LTC Survey Trends Report
January 2025

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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 F560, the resident's right to refuse certain room changes.

We are unsure how the Executive Orders signed by President Trump shortly after taking office will impact the revised interpretative guidance CMS recently released. However, we are encouraging you to move forward with implementation. This will prevent rushed compliance needs closer to the effective date of March 24. LeadingAge Iowa has a resource page dedicated to tools for complying with the revised guidance.

Survey Activity

District	Average Months for Providers with Recert	Number of Providers over 12 Months	Longest Survey Timespan
Statewide	11.5 months	7 nursing homes	15 months

Recertification:

- 29 total recertification surveys reviewed with 4.6 deficiencies on average per recertification survey with deficiencies.
    - Of the 27 recertifications with at least one deficiency, 6 providers received a fine (or 22%).
    - Of the 29 recertifications, 2 providers had deficiency free surveys (or 7%)

Complaint/Incidents:

- 56 providers with complaint/incident surveys reviewed with 3 deficiencies on average per survey reviewed with deficiencies.
    - Of the 28 complaint/incident surveys with at least one deficiency, 10 received a fine (or 36%).
    - Of the 56 complaint/incident surveys, 28 did not receive a deficiency (or 50%).

Enforcement Actions

CY 2024	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVG NUMBER OF DEFICIENCIES
CY 2024 TOTALS	**$1,025,550**	**$2,786,137.02**	**36 Denials; 14 DPOC; 1 State Monitor; 1 Termination; 1 Voluntary Termination; 1 Temporary Management**	**$3,811,687.02**	**6.1 deficiencies**

CY 2025	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVG NUMBER OF DEFICIENCIES
JANUARY	**$69,750**	**0**		**$69,750**	**4.6 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

January Deficiencies with State Fining and Citation

F600; 58.43(1); D; $500. Resident #3 reported that Staff A backed them against a wall and yelled at them about the status of their room. Staff A indicated they never backed the resident against a wall and indicated they removed several boxes of gloves from under their bed. The resident notified the police of the incident, which was unfounded. The administrator and DON indicated they told the staff member to not be around the resident but continued to allow them to work with other residents.

F600; 58.43(1); D; $500. A staff member was helping the nurse check the blood sugar of a resident that had increased behaviors. Staff A helped hold the resident's hands while the nurse was checking the blood sugar, however, when Staff A went to grab the resident's hands, they pulled their head away and the nurse stated "if you bite me I will knock all the teeth out of your mouth" and raised their hand. Staff A intervened and the staff member put their hand down. During subsequent interviews, other staff indicated that they heard the same staff member tell residents “If you hit me, I'm going to smack you back".

F600; 58.43(1); J; $500 (Held in Suspension). Resident #1 reported incidents of abuse with Staff A indicating that Staff A started messaging him on Facebook and then would spend more time in his room during working hours, eventually coming in on days off. During the interactions Staff A asked the resident to touch her inappropriately, sent nude photos to the resident, and asked if they could have intercourse but the resident declined as he was unable to, due to medical conditions. The staff member continued to reach out to the resident following the allegations and provided the resident's information to her brother. Resident #1 had a history of bipolar disorder and reported to the surveyor that they were more isolated and withdrawn following the incident as they felt everyone was judging them.

F600; 58.43(1); G; $4,250. Resident #1 refused to allow staff to perform personal care. The staff member held the resident's wrists as they were combative and trying to bite. The resident received skin tears from the staff holding their wrists. Resident #2 also received a skin tear from staff holding their wrists while providing care to them.

F602; 58.15(2)i(2); D; $500. The nursing home did not prevent drug diversion for controlled substances. During investigation, controlled substance records had differing total remaining amounts without documentation of administration of the missing contents. Review of video camera footage showed a nurse remove what appeared to be liquid controlled substances and place into their cup. Staff reported during interviews that the nurse displayed signs of possible impairment.

F602; 58.43; D; $500. A resident's phone was missing and when the family activated a different phone for them, they received text messages that appeared to be staff from the nursing home. The nursing home investigated the incident and terminated a staff member for the incident.

F607; 58.9(3); E; $500. Staff A began work on 5.28.24 at 5:55 a.m. and a background check was not completed until 1:57 p.m. that day.

F607; 58.11(3); E; $500. Staff B started working on 8.4.24 and did not have a background check completed until the surveyor requested their file on 1.8.25.

F607; 58.11(3); E; $500. Two staff member files lacked DHS evaluations on criminal backgrounds approving them to work.

F609; 58.43(9); D; $500. The nursing home did not report an allegation of abuse to DIAL within 2 hours and did not report a missing Fentanyl patch within 24 hours.

F609; 58.43(9); D; $500. An allegation of abuse was not reported to DIAL in a timely manner.

F609; 58.43(9); D; $500. The nursing home did not report alleged verbal and physical abuse to DIAL.

F609; 58.43(9); D; $500. An allegation of abuse was not reported to DIAL in a timely manner when a staff member posted a video of a resident on Snapchat.

F609; 58.43(9); D; $500. Incidents of staff holding resident's wrists while performing care that resulted in skin tears were not reported to DIAL as possible abuse.

F609; 58.43(9); D; $500. Missing narcotics were not reported to DIAL.

F686; 58.19(2)b; G; $7,000 (Held in Suspension). Resident #1's record previously identified a pressure ulcer to their heel which was resolved on 12.18.24. On 12.26.24 the resident was sent to the hospital and treated by the wound center nurse. During the initial assessment by the wound care nurse, pressure ulcers were noted including a stage 3 to the coccyx and unstageable to the left heel and left posterior knee. The resident's nursing home record did not have documentation of these pressure ulcers.

F689; 58.28(3)e; J; $8,250 (Held in Suspension). A non-certified nurse aide was in the dining room observing one resident and assisting another. Resident #1 started choking and Staff A was unable to complete the Heimlich maneuver. They attempted to get help, but their walkie talkie was not working. Staff A started yelling when a dietary staff heard them and went to find additional support. When the nurse arrived, they were able to get a small portion of food out, but the resident still could not cough. EMTs arrived and took over. The resident was transported to the ER and attempts to remove the obstruction were unsuccessful. The resident passed away later that evening. Resident #3 had a diagnosis of dysphagia and Resident #1 recently had a swallow study in which a mechanical soft diet with honey thick liquids were recommended but the resident declined the diet change and a managed a risk agreement was completed.

F689; 58.28(3)e; G; $4,750. An incident report for Resident #1 indicated that staff gave them coffee overnight per their request. The resident had terminal restlessness and accidentally spilled the coffee on their lap resulting in a burn to their inner thighs. Staff placed ointment on the burns, notified hospice and the primary care provider. Morphine was administered for increased pain related to the burns and over the next several weeks was increased in dose and frequency for ongoing severe pain.

F689; 58.28(3)e; G; $8,500. Resident #35 fell on 11.22.24 when they were walking with staff and caught their sock/slipper when crossing their feet over each other. During the fall, the resident bumped their head on a cabinet. Four follow-up assessments were not completed after the fall. Completed documentation lacked assessments of pain until the resident developed behaviors on 11.27.24 which progressed as time went on. On 12.2.24, the physician was notified of the fall (previously not completed) and increased pain. The physician ordered physical therapy for the resident. Physical therapy notes on 12.5.24 identified the resident had difficulty bearing weight. Physical therapy suggested reporting the findings to the physician and requesting an x-ray. The x-ray was completed on 12.6.24 and identified a mildly displaced subcapital right femoral neck fracture.

F689; 58.28(3)e; G; $15,000 (Treble/Held in Suspension). Staff assisted a resident with transferring and did not use a gait belt. During the transfer the resident's knees gave out and they were lowered to the floor. An x-ray of the resident’s ankle revealed a fracture.

F689; 58.28(3)e; G; $4,000. A staff member left Resident #5 while they were standing in the bathroom to place their watch on the charger near the window in their room. Resident #5 fell while standing unassisted and sustained a left femur fracture.

F689; 58.28(3)e; K; $7,250 (Held in Suspension). Resident #1 was found by a staff member with their legs laying on top of an electric baseboard heater. Due to non-healing burns, the residents' spouse requested they be transferred to the hospital. The hospital diagnosed the resident with third degree burns which required debridement of necrotic tissue. During investigation, it was determined the resident possibly had their legs on the heater for an hour undetected. During the survey, the surface temperature was 124 degrees and the heater did not have a protective device that covered the surface. All rooms on three hallways in the building had similar heaters without protective devices and surface temperatures ranging from 124 degrees to 130 degrees.

F725; 58.28(3)e; G; $4,250. Resident #3 fell and hit their head. When the resident was interviewed, they stated that when the staff member assisted them to bed in the evening, they put their walker over by their dresser where they could not reach it. The independent resident attempted to get to their walker but fell between the bed and the walker. The resident's call light was near their bed and staff did not come to check on them throughout the night. During investigation, the resident possibly laid on the hour for 2 – 4 hours before hearing a staff member in the hall and yelling out for help. It was also identified that the staff member assigned to the resident's household told staff they did not check on the resident all night. A nurse also reported that the staff member was found asleep while on duty.

F755; 58.21; J; $5,000 (Held in Suspension). During observations the surveyor noted a plastic container in the medication cart that contained 9 unlabeled syringes with medication in them. The staff identified them as morphine and lorazepam that was drawn up by the managers which had been occurring for approximately 2 months. In addition, staff failed to reconcile the narcotics on multiple occasions.

TOP CITATIONS

F-TAG #	
F689	Accidents/Hazards/Supervision/Devices
F550	Resident Rights/Exercise of Rights
F725	Sufficient Nursing Staff
F658	Services Provided Meet Professional Standards
F812	Food Procurement – Store/Prepare/Serve Sanitary

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

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

58.10(8) – Cited 1 time when staff did not follow isolation precautions for COVID-19, did not follow physician's orders for antibiotic eye drops and did not change gloves appropriately when emptying a catheter drainage bag.

F550 – Cited 13 times for failure to treat residents with respect, dignity, and privacy by:

- Staff refused to provide care for a resident.
- 7 times when staff spoke rudely, yelled or were unkind to residents.
- 2 times when residents were exposed to the public.
- Staff spoke disrespectfully of residents and staff in resident's rooms.
- A resident reported that staff refused to accommodate their shower time preference.
- Staff would not provide a resident's dentures to them when they asked.
- 2 times when staff were reported to be rough while caring for residents.
- A resident spilled their oatmeal, and staff cleaned it up without offering them any additional food.
- Staff did not knock on the resident's door prior to entering.
- A resident had to go into the hallway and yell for assistance to get staff to help them.

F558 – Cited 2 times when call lights were not within reach for the resident.

F572 – Cited 1 time when resident's rights were not provided in writing.

F578 – Cited 3 times when the resident's code status did not match the signed forms throughout the resident's record.

F580 – Cited 2 times for:

- The physician was not notified of a hip fracture immediately. Staff placed a copy of the report on their desk for them the following day when they did rounds.
- The family was not notified when the resident had low blood glucose levels or new orders from a physician's visit.

F582 – Cited 3 times when:

- 2 times when a NOMNC form was not issued.
- 2 times when skilled discharge notice was provided less than 48 hours in advance.

F583 – Cited 1 time when staff posted a resident video on Snapchat.

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

- A wheelchair was in disrepair.
- Baseboard heaters had bent safety grates.
- Room temperatures in the shower room were below the required levels.
- The residents' rooms were in disrepair.
- Cleanliness concerns were identified in resident rooms.
- Odors of urine were noted throughout the halls.

F607 – Cited 1 time when the nursing home did not investigate misappropriated medications.

F610 – Cited 5 times for:

- 2 times when missing narcotics were not investigated.
- 2 times when allegations of abuse were not investigated.
- 2 times when the alleged perpetrator was not separated from victim(s).

F622 – Cited 1 time when the nursing home did not notify the resident or their representative of their rights to appeal a transfer to another nursing home.

F623 – Cited 1 time when written notice of transfer was not provided in advance, including the right to appeal the transfer.

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

F637 – Cited 1 time when a significant change MDS was not completed when hospice services were discontinued.

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

F641 – Cited 7 times when:

- 2 times when aspirin was coded as an anticoagulant.
- Warfarin was not coded on the MDS.
- An active diagnosis was not coded on the MDS.
- Hospice was not coded accurately on the MDS.
- A diuretic was not coded on the MDS.
- An antipsychotic medication was not coded on the MDS.
- Clopidogrel was coded as an anticoagulant.
- Trulicity was coded as insulin.
- Medical records were deleted, and staff were instructed to falsify documentation.

F642 – Cited 1 time when documentation was deleted from a resident's record and the staff were instructed to falsify documentation.

F644 – Cited 1 time when all mental illness diagnoses were not included on the PASRR.

F645 – Cited 2 times when:

- A Level 1 was not submitted before expiration of a 60-day exemption.
- A new PASRR was not completed with a new mental illness diagnosis.

F656 – Cited 7 times for:

- Staff did not follow the care plan.
- The care plan did not include:
    - Pressure ulcers
    - 2 times for antipsychotics
    - Antianxiety medications
    - 3 times for antidepressant medication.
    - Antiviral medication.
    - 3 times for targeted behaviors for psychotropic medication use.
    - UTI
    - Oxygen
    - Enhanced Barrier Precautions
    - Diuretics
    - Antibiotics
    - Anticoagulants

F657 – Cited 6 times for:

- The care plan was not followed.
- The care plan was not updated to include:
    - Hospice
    - Wanderguard devices
    - Catheter
    - Behaviors for psychotropic medications.
    - 2 times for fall interventions.
    - Edema
    - Skin integrity concerns
    - Antidepressants
    - Antianxiety medications.

F658 – Cited 11 times for:

- 8 times when physician's orders were not followed.
- Medications were not administered within the scheduled time frame.
- The physician wasn't notified of a blood glucose level outside established parameters.
- A low blood glucose level was not rechecked.
- Blood pressure parameters were not established for holding an antihypertensive medication according to manufacturer's recommendations.

F660 – Cited 2 times when:

- The nursing home did not provide accurate information when referring a resident to another nursing home.
- The family was not consulted about transferring a resident to a different nursing home.
- A resident was discharged to a hotel without adequate supplies or services.

F677 – Cited 6 times for failure to provide/assist with:

- 3 times for bathing/showers.
- Incontinence care
- Toileting assistance
- Oral care
- Shaving
- Use of assistive devices with transfers.

F684 – Cited 6 times for:

- Failing to complete follow up assessments when a resident had COVID-19.
- Not completing an assessment on the resident's abdomen when they had nausea and vomiting with a history of bowel obstruction.
- Not following the policy and procedure on bowel protocols.
- Not completing an assessment on a resident when an aide reported a possible change in condition.
- Vitals were not checked prior to transferring to an emergency room.
- Failing to complete post-fall assessments.
- Failing to complete skin assessments.

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

F689– Cited 15 times for:

- Staff pushed a resident in a wheelchair without foot pedals.
- Not attempting to determine a root cause analysis after falling.
- 2 times for not updating the care plan with new interventions after falls.
- 2 times for not using gait belts during a transfer.
- Care planned interventions were not followed to prevent further resident-to-resident incidents.
- 2 times when care planned fall interventions were not followed.
- Medication carts were unlocked and unsupervised.

F691 – Cited 1 time when staff did not complete colostomy care according to the care plan.

F692 – Cited 1 time when meals were not provided to a resident who was at dialysis over the lunch hour.

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

F712 – Cited 1 time for not completing all required physician visits.

F725 – Cited 13 times for:

- Not having adequate certified staff to assist residents during mealtimes.
- 9 times when call lights were not answered in a timely manner.
- A resident reported they had to search for staff to assist their roommate with needs.
- 2 times when the scheduled staffing did not follow what was identified in the facility assessment.

F726 – Cited 1 time when the use of a gait belt during a transfer was not included in the competency assessment.

F727 – Cited 1 time when the DON routinely worked as the charge nurse and the census averaged 70+ residents.

F728– Cited 1 time when a staff member worked as a nurse aide without completing a training and competency program.

F755 – Cited 6 times when:

- 3 times when narcotics were not accurately reconciled.
- The nurses did not verify the number of narcotics delivered by the pharmacy.
- Medication carts were unlocked and unsupervised.

F757 – Cited 2 times for:

- The consultant pharmacist did not identify on a medication regimen review that a resident did not have a diagnosis for antiviral treatment.
- The antibiotic stewardship program was not followed for a prophylactic antibiotic.

F758 – Cited 1 time when target behaviors were not identified for psychotropic medication use.

F759 – Cited 1 time for a 16% medication error rate including extended-release medications being crushed, doses were incorrect, insulin pens were not primed before or held in the skin after administration.

F760 – Cited 2 times when:

- 46 units of insulin were going to be administered instead of 50 units.
- Fosamax was administered after the resident ate breakfast, which is not in accordance with the manufacturer's recommendations.

F761 – Cited 3 times when:

- Medications were not secured when delivered from the pharmacy.
- Medication carts were unlocked and unsupervised.
- Syringes filled with morphine and lorazepam were not labeled.

F791 – Cited 1 time when the resident reported chipped teeth, and the nursing home did not assist with arranging dental services.

F801 – Cited 2 times when a qualified dietary manager was not employed.

F803 – Cited 2 times for:

- Puree portions were not accurate.
- All menu items were not served.

F804 – Cited 4 times for:

- 3 times when hot food temperatures were below 135 degrees.
- Temperature logs lacked several entries.

F812 – Cited 11 times for:

- 2 times for concerns with general cleanliness of the kitchen.
- The dining room carpet had stains present.
- 5 times when gloves were not used appropriately.
- 3 times when food was outdated and not discarded.
- 2 times for staff not using hairnets.
- 6 times when food items were not labeled or dated.
- 3 times when staff touched eating and drinking surfaces when distributing meals.
- Scoops were stored within the containers.
- Clean dishes were stored near a drain that was not clean.
- Hand hygiene was not performed appropriately.
- Utensils were placed on the preparation table without a barrier.
- Food was transported through the hall without a cover.

F825 – Cited 1 time when physical and occupational therapy evaluations were not completed until six days after admission for a skilled resident who had a hip replacement.

F842 – Cited 4 times when:

- There was not an inventory record present.
- Progress notes were saved as drafts so they could be altered before being locked.
- The electronic health record was left open on a laptop without a staff member present.
- A narcotic record could not be located for a resident.

F851 – Cited 2 times when the PBJ report did not include:

- Hours the DON worked on the floor.
- When Assisted Living staff worked in the nursing home.
- Staffing agency hours.

F865 – Cited 2 times when an effective QAPI process was not implemented based on repeat deficiencies.

F880 – Cited 10 times for:

- 4 times when enhanced barrier precautions were not implemented/followed.
- 2 times when gloves were not changed appropriately.
- 4 times when hand hygiene was not completed.
- 2 times for catheter tubing touching the floor.
- When emptying a catheter drainage bag, staff did not place a barrier down.
- PPE was not removed before exiting the resident's room.
- Sleeves on an isolation gown were rolled up, exposing the person's arms.
- Appropriate precautions were not implemented when a resident had Influenza A.
- Reusable equipment was not sanitized between residents.

F883 – Cited 2 times for:

- Not administering an influenza vaccine when the resident consented.
- A pneumonia vaccine was not offered when they met CDC criteria.

F887 – Cited 1 time when a COVID-19 vaccine was not administered, and the resident consented to it.

F908 – Cited 1 time when staff under the age of 18 were using mechanical lifts.

F921 – Cited 1 time for floor tiles missing from the shower room floor and the grout appeared dirty.

F925 – Cited 2 times for:

- Signs of mice in the building.
- Signs of cockroach infestation.

F943 – Cited 1 time when dependent adult abuse was not recertified within the three years.

F948 – Cited 1 time when a spouse of another resident was assisting a resident with eating and was not trained as a paid feeding assistant.

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