LTC Survey Trends Report
March 2026

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REGULATORY REVIEW & SURVEY UPDATES

by Kellie Van Ree, Vice President of Clinical Services & Education Strategy

A new regulatory review article on F604 - Physical Restraints was recently included in a newsletter.

Additional Resources on Physical Restraints for your use:

- Physical Restraint Quality Measure webcast
- Physical Restraint Quality Assurance Guidance and Worksheet

While the CMS QCor website hasn't been updated related to fines, I was able to find 2025 information on the CMS Nursing Home Provider Data website. You can see updated numbers for the Calendar Year 2025 later in this report.

Survey Activity

District	Average Months for Providers with Recert	Time Since Last Survey	Longest Survey Timespan
Statewide	12.6 months	18 nursing homes are currently 13 months since their last recert.	13 months

Recertification:

- 41 total recertification surveys reviewed with 6 deficiencies on average per recertification survey with deficiencies.
    - Of the 40 recertifications with at least one deficiency, 10 providers received a fine (or 25%).
    - Of the 41 recertifications, 1 provider had a deficiency free survey (or 2%)

Complaint/Incidents:

- 35 providers with complaint/incident surveys reviewed with 2.7 deficiencies on average per survey reviewed with deficiencies.
    - Of the 18 complaint/incident surveys with at least one deficiency, 6 received a fine (or 33%).
    - Of the 35 complaint/incident surveys, 17 did not receive a deficiency (or 49%).

Enforcement Action

CY 2026	State Fines	Federal CMPs	Enforcement	Total	Avg number of deficiencies
January	$55,250			$55,250	6.2 deficiencies
February	$55,500			$55,500	5.5 deficiencies
March	$103,250			$103,250	6 deficiencies

Calendar Year 2025 Totals:

State Fines - $592,250; Federal CMPs $2,175,610; Total $2,767,860; 14 Denials; 2 DPOCs; Average of 5.5 deficiencies per recertification survey.

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; G; No citation. The nursing home failed to implement interventions to ensure residents were safe from another resident who went into a female residents room and touched them while they were in bed and attempted to get into bed. The resident began yelling, which is when staff responded. A similar situation happened with another female resident when a male resident went into their room and started touching their buttocks and got into bed with them.

F607; 50.9(3); D; $500 (Held in Suspension). Staff L's background check was completed during a different employment period. There weren't criminal background checks and DHS approval to work within 30 days of this employment.

F609; 58.43(9); D; $500. An allegation of resident-to-resident abuse wasn't reported to DIAL when a resident told another resident not to go in their room again or they would give them something to cry about.

F609; 58.43(9); D; $500. An injury of unknown origin was not reported to DIAL within 2 hours as required.

F609; 58.43(9); D; $500. An allegation of resident-to-resident abuse wasn't reported to DIAL within 2 hours.

F609; 58.43(9); D; $500. Failed to report an allegation of resident-to-resident abuse within 2 hours.

F609; 58.43(9); E; $500. Incidents of resident-to-resident abuse were not reported for three different incidents.

F609; 58.43(9); D; $500. An allegation of abuse wasn't reported to DIAL timely including when a resident reported that a staff member swatted them on the should to "instruct them to let go of the rail" and that staff didn't listen to them.

F609; 58.43(9); D; $500 (Held in Suspension). The nursing home didn't report or thoroughly investigate an injury of unknown origin when a resident sustained a fracture in their finger.

F609; 58.43(9); D; $500. Resident-to-resident abuse allegations weren't reported to DIAL within 2 hours as required.

F609; 58.43(9); D; $500. An allegation of abuse was not reported to DIAL when a staff member placed a resident in their room and closed the door, so they didn't have to hear the resident.

F610; 58.43(9); D; $500 (Held in Suspension). The nursing home didn't thoroughly investigate an allegation of abuse based on omitting written witness statements and additional resident interviews from the investigation.

F689; 58.28(3)e; G; $5,750. Resident #12 had an order for a heating pack to their abdomen for 20 minutes daily for abdominal discomfort. On 11.21.25, the resident was found to have a large blister on the lower left quadrant of their abdomen which the resident expressed was likely from a hot pack they received yesterday. The wound clinic treated the area including chemical debridement for a 2nd degree thermal burn. Staff failed to document an intercepted fall when a resident was found partially on the bed and partially off. The fall lacked any follow up assessments, but the resident was later found to have a partial Achilles tendon tear. While assisting Resident #50 to ambulate from their restroom to the recliner the staff let go of the gait belt and the resident fell.

F689; 58.28(3)e; G; $9,000. During ambulation a resident fell and complained of pain to their arm and shoulder. The resident was diagnosed with a fractured shoulder and elbow. During interviews staff indicated that when they entered the room to assist after the fall that the resident didn't have a gait belt on and the walker wasn't nearby. The staff member also indicated that the DON stated they should have used the mechanical lift to assist the resident off the floor instead of lifting them. Another resident fell when staff attempted to assist them in standing without the use of a gait belt and the resident got stuck between the toilet and the wheelchair causing an ankle fracture. A third resident was noted to have pain in their shoulder without an identified cause. During an interview with the resident's roommate, they stated that they had a concern that the staff transferred the resident without a mechanical lift the week before as they saw the staff wheel the resident into the room and then it sounded like they threw the resident into bed and the resident started crying out. According to the roommate, they expressed their concerns to staff members who reported to the administrator.

F689; 58.28(3)e; J; $29,250 (Treble/Held in Suspension). Resident #8 is a bariatric patient and required a mechanical total body lift with 2 assist for transfers. A mechanical lift sling size risk evaluation completed indicated the resident required an XXL lift sling for safe transfers. On 2.27.26 staff attempted to transfer the resident from their recliner to bed using a hospital slide sheet. The straps on the slide sheet were attached to the Hoyer lift and when they began lifting the resident, the sheet started to rip so the staff lowered the resident back into their chair. They called the ambulance to assist with transferring the resident back to bed in which they attempted to use the slide sheet to transfer, and it ripped further. Additionally, the resident reported a grievance about not having adequate slings to use during transfers. During interviews staff showed the surveyor the stock of lift slings and when they identified which sling the resident uses it was reported as an XL (instead of XXL) based on the ribbon color, but the tag was torn and wording was worn off so the surveyor was unable to identify the sling size and weight. During a different interview, staff indicated that they didn't have the appropriate sling size for the residents and that there weren't enough staff to provide transfer assistance on some days, so they didn't get the resident out of bed. During a different observation Resident #39's assessment indicated they required a lift sling - size large and was using a size medium sling.

F689; 58.28(3)e; G; $6,000. Resident #1 was assisted to use the bed pan and when they rolled over their legs fell out of the bed causing their upper body to slide out as well. The fall resulted in a femur fracture. During interview, the resident reported that the staff members typically rolled them toward them when assisting with bed mobility and this time the staff member pushed them away from them and pushed them out of bed. There was only one staff member assisting at the time, so they were unable to stop the fall from occurring.

F692; 58.20(1); G; $7,500. Resident #4 required tube feedings and their care plan included actual or potential risk for altered nutrition status based on an “NPO” (nothing by mouth) status. A nutrition assessment completed by the dietitian on 1.13.26 recommended to increase their nutritional solution amount from 240 ml 5 times per day to 250 ml 5 times per day and increase water flushes from 30 ml before and after feedings to 60 ml due to being below estimated needs. In February, the resident refused the tube

feedings 50 times on various scheduled feedings. The staff discontinued the order on 2.25.26 and on 2.26.26 implemented 300 ml twice daily for tube feeding with 50 ml of water before and after feedings - this decreased the tube feeding formula from 1250 to 600 and water from 500 to 200 per day. The resident's weight was noted as 130 pounds on 1.10.26 and decreased to 119.5 on 3.25.26. The dietitian wasn't notified of the refusal of tube feeding or of the changed order for feedings. The dietitian was unable to find the order or directions from the physician to decrease the number of feedings.

F697; 58.20(1); G; $7,500. Resident #9's MDS indicated they had pain rating of 8/10, that the frequency was almost constant and impacted their day-to-day functioning and sleep. Pain medication upon discharge from the hospital included Oxycodone 5-10 mg every 4 hours as needed, Robaxin every 6 hours as needed, Tylenol 325 mg 1-2 tablets every 4 hours as needed, Lidoderm patch daily, and Lyrica twice daily. The nurse practitioner transcribed the orders and included these medications which were not in accordance with the surgeon - Lorazepam every 4 hours as needed, discontinued oxycodone and ordered Tramadol, However, they were unable to access Tramadol, so the order was switched back to Oxycodone 5mg (not 10) every 4 hours as needed for moderate pain. During a follow up visit the resident indicated they have difficulty receiving pain medications with significant reports of pain. Review of multiple days of pain ratings indicated the resident reported mostly 7-10 on 10 scale for pain with sporadic interventions for pain relief, including after the above appointment. During interviews the resident stated that the staff wouldn't administer pain medication when he asked for it.

F757; 58.19(2)j; J, $8,250 (Held in Suspension). Resident #2 was noted to have a large bruise in their pubic area. The staff failed to identify that the resident was recently started on two antibiotics that interfered with their Warfarin. When the bruise was noted, staff didn't monitor the residents' INR. The resident's spouse noted the bruise, and the spouse checked their INR which was 7.3. Before new orders could be implemented, the resident's condition changed in which they were transported to the hospital where they were noted to have a large internal bleed and at the hospital their INR was 13. The bleed was so significant that the hospital was unable to stop it which resulted in starting hospice care and passing away shortly after.

F760; 58.19(2)a; G; $15,000 (Treble/Held in Suspension). Resident #35 received an order for Oxycodone HCL 15 mg every six hours on 3.6.26. The supply provided by the pharmacy was previously 5 mg tablets, which instructed the staff to administer 3 tablets to total 15 mg. However, a new supply was 15 mg tablets and directed staff to administer 1 tablet. On 3.24.26, the staff documented using 2 tablets at 5 mg each and 1 tablet at 15 mg each totaling 25 mg instead of 15 mg. On 3.25.26 at 6 a.m. and 11:57 a.m. staff administered 3 tablets of 15 mg Oxycodone, totaling 45 mg instead of 15 mg. At 1:20 p.m. the resident appeared pale with garbled speech, they were only able to follow basic commands and their pupils were pinpoint. A new order was obtained at 6:04 p.m. to hold the Oxycodone until further notice. The resident's family was notified of the condition and decided to keep the resident at the nursing home and later in the day they were more responsive and able to eat supper.

F760; 58.19(2)a; L; $7,250 (Held in Suspension). During observation the medication carts included plastic medication cups with pills inside them and white paper med cups placed on top with names written on them. In one cart there were 21 of these while the other had 18. Additionally, there were 6 insulin pens with attached pen needles unlocked in a container and had pre-dialed dosage amounts. During interviews, staff indicated that they were trained to set medications up prior to medication pass at this building. The staff were provided with education, however, during subsequent observations were still setting up medications in advance of administering them which was observed on the video camera footage. Staff also administered insulin without priming the pen first.

F760; 58.19(2)a; G; $5,250 (Held in Suspension). Resident #103 received the wrong medications and a short while later, they were noted to be pale, head drooping, and unable to speak. During an assessment, the residents blood pressure and heart rate were low and they were sent to the hospital. The incorrect medications included Losartan, Carvedilol, Diltiazem, Hydroxyzine, Eliquis, Donepezil, Ezetimbe, Fluoxetine, Rosuvastatin. The resident was moved to another room, and the staff member pulled the medications from the incorrect room and placed them in this resident's spot in the medication cart. Resident #105 received a new Donepezil from the pharmacy, and the staff member administered the medication and placed the card on the medication cart without signing it out. The staff member then went to the DON office as requested. A different staff member then returned to pass medications and administered the medication as ordered; unaware the other staff member gave the medication. Resident #102 had an order for 100 mg of Tramadol every 6 hours as needed for pain, but staff administered 50 mg instead of 100 mg on 4 different days.

TOP DEFICIENCIES

F-TAG #	
F880	Infection Prevention & Control
F689	Accidents/Hazards/Supervision/Devices
F812	Food Procurement, Store/Prepare/Serve - Sanitary
F641	Accuracy of Assessments

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

- Staff swearing at residents.
- Stood while assisting residents to eat.
- Residents had to wait in the dining room for a long time before breakfast could be served and staff didn't offer drinks or snacks.
- Expressed concerns with staff being rude to them.
- A staff member told a resident they were too heavy to be pushed in a wheelchair.
- A staff member videorecorded a conversation without the resident's consent.

F552 – Cited 7 times when residents or their representatives weren't offered the opportunity for informed decision making related to psychotropic medications.

F554 – Cited 1 time when medications were left with a resident.

F558 – Cited 2 times for:

- Call light not functioning properly.
- Female urinals weren't replaced routinely.

F567 – Cited 1 time when resident's funds weren't available on the weekends or evenings.

F576 – Cited 2 times when:

- Resident's mail was open when they received it.
- The residents didn't have access to a telephone where they could make/take private calls.

F578 – Cited 2 times when the resident's record for code status didn't match their IPOST.

F580 – Cited 4 times when the resident's physician and/or representative weren't notified of:

- An ankle injury
- Change in condition requiring transfer to the ER
- Weight gain

- Bruise to their eye

F582 – Cited 6 times for:

- 3 times when no ABN or NOMNC was provided
- 2 times when the forms lacked the estimated charges
- The resident waived the 48-hour notice, but the documentation lacked explanation of why
- The reason Medicare wouldn't pay was not on the form.
- Notices weren't provided at least 48 hours in advance.

F584 – Cited 6 times for:

- 4 times when linens weren't changed on resident beds
- Room cleanliness
- Missing cell phone
- Meals were served on Styrofoam

F600 – Cited 4 times when:

- Staff weren't separated from residents pending investigation.
- Victim residents weren't separated from the perpetrator residents following resident-to-resident abuse.
- Staff yelled and cussed at residents.
- A resident was forced to return to their room and the staff shut the door.
- A staff member had an inappropriate sexual relationship with a resident.

F605 – Cited 10 times when:

- A GDR request wasn't addressed.
- 6 times when the care plans lacked non-pharmacological interventions.
- 3 times when target behaviors weren't identified on the care plan.
- Antipsychotic medication was not discontinued according to the physician's order.
- A GDR was not attempted according to the physician's order.
- A PRN psychotropic wasn't limited to 14 days.

F609 – Cited 1 time when abuse wasn't reported within 2 hours to DIAL, however, the deficiency was identified as past non-compliance.

F610 – Cited 2 times when:

- An allegation of resident-to-resident abuse wasn't investigated and interventions reviewed.
- A staff member wasn't separated from residents following an abuse allegation.

F627 – Cited 3 times for:

- An active discharge plan wasn't identified for a tenant who wanted to go home.
- 2 times when residents weren't evaluated immediately prior to hospital discharge for involuntary discharges.

F628 – Cited 6 times for:

- 2 times when the long-term care ombudsman wasn't notified of the transfer or discharge.
- Discharge instructions weren't present in the resident's record.
- 2 times when a discharge recapitulation wasn't completed.
- A bed hold notice wasn't provided.

- The transfer documentation wasn't included in the record.

F636 – Cited 1 time when hearing wasn't accurately coded on the MDS.

F637 – Cited 3 times when significant changes weren't completed for the MDS, 1 of which included hospice and 2 changes in ADLs.

F640 – Cited 1 time when discharge MDS' weren't completed timely.

F641 – Cited 13 times when:

- 2 times for hospice
- 5 times for Level 2
- Prognosis less than 6 months wasn't coded for a hospice resident.
- The dental status wasn't accurate.
- CPAP was not coded.
- Pressure ulcer wasn't coded but one was present based on record review.
- 2 times for urinary catheters.
- Feeding tube
- Smoking status
- Diagnoses of heart failure.
- A diagnosis of schizophrenia was coded based on a 1990 evaluation that lacked further documentation to indicate the schizophrenia diagnosis was still applicable and appropriate.
- Medications including:
    - Anticoagulants
    - Antipsychotics
    - 2 insulin
    - Antianxiety

F644 – Cited 4 times when:

- 2 times when the care plan failed to include the level 2 recommendations.
- 2 times when the level 1 wasn't revised based on new mental illness diagnosis.

F656 – Cited 3 times when the care plan didn't include the following:

- Antianxiety
- Diuretics
- Contracture
- Antidepressants
- Opioids
- Antipsychotics
- Anticoagulants
- Catheter

F657 – Cited 6 times when:

- Residents reported not being invited to their care conference.
- The care plan was not updated to include:
    - 2 times for hospice
    - Medications discontinued

- Dialysis
- Infected teeth
- PASRR recommendations
- Over the counter medications found in resident's room
- Current diet
- UTI
- MDRO
- IV antibiotics

F658 – Cited 7 times for:

- The physician wasn't notified when items were outside of the established parameters.
- Administered insulin after 30 days.
- Staff took 2 residents medications into the same room and a resident took the wrong resident's medications.
- Medications were put back into the medication cart when a resident refused them.
- Medications were administered orally instead of via g-tube as ordered.
- 2 times when medications were not administered as ordered.
- Medications weren't administered within the 1 hour before/after time frame.
- Wound assessments weren't completed.

F677 – Cited 11 times when residents were not provided:

- 2 times for nail care
- 7 times for bathing
- Oral care
- Hair shampoo
- Dressing

F684 – Cited 11 times for:

- The physician wasn't notified of resident refusals of treatment.
- Blood glucose levels were not monitored with insulin administration as ordered.
- The physician wasn't notified of a diagnostic test result that indicated the presence of a pulmonary embolism.
- Ensure that residents went to their scheduled appointments.
- The physician wasn't notified of weight changes.
- Assessments/interventions were not completed:
  - 4 times for neuros after possible head injury
  - Possible injuries reported
  - Low blood pressure
  - 3 times for weekly assessments of wounds
  - Bruised eye

F685 – Cited 1 time when the nursing home didn't assist in obtaining hearing aids when a resident was hard of hearing and expressed desire to have them.

F686 – Cited 3 times for:

- Weekly assessments weren't completed.
- The TAR didn't have a documented treatment for the pressure ulcer.
- Interventions weren't implemented to reduce pressure when at risk.

F688 – Cited 7 times for:

- 5 times when restorative programs weren't provided as ordered.
- The hand splint wasn't applied.
- A restorative program wasn't developed for a resident.

F689– Cited 15 times for:

- 2 times when smoking assessments weren't completed.
- 2 times when care planning smoking interventions weren't implemented.
- 4 times when foot pedals weren't placed on the resident's wheelchairs before staff pushed the wheelchair.
- Elopement risk assessments weren't completed.
- A staff member left a resident outside, unsupervised who was at risk for elopement.
- 2 times when staff failed to provide adequate supervision to prevent falls.
- The care plan wasn't updated with fall interventions.
- A root cause analysis wasn't completed and the care plan updated.
- 2 times for safety measures identified in the manufacturer's recommendations weren't followed such as locking the wheelchair during a mechanical lift transfer.

F690 – Cited 2 times for:

- Not cleansing the buttocks following an incontinent episode.
- Staff applied barrier cream after incontinent care without changing their gloves.

F692 – Cited 2 times when residents weren't weighed according to the care plan/order.

F693 – Cited 2 times when:

- Physician orders weren't followed for flush and feeding amounts.
- The staff pushed the feeding instead of allowing it to flow via gravity.

F695 – Cited 5 times when:

- 2 times when there wasn't an order to clean the CPAP.
- Oxygen flow rate wasn't followed.
- Nebulizer equipment wasn't changed according to policy.
- The care plan and MDS lacked identification of BiPap use.

F697 – Cited 1 time when the care plan lacked non-pharmacological interventions to reduce pain.

F698 – Cited 3 times for:

- 2 times when post-dialysis assessments weren't completed.
- The staff didn't ensure that a transfer sling was in place which lead to missed dialysis appointments.

F710 – Cited 1 time when the physician wasn't notified of an intercepted fall and the staff didn't communicate MRI results to the ordering physician.

F725 – Cited 11 times when:

- 10 times for call light response times longer than 15-minutes.
- Staff didn't assist with care timely.
- The nursing home wasn't staffed according to the facility assessment.
- Staff failed to respond to an audible tube feeding alarm.
- A resident couldn't be readmitted from the hospital due to staffing.

F726 – Cited 1 time when agency staff failed to have proper orientation prior to working with residents.

F727 – Cited 2 times for failure to have RN coverage for 8 hours each day.

F730 – Cited 1 time when performance evaluations were not completed in the last 12 months.

F732 – Cited 1 time for failure to post staffing for 18 of 31 days.

F755 – Cited 3 times for:

- There wasn't a process for receiving controlled medications.
- 2 times staff failed to document when controlled medications were administered on both the reconciliation record and the MAR.
- Narcotics weren't destroyed promptly after discontinuation.

F757 – Cited 3 times for:

- There wasn't supporting documentation to justify not completing a GDR for Lorazepam
- There wasn't documentation that the physician addressed the long-term use of an antibiotic.
- An INR was not completed as ordered.

F759 – Cited 5 times for medication errors over 5% during observation including the following examples:

- 3 times for incorrect doses.
- Medications omitted
- Insulin was held without notifying the physician
- Medications were given at the wrong time.
- Medications weren't crushed fine enough so the staff member just took the chunks out and threw them away.
- The staff didn't assist the resident in turning on the nebulizer or ensuring it was all administered.
- The resident wasn't instructed to rinse their mouth following a steroid inhaler
- Medication wasn't administered with food when necessary.

F760 – Cited 11 times for:

- Medications weren't administered.
- 2 times when the dose was incorrect.
- Insulin administration wasn't documented
- Medications weren't sent to dialysis
- 2 times when the insulin pens weren't primed.
- IV antibiotics weren't administered.
- Expired medications were administered.

F761 – Cited 2 times when:

- Controlled substances weren't stored under double lock as they were set up early.
- The medication cart was unlocked and unsupervised.

F791 – Cited 1 time when a resident had a tooth abscess that was not addressed or assisted with scheduling an appointment.

F801 – Cited 1 time when there wasn't a CDM employed.

F802 – Cited 1 time when there wasn't sufficient dietary staff to serve meals timely.

F803 – Cited 1 time when menu substitutions weren't approved by the dietitian.

F804 – Cited 6 times when food wasn't maintained above 135 degrees or below 41 degrees for room trays.

F805 – Cited 2 times when:

- The puree portion sizes were not accurate.
- A resident on mechanical soft diet was given a Snickers bar.

F811 – Cited 1 time when a paid feeding assistant helped a resident at risk for aspiration.

F812 – Cited 15 times for:

- The cleaning schedule was not followed.
- 6 times when items were not labeled or dated when opened.
- Meats were not thawed appropriately.
- 3 times when food was not discarded timely.
- Hand hygiene wasn't completed.
- 5 times when gloves were not changed to avoid cross contamination of food.
- 9 times for cleanliness concerns.
- A plate was served to a resident on accident, was taken away from that resident and given to a different resident without getting a new plate.
- 2 times when staff failed to wear hair and beard nets.
- Staff failed to document dishwasher chemical checks, refrigerator and freezer temperatures.
- Staff stacked bowls on top of each other with food in it which contaminated the top of the food.

F842 – Cited 3 times when:

- Staff failed to document administration of medication.
- Medications were documented as destroyed but were still present in the medication cart.
- Weights weren't documented accurately.
- Tasks were signed that were not completed by the individual.
- Electronic records were visible to the public.

F849 – Cited 1 time when the care plan didn't include all required hospice elements such as the hospice provider, the services provided, and the location of the hospice care plan.

F851 – Cited 2 times when agency staffing hours were not reported to PBJ and the hours weren't accurate that were submitted.

F865 – Cited 5 times when providers didn't have effective QAPI processes based on repeated deficiencies cited and to correct multiple medication errors.

F868 – Cited 2 times when the infection preventionist and/or director of nursing weren't present at the quarterly meetings.

F880 – Cited 23 times for:

- 7 times when gloves weren't changed appropriately.
- 10 times when hand hygiene wasn't completed.
- 10 times when enhanced barrier precautions were not followed.
- A dressing from a wound fell on the floor and staff didn't pick it up when they were finished with the treatment.
- 4 times when reusable equipment was not disinfected.
- 2 times when clean linen wasn't covered when transported in the hall.
- 2 times when staff used alcohol swabs to clean off reusable items such as the glucometer and stethoscope.
- Oxygen tubing was on the floor.
- 3 times when a barrier was not placed underneath supplies.
- 2 times when a urinary catheter drainage bag and tubing touched the floor.
- The water plan didn't include a review of stagnant water lines.
- Multiple residents' insulin pens were stored in the same bin.
- 3 times when staff failed to wear appropriate PPE when a resident was in transmission-based precautions.
- Staff lifted the catheter drainage bag above the bladder level.
- The filters on the BiPap machine weren't cleaned.

F883 – Cited 3 times when pneumonia vaccinations weren't offered or administered.

F926 – Cited 1 time when a resident was using oxygen and smoking at the same time.

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

LeadingAge Iowa