LTC Survey Trends Report
April 2025

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RESIDENTS PROVIDING SERVICES IN NH & SURVEY UPDATES

by Kellie Van Ree, Director of Clinical Services

The Regulatory Review article for this month reviewed F566 related to residents providing services in the nursing home.

The revised surveyor guidance was effective on April 28, 2025. With surveys reviewed during the month of April, there did not appear to be any deficiencies cited based on the revised guidance.

Survey Activity

District	Average Months for Providers with Recert	Number of Providers over 12 Months	Longest Survey Timespan
Statewide	10.5 months	2 nursing homes	14 months

Recertification:

- 36 total recertification surveys reviewed with 6.2 deficiencies on average per recertification survey with deficiencies.
    - Of the 31 recertifications with at least one deficiency, 4 providers received a fine (or 13%).
    - Of the 36 recertifications, 5 providers had deficiency free surveys (or 14%)

Complaint/Incidents:

- 55 providers with complaint/incident surveys reviewed with 2.5 deficiencies on average per survey reviewed with deficiencies.
    - Of the 24 complaint/incident surveys with at least one deficiency, 6 received a fine (or 25%).
    - Of the 55 complaint/incident surveys, 31 did not receive a deficiency (or 56%).

Enforcement Actions

CY 2025	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVG NUMBER OF DEFICIENCIES
JANUARY	**$32,250**	**$334,986.50**	**2 Denials; 1 DPOC**	**$367,236.50**	**4.6 deficiencies**
FEBRUARY	**$61,250**	**$117,238.50**	**2 Denials; 1 DPOC**	**$178,488.50**	**8.3 deficiencies**
MARCH	**$70,000**	**$47,307**		**$117,307**	**5.6 deficiencies**
APRIL	**$30,500**	**0**		**$30,500**	**6.2 deficiencies**

Fines identified in this report are per the Iowa Department of Inspections and Appeals website (state) and QCor (federal). Total fine amounts may change based on appeal rights and reduction rules.

CITATIONS WITH FINES

April Deficiencies with State Fining and Citation

50.7(4); $500. Resident #161 left the nursing home without the staff's knowledge. When the resident was noted to be missing, the staff implemented procedures for a missing resident and the resident was located by a nurse aide in the neighborhood near the nursing home. The nursing home did not report the incident because the resident's BIMS score was 13 indicating intact cognition, but the resident had a diagnosis of dementia.

50.9(3)b; $500. Staff A did not have a background check completed prior to hiring.

F600; 58.43; G; $500 (Held in Suspension). Resident #50 was noted to have two sexual interactions with other female residents including touching another resident's vaginal area over their clothing and then a subsequent incident when they were found in a female resident's room who was asleep, and the female resident's incontinent product was pulled down as the resident performed a sexual act on the resident. Staff immediately removed the resident and called the nurse to the room stat. Interventions on their care plan included staff were to know the resident's whereabouts at all times, specifically when in the hallway, a motion sensor, 15-minute checks using a video monitor, medication adjustments, and 1:1 whenever they were out of their room. The staff also attempted to transfer the resident to another nursing home.

F609; 58.43(9); D; $500. The nursing home did not report missing liquid morphine.

F609; 58.43(9); D; $500. Following discharge, a resident reported that they transferred $22 to a C.N.A via PayPal and they paid them back $10 but not the remaining balance. The allegation was not reported in a timely manner.

F609; 58.43(9); D; $500. Staff M was reported to have an inappropriate (possibly sexual) relationship with a male resident. The resident was reported to give the staff member money to purchase things such as a phone and cash for a birthday present. The staff member was also suspected of possibly taking medications as there were medications missing from the resident's supply. The nursing home did not report the incidents because the resident had intact cognition and denied that they occurred.

F609; 58.43(9); D; $500. An allegation of possible abuse was not reported to DIAL in a timely manner when a resident accused a staff member of pushing them into bed.

F684; 58.19(2)a; G; $5,250 (Held in Suspension). Resident #2 received hemodialysis three times per week and had orders to monitor weight and vital signs on dialysis days as well as thrill and bruit to dialysis access site every shift. On 3.15 and 3.19 a negative result for thrill and bruit (indicating they were not felt) was documented without physician notification. The resident also had orders for a fluid restriction, but lacked the amount of the fluid restriction. Resident #2 was transferred to the hospital on 3.22 due to changes in condition including a high heart rate, low blood pressure, and an oxygen saturation level of 70%. The nurse was unaware of the resident receiving dialysis until a driver showed up to transport them and an assessment was not completed upon their return. On 4.2.25, the surveyor observed Resident #9 on the floor with staff assisting them. Upon review of the residents' record the following day, it was noted that there were no fall incident reports or assessments completed.

F684; 58.19(2)j; G; $4,000. Resident #30 was noted to have skin integrity concerns that did not have an adequate skin assessment completed until the surveyor asked the nursing home staff about it. Additionally, the resident had orders for oxygen at 3L as needed to maintain oxygen saturation levels above 90%. The resident had several instances of oxygen saturation levels below 90% documented, however, the oxygen was not documented as administered.

F684; 58.19(2)j; G; $3,500. Staff did not complete skin assessments in a timely manner and notify the physician.

F689; 58.28(3)e; G; $3,250 (Held in Suspension). Staff assisted Resident #7 with a transfer and did not use their walker as indicated in their care plan. During the transfer staff pulled up on the residents' pants instead of using the gait belt which was applied. During an interview Resident #3's family expressed concerns that they were transferred using a sit to stand lift instead of a full body mechanical lift and only 1 staff assisted them resulting in injury. Additionally, during observation of the sit to stand lift there were rough areas of the lift including sharp edges that could possibly cause injury.

F689; 58.28(3)e; G; $3,250. The staff left a resident alone in their bathroom while using the toilet and the care plan indicated that the resident was at high risk for falls, needed assistance with transfers, and directed staff to not leave unattended in the bathroom. As a result, the resident fell and received abrasions.

F689; 58.28(3)e; G; $7,750. Resident #20 had falls including tripping over the wheelchair pedals on their wheelchair when staff did not remove them, causing the resident to have additional falls ultimately resulting in head trauma. The resident also did not have a completed incident report for a fall.

TOP DEFICIENCIES

F-TAG #	
F880	Infection Prevention & Control
F689	Accidents/Hazards/Supervision/Devices
F812	Food Procurement, Store/Prepare/Serve - Sanitary
F684	Quality of Care
F758	Unnecessary Medications (Psychotropic)

These are the top citations from Iowa surveys conducted in April according to 2567 reports.

Comprehensive List of Deficiencies (in addition to Fines) Cited in April:

58.12 – Cited 1 time when a nursing home did not submit eligible residents to the IDVA website within 30 days of admission.

F550 – Cited 7 times for failure to treat residents with respect, dignity, and privacy by:

- 2 times when staff were observed by others not speaking kindly to residents.
- Staff did not follow the care plan for transfer status and the resident stated that they "manhandled" them.
- Staff were waking residents up in the middle of the night.
- Reported that staff were rough when providing care.
- Staff worked with ear buds in their ears and did not speak to the residents.
- A resident had to wait in a public area with soiled garments.
- The staff did not provide care for or reposition a resident as they were noted in the same location and clothing as the day prior.
- Staff did not knock on residents' doors prior to entering.
- A resident had their electric wheelchair taken away without a physician's order to do so and the resident reported that it significantly changed their ability to be independent.
- A resident reported that a staff member pushed them down in their bed.

F578 – Cited 3 times when the residents' records did not have code status paperwork.

F580 – Cited 2 times for:

- Failure to notify both the physician and family of a change in condition.
- Failure to notify the physician of a weight change according to established parameters.

F582 – Cited 2 times for:

- Failure to issue a NOMNC.
- Failure to issue an ABN.

F584 – Cited 4 times for failure to provide a homelike environment by:

- Missing personal items.
- 2 times for cleanliness in resident rooms.
- There was a black substance in the shower room that appeared like mold.
- There was mold on the pipes to the heating and cooling units.

F602 – Cited 2 times for:

- Staff borrowed money from a resident and did not pay the resident back the entire amount.
- A staff member was accused of having a possible inappropriate relationship with a resident for money and medications.

F607 – Cited 1 time when a staff member did not have a background check completed prior to hire.

F610 – Cited 1 time when an allegation of a possible inappropriate relationship between a staff member and resident was not investigated.

F623 – Cited 4 times when the LTC Ombudsman was not notified of transfers.

F625 – Cited 5 times for:

- 4 times for not providing a bed hold notice.
- The bed hold notice did not include the cost to hold the bed.

F637 – Cited 1 time when a significant change MDS was not completed when a resident was admitted to hospice.

F638 – Cited 1 time when MDS assessments were not completed timely.

F640 – Cited 2 times when discharge MDS' were not submitted to CMS timely.

F641 – Cited 4 times when:

- 2 times when medications were not coded accurately.
- Side rails were coded as a restraint and should not have been.
- Falls were coded with a major injury without supporting documentation of an injury.

F644 – Cited 4 times when:

- The Level 2 was not included in the care plan.
- Specialized services were not provided as indicated in the Level 2.
- 3 times when a new Level 1 was not submitted with a new mental illness diagnosis.
- A new Level 1 was not submitted with a new psychotropic medication.

F645 – Cited 1 time when a Level 1 was not submitted prior to the short term approval expired.

F656 – Cited 8 times for:

- 3 times when care plan interventions were not followed.
- The resident or their family was not invited to care plan meetings.
- The care plan did not include:
    - Enhanced barrier precautions.
    - Antidepressants
    - 2 times for antipsychotics.
    - 2 times for opioids.
    - 2 times for diuretics.
    - Insulin
    - Dialysis
    - 2 times for anticoagulants
    - Nonpharmacological interventions for pain.
    - Target behaviors for psychotropic medication use.

F657 – Cited 7 times for:

- The care plan was not followed.
- The care plan was not updated to include:
    - PTSD and triggers.
    - Resident-to-resident incidents.
    - 2 times for falls.
    - Edema.
    - Skin breakdown and preventative measures.
    - Code status.
    - Restorative.
    - Removal of an electric wheelchair.
    - Use of a paid nutritional assistant.

F658 – Cited 6 times for:

- The physician was not notified in a timely manner when a resident hit their head.
- Documentation was not included in the record when the family declined for the resident to be taken to the ER.
- No documentation was present on follow up when the resident's laboratory results were not returned.
- 2 times when medications were left with the resident.
- Physician orders were not followed.
- Medications were administered for more than one hour after they were scheduled.
- Orders were not transcribed timely.

F661 – Cited 1 time when there was not a discharge recapitulation in the resident's record.

F676– Cited 1 time when recommended restorative programs were not implemented.

F677 – Cited 9 times for failure to provide/assist with:

- 4 times – bathing.
- 3 times – oral care.
- Incontinence care
- Nail care
- Repositioning

F684 – Cited 14 times for:

- 3 times when assessments were not completed after an incident.
- An assessment was not completed when a resident went a prolonged period without a bowel movement.
- 2 times when assessments were not completed for changes in vital signs.
- 3 times when assessments were not completed for skin breakdown.
- An assessment was not conducted for signs of a UTI.
- 2 times when assessments were not completed and the physician notified for high or low blood sugars.

F686 – Cited 8 times for:

- 3 times when interventions were not implemented to prevent pressure ulcers.
- 3 times when treatments were not completed as ordered.
- 2 times when the care plan interventions were not followed.
- 2 times when assessments were not completed on pressure ulcers.

F688 – Cited 6 times for:

- 4 times when restorative programs were not completed.
- 3 times when splints/braces were not applied as ordered.

F689– Cited 16 times for:

- New interventions were not implemented to prevent falls.
- A shower room was unlocked and unattended with the shower running.
- 5 times when staff pushed residents without wheelchair foot pedals.
- Staff did not safely transfer the resident according to the care plan.
- 2 times when fall interventions were not followed.
- 2 times for resident's eloping from the building.
- A wheelchair was not secured tightly into a transportation van causing the wheelchair to tip.

F690 – Cited 2 times when the catheter bags and tubing were touching the floor.

F692 – Cited 1 time when a physician and family were not notified of a significant weight loss.

F693 – Cited 1 time when staff pushed medications in a feeding tube instead of via gravity.

F695 – Cited 5 times when:

- The staff did not complete follow-up monitoring of oxygen saturation levels when they were previously low.
- 2 times when the oxygen flow rate was not followed as ordered.
- 2 times when the oxygen tubing was not changed per the physician's order.

F697 – Cited 1 time when as needed pain medication was not administered for a resident reporting significant pain.

F710 – Cited 1 time when a physician was not notified of a medication error.

F725 – Cited 7 times for:

- 5 times for call lights not answered timely.
- Incontinent care was not completed.
- Bathing was not completed.

F726 – Cited 2 times when:

- Staff did not have competencies evaluated to care for a wound vacuum.
- Nurses did not complete assessments when necessary.

F728 – Cited 1 time when the nursing home did not ensure that a nurse aide was eligible on the DCW registry prior to hire.

F730 – Cited 1 time when evaluations were not completed on a nurse aide.

F732 – Cited 1 time when the posted staffing did not include the resident census, total hours worked by category, and identify nurse hours on each shift.

F755 – Cited 7 times when:

- The pharmacy filled medications that were discontinued.
- 2 times when prescribed medications were not available to administer.
- Narcotic reconciliation was not accurate.
- Staff compounded cream and powders together for a treatment.
- Orders were not clarified which delayed a medication being administered.
- Narcotics were not documented on both the MAR and the narcotic record.

F757 – Cited 3 times when:

- Side effects of high-risk medications were not included on the resident's care plan.
- There was not a process to increase the frequency of INR monitoring when the resident began an antibiotic.

F758 – Cited 11 times when:

- A GDR was not addressed when requested.
- 5 times when target behaviors were not addressed for psychotropic medications.
- 5 times when non-pharmacological interventions were not identified for psychotropic medications.
- Side effects for psychotropic medications were not identified on the care plan.
- There was no clinical rationale documented when a GDR was declined.

F759 – Cited 3 times for medication errors greater than 5% including:

- Failure to prime insulin pens.
- 2 times for incorrect doses.
- An extended-release medication was crushed.
- A medication was not administered that should have been.
- The insulin pen was not held in the skin following the injection as required.

F760 – Cited 7 times for:

- 2 times when insulin pens were not primed prior to use.
- 3 times for an incorrect insulin dose administered.
- Insulin was administered outside of established parameters.
- Medications were administered after being discontinued.
- A non-diabetic resident was given insulin.

- The insulin pen was not held in the skin following the injection as required.

F761 – Cited 1 time when medications were not locked up and were unsupervised.

F803 – Cited 5 times for:

- 2 times – puree portions were not accurate.
- 2 times – not all items on the menu were offered.
- Substitutions were not approved by the dietitian.

F804 – Cited 4 times for hot food temperatures being less than 135 degrees.

F805 – Cited 1 time when bread was not added to the pureed food.

F811 – Cited 1 time when a paid nutritional assistant was not aware of what residents they could or could not assist.

F812 – Cited 14 times for:

- 4 times – items open and not dated/labeled.
- 3 times – cleanliness.
- Hairnets/beard nets were not used by staff.
- 3 times – food handling concerns.
- 2 times - food was expired and not discarded.
- 4 times – did not complete hand hygiene appropriately.
- Serving utensils were placed on a contaminated area.
- Glasses were carried by staff touching the rim.
- Food was transported in the hall without a cover.
- Food was stored under thawing meat.
- Equipment cleanliness.
- Cold food was not maintained at or below 41 degrees.

F836 – An interim administrator did not apply for their provisional license and there was not a licensed administrator employed.

F842 – Cited 3 times when:

- Records were not maintained confidential.
- An elopement was not documented in the resident's record.
- Narcotic records were not accurate.

F851 – Cited 3 times when PBJ data was not accurately submitted, including:

- Management nurses were not submitted as working the floor.
- Agency hours were not reported.
- The report was not accurate but did not indicate specifically what was inaccurate.

F865 – Cited 4 times when:

- 2 times for the QAPI process was ineffective based on repeat deficiencies.
- 2 times when the plan of correction was not followed for ongoing monitoring.

F868 – Cited 1 time when the required individuals were not present at the quarterly meetings.

F880 – Cited 21 times for:

- 10 times when enhanced barrier precautions were not followed.
- A barrier was not placed under the graduate when emptying a catheter drainage bag.
- PPE was not applied when entering a transmission-based precautions room.
- Infection control policies were not reviewed within the last 12 months.
- 4 times when hand hygiene was not performed appropriately.
- Catheter tubing and drainage bag touched the floor.
- Clean equipment touched saturated bedding.
- A barrier was not placed under an open wound when placed on the resident's bedding.
- An insulin pen was not discarded when administered to another resident besides the one it was prescribed for.
- There was not a process for routine infection surveillance.
- Oxygen tubing was not changed according to the policy.
- There was not a water management plan.
- Reusable equipment was not disinfected between residents.

F883 – Cited 3 times for:

- Documentation was not maintained when the resident refused pneumonia vaccines or what education was offered.
- Pneumonia vaccines were not offered.
- Influenza vaccines were not offered.

F887 – Cited 2 times when COVID-19 vaccines were not administered.

F921 – Cited 1 time for cleanliness and disrepair in resident areas.

F925 – Cited 2 times for:

- Residents expressed concerns about mice infestation.
- The staff did not follow the policy when they found a bed bug.

F947 – Cited 1 time when nurse aides did not complete 12 hours of in-service in the last 12 months.

For comments or questions related to the LTC Survey Trends Report, please contact Kellie Van Ree, LAI's Director of Clinical Services.

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