LTC Survey Trends Report
August 2025

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LeadingAge Iowa

ASSURANCE OF FINANCIAL SECURITY & NURSING HOME SURVEY UPDATES

by Kellie Van Ree, Director of Clinical Services

The Regulatory Review article for this month reviewed F570 related to the nursing home's requirement to secure a financial security bond when they accept residents' funds.

A few recertification surveys are now extended beyond 12 months; however, the majority remain at less than 12 months.

This month there were a few immediate jeopardy concerns identified but overall remains significantly lower than in previous years.

Survey Activity

District	Average Months for Providers with Recert	Number of Providers over 12 Months	Longest Survey Timespan
Statewide	10.7 months	13 months = 6 *12 months = 18 *11 months = 37	13 months

Recertification:

- 31 total recertification surveys reviewed with 6.3 deficiencies on average per recertification survey with deficiencies.
    - Of the 27 recertifications with at least one deficiency, 3 providers received a fine (or 11%).
    - Of the 31 recertifications, 4 providers had deficiency free surveys (or 15%)

Complaint/Incidents:

- 39 providers with complaint/incident surveys reviewed with 2.9 deficiencies on average per survey reviewed with deficiencies.
    - Of the 21 complaint/incident surveys with at least one deficiency, 9 received a fine (or 43%).
    - Of the 39 complaint/incident surveys, 18 did not receive a deficiency (or 46%).

Enforcement Action

CY 2025	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVG NUMBER OF DEFICIENCIES
JANUARY	**$32,250**	**$301,215**	**2 Denials; 1 DPOC**	**$333,465.00**	**4.6 deficiencies**
FEBRUARY	**$50,250**	**$63,498.50**	**3 Denials; 1 DPOC**	**$113,748.50**	**8.3 deficiencies**
MARCH	**$64,000**	**$59,302.75**	**1 Denial**	**$123,302.75**	**5.6 deficiencies**
APRIL	**$22,000**	**$66,225.25**	**1 Denial**	**$88,222.25**	**6.2 deficiencies**
MAY	**$27,750**	**0**		**$27,750**	**5 deficiencies**
JUNE	**$53,500**	**0**		**$53,500**	**5.9 deficiencies**
JULY	**$86,740**	**0**		**$86,750**	**3.7 deficiencies**
AUGUST	**$97,750**	**0**		**$97,750**	**6.3 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.

Congratulations to Gracewell, an Eventide Home on a deficiency free survey!

CITATIONS WITH FINES

August Deficiencies with State Fining and Citation

50.7(5) $500. The nursing home did not report when Resident #23 attempted to commit suicide by sticking a pen in their antecubital area.

F600; 58.43; D; $500. A resident was not free from abuse when a staff member tapped them on the head during care.

F600; 58.43; D; $500 (Held in Suspension). The staff did not provide care and transfers according to the residents' care plan and therapy recommendations as they were using stand/pivot transfer techniques when the care plan and therapy recommendations directed use of a mechanical lift. The resident pointed out multiple bruises to their forearm as a result.

F609; 58.43(9); D; $500. Resident #6 reported that their friend gave them $10 and the following day it was missing and felt like a nurse aide took it. The allegation was not reported to DIAL.

F609; 58.43(9); D; $500. Staff members witnessed another staff member forcefully hold a residents' arms down while performing care and swearing at the resident. The incident was reported but not until several days later which delayed reporting to DIAL.

F609; 58.32(9); D; $500. A schedule-III medication was missing and was not reported to the State Agency in a timely manner.

F609; 58.43(9); J; $500 (Held in Suspension). Resident #51 reported to the surveyor during an interview that staff pulled him from his bed which caused several bruises on their forearms. During review the progress notes lacked documentation of the dark purple bruises that the resident pointed out to the surveyor. During interviews with the staff, they indicated that the resident blamed them for the bruises and that they received directions to use a stand/pivot transfer with the resident but the care plan and therapy recommendations indicated the resident required use of a mechanical lift. The staff did not report the allegations to the administrator or DIAL.

F610; 58.43(9); E; $500. An allegation of abuse was not thoroughly investigated based on not interviewing other residents on the unit and physical assessments completed to identify if injuries were present to other residents in the unit.

F627; 58.40(9)a; J; $5,500 (Held in Suspension). The nursing home did not plan for a safe discharge for Resident #2 as they left the nursing home on their electric scooter without notifying the nursing home to go to their friend's house. The resident later traveled to a convenience store where the cops found them and the administrator went to the convenience store. The resident reports that the administrator was mad at them for leaving and had the resident sign a discharge AMA form and left the resident at the convenience store. The resident returned to the building later that morning and was readmitted.

F684; 58.19(2)j; J; $8,500 (Held in Suspension). Resident #3's care plan was updated on 8.6.25 with a focus of impaired circulation and peripheral artery disease. Prior to this date, the care plan did not reflect any interventions for impaired circulation or PAD. Additionally, the care plan also lacked non-pharmacological interventions to aid in pain relief. On several occurrences, the resident's pain was documented as 10/10 on without any follow up documentation on pain relief. For several days in August, the resident had significant pain to their lower extremities which included crying and rubbing their legs. An unstageable pressure ulcer

was noted to their right heel on 8.3.25 at 1:10 p.m. On 8.4.25 at 1:38 p.m. the wound form for the right lower extremity indicated the leg was purple, cold to touch with complaints of extreme pain. The resident was transferred to the hospital and subsequently to a different hospital due to complete loss of circulation in the leg. On 8.5.25 the staff documented the resident had a thrombectomy to restore blood flow with a possible amputation in the future. The resident previously had femoral artery bypass graft and a wound vac to the incision. Staff indicated the resident was crying out in pain and required more assistance beginning on 8.3 without documented assessments and intervention other than communication about pain.

F686; 58.19(2)b; G; $5,500 (Held in Suspension). Resident #3 had a Stage 2 and a Stage 3 pressure ulcer on the most recent MDS, and the care plan identified a risk for alteration in skin integrity. The wounds did not have a corresponding treatment ordered. On 5.16.25, the resident was noted with a suspected deep tissue injury to their heel. That evening the resident had a change in condition and was sent to the ER for evaluation. The ER notes included three pressure areas including to the shoulder, right heel, and left heel. During observation, the resident did not receive dressing changes to their coccyx or right buttock pressure areas with incontinence care, did not have protective heel boots or pillows, did not have dressing orders upon admission or a way to offload pressure.

F689; 58.28(3)e; J; $8,000 (Held in Suspension). On 7.8.25, a dietary aide heard pounding on the courtyard door and when they opened the door, Resident #1 reported they had been locked outside all night, was crying, shaking, and visibly upset from the incident. The administrator and DON indicated that the door was not locked, but the resident reported that it was very heavy, and they were unable to open it. They educated Resident #1 to take their cell phone when they went out to smoke and installed doorbells with receivers at each nurse's station. During investigation, it was identified that Resident #1 was outside from 8 p.m. on 7.7.25 until 6 a.m. the following morning. During this time, there was rain, thunderstorms, and lightning. The resident expressed being very cold and wet during the night, stating they pulled their arms and legs inside their shirt to try to warm up. The surveyor and staff walked through the courtyard and the door would not fully close, so the administrator pushed the door shut to stop the alarm from sounding. When they attempted to get back in, they were unable to. Resident #2 reported to surveyors that they left the building on 7.3.25 at 6:15 p.m. in a motorized wheelchair to go to their friend's house to visit their dog. On 7.4.25 at 3:00 AM the resident asked their friend to call the nursing home to tell them they were ready to come back. While they waited to be picked up, the resident attempted to use the bathroom but was incontinent and embarrassed as they had to sit in BM and clean their friend's bathroom. The resident left the friend's house to go back to the nursing home in their motorized wheelchair and at approximately 5:30 a.m. stopped at a convenience store where the cops found them. The resident reported to the surveyor that the administrator went to the gas station and got upset with the resident for leaving and not letting anyone know and asked them to sign an AMA discharge paper. The resident was mad about the situation and signed the paper but then realized that they needed help from the staff, so they returned to the nursing home. During staff interviews, they reported it was more than two hours after the resident left that someone recognized they were gone. During interview with the DON and Administrator, they indicated that they attempted to search for the resident for a couple hours and were tired so they went to bed and allowed the police to continue searching. During the night, they acknowledged the nurse tried to call them when the resident said they were ready to return but did not hear the phone call and the Administrator stated they didn't have a way to transport the resident back to the nursing home at that hour. The resident returned to the nursing home independently at 9:30 a.m. on 7.4.25. Resident #5 was observed yelling at the staff as they could not open the door to come back in from smoking. The resident reported ringing the doorbell, but no one responded.

F689; 58.28(3)e; J; $7,000 (Held in Suspension). Resident #9 was at risk for elopement and staff placed a wandering alarm on them but they had a history of removing the bracelet. There were also numerous progress notes included in the resident's record of wandering behaviors. On 6.4.25 Resident #9 was given medication for agitation between 6:30 and 7. When the nurse went into their room at 9 p.m. the resident was

not present. They did a search of the building and then went outside where they found the resident by a cement wall, the resident complained of pain upon assessment and EMS was called. During investigation it was identified that the doors to the AL were not locked or alarmed, and some installed alarms were turned off. The hospital notes indicated the resident had acute right rib fractures. Resident #10 required a slide board and assistance of two staff. On 7.24.25, Resident #10 had a fall and it was noted that the wheelchair brakes were not locked and a staff member transferred the resident without a second person assisting them.

F689; 58.28(3)e; G; $5,000. Resident #5 was assisted with ambulation and transfer when they stated they were not able to walk further. Staff brought the wheelchair up for them to sit in but the resident sat before the wheelchair was close enough resulting in the resident falling to the floor. After the fall, the resident complained of pain in the left arm and was sent to the ER where they identified a fracture of the left shoulder. It was identified that the staff did not use a gait belt during the transfer which resulted in a fall.

F689; 58.28(3)e; G; $14,250 (Treble/Held in Suspension). Resident #20 was admitted to the nursing home from the assisted living program. On admission the resident was identified as a high fall risk and had a fall at the assisted living. After admission the resident had a fall on 5.22.25 and 5.25.25 which lacked identified interventions. On 6.7.25 the resident's call light was activated and staff immediately responded but on their way to the room heard a loud noise and the resident was on the floor with blood everywhere and complained of pain to their head. At the time, the resident's daughter declined sending the resident to the ER as the bleeding was stopped. However, later in the shift the laceration was bleeding and the staff suggested sending to the ER where Resident #20 was diagnosed with multiple brain bleeds. Upon returning to the nursing home, the resident had several more falls which lacked interventions to prevent further falls.

F740; 58.28(3)e; 58.28(3)e; J; $30,000 (Treble/Held in Suspension). Resident #1 was accused of grabbing Resident #3's leg while they passed by them in their wheelchair which left bruises on Resident #3's leg. Based on the incident, the nursing home served Resident #1 with an emergency involuntary discharge notice on 6.30.25. The social worker assisted the resident with appealing the decision, but on 7.22.25, the resident received notice the decision was upheld. The social worker offered to assist with a second appeal but the resident declined and asked for boxes to pack and for assistance on searching for alternate placement as the place that accepted the resident was not their first choice. On 7.25.25 at 5:30 a.m. staff discovered Resident #1 deceased in their room after a successful suicide attempt. 1:1 supervision for Resident #1 was previously implemented based on the resident-to-resident incident; however, due to two staff members calling in for their shift, the 1:1 was discontinued so the staff could work the floor. Staff implemented two-hour checks and there were no concerns documented until approximately 5:30 a.m. During record review, the care plan did not include updates on the assault, involuntary discharge, 1:1 supervision. The progress notes did not include social services notes and psychosocial assessments despite the resident having a history of suicide attempts.

F741; 58.20(2); 58.39(2)c; J; $10,000 (Held in Suspension). The nursing home did not recognize and address potential statements and behaviors that indicated a risk for self-harm in Resident #1 who had a history of major depressive disorder, suicidal ideation, and was issued an involuntary discharge notice due to an assault on another resident. The resident was to be discharged to another nursing home on 7.25.25, however, in the early morning hours staff found the resident laying in a pool of blood after successfully committing suicide. During interviews, staff heard the resident making several phone calls to their bank and instructing them to give their money to their nephew if anything happened to them as well as telling the social worker to not feel guilty about anything. A family member reported that they received a message from the resident on 7.24.25 indicating that "it's check out time" and were concerned they were referencing suicide. The family member called the nursing home but did not get an answer, so they left a message to keep a close eye on them and was under the impression the resident was under 1:1 supervision. Staff were unaware of how to listen to the voicemails and at times the phone volume was turned off/down.

TOP DEFICIENCIES

F-TAG #	
F880	Infection Prevention & Control
F689	Accidents/Hazards/Supervision/Devices
F684	Quality of Care

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

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

F550 – Cited 10 times for failure to treat residents with respect, dignity, and privacy by:

- A resident was forced to complete ADLs by staff.
- 2 times when staff cursed at residents.
- Food was taken away from a resident which was inconsistent with speech therapy recommendations.
- Staff were talking on their cell phones while providing care to a resident.
- The nursing home did not have adequate incontinent supplies.
- Catheter drainage bags were not covered by dignity bags.
- A resident's commode was not emptied.
- A staff member told a resident to leave the dining room.
- A staff member talked to other individuals while assisting a resident with eating.
- A resident was forced to go to the dining room for meals when they wanted to stay in their room.
- A resident was locked out of the building all night and staff made them think it was their fault because they didn't take their cell phone with them.
- A resident missed activities due to delayed care.
- Wheelchairs were dirty.
- A sign about toileting was placed in the residents' room without their permission to do so.
- Clothing was stained.
- Staff completed room searches without consent and removed items without the residents' knowledge.
- Residents were made to go to bed at a specific time.

F552 – Cited 1 time when the staff did not assist a resident with cognitive impairment in obtaining an alternate decision maker which was included in the resident's PASRR recommendations.

F553 – Cited 1 time when quarterly care conferences were not completed.

F554 – Cited 1 time when a resident administered their own insulin but did not have an assessment to complete self-administration of medications.

F558 – Cited 3 times when call lights were not within the resident's reach.

F561 – Cited 1 time when the nursing home did not allow a resident to continue smoking upon a change in policy to a non-smoking campus.

F567 – Cited 1 time when residents did not always have access to their funds.

F578 – Cited 1 time when the IPOST was not reflected accurately in the resident's record.

F580 – Cited 7 times when the physician and responsible party were not notified of:

- Weight loss
- Vital sign abnormalities
- Incidents
- Wounds
- Lab results
- Low blood glucose levels
- X-ray order

F582 – Cited 3 times when:

- 2 times when no NOMNC or ABN was presented as applicable.
- A resident's representative was not notified when skilled care ended.

F584 – Cited 5 times for failure to provide a homelike environment by:

- 3 times for stained carpet.
- Bed bugs
- Did not mop according to their policy.
- Fans were excessively dirty.
- Register covers were not on properly.
- Wall paper was peeling.

F600 – Cited 3 times when:

- A staff member threatened a resident and pulled on their arm.
- There was an inappropriate relationship between a resident and staff member based on text message exchanges.
- A staff member shared a video on social media and referred to the resident as "crazy".

F605 – Cited 4 times when:

- 3 times when non-pharmacological interventions were not included in the care plan.
- 2 times when target behaviors were not identified in the care plan.
- A GDR that was declined by the physician did not have a clinical rationale for declining.
- Staff did not allow adequate time for effectiveness of a medication before administering another medication.

F607 – Cited 1 time when a criminal background check was not completed prior to hire.

F610 – Cited 1 time when the nursing home did not investigate allegations of staff pulling on the resident's arms.

F627 – Cited 1 time when a bed hold notice was not given to a resident due to them owing the nursing home money and the resident was not allowed to return to the nursing home following hospitalization.

F628 – Cited 6 times for:

- 2 times when the bed hold notice was not signed according to the policy and procedures.
- A bed hold notice was not provided.
- Accurate rules were not cited when they provided an involuntary discharge notice.
- 2 times when the LTC Ombudsman was not notified of transfer/discharge.

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

F640 – Cited 1 time when an MDS was not submitted timely.

F641 – Cited 3 times when:

- The MDS was not accurately coded by:
    - Insulin was coded when not administered.
    - Elopement alarms were not coded when used.
    - Weight loss was not coded but should have been.
    - An MI diagnosis was not coded.

F644 – Cited 3 times when:

- Level 2 recommendations were not included in the care plan.
- 2 times when a new Level 1 was not completed for a new MI diagnosis.

F656 – Cited 10 times for:

- 4 times when staff did not follow the care plan.
- The care plan did not include:
    - 2 times for antidepressants
    - 2 times for antianxiety medications
    - Foley catheter
    - Behaviors
    - Non-pharmacological interventions for psychotropic medication use.
    - Diabetes
    - 2 times for oxygen
    - Antipsychotic medications
    - ADL assistance

F657 – Cited 6 times for:

- The care plan was not updated to include:
    - Weight loss
    - Discontinued dialysis
    - New MI diagnosis
    - ADL assistance
    - Discontinued diuretic
    - Fall interventions
    - Foley catheter
    - Wounds
    - Nutrition
    - Code Status

F658 – Cited 7 times for:

- Speech therapy recommendations were not followed.
- The physician was not notified of a weight gain.
- 3 times for following physician orders.
- The pharmacy sent incorrect medications that were administered to the resident.
- An order was not transcribed.
- Medications were not available to administer.

F677 – Cited 3 times for failure to provide/assist with:

- Baths/showers
- Toileting
- Nail Care

F679 – Cited 1 time when there were not opportunities for the resident to go outside when the weather was nice.

F684 – Cited 12 times for:

- 4 times when assessments were not completed and/or documented on new skin concerns.
- 2 times when assessments were not completed for a change in condition.
- An incident was not reported to the nurse when a resident hit their head.
- Assessments were not completed when the resident went or returned from the ER.
- Pre- and post-dialysis assessments.
- Physician orders were not followed.
- Elopement risk assessments were not completed.
- An order was not obtained prior to a resident receiving a medication.
- Did not complete post fall and neurological assessments per policy.

F688 – Cited 2 times when restorative care was not provided.

F689– Cited 13 times for:

- 2 times when care planned fall interventions were not followed.
- A resident with suicidal ideation/attempts had 1:1 supervision discontinued without a new intervention implemented.
- Staff did not supervise the memory care unit per their policy.
- 2 times when residents were transported in wheelchairs without foot pedals.
- Adaptive equipment was not in good repair.
- 2 times when root cause analysis was not conducted after a fall.
- 15-minute checks were not documented as completed.

F690 – Cited 7 times for:

- 2 times when staff did not follow up on a urinalysis.
- A catheter order was not clarified.
- Catheter output was not documented.
- The order for a catheter was not transcribed or include the amount of fluid to be placed in the bulb.
- 2 times when catheter drainage bags were on the floor.
- Did not follow an order to flush a catheter.
- Staff did not perform incontinent care timely.

F692 – Cited 2 times when:

- Meal intakes and supplements were not documented.
- The nursing home did not identify and intervene for a resident with a weight loss.

F693 – Cited 3 times for:

- 2 times when tube feeding orders were not followed.
- Did not measure the amount of formula.
- Did not check for gastric residual prior to administering flush/formula.
- Administered medications via push instead of allowing to flow via gravity.

F695 – Cited 4 times when:

- 3 times when the oxygen was not set at the correct flow rate.
- The CPAP settings were not included in the medical record.
- The CPAP was not on the care plan.
- There was not an order for a CPAP.

F697 – Cited 1 time when staff did not provide PRN medications for expressed pain.

F698 – Cited 2 times for:

- No documented communication to/from the dialysis center.
- Did not complete pre- and post-dialysis assessments.

F725 – Cited 7 times when:

- 6 times for call light response time.
- A resident reported that staff were not providing care due to staffing.
- Did not provide care in a timely manner.

F726 – Cited 1 time when staff were not competent with administering medications.

F727 – Cited 1 time when RN coverage was not present for one day during the review.

F732 – Cited 1 time when the staff posting did not have total hours worked or split between RN and LPN hours.

F740 – Cited 1 time when a crisis intervention and safety plan was not included in the care plan according to the Level 2 recommendations.

F755 – Cited 5 times when:

- Medication administration was not observed by staff.
- Medications were not documented as administered on the MAR.
- Narcotics were not destroyed upon discharge.
- Narcotics were not reconciled appropriately.
- Medications were not available from the pharmacy.

F759 – Cited 5 times for medication errors including:

- 2 times for the correct dose.
- The blood sugar was not checked as ordered.
- 2 times when insulin was administered after the person ate.
- Medications were not held based on established parameters.
- 2 times when insulin pens were not primed.
- Medications were administered outside of the ordered timeframe.

F760 – Cited 6 times when:

- Medications were administered twice to the same resident.
- 2 times when insulin was administered after the resident ate.
- 2 times when medications were omitted.
- 2 times when insulin pens were not primed.

F761 – Cited 3 times for:

- The medication refrigerator was between 46-50 degrees.
- Medication cart was unlocked and unsupervised.
- Keys to the narcotic box were not secure at all times.

F803 – Cited 2 times when portion sizes were not correct according to the therapeutic menu.

F804 – Cited 2 times when hot food was not maintained at or above 135 degrees.

F805 – Cited 1 time when the diet order was not followed.

F809 – Cited 1 time when meals were served up to 2.5 hours late.

F812 – Cited 9 times for:

- Meat in the cooler stored above other ready to eat food items.
- 3 times for food handling techniques.
- 2 times when equipment was not clean.
- 3 times when items were not labeled or dated.
- 2 times when items were not discarded when expired.
- Placed utensils down without sanitizing the work area or placing a barrier down.
- Equipment was not sanitized when necessary.
- 2 times when staff did not complete hand hygiene.
- Hairnets were not used when in the kitchen.
- Clean dishes were held against clothing.

F842 – Cited 4 times when:

- Signed MARs that medications were administered when they were not available at the nursing home.
- An incident was not documented in the resident's record.
- An order was not transcribed.
- Staff did not document an assessment.

F851 – Cited 3 times when:

- Agency hours were not reported.
- The DON hours were not included when they worked as a nurse.
- The staffing hours did not match the schedule.

F865 – Cited 6 times when the nursing home did not have an effective QAPI process based on repeat deficiencies.

F868 – Cited 2 times when the IP and Medical Director did not attend QA meetings.

F880 – Cited 19 times for:

- 14 times when enhanced barrier precautions were not used.
- Droplet precautions were not implemented when the resident had signs of an acute respiratory illness.
- 2 times when supplies were set down in the resident's room without placing a barrier underneath them.
- 10 times when hand hygiene was not completed appropriately.
- 3 times when gloves were not changed appropriately.
- Catheter bag/tubing was on the floor.
- 6 times when reusable resident equipment was not sanitized between residents.
- Incontinent cares were not performed appropriately.
- A gown or clothing cover was not used when handling soiled linen.
- The catheter drainage bag was not under the level of the resident's bladder.

F883 – Cited 2 times for:

- The resident was not assessed for pneumonia vaccines or provided education/offer the vaccine.
- Did not administer a vaccine when the resident consented to it.

F921 – Cited 1 time when the toilets were dirty, the beds were not made timely, and the screens needed repaired/replaced.

F926 – Cited 1 time when the residents were not educated on changes in designated smoking areas.

F943 – Cited 1 time when dependent adult abuse training was not completed within 6 months of hire.

F947 – Cited 1 time when temporary staff were not educated and determined competent prior to allowing them to work with residents.

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

LeadingAge Iowa