# Compliance Tips from IHCA's Survey Results Committee
# September 2020

**Total Number of Survey Reports: 53**

**Survey Composition:**
**Annual:** **0** Surveys 0 Deficiency Free
**Complaints:** **42** Surveys **15** Unsubstantiated
**Self-Reports:** **11** Surveys **1** Unsubstantiated
**Mandatory Reports:** **0** Surveys **0** Unsubstantiated
**COVID-19 Infection Control: 35** Surveys **13** Deficiency Free

**State Fines: $9,000**
**State Fines in suspension: $ 74,000**

**Most Commonly Cited Iowa Tags:**

**F 880 – Infection Prevention and Control (14)**

**F 684 – Quality of Care (6)**

**F 580 – Notify of Changes (Injury/Decline/Room, Etc.) (5)**

**F 689 – Free from Accidents and Hazards (5)**

**Tags Resulting in Actual Harm or Higher Citations and Fines:**

**F 686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers 1 J Level Tag & 1 G Level Tag**
**F 689 – Free from Accidents and Hazards 3 J Level Tags & 1 G Level Tag**
**F692 – Nutrition/Hydration Status Maintenance 1 G Level Tag**
**F760 – Residents are Free of Significant Med Errors 1 J Level Tag**
**F 880 – Infection Prevention and Control 2 K Level & 1 L 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=15451 | | Total Number of Surveys=60583 |
| F0880 | Infection Prevention & Control | 4,659 | 23.5% | 7.7% |
| F0884 | Reporting - National Health Safety Network | 2,513 | 7.7% | 4.1% |
| F0689 | Free of Accident Hazards/Supervision/Devices | 1,527 | 8.6% | 2.5% |
| F0812 | Food Procurement, Store/Prepare/Serve Sanitary | 1,136 | 6.9% | 1.9% |
| F0684 | Quality of Care | 1,118 | 6.3% | 1.8% |
| F0656 | Develop/Implement Comprehensive Care Plan | 1,004 | 6.0% | 1.7% |
| F0761 | Label/Store Drugs and Biologicals | 802 | 5.0% | 1.3% |
| F0609 | Reporting of Alleged Violations | 704 | 4.0% | 1.2% |
| F0686 | Treatment/Svcs to Prevent/Heal Pressure Ulcer | 647 | 3.8% | 1.1% |
| F0657 | Care Plan Timing and Revision | 606 | 3.6% | 1.0% |

*Additional detailed national, regional, state and facility-specific CMS regulatory data can be found S&C's Quality, Certification, and Oversight Reports (QCOR).

**Deficiencies and Fines** (sorted ascending by F-tag number)

### F550 – Resident Rights/Exercise of Rights

- Facility failed to provide the resident with dignity and respect. Resident felt she was rushed too fast with cares and they were not respecting her and that the staff gossiped about her. D
- Facility failed to provide dignified care for 1 of 3 residents. CNA with gloved hands handed the garbage can with her gloved hand over the top of the resident and failed to remove the dirty gloves and perform hand hygiene after touching the garbage can. CNA placed the clean brief on the resident still wearing the same dirty gloves. CNA failed to remove the wet fitted mattress sheet from under the resident. RN failed to complete hand hygiene before removing 4 non-stick pads and 4 ABD pads and laid them on the treatment cart without a clean barrier underneath. D
- Resident would not stay in his room in evening and insisted on being in lounge area to watch tv while it was being sanitized. Staff spoke unkindly to resident and used chairs to barricade resident in hallway to keep out of lounge area. D

### F558 – Reasonable Accommodations of Needs/Preferences

- Facility failed to provide reasonable accommodations to meet the residents needs to communicate efficiently. Resident unable to effectively communicate or use call light, due to contracture in hands and facility stated unable to use pressure call light due to their call light system and client felt unsafe not being able to use call light.

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

- Facility failed to ensure resident deposited personal funds were held, safeguarded, and managed in a manner that prevented misuse for 2 of 3 residents reviewed. D
- Facility failed to notify the resident's representative and/or physician of changes. The resident had progress notes that documented Speech Therapy recommendations received that changed the resident's fluids from thin to honey thickened consistency, and the clinical record lacked any notification to the physician or resident's representative. Clinical record lacked documentation the facility notified the ARNP or the resident representative of significant weight loss. Resident with extended bladder was admitted to the hospital with acute distention of urine and 2,150cc drained, and facility did not notify ARNP of distended bladder. D

- Facility failed to notify the resident's representative of any change in condition. The resident's record lacked documentation of notification to the resident's representative related to weight loss. D
- Facility failed to document family notification for 2 of 4 residents. Resident had new pressure ulcer and the family was not notified. Resident had COVID test and family was not notified of results. D
- Facility failed to notify the residents family of changes in residents condition and new orders. Resident had vasovagal response when raising hoyer to get out of shower and became weak and nonresponsive but came back around within 3 minutes. Several weeks later had several more episodes and speech was garbled and medications held several different times and family was not notified. D

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

- Facility staff failed to report an incident of neglect and immediately segregate the alleged perpetrator for one of five residents reviewed. Residents careplan stated she was to be followed with a wheelchair when ambulating and to have a gait belt on. CNA was ambulating the resident with no wheelchair follow and no gait belt. The resident's legs gave out and she fell face forward onto the floor. She did go to the ER with swollen left knee, x ray was negative for fracture or injury. D

### F609 – Reporting of Alleged Violations

- Facility failed to report an alleged violation involving abuse to the department for 2 of 4 sampled residents 2 staff members who were assisting with cares, when a resident got combative and one of the staff members pushed the residents arms into her stomach ache and when caring for another resident, pulled her sweater off roughly over her head, causing it to get tight around her neck and the staff member who observed both incidents did not report it until the next morning.
- Facility failed to report an allegation of physical abuse to DIA immediately as required.

### F622– Transfer and Discharge Requirements

- Facility failed to provide a safe and orderly discharge for one resident who left the facility against medical advice. The facility failed to provide discharge instructions for medications (including insulin) or a newly amputated leg to the resident or family member that picked him up. The facility did not inquire or ensure that he had medications or supplies needed upon discharge. The record did not indicate that he left AMA.

### F626 –Permitting Residents to Return to Facility

- Facility failed to allow a resident to return to the facility following acute hospitalization and involuntary discharged the resident without proper notification. D

### F636 – Comprehensive Assessments & Timing

- Facility failed to complete a comprehensive MDS assessment for 5 of 6 residents. Residents admission MDS contained an assessment reference date of 7/13 and required completion by 7/15, and the facility did not complete the MDS assessment. A residents annual MDS assessment not completed within the 366 days as required per RAI. E

### F637 – Comprehensive Assmt After Significant Change

- Facility failed to complete a required Significant Change Minimum Data Set assessment. A review of the MDS table lacked a significant change assessment completed after admission to hospice.

**F638 – Quarterly Assessment At Least Every 3 Months**

- Facility failed to complete a quarterly MDS assessment.

**F655 – Baseline Care Plan**

- Facility failed to complete a baseline care plan within 48 hours of admission into the facility for 1 of 2 residents.

**F656 – Develop/Implement Plan of Care**

- Facility failed to develop a care plan for one resident. The Wander Risk Assessment documented the resident as a high risk for wandering. The Progress notes documented the resident eloped. The DON stated she would expect staff to identify the resident as at risk of wandering on the care plan. D

**F657 – Care Plan Timing and Revision**

- Facility failed to review and revise care plans for 2 of 6 residents reviewed. First care plan failed to state resident needed assist of two staff to go outside to smoke. Second care plan failed to show EZ stand transfer vs Hoyer lift.

**F658 – Services Provided Meet Professional Standards**

- Facility failed to meet professional standards of quality services of 2 of 3 residents reviewed involving medication management and administration. The medication administration record revealed staff administered Tramadol 8 times to the resident, but staff failed to document 6 doses on the MAR and failed to document assessment of the resident. D
- Facility failed to meet professional standards of quality when following physician orders. The residents MAR identified the resident did not receive a Fentanyl patch as ordered and the record lacked documentation of weekly weights as ordered. D
- Facility failed to administer medications as ordered by the physician. Resident was admitted on 3/13/2020 in the late afternoon and medications did not get ordered and delivered to be given to the resident until 3/15/2020. D

**F677 – ADL Care Provided for Dependent Residents**

- Facility failed to provide the necessary services for incontinence care and bathing. Resident was to be checked every 2 hours for incontinence and when the hospice aide arrived she reported the resident was so wet that the brief stuck to the resident at 11:00AM, the resident stated she had not been checked since 5AM. The resident did not receive any baths except when the Hospice would come to the facility. Baths consistently not being given and no documentation as to why or if the residents refused. E
- Facility failed to assure residents receive 2 baths per week for 3 of 8 residents. D

**F684 – Quality of Care**

- Facility failed to provide weekly measurements, assessments, and accurate documentation for non-pressure skin integrity injury. The care plan failed to identify a new skin wound. D
- Facility failed to provide adequate assessment and timely intervention for a resident with a change in condition for 1 resident. Skilled charting documented the resident had bladder distention, when they stood for the commode urine ran out of the resident. The note documented the facility would notify the on call, but the clinical record lacked any documentation that the facility notified the physician. D
- Facility failed to implement a physician's order after a fall. Physician gave an order on 6/18 for PT to evaluate and treat, on 7/27, and PT had not seen that patient as of this date. D

- Facility failed to complete timely post-fall assessment, interventions, and physician notification. Resident was found in room on knees. Two staff assisted the resident back to bed with no injuries noted. The day LPN thought the night LPN would fill out the documentation and call the physician since it happened on their shift. D
- Facility failed to complete follow-up nursing assessments for a resident identified with a change in medical condition and failed to complete daily respiratory assessments on all residents to quickly identify COVID-19 signs or symptoms. E
- Facility failed to obtain weekly weights for resident and failed to provide assessment of resident with a medical condition. D

### F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcers

- Facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure ulcers and also failed to ensure residents with pressure ulcers received necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing. Staff had an order to apply duoderm to open area on left hip and back and this order did not get carried out for 4 days. The physician ordered cultures for the wound on 4/10 and it wasn't charted until 4/12 and on 4/17 the resident was transferred to the hospital for antibiotic therapy. Residents careplan documented risk for pressure ulcers and to reposition frequently, review of the careplan revealed it failed to contain any interventions for pressure relieving devices for the bed or chair. A residents chart lacked documentation that showed staff had done a comprehensive skin assessment. **J $8,500**
- Facility failed to assure a resident without pressure ulcers did not develop pressure ulcers. A resident who was admitted after a hip fracture repair had no pressure ulcer, was sent to ER due to abnormal labs and the hospital documented the resident admitted with a deep purple tissue injury to the right heel, appearing purple, painful, and nonblanchable. D
- Facility failed to provide complete documentation for a resident with pressure ulcers. On the MDS admission assessment completed, it revealed the resident did not have any pressure ulcers upon admission. A review of the nursing admission Data Collection sheet revealed: Section J admission skin sweep to identify skin impairments, had not been completed. The Braden Scale score had not been completed. Review of weekly skin assessments revealed left heel with blister. D
- Facility failed to do comprehensive assessment of residents wound after hospital admission (no measurements or assessments) and failed to demonstrate subsequent pressure ulcer was unavoidable**. G $3,000**

### F688 – Increase/Prevent Decrease in ROM/Mobility

- Facility failed to ensure resident's with limited range of motion or assistive devices received appropriate care, treatment and services to maintain current range of motion and/or to prevent further decrease in range of motion. DON stated they do not have the staff to do restorative program. E

### F689 – Free from Accidents and Hazards

- Facility failed to ensure the resident remained free from accidents and hazards Staff did not respond to door alarm because she thought a staff member went out to smoke, but a resident had went out the door and eloped. D
- Facility staff failed to ensure a resident received transfer assistance as directed by her care plan and facility directives. There was from therapy to not walk the resident at this time per therapy. CNA was ambulating resident when she fell face first. **G $6,750**

- Resident Elopement- resident had a number of interventions but continued to exit seek. Resident eloped and was found approximately 1/2-1 mile away at the corner of two four lane streets but had no injuries. Facility had been short one CNA in unit due to call off. There had not been an alarm on first floor exit. After corrective measures lowered severity to a D. **J $6,000**
- Facility failed to adequately supervise residents when outside smoking. Resident walked away from facility while staff failed to maintain constant supervisions as directed in care plan. Resident was found with no injury. Past noncompliance IJ. Elopement book not up to date. Head to toe assessment didn't contain vitals. **J $8,000**
- Failed to provide adequate nursing supervision of residents in courtyard patio. Facility failed to maintain adequate supervision of resident and didn't know she had entered courtyard. Found resident on ground after a fall. Heat index 90 degrees. Resident's temperature was 101.4 degrees when found and took 1 hr 15 minutes to return to normal. Resident had large red marks as result of the incident. Record had shown she was severely impaired in daily decision making and exhibited wandering behavior. Care plan had identified as risk for falls related to dementia. Had fallen multiple times before. Record shows multiple other issues with wandering and other behaviors. **J $7,750**

## F692 – Nutrition/Hydration Status Maintenance

- Facility failed to assure a resident maintained acceptable parameters of nutritional status and sufficient fluid intake to maintain hydration. Speech Therapy note recommends changing residents liquids from thin to honey thickened, and the clinical record lacked any notification or diet change. The Frazier Free Water Protocol was developed for the resident to help with fluid intake and the clinical record lacked any documentation the interdisciplinary team notified of or considered implementing this to help with resident's hydration. **G $8,500**
- Facility failed to assess a resident's weight accurately, and appropriately intervene for 1 of 7 clients. Residents record lacked documentation of notification to the physician of weight loss. D
- Facility failed to ensure recommendations from the dietician were implemented in a timely manner to avoid further weight loss. D
- Facility failed to assess resident at high risk for dehydration and failed to initiate interventions to prevent overall health decline. Resident had care plan that said was at risk for nutritional deficit b/c meals in room and possible decreased intake/appetite b/c of acute illness. Resident had 7.8% weight loss in 30 days. Resident admitted to hospital. Record lacked documentation of intakes/outputs and assessment for dehydration. Hospital physician said if staff had monitored or taken more aggressive rehydration measures hospitalization could have been avoided. D

## F725 – Sufficient Nurse Staffing

- Facility failed to assure that there was sufficient qualified nursing staff available at all times to provide nursing and related services to meet the residents' needs by answering residents call lights in a timely manner. D
- Facility failed to provide a sufficient number of staff to answer call lights in a timely manner. The facility also failed to provide a sufficient number of staff to complete meal service, dining assistance, transfer, and repositioning to meet the basic care needs of resident on the second shift. E

## F755 – Pharmacy Svcs/Procedures/Pharmacist/Records

- Facility failed to account for Narcotic Medications for one resident. The MAR lacked documentation of administration for the Fentanyl patch. D

## F760 – Residents are Free of Significant Med Errors

- Facility failed to ensure residents were free from significant medication errors. Facility had an order from the hospital for apixaban which they did not administer even though it was ordered, the client had signs of stroke and was sent by ambulance to the hospital and was admitted with a subacute infarct. **J $8,000.**
- Facility failed to transcribe all admission orders into the EHR record which led to med error with an anticoagulant not given daily as ordered (entered as one time a day every 45 days instead of every day for 45 days). D

### F802 – Sufficient Dietary Support Personnel

- Failed to ensure dietary staff had appropriate competencies. Multiple staff departures. New staff not trained on dietary orientation form and b/c of pandemic new dietary supervisor had not yet received formal training. F

### F807 – Drinks Avail to Meet Needs/Preferences/Hydration

- Facility failed to ensure residents were provided access to fresh ice water to meet their needs and preferences.

### F812 – Food Procurement, Storage, Preparation, Sanitization

- Facility failed to serve drinks in accordance with professional standards for food service safely during evening snack and drink pass. Staff filled grey tub with ice and placed and placed two pitchers containing drinks in the grey tub and then scooped ice out of the grey tub into cups. E

### F880 – Infection Prevention and Control

- Facility failed to ensure staff utilized proper infection control protocols for 6 out of 6 residents. The facility also failed to ensure appropriate amount of PPE was readily available for staff use and that staff were properly screened for infection control. Facility did not have anyone at the front of the facility to check surveyors' temperatures. The facility had surveyors fill out a questionnaire, however, nobody checked the surveyor's questionnaire or temperatures to allow admittance. In addition, the screening log for staff, had 4 staff names listed with on check-in temperatures documented. Hallway for residents in quarantine for COVID 19 had three disposable gowns which were not being utilized by staff and were not in the waste bin. Staff who was in the quarantined hall left with their gown on into the other part of the building. E
- Facility failed to assure appropriate infection control interventions. Staff assisted a resident to toilet and did not have eye protection on and mask did not cover her nose. Staff while wearing gloves scratched her head, moved the bed, took the resident's left hearing aide out, and touched her facemask. Residents not wearing masks while staff are working with them. E
- Facility failed to implement transmission based precautions for a resident with acute respiratory symptoms. Resident with nonproductive cough and nasal congestion for multiple days without be put in quarantine. D
- Facility did not wear appropriate personal protective equipment as indicated by IDPH for the prevention of COVID-19 throughout the facility. PT working with patients did wear a mask, but no face shield or goggles. 2 staff providing cares did not wear a face shield or goggles and one of the staff's face mask fell below their nose showing the top of their mouth and did not reposition it. Staff who was seeing a resident i droplet precautions removed their face shield outside the residents room and place face shield on hook outside the door without sanitizing it. F
- Facility failed to prevent the risk for serious harm, transmission and infecting residents related to failure to separate COVID-19 positive and negative residents for 4 of 64 residents. The facility failed to cohort or isolate COVD-19 positive and negative residents. 2 different residents who were positive were rooming with residents that were negative. **K $6,750**

- Facility failed to implement a comprehensive infection control program to mitigate the risk of the spread of infection during a COVID-19 outbreak by failing to prevent a staff person with signs and symptoms of COVID-19 from working with residents after symptoms of illness was reported to administrative staff prior to the start of her shift. Staff nurse reported to work and was having multiple signs and symptoms of COVID which she did answer yes to on the questions, but couldn't find anyone to replace her so worked a 12 hours shift with symptoms, went to ER the next day and was COVID positive. **L $8,750**
- Facility failed to ensure staff followed proper infection control practices for hand hygiene and clean linen handling when providing care for 2 of 4 residents. LPN leaving a COVID hall with gloves on, did not remove gloves once she went thru door or use hand sanitizer on the table next to the door. CNA peeled one glove off over the other glove into a ball and tossed the gloves across the hall where they landed on a table next to an isolation cart. D
- Facility failed to use appropriate personal protective equipment for isolation precautions, disinfect PPE, disinfect equipment and perform appropriate incontinent care for 3 of 7 residents. CNA entering an isolation room failed to put on her face shield. Staff did not sanitize the face shield or change the N95 mask when exiting the droplet precaution room. Staff failed to wear an isolation gown, wear the face shield correctly ( was on, but worn high on the forehead, so it failed to cover her eye glasses or N95 mask), and failed to disinfect the face shield or change the N95 mask when exiting the room. CNA performing pericare did not change gloves when touching the garbage can or sanitize hands. F
- Facility failed to secure all persons working in the facility were educated on the facility's infection control policies and procedures, completed competency checks for hand hygiene and donning or doffing of PPE, and wore PPE within 6 feet of a resident. CNA from a staffing agency was not shown how to don and doff PPE and was not told the resident was COVID positive, but that they were in isolation because they left for dialysis several times a week, but the resident did have a COVID positive test. E
- Facility failed to implement CMS and CDC recommended infection control practices in order to control and prevent the potential spread of COVID-19 amongst residents and staff. The facility allowed staff to work and provide care to residents after reporting signs and symptoms of COVID-19, and subsequently tested positive for COVID-19. The facility failed to ensure staff that provided care to residents, and working in COVID-19 positive resident areas or presumed positive resident care areas word appropriate PPE. The facility staff care for residents which tested positive for COVID-19, and then assisted with the care of other residents in the facility. The facility reported they had an outbreak of COVID-19, a total of 55 residents that tested positive and 10 residents that died of COVID-19. The facility also did not ensure all staff were thoroughly screened before they began their scheduled shifts. **K $10,000.**
- Facility failed to flow hand hygiene requirements for three of four stations in facility. Including touching mask then touching resident and tray tables. Other instance included failure to perform hand hygiene between contact with his mask and other services. A laundry aid passed clean clothes out going into a quarantine room and failed to apply PPE before going into quarantine room or to perform hand hygiene when leaving entering and leaving resident rooms. Staff failed to clean lift between resident use. Medication aide placed clothing protectors on two residents and moved wheelchair pedals before hand hygiene. Then placed clothing protectors and a third resident without performing hand hygiene between each contact. Failed to perform hand hygiene between resident interactions. E
- Staff failed to wear gloves when doing blood sugar check. Failed to disinfect glucometer- only used swab didn't wipe whole machine for two of two residents observed. D

- Facility failed to ensure staff wore masks in resident areas and goggles when within 6 feet of residents in multiple scenarios. One aide had mask pulled under chin while giving manicures, another while eating at nursing station, another passed within a foot of residents without masks while walking down hall. Also observed LPN walking towards nurses' station without mask walking down hall and Nurse Aide pushing resident in wheelchair with mask below her nose and mouth. E
- Facility failed to implement transmission-based precautions for a resident with acute respiratory symptoms/symptoms of COVID. Resident had fever of 99.2 but also new cough and headache. D

**F943 – Abuse, Neglect, and Exploitation Training**

- Facility failed to ensure all staff had mandatory reporter dependent adult abuse training within 6 months of hire. D
- Failed to ensure that 3 staff completed dependent adult abuse training. D

## Nursing Facility Survey Frequency

As of September 14, 2020: CMS lists 144 Iowa facilities (33.3%) of all facilities as past 15 months since last annual survey. Region 7 average rate is 28.9%. National average is 33.1%.

No annual surveys were completed this month.