LTC Survey Trends Report
July 2025

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LeadingAge Iowa

CONVEYING BALANCES ON RESIDENT TRUST FUNDS & NURSING HOME SURVEY UPDATES

by Kellie Van Ree, Director of Clinical Services

The Regulatory Review article for this month reviewed F569 related to accounting and records for resident funds.

The longest survey remains at 12 months and during the last DIAL association update call they indicated a possible focus on complaint and incident surveys coming up which may delay the recertification period.

The overall prevalence of fining and immediate jeopardy deficiencies remains lower than previously noted.

Survey Activity

District	Average Months for Providers with Recert	Number of Providers over 12 Months	Longest Survey Timespan
Statewide	10.8 months	None *12 months (June) = 15 *11 months (June) = 31	12 months

Recertification:

- 37 total recertification surveys reviewed with 3.7 deficiencies on average per recertification survey with deficiencies.
    - Of the 28 recertifications with at least one deficiency, 4 providers received a fine (or 14%).
    - Of the 37 recertifications, 9 providers had deficiency free surveys (or 24%)

Complaint/Incidents:

- 28 providers with complaint/incident surveys reviewed with 3.7 deficiencies on average per survey reviewed with deficiencies (this number may be skewed because of one complaint survey with a higher number of deficiencies).
    - Of the 13 complaint/incident surveys with at least one deficiency, 5 received a fine (or 38%).
    - Of the 28 complaint/incident surveys, 15 did not receive a deficiency (or 54%).

Enforcement Action

CY 2025	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVG NUMBER OF DEFICIENCIES
JANUARY	**$32,250**	**$252,419.50**	**2 Denials; 1 DPOC**	**$284,669.50**	**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**

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 Meth-Wick Communities on a deficiency free survey!

CITATIONS WITH FINES

June Deficiencies with State Fining and Citation

F609; 58.43(9); D; $500. A staff member posted a Snapchat story of a resident without their consent which included text that the resident is unable to hear. The incident was not reported to DIAL.

F686; 58.19(2)b; G; $7,000. Resident #1 returned from the hospital on 4.17.25 with a note that there were slits to their buttocks and that they would have the wound care nurse follow up. On 4.21.25 the wound care nurse assessed the resident but did not document an assessment on their buttocks. On 4.23.25 with the weekly wound documentation, the buttock wound was listed as Stage 3. The wound continued to deteriorate until it was considered unstageable and eventually, they were transferred to the ER for cellulitis.

F686; 58.19(2)b; G; $6,250 (Held in Suspension). Resident #8 developed a pressure ulcer to their foot related to a foot cradle/board at the end of their bed that the resident had their foot against causing the pressure. The wound deteriorated over time and staff did not notify the physician of deterioration within a timely manner. Additionally, on observation, care planned interventions were not in place. Resident #9's care plan did not include recommendations for turning and repositioning schedule and staff did not complete the wound care as ordered.

F688; 58.19(2)h; G; $4,500 (Held in Suspension). Resident #10 developed contractures to their hands, leading to wounds to the palms of their hands. During record review it was noted that the resident did not receive their restorative range of motion per therapy recommendations. Upon worsening of the contractures, the therapist recommended using a carrot splint which was not in their hands during surveyor observation.

F689; 58.28(3)e; G; $4,750 (Held in Suspension). Resident #2 was being transported to an appointment that was approximately an hour and 40 minutes from the building when they had to stop to use the restroom. The residents' care plan indicated they used assistance with transfers and ambulation with a gait belt and cane as well as assistance with toileting and dressing. While walking to the bathroom, the resident fell due to dizziness and was transported to the ER via ambulance. A staff member did not accompany the resident to the appointment. Resident #1 and #37 both had falls from a sit-to-stand lift due to sling malfunctions. During observation of the slings, one was manufactured by a different company than the lift and stated to "only use with the same manufacturer lifts" and the other sling's tag was not readable.

F689; 58.28(3)e; G; $6,750. Resident #49 was at risk for falls related to a diagnosis of multiple sclerosis and used a restraint when in the wheelchair to aid in positioning. The resident had a fall when they were using the commode which resulted in bilateral femur fractures. The resident and spouse requested that when using the commode, the staff place a Velcro strap around their legs to prevent falling however staff were told that the resident wanted a gait belt and that they could not use a gait belt because it was a restraint. The resident refused to have staff stay in the room as they needed privacy while using the commode. The resident's record lacked documentation of attempted interventions to assist with safety while on the commode despite staff identifying that the resident did not appear stable enough to sit there independently.

F689; 58.28(#)e; G; $20,750 (Treble; Held in Suspension). Resident #101 was assisted with a lift off the toilet. While performing perineal care, the resident slid down the lift and was reporting significant pain in their knees. Staff assisted the resident to the floor. During the transfer, the staff used a pillow in front of their knees on the lift and a rolled blanket between their legs but did not use the leg strap as the resident refused. During interview and review of therapy services, therapy was unaware of the added pillow and blanket or that the resident refused the leg strap on the lift. Resident #102's care plan was not updated timely with a

change in transfer status which led to a fall for the resident. During a separate incident a staff member transferred the resident by using a bear hug instead of a mechanical lift as directed in the care plan.

F689; 58.28(3)e; G; $2,500 (Held in Suspension). Staff transferred resident #2 by themselves and were attempting to unfold the Broda chair while holding the resident's foot when they dropped the resident's root and the resident received a laceration on their toe.

F689; 58.28(3)e; K; $5,000 (Held in Suspension). During initial observations, an unapproved extension cord was noted in a resident's room that had exposed wires. As the administrator picked up the cord there was a loud pop causing the administrator to drop the cord. Further inspection also identified that there was a burn mark under the cord. Resident #2 eloped from the building and staff were unaware until an agency staff member saw the resident while they were in their car near the building.

F689; 58.28(3)e; G, $2,500. During transportation to an appointment, the van driver hit the brakes on the van too hard causing Resident #36 to slide out of their wheelchair and onto their foot pedals. The resident only had a lap belt on and did not have the shoulder belt on. The resident reported the incident upon returning to the nursing home, but the van driver did not report the incident to the nurse at the time or upon return.

F689; 58.28(3)e; G; $4,750 (Held in Suspension). Resident #45 had orders for an x-ray on 7.15.25 and the primary care provider provided orders to send the resident to the ER for a broken right femur. Late entry progress notes for 7.8.25 indicated that the restorative aide bumped their foot while staff had them in the shower chair. The nurse assessed the area and noted scabbing to both feet with one that had been partially removed. According to an interview with the resident, they stated that during a shower on 7.8.25, the staff transferred them without a lift and when they got to the shower bench one of the staff commented that their leg was twisted under the shower bench. The resident did not have pain due to being paralyzed but stated their knees were more swollen.

F693; 58.19(1)n(7); G; $7,000. Staff were not trained in how to properly administer medications via a PEG tube. The orders included directions to staff to crush all medications together and administer the medication via the PEG tube with 30 cc flush before and after. This led to the PEG tube being clogged and the resident was hospitalized multiple times to receive artificial hydration and nutrition until interventional radiology was able to replace the tube.

F805; 58.24(5)c; G; $5,000. Resident #2's diet order included mechanical soft diet with ground meat. The resident received cut up sausage links instead of ground meat leading to a coughing/choking spell. The resident was sent to the hospital five days later and diagnosed with aspiration pneumonia. Resident #3 was served a cheeseburger without the meat cut up as directed by the resident's diet order.

F805; 58.20(1); J; $10,000 (Held in Suspension). Resident #3’s diet indicated the resident was unable to have bread. The care plan lacked directions on diet other than to provide the diet as ordered, feed one item at a time and sit up straight. Additionally, the Kardex lacked information on diet order and restrictions. On 7.17.25 the resident had a low blood glucose level, and the staff member gave the resident orange juice and peanut butter toast. A short while later the blood glucose was still low, and a protein shake was given. The resident then was noted sitting on the side of the bed heaving and bringing up mucous. The resident's vital signs were taken, and it was identified that they had a low oxygen saturation level which prompted the staff to send them to the ER. Upon review of the hospital records, the resident was admitted for acute hypoxia related to respiratory failure due to aspiration pneumonia. During interviews it was identified that the staff did not know that the resident was not supposed to have bread.

TOP DEFICIENCIES

F-TAG #	
F689	Accidents/Hazards/Supervision/Devices
F880	Infection Prevention & Control
F812	Food Procurement, Store/Prepare/Serve - Sanitary

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

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

58.12(1) – Did not submit veteran's status to the IDVA website within 30 days of admission.

F550 – Cited 5 times for failure to treat residents with respect, dignity, and privacy by:

- A staff member forcefully removed a spoon from a resident's hand and didn't talk to the resident while they were assisting them with eating.
- Stained clothing was not changed for residents in a timely manner.
- A resident complained of staff personalities being "cold".
- Stand lift batteries were not functioning appropriately which led to delayed transfers and lifts dying in the middle of a transfer.

F552 – Cited 1 time when the resident's family was not notified of a change in psychotropic medications.

F554 – Cited 1 time when assessments were not completed for self-administration of medications when a resident preferred to administer their own insulin once the nurse drew it up.

F560 – Cited 1 time when the resident was not notified in advance of a room change or why the room change was occurring.

F578 – Cited 3 times when the code status was not accurate in the resident's record according to their signed forms.

F580 – Cited 4 times when the physician and responsible party were not notified of:

- Elopement
- COVID-19
- Psychotropic medication change.
- Refusal to use an orthotic device.
- Fall
- Refusal to eat and weight loss.
- Weight gain.

F582 – Cited 2 times when:

- The cost was not included on the ABN form.
- A NOMNC was not issued to the resident or responsible party.

F583 – Cited 1 time when medical records were accessible to the public.

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

- Items in the resident room were in disrepair.
- Excessive debris was noted on the floor.
- Beds were not made in a timely manner.
- The dining room chairs were dirty with dried food and liquid.

F585 – Cited 1 time when the nursing home did not take prompt efforts to resolve grievances.

F600 – Cited 2 times when:

- Adequate care was not provided, resulting in a fall.
- Verbal abuse allegations by staff.
- A video of a resident was posted on Snapchat.
- A resident reported that another resident was taking their money and there was concern about a possible inappropriate relationship between two residents.

F605 – Cited 1 time when the care plan did not include non-pharmacological interventions before as needed high-risk medications including opioid and psychotropic medications were administered. *Note: Requested clarification on Opioids from DIAL.

F607 – Cited 2 times when:

- The nursing home did not follow their abuse policy for an allegation of abuse.
- DHS evaluation was not completed on a staff member's criminal background.

F610 – Cited 1 time when an alleged perpetrator was not removed from having access to residents during investigation.

F628 – Cited 4 times for:

- 3 times when the LTC Ombudsman was not notified of a transfer/discharge.
- The bed hold notice was not provided to a resident or their representative.

F636 – Cited 1 time when MDS' were not completed timely.

F637 – Cited 2 times when a significant change MDS was not completed for:

- Admission to Hospice.
- Changes in ADL assistance triggered a significant change.

F638 – Cited 1 time when a quarterly MDS was not completed in a timely manner.

F641 – Cited 4 times when:

- Several MDS' were not completed as required.
- The MDS was not accurately coded by:
    - Therapy minutes.
    - PTSD was not coded as an active diagnosis.
    - Ozempic was coded as insulin.
    - Plavix was coded as an anticoagulant.

- A level 2 was not coded.

F644 – Cited 2 times when:

- A new PASRR was not submitted with a new MI diagnosis.
- A PASRR was not submitted when a short-term approval expired.

F655 – Cited 1 time when the baseline care plan was not completed within 48 hours of admission.

F656 – Cited 5 times for:

- Staff did not follow the care plan.
- The care plan did not include:
  - Behaviors
  - Hospice
  - Catheter
  - Depression
  - Anxiety
  - ADL assistance
  - UTI

F657 – Cited 4 times for:

- Care conferences were not documented.
- The care plan was not updated to include:
  - Accurate assistance based on documentation in the resident's record.
  - G-tube
  - Relationships between residents.
  - PTSD
  - History of suicide attempts.

F658 – Cited 3 times for:

- Insulin was held without a physician's order and did not notify the physician of holding the insulin.
- Routes were not included in the documentation on the MAR/TAR.
- Physician's orders were not followed.

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

- 2 times – bathing
- Incontinent care

F679 – Cited 1 time when residents expressed that activities did not meet their interest.

F684 – Cited 5 times for:

- Assessments were not completed on the following:
  - Pain
  - Emesis
  - Neuros
  - Side effects of psychotropic medications
  - Respiratory

- Lymphedema wraps were not documented.
- Skin assessments were not completed routinely when skin breakdown was noted.

F686 – Cited 3 times for:

- Skin assessments were not completed for pressure ulcers.
- Did not follow orders for treatments.
- 2 times when resident's were not repositioned per their care plan.

F689– Cited 14 times for:

- Fall interventions were not followed.
- The care plan was not followed for assistance with transfers.
- A gait belt was not used during a transfer.
- 2 times when hazardous items were not securely stored.
- Foot pedals were not used when residents were pushed in the wheelchair.
- Lift safety recommendations were not followed per manufacturer's recommendations.
- Fall interventions were not reviewed to ensure they were appropriate.

F690 – Cited 3 times for:

- Physician's orders were not followed regarding catheter changes.
- Urine output was not monitored when the resident had a catheter.
- The catheter drainage bag was noted on the floor or garbage can and was placed above the bladder.

F692 – Cited 1 time for not monitoring intake and responding to weight loss.

F693 – Cited 1 time for not flushing the g-tube per the physician's orders.

F695 – Cited 5 times when:

- 2 times for not applying oxygen per physician's orders.
- Flow rates were not correct.
- 2 times when the oxygen tubing and humidification were not changed per policy.
- The oxygen concentrator was not working appropriately.

F699 – Cited 1 time when suicidal ideations were not addressed in the care plan, mental health behaviors were not monitored for possible triggers.

F725 – Cited 5 times when call lights were not answered in a timely manner.

F744 – Cited 1 time when residents were placed by the nurse's station and not provided activities.

F755 – Cited 1 time when narcotics were not destroyed when discontinued.

F760 – Cited 3 times when:

- Insulin was not administered.
- The insulin pen was not left in the skin following injection.
- An insulin pen was not primed prior to the injection.

F761 – Cited 2 times for:

- Medication sitting on top of a cart that was not supervised.
- Medication carts were unlocked and unsupervised.

F800 – Cited 1 time when diet orders were not followed including double portions, extra butter, and gravies.

F803 – Cited 4 times for:

- 3 times when correct portion sizes were not served.
- 2 times when all items on the menu were not served.

F804 – Cited 4 times when:

- 3 times when hot food temperatures were not held above 135 degrees.
- 2 times when the food was not palatable and lacked flavor.

F805 – Cited 1 time when puree portions were not correct.

F812 – Cited 6 times for:

- 3 times with food handling concerns were observed.
- Expired food was not discarded.
- Refrigerator temperatures were not monitored.
- Did not ensure that dishwasher sanitizer levels were appropriate.
- 3 times for cleanliness concerns.
- 2 times for concerns with hand hygiene.
- The dishwasher temperature log was not routinely completed.

F842 – Cited 1 time when the nursing home did not document efforts to transfer the resident to another nursing home according to the families request.

F851 – Cited 2 times when PBJ reports were not accurate based on agency staff and nurse hours were not reported accurately.

F865 – Cited 2 times when the nursing home did not have an effective QAPI process based on repeat deficiencies.

F880 – Cited 11 times for:

- 3 times when reusable equipment was not sanitized between residents.
- 4 times when gloves were not used or changed appropriately.
- 4 times when hand hygiene was not completed when necessary.
- 4 times when enhanced barrier precautions were not followed.
- 3 times when the catheter drainage bags were stored on the floor or garbage can.
- 2 times when laundry staff did not use gown with sorting dirty clothing.
- Items were placed on a resident's bed without a barrier.

F881 – Cited 1 time when the nursing home did not use criteria to establish actual infections for antibiotic use.

F882 – Cited 1 time when the infection preventionist worked less than part time on infection control.

F883 – Cited 4 times for:

- 2 times when pneumonia vaccines were not offered.
- 2 times when influenza vaccines were not offered.
- Education on vaccines was not provided and consents not obtained.

F887 – Cited 1 time when education was not provided and consents were not obtained prior to administering COVID-19 vaccines.

F908 – Cited 1 time when batteries were not working properly for mechanical lifts.

F919 – Cited 1 time when the call light system malfunctioned.

F940 – Cited 1 time when staff were not trained on mechanical lift slings including appropriate sizes.

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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