LTC Survey Trends Report
March 2025

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LeadingAge Iowa

TRAUMA INFORMED CARE & SURVEY UPDATES

by Kellie Van Ree, Director of Clinical Services

The Regulatory Review article for this month reviewed F699 related to trauma informed care practices.

As a reminder, a revised QSO memo was released which delayed the effective date of the revised interpretive guidance until April 28, 2025. You can find more information on this topic here.

Survey Activity

District	Average Months for Providers with Recert	Number of Providers over 12 Months	Longest Survey Timespan
Statewide	10.8 months	3 nursing homes	14 months

Recertification:

- 37 total recertification surveys reviewed with 5.6 deficiencies on average per recertification survey with deficiencies.
    - Of the 34 recertifications with at least one deficiency, 2 providers received a fine (or 6%).
    - Of the 37 recertifications, 3 providers had deficiency free surveys (or 8%)

Complaint/Incidents:

- 50 providers with complaint/incident surveys reviewed with 2.3 deficiencies on average per survey reviewed with deficiencies.
    - Of the 24 complaint/incident surveys with at least one deficiency, 12 received a fine (or 50%).
    - Of the 50 complaint/incident surveys, 26 did not receive a deficiency (or 52%).

Congratulations to Halcyon House and Iowa Veteran's Home on deficiency free surveys!

Enforcement Actions

CY 2024	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVG NUMBER OF DEFICIENCIES
CY 2024 TOTALS	**$780,500**	**$3,895,563.40**	**41 Denials; 9 DPOC; 1 State Monitor; 1 Termination; 1 Voluntary Termination; 1 Temporary Management; 2 Mandatory Denials**	**$4,676,063.40**	**6.1 deficiencies**

CY 2025	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVG NUMBER OF DEFICIENCIES
JANUARY	**$46,750**	**$149,495**	**1 Denial; 1 DPOC**	**$196,245**	**4.6 deficiencies**
FEBRUARY	**$85,000**	**0**		**$85,000**	**8.3 deficiencies**
MARCH	**$70,000**	**$47,307**		**$117,307**	**5.6 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

March Deficiencies with State Fining and Citation

F600; 58.43(1); D; $500. While Resident #3 was asleep, a staff member went into their room, opened their locked drawer and took $55 cash. The resident's family had a camera in the room which showed the staff member opening the drawer while the resident was sleeping, picking something up and putting it in their pocket.

F609; 58.43(9); D; $500. An allegation of abuse was not reported within two hours of the allegation to the State Agency.

F609; 58.43(9); D; $500. An allegation of abuse was not reported within two hours of the allegation to the State Agency when a resident's money was missing.

F609; 58.43(9); D; $500. A C.N.A. reported seeing their coworker hit a resident but did not report the incident until the following day, outside of the 2-hour requirement.

F609; 58.43(9); D; $500. A resident reported that the aide that helped provide care to them was very rough and mean, the resident's roommate also reported concerns, and the nurse later heard the staff member being snippy and hostile. The incident was not reported to DIAL within 2 hours as required.

F609; 58.43(9); D; $500. During an interview, a resident reported that a staff member threw them down on the toilet while assisting them.

F684; 58.19(2)j; G; $7,000. On 2.23.25 Resident #1 was lowered to the floor to attempt to prevent injuries from falling. The progress notes lacked documentation of the incident. The nurse aides that lowered the resident to the floor indicated they notified the nurse, but an assessment was not completed. The staff assisted the resident off the floor, and then to the bathroom, before placing them in bed. The following day the resident began yelling out in pain, refused to allow staff to touch them or provide care. The ADON was notified but also did not complete an assessment. The ADON notified the DON who assessed the resident, called the doctor, and obtained an order for oxycodone. Prior to administering the resident's son wanted to discuss the medication and condition with other family. The following day the ADON directed the staff to call the doctor and request an x-ray when Resident #1 continued to have pain which showed a displaced hip fracture.

F686; 58.19(2)b; J; (No State Citation on Page). A nurse aide noted a reddened area to Resident #1's coccyx in January 2025 which lacked assessments of the area, notification of physician, or family. The area later opened and appropriate assessments were not completed along with notifying the physician and family. On 3.6.25, the resident was admitted to the hospital with a Stage 4 sacral pressure ulcer and passed away two days later related to MRSA and cellulitis in/around the ulcer.

F686; 58.19(2)b; G; $4,750. Resident #3 had a history of non-ulcer wounds to their toes which were identified upon a readmission from the hospital in May 2024. On 7.2.24, the wound assessment identified deterioration in the wound, but the physician was not notified. On 8.13.24, an antibiotic was initiated for cellulitis along with deterioration of the wound. Increased redness and drainage was noted on 9.24.24 resulting in a referral to a wound nurse. On 9/26/24 the resident had an appointment and was admitted to the hospital to amputate the toe. During interviews, staff reported that the wound treatment did not appear to be routinely changed and concerns were reported to the DON. While the surveyor observed a staff provide care to the resident, the staff were unaware of wounds but knew the resident had cream for their buttocks. During review of the resident's record there was an order for Mepilex to be changed every 3 days and as needed

that was not in place. A Non-Ulcer skin assessment was started on 2.3.35 that documented an open area to the inner buttock but did not have any follow up measurements or descriptions.

F686; 58.19(2)b; G; $7,250. Resident #14 was admitted to the nursing home and identified at risk for pressure ulcers. The care plan indicated the resident had hemiplegia and was dependent on staff for bed mobility. The residents' interventions lacked repositioning directions or assistance necessary for bed mobility. On 3.2.25 staff noted wounds on the resident's heels, and buttock, with purulent drainage. During observations the surveyor noted that the resident did not have treatment over the wound. Subsequent observations included long periods when the resident went without being assisted to reposition.

F686; 58.19(2)b; G; $15,000 (Treble/Held in Suspension) Resident #18 had bilateral heel ulcers without measures to prevent worsening or development of new. Additionally, a blister was identified that the physician was not notified for 19 days and orders were not received for a treatment. Resident #2 had a stage 4 ulcer to their coccyx along with interventions to limit sitting up to 2 hours but lacked direction on rolling side to side and an alternating pressure mattress. The resident reported that staff member recently found a new open area on their buttocks which was confirmed in a note. Additionally, the new area did not have treatments ordered for 3 days. Resident #25 had an order for Mupirocin External Ointment to an area on their buttocks which was not available for two days due to awaiting pharmacy delivery.

F686; 58.19(2)b; G; $5,250. Resident #1's record included pressure ulcers identified on 10.25.24 along with a new open area on their gluteal fold. Physician visit notes from the same day indicated the resident's skin was intact. On 11.1.24, the NP also visited the resident but was unable to visualize the area and asked that the wound NP follow. The wound NP visited the resident on 11.5.24 and provided an order for a treatment to a now Stage 3 pressure ulcer along with recommendations for pressure relieving device to the wheelchair. The order was not implemented until 14 days after it was received. Additionally, the nursing staff were unable to implement the new treatment for several days as they documented that they were awaiting supplies from the pharmacy. Resident #3 had a stage 3 pressure ulcer identified in November 2024 with notes to obtain a cushion for their chair, however, this was not implemented as additional notes in January and February directed staff to place a cushion in their chair. Resident #4's MDS with an ARD of 2.3.25 indicated the resident had a diagnosis of a Stage 3 pressure ulcer but did not code a pressure ulcer at the time. On 2.11.25, staff documented a stage 3 (new) pressure ulcer to the left gluteal cleft, however, treatment was not initiated to the area until 2.18.25.

F689; 58.28(3)e; G; $6,000 (Held in Suspension). Resident #2's care plan directed two staff for transfer assistance. On 11.19.24, staff lowered the resident to the floor and the resident was then complaining of severe pain and unable to move their leg. They were sent to the ER where they were diagnosed with a ligamentous injury where they were ordered to wear an ace wrap and be non-weight bearing. According to the event report, students transferred the resident without a gait belt and proper transfer which resulted in the fall with injury.

F692; 58.19(2)d; $6,250. Resident #13's was independent with eating, on a therapeutic diet and had a Stage 4 pressure ulcer. Their care plan included a nutrition focus which directed staff to obtain and record weights, report any significant changes and encourage proteins. The residents' weight was not obtained from 1.7.25 until 2.21.25 and a 12.77% weight loss was noted. The next weight was not obtained until 3.10.25 which included additional weight loss of 15.84% compared to the January weight. Following a hospitalization for norovirus, the resident was not weighed upon readmission. A nutritional assessment completed on 1.31.25 used the 1.7.25 weight to calculate any potential weight loss. The note included some edema noted but did not include sores in the resident's mouth or any nutritional recommendations. The dietitian asked for the

resident to be weighed again to verify accuracy, which was not completed and lacked additional interventions based on the weight loss.

F713; 58.19(2)j; $15,500 (Treble). Resident #2 was admitted to the nursing home in December 2024 following a hip fracture with surgical repair. The resident was confused and would transfer independently. On 2.3.25, Resident #2 had an unwitnessed fall and reported pain in their right hip. Despite having hip pain, two staff assisted them off the floor to their bed. The nurse then faxed the physician regarding the assessment findings. The resident continued to report pain and had a decline in functional status which prompted the nurse to contact the orthopedic physician about the pain on 2.5.25. The resident was not transferred to the emergency room for evaluation until 2.8.25 in which they were diagnosed with a right pubic rami fracture, hypoxia, and COVID-19.

TOP CITATIONS

F-TAG #	
F689	Accidents/Hazards/Supervision/Devices
F880	Infection Prevention & Control
F812	Food Procurement, Store/Prepare/Serve - Sanitary
F550	Resident Rights/Exercise of Rights
F656	Develop/Implement Comprehensive Care Plan

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

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

F550 - Cited 12 times for failure to treat residents with respect, dignity, and privacy by:

- Staff refused to provide care to residents.
- Forced a resident to take medications by holding their hands and head.
- They did not pull a resident's pants up when in bed and left them around their ankles.
- 2 times when staff slapped residents.
- The staff did not knock on a resident's door prior to entering.
- Residents were not dressed in appropriate seasonal clothing, including when a resident went out in the cold with shorts and a t-shirt on to smoke.
- 2 times when residents reported that staff were rough/mean with care.
- Staff stood by the residents as they assisted them with eating.
- 2 times when residents were told to go to the bathroom in their incontinent product.
- A lack of sufficient staffing or response to needs resulted in resident incontinence.
- A nurse administered a suppository to a resident when they told them they did not want it.

F567 - Cited 1 time when the admission agreement did not include the room rate.

F578 - Cited 1 time when the residents code status was not addressed upon admission.

F580 - Cited 4 times for not notifying the family and/or the physician of falls, new medications, and changes to medication doses.

F582 - Cited 4 times for:

- 2 times when a NOMNC was not given to the resident/representative.
- At least 48 hours advance notice was not provided when discontinuing skilled services.
- The NOMNC and ABN were not signed (or attempts documented to have them signed).

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

- 2 times when areas were in disrepair.
- Resident rooms were not cleaned.
- An inventory form was not updated.
- Urine odors were noted throughout the building.

F585 – Cited 1 time when the grievance policy was not followed by documenting the grievance on the appropriate form.

F609 – Cited 1 time when an allegation of abuse/suspicion of a crime was not reported to the State survey agency and law enforcement.

F610 – Cited 2 times when allegations of abuse were not thoroughly investigated and the victim separated from the perpetrator.

F623 – Cited 5 times when:

- 5 times when the LTC Ombudsman was not notified of transfers to the hospital.
- Documentation was not completed indicating the family was notified of a transfer to a hospital prior to the transfer.

F625 – Cited 6 times for not providing a bed hold notice and not ensuring the cost was included on the notice.

F626 – Cited 1 time when the nursing home refused to allow the resident to return from the hospital.

F637 – Cited 3 times when a significant change MDS was not completed when a resident was admitted/discharged from hospice.

F640 – Cited 2 times when discharge MDS' were not completed or submitted.

F641 – Cited 8 times when:

- A discharge MDS was not completed.
- The MDS was not accurately coded:
    - 3 times when PASRR Level 2 was not coded.
    - Oxygen was not coded.
    - CPAP was not coded.
    - Hospice was not coded.
    - A wander alarm was not coded.
    - A feeding tube was coded on the MDS but was not accurate.
    - Buspirone was coded as an antidepressant instead of an antianxiety medication.
    - A resident was coded as being up to date on their pneumonia vaccines but were not according to current CDC guidance.

F644 – Cited 5 times when:

- 3 times for a significant change Level 1 being completed for a new MI diagnosis.
- The care plan did not include specialized services identified in the Level 2.
- The diagnosis and medications were not accurately reflected in the Level 1.

F655 – Cited 1 time when the baseline care plan was not implemented, and the resident/responsible party did not sign that the care plan was reviewed with them.

F656 – Cited 12 times for:

- 3 times when staff did not follow the care plan.
- The care plan did not include:
    - 2 times – Diabetes diagnosis.
    - 2 times – insulin
    - 3 times – antidepressants
    - 3 times – antipsychotics
    - 2 times – opioids
    - Contact isolation
    - Smoking
    - 2 times – behaviors
    - 2 times – oxygen
    - 2 times – Level 2 recommendations
    - Non-pharmacological interventions prior to using psychotropic medications.
    - 2 times – antianxiety medications
    - Fluid restriction

F657 – Cited 6 times for:

- Care Conferences were not offered to residents.
- The care plan was not updated to include:
    - 2 times – ADL changes.
    - Therapy
    - 3 times – Hospice Services
    - Oxygen
    - Weight changes
    - Falls

F658 – Cited 8 times for:

- 3 times – Not following physician orders.
- Left medications in the resident's room without observing administration.
- A staff member prepared medication and signed off administration but another nurse administered.
- Did not prime an insulin pen.
- Medications were administered orally but ordered via g-tube.
- Orders were not transcribed accurately.

F676– Cited 3 times when recommended restorative programs were not implemented.

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

- Shaving
- Personal hygiene
- Oral care
- 3 times – bath/showers.
- Eating

F684 – Cited 11 times for:

- Dietitian recommendations were not followed.
- Treatment orders did not include all identified open areas.
- 3 times when weights were not obtained and medications administered as ordered.
- 2 times when staff failed to assess and appropriately intervene for blood glucose levels outside of established parameters.
- 3 times when assessments were not completed on skin conditions.
- Staff did not follow up on abnormal labs or x-ray results.
- Did not have an order for compression socks.
- Medications were not obtained in a timely manner from the pharmacy.

F686 – Cited 2 times for:

- Did not implement preventative measures for pressure related to a fitted device.
- Did not follow care plan for pressure ulcer treatment and prevention.

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

F689– Cited 17 times for:

- An assessment was not completed when a resident was noted vaping in their room.
- 4 times – staff did not use a gait belt when assisting with a transfer.
- 4 times – root cause analysis and new interventions were not implemented after falls.
- 2 times – care planned safety interventions were not followed.
- Shower rooms were not locked exposing residents to chemicals and sharp items.
- 2 times – residents were pushed in wheelchairs without foot pedals.
- 2 times – staff did not ensure that wandering alarms were appropriately functioning.
- Residents were not supervised to prevent recurring wandering into other resident's rooms.

F690 – Cited 3 times when the catheter bags and tubing were touching the floor.

F693 – Cited 1 time when staff pushed tube feedings instead of via gravity.

F695 – Cited 6 times when:

- Oxygen orders were not followed.
- Oxygen cylinders were not refilled when empty.
- The MAR did not include documentation on the number of liters used.
- Did not change and label oxygen tubing per the policy.
- Did not intervene when oxygen saturation levels were lower than established parameters.

F697 – Cited 2 times when pain was assessed and interventions implemented for residents complaining of pain.

F698 – Cited 3 times for:

- Not completing pre- and post-dialysis assessments.
- Did not document communication between the nursing home and dialysis center.
- Did not notify a doctor of weight gain for a resident on dialysis.

F699 – Cited 2 times when residents had diagnoses of PTSD but the nursing home did not assess for possible triggers and care plan the trauma.

F710 – Cited 2 times for:

- Not ensuring the physician collaborated on resident care and followed up with a specialist.
- The nursing home did not ensure that abnormal labs and x-ray results were reported to the ordering physician.

F712 – Cited 1 time when the physician did not complete visits at least every 60 days and alternate visits with the nurse practitioner.

F713 – Cited 2 times when:

- The physician wasn't notified of a change in the resident's condition following an ECT treatment.
- The physician did not respond timely to abnormal test results.

F725 – Cited 1 time when call lights were not answered in a timely manner.

F726 – Cited 1 times when nurses were unaware of how to flush a suprapubic catheter.

F727 – Cited 2 times when there was not an RN on duty for 8 consecutive hours in a 24-hour period.

F741 – Cited 1 time when behaviors were not documented for psychotropic medications.

F744 – Cited 1 time when dementia was not addressed in the resident's care plan.

F755 – Cited 1 time when a medication cart was unlocked and unsupervised.

F756 – Cited 1 time when a medication regimen review was not followed up on.

F758 – Cited 7 times when:

- Non-pharmacological interventions were not documented prior to administering a PRN psychotropic medication.
- 2 times – GDR requests were not completed when requested.
- 4 times – The care plan did not include targeted behaviors and non-pharmacological interventions.
- Did not follow up on a pharmacist's request for documentation supporting medication use.
- PRN psychotropic medication was not limited to 14-days.

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

F761 – Cited 3 times when:

- Medication labels and orders did not match.
- 2 times – medications were easily accessible to residents as they were not secured.

F800 – Cited 1 time when staff did not check the temperature of a food after microwaving it.

F801 – Cited 1 time when a qualified dietary manager was not employed.

F803 – Cited 3 times for:

- 2 times – puree portions were not accurate.
- A mechanical soft diet was not served as ordered.
- Puree food was not reheated appropriately.
- Not all items on the menu were served.

F804 – Cited 4 times for:

- The temperature of the food served was not checked prior to serving.
- 3 times – food temperatures were not within safe ranges.

F812 – Cited 15 times for:

- 4 times – items open and not dated/labeled.
- The ice scoop sat on top of the machine.
- 4 times – cleanliness.
- 3 times – refrigerators and freezers did not have thermometers or temperatures documented routinely.
- 3 times – hairnets were not used by dietary staff.
- 9 times – food handling concerns.
- 3 times – sanitizer levels in buckets and dishwashers were not monitored.
- Food was expired and not discarded.
- Food was stored near chemicals.

F842 – Cited 4 times when:

- Documentation was not completed for:
    - Vital signs
    - Insulin administration
    - Wound treatments
    - Falls
    - Inventory list

F851 – Cited 5 times when PBJ data was not accurately submitted, including:

- Staff were not punching in under the correct job codes.
- 2 times – agency hours were not submitted.
- DON hours were not accurately reported when they worked on the floor.

F865 – Cited 3 times when an effective QAPI process was not implemented based on repeat deficiencies.

F868 – Cited 1 time when there were not enough staff in attendance for a quarterly meeting.

F880 – Cited 16 times for:

- 9 times – enhanced barrier precautions followed.
- 4 times – gloves changed appropriately.
- 5 times – hand hygiene completed when necessary.
- 2 times – reusable equipment sanitized between residents.
- 3 times – barriers were not placed under items in resident rooms.
- Did not test for influenza with an acute respiratory illness outbreak.
- 2 times – medications were touched with bare hands.

- Droplet precautions were not followed.
- Soiled linens were transported held by staff and were against their uniform.
- The medical director did not review the policies annually for infection control.
- A catheter drainage bag hung on the side of a garbage can.

F881 – Cited 1 time when antibiotic use was not tracked per antibiotic stewardship practices.

F883 – Cited 3 times for:

- Pneumonia vaccination status was not assessed.
- 2 times – pneumonia vaccines were not administered when appropriate and consented to.

F887 – Cited 1 time when a COVID-19 vaccine status was not assessed.

F919 – Cited 1 time when the call light system was not functioning appropriately.

F921 – Cited 1 time when window curtains were falling down, and the windows were not clean.

F943 – Cited 1 time when dependent adult abuse certification expired before staff renewed it.

F947 – Cited 1 time when nurse aides did not complete 12 hours of in-service in the last 12 months.

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

LeadingAge Iowa