LTC Survey Trends Report December 2024

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LeadingAge Iowa

CHOICE OF ROOMMATES & SURVEY UPDATES

by Kellie Van Ree, Director of Clinical Services

The Regulatory Review article for this month reviewed F559, the resident's right for reasonable accommodation and allowing for resident preferences.

LeadingAge Illinois/Iowa is hosting a webinar on the revised surveyor guidance on January 30, 2025. Members can register for this webinar for ***free***! I've also been working on several resources related to the revised guidance which you can find here.

Survey Activity

District	Average Months for Providers with Recert	Number of Providers over 12 Months	Longest Survey Timespan
Statewide	12.9 months	10 nursing homes	16 months

Recertification:

- 23 total recertification surveys reviewed with 6.8 deficiencies on average per recertification survey with deficiencies.
    - Of the 18 recertifications with at least one deficiency, 5 providers received a fine (or 28%).
    - Of the 23 recertifications, 5 providers had deficiency free surveys (or 22%)

Complaint/Incidents:

- 63 providers with complaint/incident surveys reviewed with 2.2 deficiencies on average per survey reviewed with deficiencies.
    - Of the 16 complaint/incident surveys with at least one deficiency, 6 received a fine (or 38%).
    - Of the 63 complaint/incident surveys, 47 did not receive a deficiency (or 75%).

Enforcement Actions

CY 2024	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVG NUMBER OF DEFICIENCIES
CY 2024 TOTALS	**$1,033,757.25**	**$2,945,640.34**	**27 Denials; 7 DPOC; 1 State Monitor; 1 Termination; 1 Voluntary Termination**	**$3,979,397.59**	**6.1 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

December Deficiencies with State Fining and Citation

50.9; $500. Staff D's SING report indicated a possible criminal history, however, additional documentation of the DCI report was not in the employee's file.

F606; 58.11(1); E; $500. During surveyor observations, there were concerns identified with a medication assistant including difficulty locating medications that other staff were quickly able to find and describing incorrect practices for reconciling narcotics. During the investigation it was identified that the person was employed with a staffing agency and that agency did not provide information on background checks or certification verifications. A SING report completed during the survey indicated the staff member was ineligible to work in the State of Iowa and the direct care worker website listed the staff member as an "abuser". In addition, the Director of Nursing began working prior to further research being conducted on their background check per the SING report. According to the scheduler, the DON was instructed by the Administrator to begin working, but to stay away from residents.

F607; 58.11(3); D; $500. A registered nurse had a SING report completed on 9.4.24 that indicated further research was required for their criminal background check. No additional information was included in the employees' file and they began working on 9.9.24. The complete background check was completed more than two months after the employee's hire date when the file was audited by the nursing home staff.

F609; 58.43(9); D; $500. The nursing home did not report an allegation of possible abuse to DIAL when a resident reported that a staff member placed them in a headlock and pulled on their neck while providing care.

F684; 58.19(2)j; J; $9,750 (Held in Suspension). Resident #2 was discharged from the hospital on 10.14.24 following a hip fracture and was sent to the ER via ambulance on 10.22.24. During this time the resident's skilled assessments were completed sporadically and indicated changes in vital signs without intervention. Progress notes also indicated changes in condition including fever, bloody discharge on their pants, lethargy, pocketing food, attempts to hit staff without thorough assessment or intervention. The resident's hospital notes indicated a diagnosis of dehydration and they returned to the nursing home on 10.29.24. They were admitted to hospice care and passed away on 11.7.24 with a cause of death listed as dehydration due to sepsis.

F684; 58.19(2)j; G; $6,250 (Held in Suspension). Resident #2 was admitted to the nursing home following hospitalization for paraphimosis. The staff did not follow the urology nurse practitioners' recommendations of ensuring that the resident's foreskin was returned to a normal position following catheter care which caused the resident to be sent to the urologist on more than one occasion due to increased swelling.

F686; 58.19(2)b; G; $5,500. Resident #3 had a venous stasis ulcer included on the MDS and care plan. The resident was readmitted to the nursing home on 9.9.24 from the hospital for sepsis. Progress notes following the hospitalization noted purulent drainage from a pressure ulcer that lacked documentation of size or measurements. The resident was treated at the wound clinic for the area and the nursing home was provided with treatment orders. The resident's TAR and record lacked documentation of dressing changes for 11 days in September. The resident's record lacked documentation of wound treatments from 10.1 until the resident went to the lymphedema clinic on 10.22. The resident was scheduled to return to the wound center and lymphedema clinic but due to behavioral issues, the transportation provider refused to transport the resident and the nursing home did not follow up with the lymphedema clinic. Orders and documentation of dressing changes for the wound were not obtained until 11.19.

F687; 58.20(1); J; $8,250 (Held in Suspension). Resident #32's record included an encounter note that they required diabetic shoes and a prescription was included on 7.10.24. On 8.30.24 the resident developed a heel wound. During record review the nursing home did not document any attempts or communication with outside services to obtain the diabetic shoes necessary to prevent wounds. The wound subsequently declined to the point where the resident's foot was amputated followed by a further below the knee amputation.

F689; 58.28(3)e; J; $4,010. Resident #1 exited the nursing home unknowingly through an unlocked door without an alarm sounding into the independent living building where they further exited into a parking lot. An independent living resident called law enforcement when they saw the resident attempting to open a locked car door multiple times. The staff responded to the police officers being in the parking lot which is when they identified the resident left the nursing home. During investigation it was determined the resident was out of the building for approximately 31 minutes.

F689; 58.28(3)e; G; $2,750. On 10.13.24, Resident #2 was noted on the floor when staff responded to a tapping sound. When the staff attempted to transfer the resident, they would not bear weight and when in bed the left leg was noted externally rotated. The resident was sent to the Emergency/Urgent care where they were diagnosed with a hip fracture. During investigation it was determined that a staff member originally documented that the resident did not have a fall because the nursing home recently changed a policy excluding the use of alarms. The staff member later reported to the DON that the resident fell and they did not report to the nurse to complete an assessment prior to moving the resident.

F689; 58.28(3)e; G; $3,750. Resident #15 had several similar falls related to wheelchair pedal positioning and reaching forward which resulted in lacerations to the face and head. During observations the resident's care planned fall interventions were not followed.

F689; 58.28(3)e; G; $2,750. A staff member pushed a resident in the wheelchair without foot pedals causing the resident's foot to get caught in the wheelchair, falling forward and sustaining a laceration to their nose. The resident was transported to the ER, received sutures to the laceration and was diagnosed with a fractured nose.

F689; 58.28(3)e; G; $5,000. Resident #1 had a fall from the Hoyer lift when a sling loop came off and the resident fell out of the lift sling. During interviews staff reported hooking the sling to the machine appropriately and used two staff during the transfer. Following the fall the staff changed the type of sling used for the resident's transfers. Investigation of the incident revealed that the machine was inspected by the company following the incident without any problems. The fall resulted in a head laceration, fractured hip and broken ribs.

F690; 58.19(1)j; G; $5,500 (Held in Suspension). The nursing home did not ensure that Resident #2 had a secure device in place to limit movement of the resident's catheter which resulted in penile erosion. Staff did not provide incontinence care to Resident #1 in a timely manner which resulted in the resident saturating their bed.

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
F684	Quality of Care

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

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

58.12(1) – Cited 1 time for failure to assess a resident's veteran eligibility within 30 days of admission.

F550 – Cited 6 times for failure to treat residents with respect, dignity, and privacy by:

- Staff refused to provide care to a resident.
- Residents who needed assistance with meals were forced to move to a different dining room.
- Staff did not knock on residents doors before entering.
- Other residents and staff went in the shower room while residents were receiving a shower and the shower curtain did not fully cover the shower stall.
- While assisting residents with meals, staff did not converse with the resident and left the resident several times in the midst of assisting them.
- Improper conversations between a staff member and a resident that was reported as potential abuse.
- Staff were heard swearing and complaining about residents within their hearing distance which resulted in a resident refusing to call for assistance and having urinary incontinence.

F561 – Cited 1 time when a resident was not afforded the opportunity to chose their clothing and was forced to wear a hospital gown.

F567 – Cited 1 time when a resident did not have access to their personal funds at all times.

F578 – Cited 1 time when the resident's record indicated full code and DNR.

F580 – Cited 1 time for failure to notify the family of falls and a physician of abuse allegations.

F582 – Cited 2 times when:

- An ABN form was not signed by the resident or representative.
- An ABN form was not provided when the resident's skilled services ended and they remained in the nursing home.

F583 – Cited 1 time when a family member reported finding another resident's medical records in their loved ones room.

F584 – Cited 3 times for failure to provide a homelike environment by:

- Bathrooms were not clean and in disrepair.
- Urine odors were noted throughout the building.
- Areas of disrepair in common areas and halls.
- Meals were served to residents on trays instead of removing the items from the tray.

F604 – Cited 1 time when a resident used bilateral feet restraints and a seatbelt due to a diagnosis of epilepsy. A consent and care plan were completed for the seatbelt, but the feet restraint did not have a consent and was not included in the care plan as a restraint.

F606 – Cited 1 time when an employee had a child history trigger on their background check without a completed evaluation from DHS.

F609 – An allegation of abuse was not reported to DIAL due to the resident's history of false accusations and there was no indication that abuse occurred.

F623 – Cited 3 times when the LTC Ombudsman was not notified of transfer out of the nursing home.

F625 – Cited 2 times for not providing a bed hold notice prior to transferring to the hospital.

F636 – Cited 3 times when comprehensive MDS' were not completed in a timely manner.

F637 – Cited 1 time when a significant change MDS was not completed and submitted timely.

F638 – Cited 2 times for failure to complete and submit a quarterly MDS timely.

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

F641 – Cited 1 time when hospice services and an antipsychotic were not coded accurately on an MDS.

F644 – Cited 2 times when a new PASRR was not completed for a new MI diagnosis.

F655 – Cited 1 time when a baseline care plan did not include use of an anticoagulant.

F656 – Cited 5 times for:

- 2 times when staff did not follow the fall and smoking care plans.
- The care plan did not include:
    - 2 times for insulin.
    - Opioids
    - Antidepressants
    - Dementia diagnosis
    - Pressure ulcers

F657 – Cited 5 times for:

- Residents were not invited to attend care conferences.
- The care plan was not updated to include:
    - Use of a vape.
    - Dementia diagnosis.
    - Mental illness diagnosis
    - History of UTIs and use of prophylactic antibiotics.
    - 2 times for updating code status.
    - Safe smoking interventions

F658 – Cited 7 times for:

- A resident did not have a physician's order for lymphedema wraps.
- 4 times for failure to follow the physician's orders.
- A nurse applied glue to a PICC line when bloody drainage was present instead of notifying the physician per the policy and procedures.
- Residents were not observed with medication administration.

F660 – Cited 1 time when the spouse of a resident asked for the resident to be transferred to another nursing home, but the resident's record lacked documentation of any discharge planning, notes, or a transfer form.

F661 – Cited 1 time when the nursing home did not complete a recapitulation of the resident's stay.

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

- Bathing/showers
- Correct assistance with transfers.
- Incontinence care.

F678 – Cited 1 time when the resident's record was not updated to reflect current code status.

F684 – Cited 7 times for:

- Neurological assessments were not completed following a fall according to the policy.
- 2 times when medications were not administered and the physician was not notified of the omission.
- Another resident's medications were administered to the wrong resident.
- A resident's respiratory status changed and the staff did not complete a thorough assessment and place in isolation immediately.

F688 – Cited 1 time when restorative services were not provided as care planned.

F689– Cited 10 times for:

- Root cause analysis and new interventions were not implemented for resident-to-resident incidents.
- A safety assessment was not completed when a resident used a vape.
- A resident was sent to a cardiologist's appointment without staff assistance when it was necessary.
- Staff did not use a gait belt during transfer.
- A resident did not sign themselves out of the building when they went outside (and the resident had intact cognition).
- Staff pushed residents without foot pedals on the wheelchair.
- Smoking interventions were not followed.

F690 – Cited 4 times for:

- Catheter bags noted touching the floor.
- Did not change gloves appropriately during perineal care.
- A care plan was not followed related to incontinence care.

F695 – Cited 1 times when the staff did not document the use of oxygen.

F698 – Cited 1 time for failure to complete pre- and post-dialysis assessments.

F725 – Cited 4 times for:

- The nursing home did not have documentation of 24-hour nurse coverage.
- 2 times when call lights were not answered in a timely manner.
- Staffing levels were not scheduled according to the facility assessment staffing plan.
- Staff did not acknowledge or respond to a resident when they were heard yelling from their room.

F727 – Cited 1 time when an RN was not on duty for 8 consecutive hours.

F741– Cited 1 time when a care plan did not address exit seeking behavioral interventions.

F744 – Cited 1 time when the care plan did not include a diagnosis of dementia and appropriate interventions.

F755 – Cited 1 time when staff did not return discontinued Depakote to the pharmacy.

F756 – Cited 1 time when the clinical rationale for declining a GDR request was not documented.

F758 – Cited 3 times for:

- The resident's record did not include interventions attempted prior to use of a PRN psychotropic medication.
- 2 times when a GDR was not requested for an antidepressant.
- A PRN psychotropic medication was not limited to 14-days in duration.

F760 – Cited 1 time when an insulin pen was not primed prior to administration.

F761 – Cited 4 times when:

- 3 times when the medication cart was unlocked and unsupervised.
- A narcotic medication that was destroyed was not appropriately documented.

F800 – Cited 1 time when food temperature and dishwasher logs were not consistently completed.

F803 – Cited 1 time when all items on the menu were not served with the resident's meal.

F804 – Cited 4 times for:

- 3 times when hot food was not maintained at least 135 degrees.
- The recipe was not followed for the correct amount of meat that needed placed in the casserole based on the number of servings prepared.

F808 – Cited 1 time when pureed food had chunks in it and a resident with a mechanical soft diet was served crunchy garlic toast.

F812 – Cited 11 times for:

- 6 times for not using/changing gloves appropriately.
- Food was not covered while transported in the hall.
- Areas of disrepair in the kitchen.
- 2 times for kitchen cleanliness concerns.
- A barrier was not placed prior to placing a utensil down.
- The dishwasher temperature was not hot enough to properly sanitize dishware.
- 2 times when hand hygiene was not completed appropriately.
- Ready-to-eat food was touched with bare hands.
- 3 times when items were not labeled or dated when opened.
- The fryer had oil in it and was uncovered.
- Dishes were dirty when staff placed food on them to serve to the resident.

F838 – Cited 2 times when the nursing home self-identified a facility assessment was not complete.

F842 – Cited 3 times when:

- Resident records were left open on a laptop.
- Medication administration and falls were not documented in the resident's record.
- Orders were signed as completed that were not implemented such as prevalon boots.

F851 – Cited 2 times when PBJ data was not submitted accurately.

F865 – Cited 2 times when:

- The nursing home did not have effective QAPI processes based on repeat deficiencies.
- A QAPI plan was not implemented.

F867 – Cited 1 time when quarterly quality assurance meetings were not held.

F868 – Cited 1 time when the individuals were not employed so they could not attempt the meeting.

F880 – Cited 12 times for:

- Reusable equipment was not disinfected between resident use.
- 2 times when a catheter drainage bag was touching the floor.
- A catheter drainage bag was held above the resident's bladder level.
- Soiled and clean linens were not covered when transported throughout the halls.
- 3 times when enhanced barrier precautions were not implemented.
- 2 times when gloves were not changed appropriately.
- The ice machine was not cleaned according to policy.
- A water cup was held with someone's fingers with one finger inside of the glass.
- Medications were touched by bare hands.
- There wasn't a water management plan in place.
- Areas in the building were unable to be cleaned due to disrepair.

- Staff and contractors did not use facemasks when there were cases of COVID-19 in the building.
- A resident soiled their bed sheets and staff did not help in a timely manner.

F881 – There was not an antibiotic stewardship program in place.

F882 – Cited 1 time when a qualified IP was not on staff.

F883 – Cited 3 times when pneumonia vaccinations were not administered according to CDC's latest pneumonia vaccination recommendations.

F887 – Cited 3 times for:

- The COVID-19 vaccine was not given but the resident consented to it.
- 2 times when resident's were not educated and offered the latest dose of COVID-19 vaccine.

F921 – Cited 1 time when several resident's bathrooms were in disrepair.

F925 – Cited 2 times when resident's had signs of bed bug infestation, and it was not promptly treated.

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

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.

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