# LTC Survey Trends Report
# June 2025

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LeadingAge Iowa

# RESIDENT FUNDS & NURSING HOME SURVEY UPDATES

by Kellie Van Ree, Director of Clinical Services

The Regulatory Review article for this month reviewed F568 related to accounting and records for resident funds.

The longest survey remains at 12 months and there are only two providers at that length of time. There are several nursing homes at 11 months since their last recertification survey. I encourage everyone to be ready for your recertification earlier than you previously would. If trends continue, nursing home providers may have surveyors enter for a recertification as soon as 10 months after their last recertification.

In the fining section, I want to draw attention to the number of fines related to abuse regulations. While these deficiencies are not frequently in the top cited deficiencies, the prevalence of a fine associated with the deficiency is high. Note that there were 15 fines issued during June, however, 67% of them were related to F600, F607 and F609.

While there was an immediate jeopardy deficiency issued in June, the prevalence of immediate jeopardy and harm level deficiencies remains lower than we've previously experienced. Additionally, a higher percentage of providers had deficiency free surveys.

## Survey Activity

| District | Average Months for Providers with Recert | Number of Providers over 12 Months | Longest Survey Timespan |
|---|---|---|---|
| Statewide | 10.6 months | None<br>*12 months (June) = 2<br>*11 months (June) = 40 | 12 months |

Recertification:

- 37 total recertification surveys reviewed with 5.9 deficiencies on average per recertification survey with deficiencies.
    - Of the 26 recertifications with at least one deficiency, 8 providers received a fine (or 31%).
    - Of the 37 recertifications, 11 providers had deficiency free surveys (or 30%)

Complaint/Incidents:

- 41 providers with complaint/incident surveys reviewed with 2.1 deficiencies on average per survey reviewed with deficiencies.
    - Of the 21 complaint/incident surveys with at least one deficiency, 6 received a fine (or 29%).
    - Of the 41 complaint/incident surveys, 20 did not receive a deficiency (or 49%).

# Enforcement Action

| CY 2025 | STATE FINES | FEDERAL CMPS | ENFORCEMENT | TOTAL | AVG NUMBER OF DEFICIENCIES |
|---|---|---|---|---|---|
| JANUARY | **$32,250** | **$334,986.50** | **2 Denials; 1 DPOC** | **$367,236.50** | **4.6 deficiencies** |
| FEBRUARY | **$50,250** | **$79,922.25** | **3 Denials; 1 DPOC** | **$130,172.25** | **8.3 deficiencies** |
| MARCH | **$64,000** | **$64,208** | **1 Denial** | **$128,208** | **5.6 deficiencies** |
| APRIL | **$22,000** | **$101,885** | **1 Denial** | **$123,885** | **6.2 deficiencies** |
| **MAY** | **$27,750** | **0** | | **$27,750** | **5 deficiencies** |
| **JUNE** | **$53,500** | **0** | | **$53,500** | **5.9 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 Edgewater, A Wesley Active Life Community and Friendship Home Association on deficiency free surveys!

# CITATIONS WITH FINES

June Deficiencies with State Fining and Citation

**50.7(1); $500 (Held in Suspension).** The nursing home did not report a major injury to DIAL when a resident sustained a fall with a fracture of their right femur.

**F600; 58.43(1); D; $500.** Resident #1 had a history of sexual advances towards other residents and the residents' care plan directed staff to provide supervision at all times to ensure their well-being. On 4.20.25 Resident #2 (male) was found in Resident #1's (female) room and both residents had their pants down with Resident #2 laying on top of Resident #1. Staff reported that approximately 5 minutes before the incident they saw both residents in the living room.

**F600; 58.43(1); D; $500.** A housekeeper was accused of pushing a resident while they were in their chair and staff directed the housekeeper to leave the resident's room. However, the housekeeper was not separated from all residents.

**F600; 58.43(1); D; $500.** An incident report for Resident #34 stated a C.N.A was attempting to block the swing of a resident; they made contact with the resident causing a scratch to the bridge of their nose and left cheek. During an interview the C.N.A. reported that while they were attempting to assist the resident, their nails cut the residents' nose and cheek causing superficial scratches. The resident reported that the nurse hit them. The resident's roommate reports hearing the staff slap the resident and throw them in bed.

**F607; 58.11(3); E; $500.** Staff A did not complete dependent adult abuse within three years of previous training.

**F607; 58.11(3); E; $500.** Staff A did not have a background check completed prior to hire.

**F609; 58.43(9); D; $500.** Allegations of abuse were not reported to DIAL in a timely manner when a staff member pushed a resident's hands away from their plate and then removed them from the dining room before they finished eating.

**F609; 58.43(9); D; $500.** Staff did not report allegations of abuse when staff spoke to a resident disrespectfully.

**F609; 58.43(9); D; $500.** An incident of alleged abuse was not reported to DIAL when a resident reported that staff were rude to them and threw their call light out of their reach.

**F609; 58.43(9); D; $500.** Did not report an allegation of possible abuse to the survey agency when a C.N.A. was accused of hitting a resident.

**F609; 58.43(9); D; Included in previous citation.** Allegations of abuse were not reported when a resident ran into another resident with their wheelchair causing them to fall as well as allegations of abuse by staff when they grabbed a resident's wrists to prevent them from leaving the dining room.

**F609; 58.43(9); D; $500.** Did not thoroughly investigate and report an allegation of abuse when a staff member left a resident on the bed pan for more than 5 hours without the call light in reach.

**F609; 58.43(9); D; $500.** The nursing home did not report that a resident had missing money to DIAL.

F658; 58.19(2)a; G; $6,000. Resident #2 received their medications and another resident's medications in error. Following the incident, the resident was noted to be lethargic with a low blood pressure, pulse, respiratory rate, and oxygen saturation. The resident was transferred to the ER where they were admitted to the ICU for close hemodynamic monitoring following ER administration of sodium bicarb and potassium. Resident #3 had orders for insulin including 15 units routinely and additional units based on blood glucose level. During observation, staff only administered 13 units of insulin to the resident when they should have received 17 units based on their actual blood glucose level.

F684; 58.19(2)j; G; $9,000. Resident #1 had a change in condition including a fever, low oxygen saturation levels, vomiting, and change of cognition. They were transported to the ER and admitted for sepsis, passing away a short time later. During interviews staff reported that the resident was not acting themselves the day prior, but the record lacked any documentation of assessments. Resident #4 sustained a fall, and staff did not complete a thorough post-fall assessment. The resident was transported to the hospital the following day after they had uncontrolled pain and diagnosed with a hip fracture.

F684; 58.19(2)j; G; $6,250 (Held in Suspension). Resident #14 sustained a fall on 5.28.25 and the fall report did not include an assessment of pain. According to the MAR, Resident #14 reported increased pain after the fall and required the use of as needed Tylenol. Based on the resident's pain levels, an x-ray was obtained on 6.1.25 that indicated the resident had a left intertrochanteric hip fracture with modest displacement. Residents #39 and #77 had orders for inhalers at their bedside and neither had an assessment to determine if they were safe to self-administer medications.

F684; 58.19(2)j; G; $7,000. Resident #1 received their lunch in their room. The nurse uncovered the food, asked the resident to eat and then administered their fast-acting insulin. Resident #1 did not eat their food and was later found to be hypoglycemic with a blood sugar ranging from 25-35. Staff did not follow up to ensure the resident ate their meal

F686; 58.19(2)j; G; $6,000 (Held in Suspension). Resident #23 was noted to have an undated patch on their heel that covered a red, open ulcer and small open blisters on the resident's toes. The resident was noted to be at risk for pressure ulcers with care plan interventions identified to assist with pressure ulcer prevention. The resident had an order for bilateral heel protectors at all times that were not in place during observation. Resident #15 developed red areas to their toes that turned into pressure areas. The resident did not have any interventions implemented to prevent worsening of the areas until the black area developed.

F689; 58.28(3)e; G; $3,250 (Held in Suspension). Resident #32 used a Hoyer lift with a large sling and two staff assistance for transfers. On 5.7.25 the staff assisted the resident with a transfer from the bed to the wheelchair and during the transfer the resident slid out of the sling and sustained an abrasion to the back of their head. During investigation of the fall, it was determined that the sling was brand new and typically would position the resident in a seated position when lifted. However, this sling kept the resident straight on their back which led to the resident falling out. During observation staff placed an oxygen tank on the floor that was not secure. During observations Resident #13 sat in a shower chair in their room for more than 30 minutes before staff assisted them to bed. The surveyor noted red indentations on the back of the resident's legs as a result. Resident #15 was in their wheelchair and ran into Resident #21 causing them to fall. During review of the resident's records Resident #15 did not have any additional interventions to ensure they were safe moving around in their wheelchair.

F689; 58.28(3)e; J; $10,000 (Held in Suspension). Resident #1 had diagnoses of PICA, intellectual disabilities, autism, and schizoaffective disorder. The residents' baseline care plan included a soft diet with ground meat. Resident #1 was assisted to walk by two staff members when they noted the resident attempted to grab other resident's food as they walked by. The staff decided to have the resident eat in their room for safety. On 5.23.25, the resident was in their room with a staff member when the kitchen delivered

the resident's meal tray. Additionally, the dietary staff delivered a plate with a slice of regular pizza for the staff member which was placed out of the resident’s reach. The resident stood up, pushed the table forward and lunged across the table to grab the pizza. Before the staff could respond, the resident wadded up the pizza and put it in their mouth. A short while later, the resident's lips turned blue, staff began the Heimlich Maneuver and called 911. Eventually the resident became unconscious, and CPR was initiated but was later stopped by EMS as the resident was a DNR.

# TOP DEFICIENCIES

| F-TAG # | |
|---|---|
| F880 | Infection Prevention & Control |
| F684 | Quality of Care |
| F689 | Accidents/Hazards/Supervision/Devices |
| F812 | Food Procurement, Store/Prepare/Serve - Sanitary |
| F550 | Resident's Rights/Exercise of Rights |

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

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

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

**59.5(1)** – Did not complete tuberculosis testing for staff on hire.

**F550** – Cited 9 times for failure to treat residents with respect, dignity, and privacy by:

- Call lights were not responded to in a timely manner.
- 5 times when residents were not provided care in a timely manner when requested.
- The staff told a resident to use their incontinence product to go to the bathroom in.
- Staff used discriminatory language when talking to a resident.
- Privacy was not maintained while providing care to a resident.
- Staff spoke disrespectfully and cursed at residents.
- A resident expressed that the food item was too hot, but staff told them it wasn't and continued to offer it to the resident as they fed them.
- Staff woke residents up in the middle of the night unnecessarily.
- The care and services provided were not explained to the residents and staff just started pulling their pants down.
- The catheter drainage bag was not placed in a dignity cover.
- The housekeeper did not listen to a resident's request to return later which led to a confrontation between the resident and the staff.

**F554 –** Cited 1 time when assessments were not completed for self-administration of medications.

**F557 –** Cited 1 time when the nursing home sent the wrong residents records to another provider.

**F567 –** Cited 1 time when a resident requested money and it was not made available to them for three days.

**F578 –** Cited 3 times when the code status order did not match the resident's desires on the IPOST/Code Status form.

F580 – Cited 3 times when the physician and responsible party was not notified of:

- 2 times for falls.
- A change in condition.

F582 – Cited 1 time when a resident/representative was not provided at least 48 hour advance notice prior to discontinuing skilled service.

F583 – Cited 1 time when privacy was not provided while performing g-tube care.

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

- Urine odors were noted.
- Room temperatures were above 80 degrees Fahrenheit.
- Cleanliness concerns.
- Missing personal items.

F600 – Cited 1 time when the nursing home did not protect a resident from verbal abuse by a staff.

F605 – Cited 7 times for:

- 3 times when as needed psychotropic medications were not limited to 14-day durations.
- Clinical rationale was not documented when as needed psychotropic medications were continued for more than 14 days.
- 2 times when non-pharmacological interventions were not identified in the resident's care plan.
- A physician was not notified following a significant change in condition when psychotropic medications were increased.
- Both the primary physician and psychiatrist were prescribing psychotropic medications.
- Psychotropic medications did not have an appropriate diagnosis documented.
- Target behaviors for administration of psychotropic medications were not documented in the resident's care plan.

F607 – Cited 1 time when background checks were not completed prior to hire.

F610 – Cited 3 times for:

- Staff were not separated from all residents after being accused of possible abuse.
- 2 times when thorough investigations were not completed on abuse allegations.

F627 – Cited 2 times for:

- A resident was discharged home with their spouse but the nursing home did not ensure the location was safe as the spouse was unable to get the resident into the house due to the use of a wheelchair for mobility and there were stairs to enter the residence.
- A discharge notice was provided but the record lacked documentation of discharge planning.

F628 – Cited 5 times for:

- 2 times when the long-term care ombudsman was not notified of a transfer.
- A discharge notice with appeal rights was not provided to the resident.
- A bed hold notice was not signed as outlined in their policy.
- 2 times when bed hold notices were not provided or the notice did not include the rate of the bed hold.
- Documentation was not present in the resident's record on transfer to the hospital.

F637 – Cited 2 times when a significant change MDS was not completed when a resident was admitted to hospice.

F640 – Cited 1 time when a discharge MDS was not submitted to CMS.

F641 – Cited 6 times when:

- A discharge MDS was not completed.
- The MDS was not accurately coded by:
    - A ventilator was coded on the MDS but was not used by the resident.
    - A diagnosis was not coded on the MDS.
    - 2 times when PASRR Level 2 was not coded on the MDS.
    - Insulin was coded on the MDS was not used in the reference period.

F644 – Cited 7 times when significant change Level 1 assessments were not completed when the resident received a new mental illness diagnosis and/or psychotropic medications.

F655 – Cited 1 time when the baseline care plan was not completed.

F656 – Cited 8 times for:

- Staff did not follow the care plan.
- The care plan did not include:
    - Diuretics
    - Pressure ulcer prevention interventions.
    - Splint
    - Actual wounds present
    - Weight loss
    - 2 times for antianxiety medications
    - Large print reading materials requested by the resident
    - ADL assistance necessary

F657 – Cited 6 times for:

- Care conference meetings were not documented in the resident's record.
- The care plan was not updated to include:
    - 3 times for fall interventions.
    - Hospice
    - PTSD/Trauma-informed care.
    - Fracture
    - Allergies
    - Code Status
    - 2 times – pressure ulcers
    - ADLs

  - Burns
  - Weight loss
  - Wheelchair safety

F658 – Cited 8 times for:

- 2 times – not following physician orders.
- PRN medications were not documented when administered.
- Did not ensure PRN medication effectiveness was documented.
- Medications were left with a resident without supervision.
- Medications were not administered timely.
- Medications were not administered by the person who prepared them.
- An appointment was not arranged when necessary, in a timely manner.
- Medications were administered to the wrong resident.

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

- 2 times – bathing.
- Clothing was not changed for multiple days.

F678 – Cited 1 time when CPR certified staff were not present 24/7.

F679 – Cited 1 time when a representative expressed concerns about the lack of activities in a memory care unit.

F684 – Cited 12 times for:

- Assessments were not completed on the following:
  - 2 times following a fall.
  - 3 times after a change in condition.
  - Neurological after a possible head injury.
- New interventions were not implemented after a fall.
- A physician was not notified of a change in condition.
- A risk-assessment was not completed on hot liquids per policy.
- The bowel protocol was not followed.
- A resident was placed on a bed pan and left for five hours without access to their call light.

F686 – Cited 3 times for:

- Treatment orders were not followed.
- The care plan was not followed to prevent pressure ulcers.
- A treatment order was not obtained until eight days after a pressure ulcer was identified.

F688 – Cited 1 time for not completing restorative programming.

F689- Cited 12 times for:

- The shower door was not locked, which allowed unsupervised access by residents.
- 2 times when the care plan did not include smoking.
- 2 times when residents were not transferred safely.
- A fall assessment was not completed.
- 2 times when safety interventions were not followed according to the care plan.
- A lighter was not stored securely.
- A resident followed a staff member out of the building unknowingly.

F690 – Cited 2 times for:

- The resident did not receive assistance to the bathroom when requested.
- EBP were not implemented for a catheter.
- Staff did not intervene based on evidence of a catheter leak.

F692 – Cited 2 times for:

- A meal was not provided to a resident.
- The physician was not notified or interventions implemented for weight loss.

F695 – Cited 2 times when:

- The oxygen cylinder was empty when checked by the surveyor.
- Oxygen tubing was not changed.

F697 – Cited 1 time when pain medications were not administered when pain was reported.

F698 – Cited 2 times when a post-dialysis assessment was not completed.

F699 – Cited 1 time when PTSD and trauma informed care interventions were not identified on the care plan.

F725 – Cited 6 times for:

- 5 times for call lights not answered timely.
- 2 times when staff did not assist residents with care in a timely manner.

F732 – Cited 2 times for:

- Staffing hours were not posted.
- The posting did not include the census.

F744 – Cited 1 time when the care plan did not include dementia.

F756 – Cited 1 time when a GDR was ordered but was not followed.

F759 – Cited 1 time when an error rate of 7% was observed based on not administering the correct medication and a medication was administered when vital signs were outside of ordered parameters.

F760 – Cited 2 times when:

- Medications were administered to the wrong resident.
- Sliding scale and scheduled insulin were not administered.

F761 – Cited 3 times for:

- 2 times when medications were left at the bedside.
- Items were not dated when they were opened.
- The treatment cart was unlocked.

F774 – Cited 1 time when the nursing home did not arrange transportation to return to the nursing home from an appointment.

F803 – Cited 3 times for:

- 3 times when accurate portion sizes were not provided.
- All items on the menu were not served.
- Nutritional supplements were not served.

F804 – Cited 2 times when temperatures were not maintained at or above 135 degrees.

F805 – Cited 4 times when:

- Food was cut up in large chunks instead of bite size.
- Corn was served to mechanically soft diet residents.
- 2 times when regular food was served to residents instead of puree.

F806 – Cited 1 time when alternate options were not provided based on the resident's preferences.

F812 – Cited 10 times for:

- Hand hygiene not completed appropriately.
- 2 times when hair and beard nets were not used.
- Food was touched with bare hands.
- 3 times when food was not covered when transported.
- 4 times kitchen cleanliness.
- Scoops were stored in the item.
- 3 times when items were not dated when they were opened.
- Meat was not thawed appropriately.
- 3 times when gloves were not changed as necessary.
- 2 times when dishes were stored wet and dirty.
- Temperatures were not maintained at or above 135 degrees.
- The dishwasher chemicals were not tested.

F825 – Cited 1 time when therapy was not provided according to the physician's order.

F838 – Cited 2 times when:

- The nursing home did not update assessments with a change of ownership.
- The facility assessment did not address g-tube and dialysis services.

F842 – Cited 2 times when:

- Showers were not documented.
- The wrong resident's information was transmitted to another provider.

**F851** – Cited w times when PBJ reporting was not submitted accurately by:

- The DON hours were not submitted.
- An RN clocked into the incorrect building code.

**F865** – Cited 3 times when the nursing home did not have an effective QAPI process based on repeat deficiencies.

**F880** – Cited 12 times for:

- 7 times when EBP was not implemented.
- A multi-dose vial was not disinfected prior to use.
- 5 times when hand hygiene was not provided.
- 4 times when gloves were not changed as necessary.
- Reusable equipment was not disinfected between residents.
- A barrier was not placed under a blood glucometer.
- Staff touched food and drinking surfaces of dishes and glassware.
- Transmission-based precautions were not implemented.

**F882** – Cited 1 time when there was not an infection preventionist employed.

**F883** – Cited 1 time when a pneumonia vaccine was not administered appropriately.

**F921** – Cited 1 time when there were notable urine odors.

**F943** – Cited 1 time when staff did not complete dependent adult abuse training within 6 months of hire.

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

LeadingAge Iowa