed to provide resident the form for appeal rights (10123) for several residents. C

F584 – Safe/Clean/Comfortable/Homelike Environment

- Failed to provide a homelike atmosphere. There was water damage in a shared bathroom, wall board was bubbling up and pulling away from the wall, floor had several stained areas and the rubber baseboard completely pulled away. D

F600 – Free from Abuse and Neglect

- Failure to recognize their persistence in providing unwanted cares in a demented resident leading to an escalation in behaviors. Resident hit a CNA and the CNA grabbed resident's nose and squeezed it in retaliation. This was reported to the DON by a second staffer. Staff and resident interviews revealed CNA has a history of being unprofessional, impatient, and gruff at times. D **$500 FINE**
- Failure to protect resident from sexual abuse. Resident with known sexual behaviors placed hands down another resident's pants. J **$7,500 FINE IN SUSPENSION**
- Failure to assure all residents remain free from abuse. Staff was abrupt when assisting the resident to the dining room and sitting down. D

F609 – Reporting of Alleged Violations

- Resident with a bruise and swelling to his eye of unknown origin was not reported to DIA as suspected abuse. Facility investigation did not determine origin of injury or suspected abuse other than the unusual location of the bruise. D

- Failure to report an allegation of abuse to DIA. Resident made allegation of staff member hitting him/her on two different occasions and later changed story. Staff reported knowing the allegation was false but still failed to report. D

F622 – Transfer and Discharge Requirements

- Facility did emergency discharge but did not state where resident would go, if resident underwent evaluation, did not mention resident's sexual behaviors, and court ordered resident to return to facility. D

F623 – Notice Requirements Before Transfer/Discharge

- Failed to notify the long-term care ombudsman who transferred to the hospital. B
- Ombudsman was not notified of a resident transfer to the hospital. B
- Failed to notify State LTC Ombudsman when residents transferred to the hospital. B
- Failed to notify the State Ombudsman for residents who transferred to hospital. B
- Failure to notify LTC State Ombudsman office of hospitalizations. Resident's names not listed on Monthly Ombudsman report list. No documentation in clinical record re: notification of Ombudsman's office. B

F625 – Notice of Bed Hold Policy Before/Upon Transfer

- Bed hold notice not given when resident transferred. B
- No bed hold notice was provided to a resident that was transferred to the hospital. B
- Failure to provide notice of bed hold policy to resident/family at time of transfer. B
- Failure to provide resident/resident representative notice of the bed hold policy at the time of transfer to hospital. B
- Failed to notify resident and/or resident's representative of the facility's policy for bed hold when residents were transferred to the hospital. B
- Failed to provide copy of the bed hold policy at the time of transfer to the hospital. B

F637 – Comprehensive Assmt After Significant Change

- Failed to complete significant change assessment after resident came off hospice. D
- Facility failed to complete a comprehensive assessment within 14-days for a significant change in condition, clinical record lacked the completion of a comprehensive assessment with the resident's increased physical needs. D
- Failed to complete a comprehensive assessment within 14-days after a significant change in the resident's physical or mental condition. D

F638 – Quarterly Assessment At Least Every 3 Months

- Fail to assure resident had an assessment completed at least every three months. D

F640 – Encoding/Transmitting Resident Assessment

- Failure to submit MDS within 14-day time frame. D
- Failed to transmit resident's MDS within required time frame, discharge assessment had a status completed but not been submitted review of the MDS 3.0 file until five months later. D

F641 – Accuracy of Assessments

- MDS coded that resident was not currently considered by the state level 2 PASRR, MDS listed schizophrenia as a diagnosis. MDS coordinator stated she must have marked the MDS wrong for residents. D

F644 – Coordination of PASRR and Assessments

- Failure to notify PASRR of diagnosis change or mental status change. D
- PASRR not redone when residents' diagnosis changed. D
- Failure to care plan specialized services required on Level 2 PASRR. D
- Failed to submit PASRR for review for resident with new mental health diagnosis. 2017 PASRR showed resident w/o mental health diagnosis and use of antidepressant. 2019 resident with Dx of Major Depressive Disorder, Delusional disorder and on Seroquel without new PASRR being submitted. D
- Fail to incorporate recommendations from PASRR Level II determinations/PASRR evaluation report into resident's assessment, care planning, transitions of care. E
- Facility failed to submit a new PASARR when resident was newly diagnosed with major depressive and generalized anxiety with delusions. D
- Resident with diagnosis- dementia, anxiety, schizophrenia: Under PASRR was documented as no does the individual have any of the following major mental illnesses which included schizophrenia, and no for does the individual have any following mental disorders and checked depression but left anxiety unchecked. D
- Failure to document in PASRR and resubmit for a change of condition. Care plan failed to identify when psychiatry/behavioral health services began as directed by PASRR assessment. PASRR dated 2015 report no psychotropic medications, current clinical records show new diagnosis of impulsiveness and depression dated 2016 and current takes Paxil and Abilify. New PASRR was not submitted. D
- Failure to incorporate recommendations from PASRR level 2. Resident was to receive therapy services and was not receiving as often as should have. D
- Failed to submit a PASRR for review with evident mental health diagnoses. PASRR showed no mental health diagnoses. Resident's admission PASSR's without Mental Health Dx's and no psychotropic medications, years later residents with new dx such as Schizophrenia and being on Psychotropic medications without new PASRR's being submitted for change in status. D

F645 – PASARR Screening for MD & ID

- Failure to submit status change level 1 after residents approved 60 days were up. D

F655 – Baseline Care Plan

- Facility failed to provide the resident, family member or resident representative with a written copy/summary of initial baseline care plans after admission to the facility, no documentation that the facility reviewed the care plan with the family, resident or the resident's representative, no documentation completed from the family regarding if it was offered, accepted, or declined. D
- 48 hr. care plan was not reviewed with the resident or family. B

F656 – Develop/Implement Plan of Care

- Care plan lacked documentation of incontinence. D
- Antipsychotic meds and interventions not listed on care plan. No target behaviors or interventions listed on care plan. Care plan had nothing regarding anticoagulant usage or interventions in place. E
- Failure to develop person centered care plans. Dental care plan failed to address residents' needs. Care plan did not identify location of wound and did not reflect interventions for wound. Cushion that was care planned was not in residents chair. Cushion that was to be ordered for resident was not ordered for a few weeks. D
- Failure to document comprehensive care plans related to cigarette smoking, transfer assist, use of side rails and interventions for falls. Fall mat not beside bed. E
- Failure to make sure residents' care plans were followed. Resident who was care planned to have assist of one for transfers and toileting was left on toilet alone. D
- Facility failed to develop an accurate care plan that reflected services provided. Review of the care plan flailed to review any documentation that addressed the resident's respiratory status and /or oxygen utilization. D
- Facility failed to develop a comprehensive care plan that included all services. Care plan lacked identification of leg treatments, resident has a diagnosis of lymphedema and cellulitis and wounds on both lower extremities. D
- Failure to develop comprehensive care plan with medications and interventions, hallucinations and suicidal thoughts. D
- Facility failed to ensure one residents care plan included resident concerns identified upon admission related to weight loss and triggering Nutritional section of MDS. D
- Facility failed to revise care plan after discontinuation of treatments. Care plan not updated after DC of Wound Vac, contact isolation for two days and ATB DC'd. D
- Fail to ensure comprehensive care plan include the antidepressant and antianxiety medications and failed to identify adverse side effects related to the medication. B

F657 – Care Plan Timing & Revision

- Care plan lacked documentation of resident only going out on porch. D
- Failed to update care plans to current resident status of falls, hospice care, use of anticoagulants, and antidepressants. D
- Fail to revise comprehensive care plan to reflect use of anticoagulant medication. B
- Facility failed to ensure the facility IDT team reviewed/revised the care plans after each assessment. Care plan with onset date of 5/2 revealed the resident's code status as Full Code through next review 10/03, signed TO 8/12 locate in front of the resident's chart under advanced directive tab directed staff to change resident code status to DNR. The authorization and order for withholding CPR dated and signed by physician revealed resident does not wish CPR in EMAR revealed resident as a DNR, care plan revealed resident requests code status of full code. D
- Facility failed to develop a comprehensive care plan re: DNR Code Status. D
- Failure to ensure that the comprehensive care plan is reviewed and revised following a change in behavior intervention. No update on new intervention of keeping resident an arm's length distance from other residents. D

F658 – Services Provided Meet Professional Standards

- CNA turned on oxygen for resident. D
- Failure to note and implement insulin order. D
- RN failed to properly observe multiple residents consume their medications when administering them. RN administered multiple residents' medication that were prepared by another RN. RN failed to prime the insulin pen prior to administering insulin. E
- Medications were administered late. E
- Failure to administer medication correctly. Error resulting in dose of Lorazepam 10 times the ordered dose. D
- Facility failed to administer medication as physician ordered. Resident had order to hold medication if SBP for <120. EMAR shows medication was administered outside of the prescribed parameters on several days and blood pressures were not consistently taken before the medication.

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

- Resident was to walk to/from meals every day with one assist and was not walked every day. Resident stated to physician they did not get the exercise needed. D

F677 – ADL Care Provided for Dependent Residents

- Failure to provide baths/showers at least twice a week. E
- Incontinence care not provided after incontinent episode. D
- Multiple residents complained of receiving only one or no baths some weeks. The bathing documentation confirmed these complaints. E
- Care plan directed staff to apply moisture barrier to skin as needed to ensure adequate bowel elimination follow facility protocol for toileting daytime and as resident allows and nighttime to allow for restful sleep pattern. Resident was incontinent of bowel and bladder and staff provide peri-care and barrier cream to buttocks. Staff acknowledge lack of toileting program, care plan nurse acknowledged it was written in error and would consider resident on a check and change. D
- Failed to assist with eating. Dietary aide serves resident pureed diet, resident stared at plate of food in front of him/her with no staff at table to assist resident. Fifteen minutes later the unit manager sat down to assist resident to eat. Another resident requested a shave and did not receive until a CNA shaved him two days later. D
- Facility failed to ensure staff provided complete incontinence care when a resident had an incontinent episode. No cleansing of the Rt buttock and bilateral hips. D

F679 – Activities Meet Interest/Needs of Each Resident

- Did not provide activities for resident that met needs. D

F684 – Quality of Care

- Failure to provide wound care per orders; skin assessment not completed upon admission. D
- Failure to provide ongoing skin assessments. D

- Facility failed to provide necessary assessments for residents with condition change, which resulted in immediate jeopardy to resident's health/safety. Resident's care plan failed to assess edema, functional decline and shortness of breath. Resident's doctor not notified of condition change; resident sent to ER, admitted for aspiration. Resident had a change in condition which was not reported to the physician, they were eventually transported to the ER and died of sepsis due to pneumonia. **J $10,000 IN SUSPENSION**
- Facility failed to provide accurate assessment/timely intervention for residents with onset of adverse symptoms. Resident had an unwitnessed fall, complained of back pain for three weeks. Physician aware and lower back x-ray revealed no fx. PRN pain meds given with little relief and a month later CT results showed T9 and T10 fx's. Resident was hospitalized and passed away on with record of death indicating resp failure and Osteomyelitis of the thoracic region. **$10,000 FINE**
- Fail to complete ongoing pain assessment. Resident chart lacked documentation of assessment of pain. D
- Failure to properly assess, treat, care for residents in accordance with professional standards of practice; failed to initiate CPR to resident with full code status. Lack of Neuro Assessments after a falls per policy of an unwitnessed fall. Resident went 24hrs prior to being sent out for continued complaints of hip pain after fall, was found to have fracture. Full code resident found without pulse, b/p or respers, lips blue, cold to touch, no CPR initiated. D

F688 – Increase/Prevent Decrease in ROM/Mobility

- Failure to provide restorative services as directed. D
- Facility failed to assure a resident with limited range of motion received appropriate treatment and services to increase ROM and/or prevent further decrease. Lack of restorative from the time the resident was discharged from PT until wife request on two months later. Resident was to get 20-30 minutes per day Monday-Friday. D
- Failure to provide restorative services as directed. E

F689 – Free from Accidents and Hazards

- Failure to provide safety interventions; alarm that was care planned not in place. D
- Failure to provide adequate supervision for a wandering resident that was hitting staff. Failure to provide safety for resident as wheelchair alarm not in place. D
- Failure to provide supervision to a dementia resident as they were found in bed with another resident. D
- Failure to put in place interventions that were listed after a fall. D
- Facility failed to safely transport residents. Resident was transported down a ramp with no foot pedals and the resident could not hold their feet up. D
- CNA pushed resident in wheelchair without foot pedals. D
- New resident on locked memory care unit was let out the locked door by a staff member who thought they were a visitor. Resident was found in parking lot trying to get into locked cars. No injuries. D
- Resident fell from a Hoyer lift and investigation could only conclude that the sling loop slipped from the lift. The resident sustained a fracture. **G $7,250 FINE**

- Staff failed to apply foot pedals to resident's chair before pushing them. Staff also failed to lock the brakes of resident's wheelchair while staff transferred wheelchair and while they repositioned resident in his wheelchair. D
- Failure to provide adequate supervision to prevent hazards from self and elements in the environment (elopement). Failure to provide supervision resulted in immediate jeopardy to residents' health and safety. When door alarm sounded staff did not go out to check grounds as per policy but proceeded to turn off alarm. **J $7,500 FINE IN SUSPENSION**
- Failure to follow door alarm procedures to ensure each resident received adequate supervision to prevent elopement. Resident was confused and needing increased monitoring due to exit seeking and it wasn't initiated, and resident was found outside by an AL employee outside looking for kids. Staff was unaware that the resident had left the building and was not looking for her. **J $4,250 FINE IN SUSPENSION**
- Failure to follow care plan interventions to prevent falls. Care plan for resident said to leave a call bell with resident when left in common areas and that did not occur. D
- Failure to safely transport resident in wheelchair. Staff noted pushing resident in w/c without foot pedals. D
- Failure to ensure the environment was free of hazards. A Rubbermaid cabinet on the north wall of the shower room was open and unlocked with 3 bottles of whirlpool chemicals available. D
- Staff did not put gait belt on resident which resulted in fall/fracture. **G $5,000 FINE**
- Fail to maintain safe environment. Resident tripped over cord to air mattress, result is fracture of left femur, septic shock and aspiration pneumonia. **G $8,500 FINE**
- Failure to provide assistive devices (alarm) to alert staff and mitigate a resident's risk for falls and injury. Fall without alarm sounding, found turned off. No mention on care plan of need for alarms as per the nurse aide worksheets. D
- Failed to ensure staff maintained a safe/secure environment. Resident got up on own and got oxygen tubing wrapped around feet and fell fracturing left hip. Staff moved resident several times with a broken hip. **G $8,750 IN SUSPENSION**

F690 – Bowel, Bladder Incontinence, Catheter Care

- Lack of proper toileting program. Catheter bag had no dignity bag and bag was touching floor. Catheter bag was above the level of the bladder. D
- Failure to assist with incontinence cares/changing bed linens in timely manner. D
- Facility failed to provide appropriate catheter care. Catheter drainage bag without privacy bag cover and attached to the garbage can. D
- Failure to handle catheter bags/tubing in a manner to reduce risk of developing infection for residents with UTI. Resident was noted to have dignity bag dragging on floor (tubing outside of the bag but not touching floor) while self-propelling in the hall. CNA was asked when he/she last emptied the bag, CNA then grabbed the cath bag from the dignity bag without washing hands to show surveyor the low output. A day later, the same resident's dignity bag and 6-inches of tubing were noted to be in contact with the floor in common area and later in bed 2-inches of tubing touching the floor. A second resident had catheter cares completed by staff members (CNAs). Catheter drain

bag fell on the floor with the spigot of drain bag touching the floor and staff picked it up and placed it in dignity bag without cleaning the bag/spigot. D
- Facility failed to ensure appropriate perineal care was completed after an incontinence episode. Abdomen and leg creases were not cleansed. Used scrubbing motion to cleanse buttocks. Removed gloves and donned new ones, without washing hands. D

F693 – *Tube Feeding Management/Restore Eating Skills
- Failure to implement trial of oral medications to be given to resident with feeding tube. Care plan directed staff to use g-tube for administration of medications as needed and fluids per orders. Order directed staff to administer medications through g-tube if the resident refused orally. Staff did not offer/encourage resident to take medication orally prior to giving by G-tube. D

F695 – *Respiratory/Tracheostomy care and Suctioning
- O2 was run at 2 LPM instead of 1 LPM as ordered by physician. D
- Failure to have a care plan that included use of oxygen. D
- Resident found with empty O2 tank and staff member did not know how to refill it. D
- Failure to follow facility directives identified in policies and care plan ensuring an obturator resident accessible for an emergent airway for resident with tracheostomy; Failed to ensure oxygen equipment maintained for oxygen use. D

F697 – *Pain Management
- Fail to treat resident's pain to extent possible in accordance with physician orders. D

F698 – Dialysis
- Facility failed to perform pre and post dialysis assessments. D
- Facility failed to complete nursing assessments and monitoring of resident before and after resident went to outpatient dialysis. D

F700 – Bedrails
- Failure to obtain consent for use of bedrails; not in care plan. E
- Electronic health record lacked documentation regarding side rail consent, no consent completed. D
- Use of grab bars and/or side rails without proper education of the risk vs benefits and signed consent. E
- Facility failed to assess bed rails and/or obtain consent for use. Hand assist bars on bed with consents. Care plan failed to identify use of the hand assist bars. Use of a top quarter rail with no consent for use. E
- Failed to assess bed side rails for risk of entrapment and obtain consent for use. D
- Facility failed to assess bed side rails of use. Consents incomplete, not dated, not current re: rails on bed (size of side rails, side rails vs assistive handrails. Safety device assessments, not up to date, or not complete. E
- Facility failed to assess bed side rails for usage and obtain consents. No side rail assessments or signed consents. D

F725 – Sufficient Nurse Staffing

- Failure to ensure staff responded and answered residents' call lights within 15-minutes and meet the needs in a timely manner; call light log for one seven-day period showed 14, 7, and 26 instances of the call light response times greater than 15 minutes. Reviewed resident council meeting minutes with concerns regarding call light times. During resident group interview multiple residents reported concerns about the staff's response to call lights. E
- Failure to provide enough staff causing restorative to not be done as stated and call lights not answered in a timely manner. E

F727 – RN 8 Hrs./7days/Wk, Full-time DON

- No RN on duty for two consecutive days. E

F729 – Nurse Aide Registry Verification, Retraining

- Failure to verify nurse assistant registry status prior to hire. Did not verify with DCW that employee was eligible. D

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

- Two CNAs did not have the 12 hrs. of required in-services. B
- Fail to assure CNA's received 12-hrs of in-service education yearly based on anniversary dates. Records show staff had 4-5 in-services for year and in-service sign-in sheets contained no information as to length of time meetings lasted. C

F732 – Posted Nurse Staffing Information

- Failure to post required nurse staffing information daily. D

F755 – Pharmacy Svcs /Procedures/Pharmacist/Records

- Facility failed to implement a procedure to ensure account of all controlled medications is maintained and periodically reconciled. LPN was preparing resident's medications and discovered Oxycodone 5/325 was not available to give. Pharmacy stated it was too early to refill and there was no controlled medication utilization record or bubble pack found. Investigation revealed 22 doses missing. Staff reported another staffer med aide had used the keys multiple times during the shift and when keys were exchanged back/forth no narcotic count was completed per protocol. Facility has no system to easily identify if a controlled med/CMUR are removed. E

F757 – Drug Regimen- Free from Unnecessary Drugs

- INR was checked three months after an order to check at four weeks. D
- Failed to check INR in two days, did it 16 days later resulting in critical INR placing resident in immediate jeopardy. **J $6,000 FINE IN SUSPENSION**

F758 – Free from Unnecessary Psychotropic Meds/PRN Use

- Failure to discontinue PRN psychotropic. D

- Failure to ensure staff utilized non-pharm approaches prior to the administration of psychotropic medication. Documentation lacked interventions attempted prior to administrating PRN Ativan. D
- Failure to complete a GDR on psychotropic medications. No specific physician rationale included for any psychotropic medications listed on GDR form, medications were not addressed individually. D
- Failure to attempt non-pharmacological interventions prior to administration of anti-anxiety medication for resident on hospice as they thought hospice services exempted the need to attempt interventions prior to administration. D
- Failure to attempt non-pharmacological interventions prior to administration of as needed psychotropic medication given. D
- Failure to monitor antidepressant side effects. Care Plan lacked documentation of the type of side effects to monitor for and report for the antipsychotic and antidepressant medication. D

F760 – Residents Are Free of Significant Med Errors

- Resident received roommate's insulin that caused her blood sugar to drop to 20 and was unresponsive and sent to ER where he/she was later admitted to ICU. **J $7,000 FINE IN SUSPENSION**
- RN and CMA were both preparing medications on same med cart and became distracted. CMA administered the wrong medication cup to one of the residents. This resident required hospitalization related to the error. D

F761 – Label/Store Drugs & Biologicals

- Med cart unlocked with no staff nearby. E
- Facility failed to properly label a medication with the date it was opened. D
- Failed to label medications in accordance with currently accepted professional principles. Ten unlabeled cups of white powder stacked in two rows in locked cabinet in front of labeled bottles of MiraLAX. Staff poured medication ahead of time and reported they knew they should not have. D

F801 – Qualified Dietary Staff

- Failure to ensure a qualified person served as the Director of Food and Nutrition Services. The person serving in the role has not taken her exam. C
- Failure to ensure facilities Dietary Service Manager had required qualifications in the absence of a full-time dietitian. E

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

- Bread and butter not on trays to residents in a unit as menu stated. E
- Resident on pureed diet did not receive proper portion size. E
- Failure to serve the menu as written, staff failed to add breadcrumbs to the sunshine carrots, did not use the correct serving utensil for vegetables. E
- Failure to provide accurate menus, meet nutritional needs by serving the correct portion size in 2/3 residents. Residents were served foods for lunch dished up with the wrong scoop size used. D

- Dietary staff failed to serve pureed garlic bread per the menu. D
- Failure to ensure all residents on pureed textured diets received proper portion size based on the planned menu. Staff didn't measure meatloaf/ketchup before/after blending. Used wrong scoop and ended up with two servings of meatloaf leftover. D
- Failed to follow planned menu (pureed texture diet, no pureed croissant observed. E

F804 – Nutrive Value/Appear, Palatable/Prefer Temp
- Facility failed to maintain the proper food temperature and food palatability.
- Failure to ensure food/drink were palatable, attractive, and at proper temperature. Mashed potatoes were 105 degrees Fahrenheit and ham was 92 degrees Fahrenheit, staff did not reheat the food nor did they serve a new plate of food. D
- Failed to serve palatable food at appetizing temperatures to residents that received room trays. Chili served with a Fahrenheit temperature of 137.4 degrees, diced pears with a Fahrenheit temperature of 67.0 degrees. Resident stated there wasn't a choice for food served and oftentimes food on the room tray was cold, also staff did not offer to reheat the food. E

F812 – Food Procurement, Storage, Preparation, Sanitization
- Containers in kitchen were dirty, cupboards/floors dirty, milk left out on counter, no thermometer in fridge, buildup in freezer, debris on stove, metal shelves, pots/pans, and appliances. Staff walked through kitchen without hairnet and did not wash hands between glove use. E
- Failure to provide clean and sanitary equipment in the kitchen. D
- Failed to assure sanitary practices in the kitchen of the special care unit. Staff member who served the meal wore gloves, touching utensils, plates, and went to the cupboard and retrieved dishes, and left kitchen to serve plates to several residents. Handled the resident's bread wearing the same gloves. Staff washed the blender container under the running water in the sink. E
- Failure to maintain a clean/sanitary kitchen. Lower shelf of refrigerator had yellow/brown heads of lettuce present; bottom contained brown crumbs. Two sprinkler heads by stove hood were noted to have gray fuzz/filaments presents. Cooler was noted to have a foul odor and contained a 3/4 full box of white and brown oranges, 1/2 box of discolored zucchini, and a box of discolored lettuce. Dietary manager reported cooler went down last week; repair person coming that day to fix the cooler. E
- Failure to prepare, distribute, store food in accordance with food service safety. Observation of kitchen revealed seven undated open items in the cooler and days later an additional four undated items noted. Expired yogurts found and additional undated open items noted. A CNA handled glasses around the rims. Another CNA handled various items with gloved hands before serving bread with hands. Staff activity director touched the rims of glasses several times while serving; used gloved hands that he/she had touched various items with to butter/serve to resident.
- Dietary staff used the alcohol prep pad on thermometer between checking temps on all food items. One meat item was not at proper temp and had to be reheated. D
- Dietary staff didn't change plastic gloves when touching non-food surfaces prior to touching food. E

- Failed to maintain a clean kitchen, cover all exposed hair with hairnets and have suitable cutting boards. Cutting boards noted to have deep grooves and fuzz on both side unsantizable. Chest freezer with approximately 1-inch thick ice accumulation around freezer on all sides, several cabinets noted to have sticky dirt/grime substances. Exposed hair not covered by hairnet. E
- RN delivered a drink to resident sitting in dining room holding glass by rim not at the base of the glass. CNA picked up glasses by placing in fingers inside the empty glasses. Staff then filled them up with fluids and dispensed them to residents. Staff grabbed spoons by the scoop and delivered them. Staff fed several residents and performed no hand hygiene between feeding them. E
- Fail to properly label/dispose of outdated food items to prevent foodborne illness. E
- Failed to handle ready-to-eat food items in a manner to prevent or reduce the risk of spreading food borne-illnesses. Cook served noon meal with gloved hands and touched plates, counter tops and steam tables and with the same gloved hand served ready-to-eat hamburger buns multiple times. D
- Fail to ensure staff served food items under sanitary conditions to reduce risk of food-borne illness during meal services. Staff touched food with gloved hands, touched counters, stove and numerous resident plates, staff continued to touch food with gloved hands throughout lunch service. E
- Failure to have sanitizable cutting boards, and upright freezer in basement in need of repair and refrigerators with fingerprints and smudges noted. Cutting boards with deep grooves and fuzz present. Numerous smudges and fingerprints in the kitchen area. Freezer in need of repair due to constantly defrosting and water dripping from lower part of unit. E
- Facility failed to assure safe handling of food/proper sanitization of dishes to reduce risk of contamination and food-borne illness. Sanitizer logs were incomplete. Test strip did not change colors when dishwasher tested. Dishwasher temperature stayed at low temp for several rinse attempts. Maintenance addressed and eventually fixed. Staff unable to determine if plates in the cupboard when appropriately cleaned. No paper or foam plates available for use during this time. F
- Fail to serve food under sanitary conditions in order to protect food from contamination. After putting on gloves, staff touched food/surfaces throughout meal service without changing gloves. E

F825 – Provide/Obtain Specialized Rehab Services

- Failed to provide restorative therapy as directed per resident's care plans as reported; failed to provide restorative services to multiple residents 3-6times per week. Staff reported due to call-ins, restorative staff would be pulled to the floor. E

F838 – Facility Assessment

- Failure to complete thorough evaluation of resident population, identify required resources and staffing levels needed to provide the necessary care and services needed for residents. Document lists the various departments throughout the facility but does not evaluate the resident population and identify resources needed to provide the necessary person-centered care and services the residents require. B

F868 – QAA Committee

- Failure to ensure Quality Assessment committee met quarterly and consist of the required members. D

F880 – Infection Prevention and Control

- Hands were not washed between glove use while cleaning wounds. Failure to prevent infection control. D
- Failure to provide proper infection control procedures during peritoneal dialysis. D
- Clean laundry was being pushed down hall without being covered - failure to ensure infection control. E
- Failed to properly handle the feeding tube before connection to the PEG. Resident's feeding tube did not have a cap on end and staff hooked it up to the resident. D
- RN failed to perform hand hygiene between residents when passing meds. D
- Failure to transport clean linens using proper infection control techniques. Clothing was lying over the side of a laundry cart. D
- Facility failed to administer medications utilizing infection control practices. Staff failed to complete hand hygiene after obtaining resident's blood sugar and after administering insulin. CMA dropped Pradaxa on medication cart picked it up with her bare hands and placed it in the medication cup with the rest of the pills. D
- Failure to follow proper infection control techniques in order to prevent infection. Staff didn't wash hands after removing gloves, set basin of water on shelf with no barrier, cleaned residents groin area without changing surfaces of the washcloth. E
- Fail to complete adequate infection control measures and sanitize a glucometer. D
- Failed to ensure staff utilized proper infection control techniques in order to prevent infection. Foley cath bag covered with dignity bag but the bag hung below the dignity cover and rested on the floor. During emptying of the catheter bag, the bag was laid onto the floor mat rather than the barrier prior to changing cath bag to a leg bag. D
- Fail to utilize proper infection control techniques during resident care. Didn't cleanse buttocks, hips or abdomen during incontinence cares. Removed gloves, didn't wash/sanitize hands prior to putting on clean brief, continued to touch other surfaces in room without washing hands until resident transferred to w/c to leave room. D
- Failed to ensure staff practiced proper infection control procedures to prevent infections. Catheter tubing touching the floor. Placed glucometer on bedside table without barrier. Took syringe cap off needle with teeth prior to injecting resident. Didn't utilizing PPE during suctioning of Trach or change gloves during cares. E

F883 – Influenza and Pneumococcal Immunizations

- Failure to offer or provide pneumonia vaccination for a resident whose status of vaccination was unknown. D

F921 – Safe/Functional/Sanitary/Comfortable Environment

- Failure to maintain a clean and homelike environment in spa areas. E

L257

- Failed to submit resident assessment reviews to Iowa Department of Veteran Affairs.

Nursing Facility Survey Frequency

As of October 3, 2019, CMS lists 60 Iowa facilities (13.7%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 7.3%. National average is 5.2%.

FFY 19 - Sept. Totals - LTC Surveys				
Provider	**City**	**Survey End Date**	**Previous Date**	**Months Between**
Accura Healthcare of Cherokee	Cherokee	7/18/2019	9/4/2018	10.57
Accura Healthcare Newton East	Newton	7/2/2019	4/19/2018	14.63
Altoona Nursing & Rehab Center	Altoona	7/30/2019	7/26/2018	12.30
Caring Acres Nursing & Rehab Center	Anita	07/02/2019	4/5/2018	15.10
Creekside	Grundy Center	7/24/2019	5/3/2018	14.90
Creston Specialty Care	Creston	7/18/2019	4/12/2018	15.40
English Valley NCC	North English	7/11/2019	4/12/2018	15.17
Faith Lutheran Home	Osage	7/11/2019	4/5/2018	15.40
Friendship Haven	Fort Dodge	7/11/2019	3/29/2018	15.63
Genesis Senior Living	Des Moines	7/24/2019	4/5/2018	15.83
Grand Ji Vante	Ackley	7/25/2019	4/26/2018	15.17
Humboldt Hospital	Humboldt	7/18/2019	5/3/2018	14.70
Keota Health Care Center	Keota	7/24/2019	4/19/2018	15.37
Linn Haven	New Hampton	7/2/2019	3/22/2018	15.57
Lutheran Retirement Home	Northwood	06/20/2019	3/19/2018	15.27
MercyOne Centerville Medical Center	Centerville	6/27/2019	3/22/2018	15.40
MercyOne Dubuque Medical Center	Dubuque	7/2/2019	2/28/2018	16.30
Northgate Care Center	Waukon	07/18/2019	4/12/2018	15.40
Parkview Manor Care Center	Reinbeck	7/18/2019	4/5/2018	15.63
Pearl Valley Rehabilitation and Healthcare - Perry	Perry	07/11/2019	4/19/2018	14.93
Perry Lutheran Home	Perry	7/11/2019	3/29/2018	15.63
Premier Estates of Toledo	Toledo	07/24/2019	4/19/2018	15.37
Regency Park Nursing & Rehab Center of Carroll	Carroll	7/18/2019	4/12/2018	15.40
Rehabilitation Center of Lisbon	Lisbon	7/2/2019	3/29/2018	15.33
Riceville Family Care and Therapy Center	Riceville	7/18/2019	4/12/2018	15.40
Rockwell Community Nursing Home	Rockwell	7/2/2019	4/5/2018	15.10
Sunnycrest Manor	Dubuque	7/11/2019	4/5/2018	15.40
University Park Nursing & Rehabilitation Center	Des Moines	7/18/2019	4/5/2018	15.63
Washington County Hospital	Washington	6/15/2019	3/29/2018	14.77
			AVERAGE	**15.41**