LTC Survey Trends Report August 2024

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LeadingAge Iowa

CHOICE OF PHYSICIAN & SURVEY UPDATES

by Kellie Van Ree, Director of Clinical Services

Continuing on with the resident's rights section of Appendix PP, I reviewed the regulation F555. The resident's have the right to choose their attending physician, except in very limited circumstances. You can view the article here.

DIAL is diligently trying to meet their CMS goals before the end of the year. Several providers had recertification in as little as 4 months since their previous recertification visit. I wrote an article in the Communique on the goals and how you can determine if you may be one of these lucky providers. You can access this article here. While DIAL has indicated they cannot maintain the amount of recertification visits we're currently seeing, they explained that their goal for the next Fiscal Year (FY) is to reduce recertification averages from 15.9 months to 12.9 months.

What does this mean?
You should anticipate that your next recertification will be sooner than you've experienced the last few years for DIAL to meet these goals. Don't wait until the last minute to begin survey preparations. It may be a best practice to begin within 6 months of your last recertification, although some providers had their recertification survey before the 6-month period even. If you need survey preparation assistance and would like to use LeadingAge Iowa's Nurse Consulting Services, please reach out. You can access the nurse consulting brochure for services and costs here.

Survey Activity

District	Average Months for Providers with Recert	Number of Providers over 12 Months	Longest Survey Timespan
Statewide	8.3 months	56 nursing homes	15 months

Recertification:

- 62 total recertification surveys reviewed with 5.4 deficiencies on average per recertification survey with deficiencies.
    - Of the 48 recertifications with at least one deficiency, 7 providers received a fine (or 17%).
    - Of the 62 recertifications, 14 providers had deficiency free surveys (or 23%)

Complaint/Incidents:

- 65 providers with complaint/incident surveys reviewed with 2.3 deficiencies on average per survey reviewed with deficiencies.
    - Of the 33 complaint/incident surveys with at least one deficiency, 15 received a fine (or 45%).
    - Of the 65 complaint/incident surveys, 32 did not receive a deficiency (or 49%).

Enforcement Actions

MONTH (2024)	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVERAGE NUMBER OF RECERTIFICATION DEFICIENCIES
JANUARY	**$104,000**	**$155,502.93**	**3 Denials**	**$259,502.93**	**6.7 deficiencies**
FEBRUARY	**$42,200**	**$384,220.54**	**3 Denials**	**$426,420.54**	**9 deficiencies**
MARCH	**$43,500**	**$97.460**	**4 Denials; 2 DPOC**	**$140,960**	**5.3 deficiencies**
APRIL	**$139,750**	**$224,933.25**	**3 Denials**	**$364,683.25**	**5 deficiencies**
MAY	**$175,500**	**$36,300**	**3 Denials**	**$211,800**	**5.1 deficiencies**
JUNE	**$181,500**	**$18,535**	**2 Denials**	**$200,035**	**6.4 deficiencies**
JULY	**$242,000**	**$16,680**	**3 Denials**	**$258,680**	**6.1 deficiencies**
AUGUST	**$125,000**	**0**	**5 Denials, 1 Termination**	**$125,000**	**5.4 deficiencies**

Congratulations to Meth-Wick Health Center & Northcrest Community on deficiency free surveys!

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

August Deficiencies with State Fining and Citation

50.7(1)a; $500. The nursing home did not report falls with major injuries for three residents including falls with a femur fracture, temple area of the head fracture, and right hip fracture.

50.7(5); $500. Did not report an attempted suicide to DIAL when a resident was found in their closet with a belt around their neck.

F600; 58.43; J; $6,250. (Held in Suspension). Resident #1 reported that Staff A provided cares in a rough manner, called them names and used curse words in their presence. The nursing home suspended Staff A but allowed them to return if they did not care for Resident #1. Other staff reported when Staff A worked, Resident #1's demeanor would change including becoming guarded, shaky, staying by other staff member's side, tearing up, and was fearful for their safety.

F600; 58.43; J; $21,750 (Treble/Held in Suspension). On 5/7/24, Staff B CMA stated they saw Resident #10 and Staff A kissing on the mouth when they entered the resident's room. Staff B gave the resident his medication and then quickly left the room. Staff A then found Staff B and asked them not to say anything and it would not happen again. Staff B reported the situation to the RN after Staff A left the building. During an interview with Resident #10's guardian, they had an email sent to the former administrator on 2/29/24 that the resident declared his love for Staff A and that Staff A took the resident in their office and locked the door so they could have privacy. The was no documentation that the incident was investigated or reported to DIAL. According to Resident #10's medical history they had cognitive impairment. A health status note in the resident's record indicated that staff member admitted to the allegations and walked out of the building. According to Staff A's file, they were terminated on 6/17/24.

F600; 58.43; D; $500 (Held in Suspension). When Resident #2 asked Staff C for another pop the staff member told them to stop yelling at them and slapped them on the hands. When the resident asked them to stop, they continued to slap them on the hands.

F600; 58.43; D; $500 (Held in Suspension). The resident reported that a CNA was rough with them during morning cares and stated that the aide threw a gait belt across the room. When the resident was interviewed, they were visibly upset and crying about the interaction.

F600; 58.43; D; $500 (Held in Suspension). While CNAs were assisting Resident #12 with cares, the resident began yelling out when one of the staff got frustrated with the resident and slapped the resident on the arm.

F600; 58.43; J; $500 (Held in Suspension). A staff member witnessed a CNA place their hand over a resident's mouth and reported to the DON on 7/29/24 at 4:30 p.m. The DON reviewed the footage of the area and noted that in addition, the staff member pushed the resident into a chair and when they attempted to stand up pushed the chair into the table. Another staff member was at the table during this time and did not intervene. The second CNA was also noted pushing against the table as the resident attempted to push the table away from themselves so they could stand up. When the surveyor reviewed the footage, it was noted that the staff member also restrained the resident's hands and wrists as the resident attempted to swing at them following being pushed into the chair. The resident attempted to remove their sweater while staff attempted to force it back onto them. The resident put their head down on the table and appeared to be crying when the staff placed the resident’s sweater on the resident's head, causing agitation.

F600; 58.43; J; $500 (Held in Suspension). Resident #2 was noted to put his hand down another female resident's shirt. The nursing home implemented 15-minute checks and initiated a discharge to another nursing home. In the interim the female resident was moved to the memory care unit for their protection. During review of the resident's record, there were no incident reports or investigations related to the incidents. Review of the 15-minute check documentation lacked several entries prior to the incident.

F600; 58.43; D; $500. Following a shower, staff were assisting a resident lie down when the resident hit the staff member. The staff member then punched the resident on the arm.

F600; 58.43; K; Termination of Provider Agreement. Resident #77 did not have interventions for safe transfers on their care plan, however, documentation indicated the resident required assistance of two staff for transfers. A progress note indicated that two staff members attempted to assist Resident #77 with a transfer. The resident did not want to get out of bed and during the transfer buckled their knees to stop the staff from transferring them. The staff then wheeled the resident into the bathroom and one of the staff told the other that they were told in report that the resident needed a lift. The other staff member told the staff member to use the gait belt and grab bar to transfer the resident. When the resident stated they could not transfer, the staff member grabbed the resident by the arm and put them on the toilet. The resident was unable to transfer, and staff lowered to the floor. During an interview, Resident #77 expressed that staff dropped them during a transfer and was in fear of being dropped again. During subsequent interviews, concerns were identified that unlicensed/uncertified staff are being used to assist the certified staff with care they are not adequately trained to do. Resident #22 resided on the dementia unit and had a history of PTSD and violence. According to record review and interviews, Resident #22 had at least three incidents of punching Resident #17 in the face including times when the police had to be called as there was only 1 staff member present and no other staff came to assist. The nursing home interventions included keeping the two residents separate but staff stated that it was impossible to do. During additional record review and interviews Resident #22 attempted to punch Resident #11, however, Resident #11 was strong enough to stop Resident #22 until staff could arrive to assist. Additional resident to resident incidents occurred between Resident #22 and Resident #24. Residents #18 and #20 had incidents where they were found in each other's bed, disrobed and were touching each other. Several incidents were reported to the DON and Administrator without any interventions in place. Staff were concerned that Resident #18 was pregnant as they had not had a menstrual cycle for approximately 3 months and appeared bloated. The physician denied an order to obtain a pregnancy test. However, staff indicated that other staff collected urine from the resident and performed a pregnancy test which was rumored to be negative.

F607; 58.11(3); D; $500. Did not complete criminal record check, dependent/child abuse registry check prior to hire.

F609; 58.43(9); J; Termination of Provider Agreement. The nursing home did not report allegations of physical and mental abuse for Resident #77 to the State Agency. According to interviews, the management staff were notified of an incident on or about August 11 that was not reported. Staff reported incidents of possible sexual abuse between Residents #18 and #20 that were also not reported to the State Agency.

F609; 58.43(9); J; (Included in F610 Citation). Residents #1 and #2 were involved in several instances of inappropriate touching including 3 days in April and 3 days in May. The nursing home did not report the incidents to DIAL until the 4th & 5th incident.

F609; 58.43; D; $500 (Held in Suspension). Did not report an allegation of abuse to DIAL in a timely manner.

F609; 58.43; D; $500 (Held in Suspension). Resident #2 reported that Staff C slapped them on the hands when they asked for another pop on 7/11/24. The administrator was notified of the incident the following morning and a self-report was filed on 7/12/24 at 11:17 a.m.

F609; 58.43(9); J; $24,000 (Treble/Held in Suspension). On 7/23/24 at approximately 8:30 p.m. Resident #1 reported concerns with how Staff A treated them while they were providing care. Staff B reported the incident to the ADON, who is Staff A's mother. The ADON spoke to the staff and resident but then continued with their duties. The following day, Staff C reported the incident to the administrator who initiated an investigation and reported it to the state at 5:13 p.m.

F609; 58.43(9); D; $500 (Held in Suspension). On 6/27/24 at 5 p.m. an incident report was completed by the DON indicating that on 6/19/24 while staff were providing cares to Resident #12 the resident began yelling out and one of the staff got frustrated with the resident and slapped their arm. The self-report was not submitted until 6/27/24 at 9:34 p.m.

F609; 58.43(9); J; $500 (Held in Suspension). A staff member that observed a CNA place their hand over a resident's mouth did not report the incident until more than 2 hours later.

F609; 58.43(9); J; $6,750 (Held in Suspension). Staff did not report allegations of sexual exploitation when they saw a staff member kissing a resident.

F609; 58.43(9); D; $500. A staff member reported that another staff member attempted to put a glove in a resident's mouth when they were being verbally aggressive and combative with care. The incident occurred on 8/3/24 and was reported the following day in the AL database and then corrected on 8/5/24. With the incident occurring on 8/3/24 and not reported until the following day, the nursing home did not submit in a timely manner.

F610; 58.43(9); K; (Included in F609 Citation). Resident #71 reported an aide treated them roughly during cares including throwing items in their room and throwing them into the wheelchair during a transfer. The situation occurred at breakfast but was not investigated until the afternoon. The nursing home did not remove the alleged perpetrator until later in the day.

F610; 58.43(9); K; Termination of Provider Agreement. Did not complete thorough investigations of allegations of abuse for Resident #77 and did not protect other residents from abuse when notified that physical and mental abuse occurred on or about August 11. Also did not investigate potential sexual abuse between Residents #18 and #20

F610; 58.43(9); K; (Included in F609 Citation). After Resident #2 reported that Staff C slapped them on their hands, the aide was allowed to finish their shift and work unattended with other residents.

F610; 58.43(9); J; (Included in F609 Citation). A staff member got frustrated with a resident as they yelled out during cares and slapped them on the arm. The incident occurred on 6/19/24 and staff did not report the incident until 6/27/24 which allowed the staff member to continue to work with residents during that time.

F610; 58.43(9); J; $500 (Held in Suspension). The nursing home did not document incidents of resident-to-resident abuse and ensure separation from other residents. There was no documentation supporting a thorough investigation including staff interviews to determine the extent of the allegations and if other residents were involved. The residents were not separated until the incident occurred a third time and the family requested something be done.

F610; 58.43(9); J; (Included in F609 Citation). Did not investigate an allegation of sexual exploitation and separate an alleged perpetrator when the nursing home received reports of potentially inappropriate text messages and relationship between a resident and staff member.

F610; 58.43(9); D; $500. Resident #5 was noted to have a bruise on their cheek and when the staff asked what happened the resident stated that they were beat up. The resident was noted to have confusion during the interview and unable to recall details of the incident. The staff failed to interview other staff to determine the extent of any potential abuse as part of the investigation.

F658; 58.20(1); G; $8,750. Progress notes for Resident #1 included increased anxiety, agitation, and wanting to hit someone. The staff notified the physician for new orders. On 8/12/24 the staff called the on-call provider due to increased behaviors including yelling in the dining room through the night, demanding 911 be called, calling the nurse names and alternate interventions did not help reduce behaviors. An order was received for Lorazepam and a UA. The UA was not obtained until 8/16/24. The resident was noted shaking that same day with a temperature of 97.1 degrees. The NP was notified with new orders to check labs which were obtained. A progress note in the early afternoon identified the resident’s oxygen saturation was 79%. Oxygen was applied and an order was obtained to send the resident to the hospital. The daughter called later that evening and indicated the resident would be admitted to the ICU and passed away while at the hospital. Late entries after the resident passed away indicated that staff attempted to get a UA on two occasions but was unable to due to incontinence.

F684; 58.19(2)j; K; Termination of Provider Agreement. Resident #78 had surgical wounds to their left side with a wound vac and 2 drains from the abdomen. The MAR/TAR did not include orders for treatments to the drains, dressing changes, and wound vac orders. The resident expressed during an interview that their physician said they could be removed when there is 5cc or less of drainage per day, but the resident indicated they couldn't know when that happened because they don't empty it. The hospital discharge orders included flushing drains and measuring drainage, which was not documented. The resident did not have skilled assessments or progress notes upon return from the hospital. Resident #22 did not have any assessments in their record from 7.1.24 to 8.1.24. On 7.23.24 the resident was not feeling well, had an unsteady gait and complained of a headache. No vital signs were documented with the resident not feeling well. The resident’s family requested transfer to the ER for evaluation and returned on 7/28/24. There were no progress notes between 7/28/24 and 7.31.24 including when the resident returned to the

nursing home, diagnosis, or additional information as to why the resident was hospitalized. On 8.3.24 the resident returned to the ER following a coffee ground emesis, and pain to their abdomen. A note on 8.8.24 indicated the resident returned to the nursing home with an NG tube placed due to gastric blockage. The baseline care plan upon return indicated the resident did not have constipation, despite having the NG tube for a blockage. On 8.22.24 the resident was again sent to the ER for emesis x 2, dark tarry stools, history of GI bleed, complaints of stomach pain. Resident #127 was admitted on 8.9.24 and did not have a baseline care plan completed. The admission assessment did not indicate safety care needs. On the day of admission at 2:47 p.m. the resident had a fall in a common area, two staff assisted the resident back into the wheelchair and nursing documented that neuro checks would be performed. On 8/10/24 at 12:37 a.m. the resident received an as needed antipsychotic medication due to behaviors of yelling help me, please, please, help me along with agitation and physical aggression towards staff which was noted to be ineffective. Later in the day the resident was noted to yell when awake, did not eat lunch, and took medications without issues. On 8/10/24 at 11 p.m. the nurse practitioner informed the nursing home that the resident should be sent to the hospital for failure to thrive and psychiatric evaluation related to aggression. On 8/11/24 at 1:45 p.m. the nurse called 911 to send the resident to the ER for evaluation and treatment of psychiatric issues and failure to thrive. During incident review the nursing home was unable to provide neurological assessments completed following the fall as indicated in the notes. The resident's record lacked follow up assessments after the fall. Examination at the ER revealed mild swelling and a bruise to the right occipital and was diagnosed with an intracranial hemorrhage and altered mental status. The resident was transferred to a different nursing home for comfort cares and passed away on 8/15/24 with the cause of death identified as intracerebral hemorrhage.

F684; 58.19(2)j; J; $10,000 (Held in Suspension). Resident #1 had orders for Warfarin with a history of having higher INRs. An INR was obtained and faxed to the physician 5/14/24 with current Warfarin orders which lacked a response by the physician. There were several documents with communication on various items with the physician/ARNP including routine nursing home visits that lacked follow up on the lack of response on the Warfarin and INR result. A pharmacy note dated 7/18/24 addressed that the most recent INR was from 5/14/24 and recommended drawing an INR unless one was completed in the last 4 weeks. On 8/22/24 communication from the physician indicated ok to draw an INR. On 8/23/24 the resident had multiple bruises noted on their back and arms without a known origin. A short time later the NP documented that the resident was evaluated as they were not at their baseline mental status and having difficulty responding to commands or sitting up. The INR was documented as 10.2 with direction to transfer to the ER. At the ER, the history and physical documented a significant brain injury involving a large hematoma on the right side of the head with characteristics indicating both acute and chronic bleeding and a midline shift towards the right. A local neurosurgery center was consulted and with the family it was decided the resident would not be an ideal surgical candidate. The resident returned to the nursing home with hospice services after INR stabilized. Resident #4 also took Warfarin with an order on 4/8/24 to check INR monthly. No documentation of an INR completed until 8/22/24.

F684; 58.19(2)j; J; $8,750 (Held in Suspension). Resident #3 had a fall on 8/13/24 at 5:15 p.m. when the staff found them lying on the floor and the wife asked for help. The resident complained of rib pain when they moved their shoulder and had a pink mark on his left torso, believed to be from the arm of the wheelchair. When staff assisted off the floor the resident complained of pain, and they later used a mechanical lift which also caused pain. The nurse indicated during an interview that they did not check the resident's lung sounds. According to the policy, the floor nurse notified the house supervisor, however, they were unsure when they could come in to check the resident. Around 6 p.m. the nurse attempted to call the house supervisor again, however, the night supervisor went to the room and assessed the resident and recommended sending them to the hospital. During a staff interview, they indicated the transfer to the hospital occurred because of a family request. According to the family members call log to the daughter, the resident's wife called at 6:24 p.m. and told the daughter about the fall. When the daughter spoke to the resident he reported his side hurt. At 6:42 p.m. and 6:44 p.m. the daughter attempted to call the nursing home. The nursing home called the daughter at 7:01 p.m. and the daughter attempted to call back 3 times between 7:07-7:08 p.m. The EMS/Fire Department reported the call was received from the nursing home at 7:56 p.m. they arrived at 8:02 p.m. and left the nursing home at 8:19 p.m. The EMS indicated the resident had left sided pain during breathing and decreased breath sounds with a low oxygen saturation rate. The hospital report indicated the resident had a collapsed lung and multiple fractures including left clavicle, shoulder blade, and several ribs. The resident was intubated as they were in respiratory distress and the family decided to extubate with comfort measures in which the resident passed away on 8/17/24. Interviews with the ER physician indicated that they had never seen someone with a ground level fall that sustained all of the fractures and swelling that they found with this resident. They also expressed concern with the delay in treatment, indicating 2 daughters asked for the resident to be transferred to the ER and met resistant. In a

subsequent interview the ER physician stated that the injuries observed with this resident did not occur instantaneously as the amount of air that leaked into the resident's subcutaneous tissue was substantial.

F686; 58.19(2)b; J; $21,750 (Treble/Held in Suspension). Resident #1 had a pressure ulcer with orders for treatment. On 6/17/24, the treatment was discontinued due to a new order received, however, the record did not have a new order. The TAR lacked treatment to the area from 6/16 - 6/21 when a new order was received. A new pressure ulcer was identified on 6/18/24 which was described as nursing home acquired and was 100% eschar. Reviewing the resident's record the documentation was blank for repositioning 17 times during the month of June. The resident was subsequently hospitalized due to an elevated white blood count and C-reactive protein.

F689; 58.28(3)e; G; $7,750 (Held in Suspension). Resident #1's care plan indicated they required assist of two staff for bed mobility. On 7/20/24 at 1:21 a.m. the resident turned their call light on and wanted to be repositioned. A CNA assisted the resident to roll to the side and they were too close to the edge of the bed when the resident rolled out of their bed. The resident complained of pain and was sent to the ER where they were diagnosed with a left femoral neck fracture.

F689; 58.28(3)e; J; $7,000 (Held in Suspension). Resident #1 was admitted to the nursing home on 7/11/24 from another care center. The admission assessment indicated they were alert but confused and determined to be an elopement risk with the alarm protocol initiated and wanderguard applied. The resident's MDS and care plan did not identify elopement risk or wanderguard placement. On 8/8/24 the resident saw the NP who ordered trazadone for insomnia and wandering. On 8/22/24 at 1:10 a.m. a CNA reported the resident was not in their bed and unable to be located after searching the building and grounds. The DON was notified and provider, awaiting further direction from the DON. At 1:30 AM the DON returned the call and instructed staff to notify the police who arrived at 1:45 a.m. On 8/22/24 the ED notes indicated at 9:11 p.m. the resident was triaged for complaints of bilateral knee pain, x-rays revealed no acute findings, was diagnosed with musculoskeletal pain and discharged on 8/23/24 at 5:13 a.m. The staff found the resident later that morning on a park bench at 6:45 a.m. During interviews the staff reported that they initially placed a wanderguard on the resident and they were unsure of who or why, but it was removed. During observations the surveyor also identified doors being propped open.

F689; 58.28(3)e; J; $30,000 (Treble/Held in Suspension). Staff H (CNA) reported on the night shift 2/10/24 that they covered two hallways. While going down one of the hallways they heard Resident #1 yell out but did not think it was anything serious. They went into a different room a few doors down to provide care and answer the call light. When Staff H was in this room, Staff I came into the room stating that Resident #1 was crying. Approximately 5-10 minutes later they went into Resident #1's room where they found them face down with the front part of their lower body on the fall mattress next to the bed and the upper part of their body, chest down on the bed. The staff noted the resident's face was between the mattress and the side rail attached to the bed. The nurse called 911 and spoke to the medical examiner who went to the nursing home that morning.

F689; 58.28(3)e; G; $9,750 (Treble/Held in Suspension). Resident #6's care plan directed staff to use 2-assist with a Sara lift in the shower. The CNA reported to the nurse as they wheeled the resident past the nurse's station that the resident did not fall in the shower. The staff reported that the resident's legs were supported and gave out without the ability to lift them farther, the resident was transferred to their wheelchair using a gait belt. The nurse assessed the resident's vital signs, they denied pain and the resident also stated they did not fall. The progress notes lacked an incident report, full assessment, family notification, provider notification, or DON and/or admin communication regarding the assisted fall in the shower room. The following day the resident reported that they fell while in the mechanical lift in the shower and stated skin tears on their arms were attributed to the fall. During investigation it was determined that the staff did not have a second helper during the transfer or when assisting off the floor.

F689; 58.28(3)e; J; $4,000 (Held in Suspension). Resident #1 was at risk for wandering/elopement with care plan interventions to wear a wanderguard. On 7/20/24 a progress note indicated the resident was not in their room and staff were unable to find them in the building. The manager on call was notified that the resident was missing and reported to staff to call the police. Meanwhile, the staff began searching outside of the building. The staff notified the nurse at 7:20 a.m. that the resident had been found and when the nurse responded the resident was noted lying face down on the pavement. There was blood noted on the pavement along with a laceration on their forehead. Staff called EMS and remained with the resident until transported to the hospital. A hospital discharge summary indicated that the resident had a right wrist fracture and facial abrasions from a fall. During interviews it was determined that the alarm was

sounding around 3 a.m. when resident #3 (who also had a wandergaurd) was self-propelling their wheelchair and they believed that resident set off the alarm, so they reset it. According to review of a neighboring business' camera footage the resident was seen leaving the building around 3:13 a.m. when they walked towards the building along a fence line that separated the parking lot from a business and fell. The DON felt that the resident set the alarm off around 3 a.m. and staff did not check outside the doors before resetting the alarm.

F689; 58.28(3)e; J; $6,500 (Held in Suspension). Resident #16's care plan directed staff to monitor for attempts to leave the building and replace wanderguard that was previously discontinued. Encourage the resident to ask for staff assistance to go outside, and not to leave the nursing home on their own without staff knowledge. On 5/7/24, Resident #16 received their medication at 7:04 p.m. and asked staff to assist with filling their bird feeder. The staff member told the resident that they would request maintenance staff to assist with that in the morning. At 10:10 p.m. an assisted living staff member brought Resident #16 into the building from outside. The resident had an abrasion on their face, wrist and both knees. At that time staff checked the exits and alarms and noted the front door alarm was bypassed, and the resident's walker was found by the front door. The video footage was reviewed and noted that the resident left the front door at 7:20 p.m. by pushing the handicap button, exited the building and went to the Assisted living building to have help finding their room. It was determined that the resident fell based on injuries identified and that the front door alarm was shut off allowing the resident to leave unnoticed for more than 2 hours. Staff did not tighten the belt around the resident's torso as the resident stood in a sit-to-stand mechanical lift.

F697; 58.20(1); J; Termination of Provider Agreement. Resident #77 was admitted to the nursing home on 8/7/24 with an order for as needed narcotic pain medication and reported 10/10 pain to both knees upon admission. The pain medication was unavailable to be administered. The nursing home did not report this to the physician until 3 days later, when the physician prescribed Tylenol. The resident continued to cry and yell out in pain during this time and did not receive the Tylenol until the following day. It was not until 8/13/24 that the resident received the Oxycodone for pain.

F697; 58.20(1); G; $2,500. Resident #109 had an order for a Fentanyl Patch; however, an order was received to hold the patch x 3 days due to the pharmacy wanting to speak to the provider. The note indicated that the ADON was notified, however, they do not recall being notified. Upon notification of the order to hold, the ADON notified the PA who contacted the pharmacy and resolved the issue of who prescribed the medication. The resident did not receive their Fentanyl patch for 2 days while it was on hold and expressed, they were in pain.

F725; L; Termination of Provider Agreement. Staff reported that there are only enough staff to make sure residents didn't get out of the building. Staff reported inadequate levels to supervise residents and could not provide showers for two weeks. There were also unlicensed personnel who were not adequately trained assisting with resident care.

F726; L; Termination of Provider Agreement. Staff did not complete wound vac or drain cares as they said they were not trained in how to complete the treatment. Resident #79 had a biliary catheter that staff did not know how to care for. Uncertified staff provided care to residents on multiple occasions.

F741; J; Termination of Provider Agreement. Resident #23's baseline care plan did not include mood or behavioral symptoms. The resident had a history of inpatient psych hospitalizations and was admitted on 6-1-24 for suicidal ideations. A pre-admit PASRR was approved for 1 year due to recurrent major depressive disorder without psychotic features, mood disorder with depressive features and identified services and supports of ongoing med management, individual therapy, behavioral health crisis intervention plan, rehab services, and community placement supports. The resident's progress note included episodes of agitation and PHQ-9 revealed minimal depression. Resident #11 had a history of self-injurious behaviors, had a PASRR level 2, the baseline care plan lacked information on PASRR services. The comprehensive care plan lacked a history of self-harm or guidance on razor blades. Progress notes indicated that the resident had scissors and razors in their room that the resident brought to the nurse. Resident #2 was noted picking at wounds and skin. The care plan lacked focus for impaired cognition, behavioral symptoms, depression diagnosis, or use of psychotropic medications, behavior monitoring or additional interventions for preventing self-harm.

F760; J; Termination of Provider Agreement. Resident #127 was admitted from the hospital on 8-9-24. The discharge orders from hospital stated to not administer antiplatelet or aspirin until 8-20-24 with follow up doctor appointment before restarting. The resident had a fall on the day of admission with a change in condition after which resulted in being transferred to the ER and diagnosed with an intracranial hemorrhage.

F835; L; Termination of Provider Agreement. Did not effectively manage the nursing home based on 10 unremoved immediate jeopardies which placed all residents at immediate risk for injury, as well as 2 IJs identified during LSC survey. The fax machine was not working, which limited communication with physicians and pharmacy. The nursing home was not able to adequately staff due to owing the agency money and another agency company didn't show up. The nursing home was using non-certified individuals to provide nursing care to residents. Corporate was making decisions about which residents to admit, and the nursing home staff didn't have any idea or provide input. The nursing home did not have adequate supplies for the residents in the building. Staff called 911 for help with a resident due to no staff on the evening shift.

TOP CITATIONS

F-TAG #	
F880	Infection Prevention & Control Program
F812	Food Procurement – Store/Prepare/Serve Sanitary
F689	Accidents/Hazards/Supervision/Devices
F658	Services Provided Meet Professional Standards
F550	Resident Rights / Exercise of Rights

These are the top citations from Iowa surveys conducted in August per DIAL 2567 reports.

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

F550 – Cited 14 times for failure to treat residents with respect, dignity, and privacy by:

- Staff were taking smoking privileges away from residents as a punishment for noncompliance.
- Did not obtain consent for psychiatric services according to policy.
- Staff told a dementia resident that their stuffed animal was stupid and that they were crazy.
- Staff spoke in a derogatory tone and used nonverbal communication such as rolling their eyes to residents and their family.
- Residents were left in the dining room up to three hours after meals ended.
- A staff member told a cancer patient they were “just going to die”.
- Staff did not help residents with their needs timely causing residents to have incontinence.
- Staff refused to help with cares and told a resident they are independent when asked.
- A resident who was a victim of resident-to-resident abuse was temporarily moved to the memory care unit for their safety.
- Staff were yelling at residents to go to bed.
- 2 times when catheter bags were not in dignity bags.
- Residents had tears in their clothing which exposed their incontinent products.
- Staff were standing while assisting residents with eating.
- Residents reported that staff were rough with transfers.
- Staff would not allow a resident to refuse their shower.
- A staff member attempted to put a glove in a resident’s mouth when they were yelling.
- Staff did not knock on doors before entering.

- Staff were talking on their cell phones while assisting residents with meals and others left residents during cares to respond to text messages.
- Staff spoke in another language to each other while providing care.

F552 – Cited 1 time when the power of attorney was not notified of a medication change and the resident was not invited to the care conference.

F554 – Cited 1 time when a bottle of chlorhexidine was left in a resident's bathroom without an assessment to determine if the resident was safe to self-administer medications.

F558 – Cited 2 times for:

- 2 times for call lights not being within reach for the resident.
- A closet door was off track and very difficult to open, restricting access to the resident's personal belongings.

F577– Cited 1 time when past survey results were not available and information on contacting the long-term care ombudsman was not posted.

F578 – Cited 2 times for:

- The care plan indicated DNR whereas the IPOST said full code.
- There was no physician signature, date, or witness signature on the IPOST form.

F580 – Cited 5 times for:

- 5 times for failure to notify the physician of medications not being available, significant change in condition, residents refusing medications, and a bruise.
- 4 times for failure to notify the family/power of attorney of significant changes in condition, transfer to a hospital, and a bruise.

F582 – Cited 1 time when an ABN was not completed when required.

F583 – Cited 1 time when a resident was left exposed for several minutes unnecessarily while the surveyor observed cares.

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

- Concerns about lack of housekeeping services expressed by residents.
- Cleanliness concerns identified during observations.
- Beds were not made in a timely manner.
- Linens with dark brown urine-like stains.
- 2 times for general disrepair of the resident's room.
- Stains present on room curtains.

F607 – Cited 4 times for:

- Did not follow the abuse policy and procedure related to protecting residents from abuse.
- A background check was not complete.
- A staff member did not have current dependent adult abuse training.

F622 – Cited 1 time when staff did not document a resident's condition leading up to a hospital transfer, did not document where the resident was discharged to, and include information sent to the hospital or other nursing home.

F625 – Cited 3 times for failure to provide bed hold notices to residents.

F636 – Cited 3 times for failure to complete admission and annual comprehensive MDS'.

F637 – Cited 4 time for:

- 3 times for failure to complete a significant change when admitted to or discharged from hospice.
- A change in ADLs that would have triggered a significant change according to the RAI manual.

F638 – Cited 3 times for not completing quarterly MDS'.

F640 – Cited 1 time when a discharge MDS was not completed.

F641 – Cited 5 times for:

- Not coding a PRN antipsychotic on the MDS.
- A hypnotic was coded on the MDS without an order for one.
- 2 times when bedrails were coded on the MDS as a restraint but should not have been.
- Coded insulin on the MDS without evidence of use during the look-back period.
- Coded a catheter was present when the resident did not have one.

F644 – Cited 8 times for:

- Not submitting a new Level 1 when:
  - 5 times for new mental illness diagnoses.
  - 2 times for new psychotropic medications.
  - A short-term approval expired.
- The care plan lacked services identified in the Level 2.

F655 – Cited 3 times when the baseline care plan did not include:

- Assistance required for transfers.
- Pain
- Surgical wounds, drains, and wound vac.
- High-risk medications.

F656 – Cited 13 times for:

- The care plan did not include:
  - 6 times for high-risk medications.
  - Dementia diagnosis.
  - Wandering
  - Required assistance with meals.
  - 2 times for behaviors.
  - Hospice
  - Edema
  - PASRR Level 2.
- 4 times for not following the care plan.

F657 – Cited 12 times for:

- Did not follow the care plan.
- The care plan was not updated to include:
    - Antibiotics
    - 2 times for falls.
    - Placement in the memory care unit.
    - 2 times for wounds.
    - Self-injurious behaviors.
    - 3 times for high-risk medications.
    - MDRO
    - Oxygen
    - 2 times for edema wear
    - 2 times for changes to ADL assistance.
    - Non-pharmacological interventions to attempt prior to administering PRN psychotropic medications.
    - Pain
    - Diagnosis of Schizophrenia
    - Hearing impairment

F658 – Cited 17 times for:

- 9 times for failure to follow the physician's orders.
- A treatment was completed in a common area, visible to other residents, staff and visitors.
- The care plan did not include information on changing a foley catheter.
- 2 times for failure to prime an insulin pen.
- 2 times for failure to leave an insulin pen injected in the skin following administration.
- 2 times for failure to administer medications within the allowable time frame.
- 2 times for failure to transcribe orders.
- An extended release pill was crushed.

F660 – Cited 1 time for not including discharge planning on the resident's care plan, did not document the discharge planning process, or the location the resident was discharged to.

F676 – Cited 1 time for not documenting restorative care provided.

F677 – Cited 7 times for failure to provide:

- 5 times for showers
- Nail care
- Oral care
- Assistance with toileting evidenced by residents with incontinent stains/spots under them.

F678 – Cited 1 time when the resident's order, care plan and IPOST did not match, and another resident did not have an IPOST completed.

F684 – Cited 12 times for:

- Staff did not assess urinary symptoms with a UTI.
- Did not document assessments after a catheter was removed.
- Did not complete post fall assessments.
- 2 times for failure to complete daily weights.

- Staff did not follow the bowel protocols established.
- Did not complete wound assessments.
- Oxygen saturations were not completed according to the physician's order.
- Did not complete follow up assessments when a resident displayed signs of possible URI.
- Staff did not administer glucagon per the physician's order for a low blood glucose level.
- Did not complete neurological assessments after hitting their head.
- Did not obtain treatment orders for a wound or document that a treatment was completed.
- Did not complete pain assessments.

F686 – Cited 9 times for:

- 2 times for not following the care plan for pressure ulcer prevention.
- Staff did not consistently document on a wound including when it was deteriorating.
- Did not complete a wound assessment.
- 2 times for not following physician's orders for treatments.
- Infection control concerns while observing dressing change procedures.
- Did not complete an admission skin assessment.
- Did not implement care plan interventions to prevent pressure ulcers.

F688 – Cited 3 times for failure to complete the restorative program.

F689– Cited 19 times for:

- A resident removed their wanderguard device and left the building.
- Staff did not complete an assessment after a fall.
- 4 times for staff not placing resident's feet on wheelchair pedals while pushing them.
- Did not protect a resident from resident-to-resident abuse.
- 4 times for failure to follow the care plan for assistance with transfers.
- Did not supervise a resident with meals according to the care plan.
- A resident was noted smoking in the parking lot, outside of designated smoking areas.
- Did not answer call lights timely to prevent a resident from falling.
- Did not evaluate fall interventions to ensure they are appropriate.
- Did not use a gait belt during a transfer.
- Did not operate a mechanical lift according to the manufacturer's instructions including tightening the safety belt when the resident was standing.
- The IT room had a hot temperature, and the nursing home propped the door open with a fan blowing the hot air out of the room.
- There were no call lights present in resident bathrooms.

F690 – Cited 5 times for:

- 4 times for not cleansing the perineal area properly during cares.
- A foley bag/tubing was on the floor.
- Enhanced Barrier Precautions were not implemented during catheter care.
- Did not change gloves or complete hand hygiene appropriately.
- The staff did not assess a resident when a catheter was removed.
- Did not document urine output.
- Did not follow the physician's order for catheter changes.

F692 – Cited 1 time for not implementing interventions for a resident with weight loss.

F693 – Cited 4 times for:

- 2 times for failure to check placement of the g-tube prior to feeding or administration of medications.
- The head of bed was not elevated.
- The enteral feeding container was not dated when opened.
- A foley catheter was used as a PEG tube when the PEG tube was leaking and did not have a replacement. The nursing home did not schedule an appointment timely to get the PEG tube replaced once removed and did not receive an order to administer the medications into the foley.

F695 – Cited 5 times for:

- 3 times for failure to change oxygen tubing.
- There was no equipment present at the bedside for a resident with a trach in the event of an emergency.
- 2 times for failure to change nebulizer equipment.
- Oxygen tanks were empty.
- Failed to sign administration of breathing treatments/oxygen.

F698 – Cited 3 times for not completing pre- and post-dialysis assessments.

F725 – Cited 10 times for:

- 2 times when staff reported a lack of staffing in sufficient quantities to ensure resident cares were able to be provided.
- There were unlicensed staff providing cares to residents.
- 7 times for failure to answer call lights timely.
- A licensed nurse was not on duty for a period of approximately 2 hours.

F726 – Cited 1 time when family reported they provided activities of daily living due to concerns identified with staff not completing them.

F727 – Cited 1 time for failure to have RN coverage 9 of 32 days reviewed.

F732 – Cited 2 times for:

- The post was not where residents could access it.
- The posting did not include the resident census.

F740 – Cited 1 time for not including self-harm on the care plan following suicide attempts.

F741 – Cited 1 time when staff used punitive restrictions and restraints on dementia residents.

F755 – Cited 6 times for:

- Not signing out narcotics in the control logs.
- Did not maintain an accurate narcotic count.
- 2 times when the residents did not have medications available to administer.
- Undated insulin pens.
- Narcotics were not double locked.

- The policy stated that two licensed nurses must count narcotics, however, medication aides were counting with a nurse.
- The wrong medication was administered to a resident.

F756 – Cited 1 time when the nursing home did not ensure a timely response regarding a GDR request.

F757 – Cited 1 time when staff administered morphine for indications that were not included on the order.

F758 – Cited 5 times for:

- PRN psychotropic medication orders were not limited to 14-days.
- A PRN antipsychotic medication was administered to relieve anxiety.
- 2 times for not attempting/requesting a GDR.
- Did not identify target behaviors on the care plan for psychotropic medications.
- Did not document non-pharmacological interventions attempted before administering a PRN antianxiety medication.

F759 – Cited 1 time for a medication error rate of 13.51% due to staff crushing all medications together to administer via g-tube without a physician's order to do so.

F760 – Cited 3 times for:

- Did not follow the hospital discharge orders that directed the nursing home to not administer antiplatelet or aspirin medications until after a follow-up appointment was completed.
- Medications were not available to administer.
- Administered medications via g-tube when the order stated to administer orally and per g-tube only as needed.

F761 – Cited 2 times for:

- The treatment cart was left unlocked.
- The medication cart and narcotic keys were left unattended in an unlocked drawer.

F800 – Cited 3 times for:

- Food temperatures not maintained for warm food at or above 135 degrees.
- Foods were burnt when served to residents.
- 2 times for serving incorrect portion sizes.

F801 – Cited 3 times for not having a qualified dietary manager.

F803 – Cited 7 times for:

- 4 times for not completing the puree process correctly which lead to incorrect portion sizes being served.
- Bread was not served with the meal according to the therapeutic menu.
- Staff did not follow the therapeutic menu and served completely different foods than what were listed.
- Staff did not support the resident's desire for a vegetarian diet by serving them meat and animal products.
- 2 times for not serving the physician's ordered diet.

F804 – Cited 6 times for:

- Hot water was used during the puree process instead of a liquid with nutritional value.
- 5 times for not maintaining hot and cold food temperatures.

F805 – Cited 1 time for the nursing home not following their plan of correction to ensure accurate diet textures are served to residents.

F808 – Cited 2 times for:

- The puree food consistency was more of a mechanical soft consistency than puree.
- The staff did not serve residents the appropriate diets according to the physician's order.

F811 – Cited 1 time when paid nutritional aides were assisting residents with feeding difficulties.

F812 – Cited 22 times for:

- 2 times for items being stored on the floor.
- 11 times for not having food items labeled and dated when opened.
- Items were kept longer than what policy stated is allowable.
- 9 times for concerns with food handling.
- Staff were not consistently documenting food temperatures.
- Did not consistently complete dishwasher logs.
- 2 times when meat was thawing over non-meat food items and when improperly thawing meat.
- 2 times when utensils were placed on equipment without a barrier down first.
- 2 times for food temperatures not being maintained during service.
- Scoops were not filled to provide accurate portion sizes to residents.
- 2 times for not wearing hair/beard nets appropriately.
- Dishes were stored wet.
- Food prep/workstations were not disinfected.
- 2 times when scoops were placed in food with the handle touching the food.
- Food was uncovered for a long period of time when staff was not serving it.
- 3 times for concerns with handwashing.
- The thermometer was not cleaned prior to checking food temperatures.
- 4 times for general cleanliness concerns in the kitchen.
- 2 times when the dishwasher temperature did not get hot enough to effectively sanitize equipment.
- 2 times for items being stored without a cover or sealed.
- Sanitizer levels were not checked in disinfecting solution.

F825 – Cited 1 time for not following speech therapies recommendations.

F842 – Cited 3 times for:

- Not documenting an allegation of abuse in a resident's record.
- A medication was not discontinued on the MAR when the dose was increased.
- Resident's medical records were visible on the computer and paper to the public.

F851 – Cited 2 times for:

- PBJ data was not submitted accurately.
- Did not report staffing agency hours.

F865 – Cited 6 times for not implementing an effective QAPI program as evidenced by repeat deficiencies.

F867 – Cited 1 time when reviewing QAPI notes they did not include items identified in the QAPI plan that would be monitored.

F868 – Cited 1 time when the infection preventionist was not in attendance at the quarterly QA meeting.

F880 – Cited 24 times for:

- 8 times for failure to implement/follow enhanced barrier precautions when indicated.
- 15 times for failure to complete hand hygiene when necessary.
- 7 times for not changing gloves appropriately.
- 4 times when staff did not place a barrier down prior to sitting reusable equipment or supplies down.
- Did not have infection tracking documentation.
- Infection control policies and procedures were not reviewed on an annual basis.
- Staff placed care items in their pockets.
- An isolation gown was used, however, staff pulled the sleeves up and exposed their arms.
- 2 times for failure to use a gown when sorting soiled linens.
- 2 times for not using appropriate PPE when a resident was in transmission-based precautions.
- Water used for cares was dumped in the sink when finished instead of in the toilet.
- A scoop was stored in the ice.
- 2 times for not covering clean linens while being transported in the hall.
- Soiled linens were noted on the floor.
- Spills from the garbage were not cleaned up.
- Lint filters on dryers were not cleaned.
- 2 times when catheter tubing and/or bags touched the floor.
- 2 times for failure to disinfect reusable equipment.
- Staff did not wear masks at all times when the building had a COVID-19 outbreak.
- 2 times when staff did not remove/change PPE when leaving a room of a resident in transmission-based precautions.

F881 – Cited 1 time when a prophylactic antibiotic was not evaluated as part of the antibiotic stewardship program.

F883 – Cited 2 times when a resident was eligible for pneumonia vaccines but they were not offered or given.

F919 – Cited 1 time when the call light system was not properly functioning.

There are additional tools to assist with survey readiness on our website!

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

LeadingAge Iowa