LTC Survey Trends Report
May 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 F567 related to resident funds in the nursing home.

As of June 2025, there are no nursing home providers that exceed 12 months since their last recertification survey. Five nursing home providers are at the 12-month period while 21 nursing homes are at 11 months.

The revised surveyor guidance was in effect during the entire month of May. There were several deficiencies cited based on the revised tag number, but when these were cited, the noncompliance was similar to previous deficiencies, just under a different tag number. For example, you will see failure to issue a bed hold notice and not notifying the LTC Ombudsman were now cited under a new F628 instead of F623 and F625 as they would have been previously.

The severity of deficiencies remains within a non-immediate jeopardy level scope and severity for all surveys reviewed and the total fines issued for the month are lower than they have been in several years. Both are positive trends for nursing home providers.

Survey Activity

District	Average Months for Providers with Recert	Number of Providers over 12 Months	Longest Survey Timespan
Statewide	10.4 months	None *12 months (June) = 5 *11 months (June) = 21	12 months

Recertification:

- 46 total recertification surveys reviewed with 5 deficiencies on average per recertification survey with deficiencies.
    - Of the 39 recertifications with at least one deficiency, 6 providers received a fine (or 15%).
    - Of the 46 recertifications, 7 providers had deficiency free surveys (or 15%)

Complaint/Incidents:

- 39 providers with complaint/incident surveys reviewed with 3.1 deficiencies on average per survey reviewed with deficiencies.
    - Of the 15 complaint/incident surveys with at least one deficiency, 6 received a fine (or 40%).
    - Of the 39 complaint/incident surveys, 24 did not receive a deficiency (or 62%).

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	**$61,250**	**$117,238.50**	**3 Denials; 1 DPOC**	**$178,488.50**	**8.3 deficiencies**
MARCH	**$64,000**	**$64,208**	**1 Denial**	**$128,208**	**5.6 deficiencies**
APRIL	**$30,500**	**0**		**$30,500**	**6.2 deficiencies**
MAY	**$27,750**	**0**		**$27,750**	**5 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 Bethany Home in Dubuque on a deficiency free survey!

CITATIONS WITH FINES

May Deficiencies with State Fining and Citation

F600; 58.43; D; $500. Resident #5 was witnessed kicking Resident #6 in the face and legs. Resident #5's care plan was not updated timely to provide interventions for staff to implement to prevent physical and verbal aggression by Resident #5.

F602; 58.43; D; $500. A former assistant administrator purchased items with resident trust funds that were not given to the residents. Staff alleged that the assistant administrator stole the items.

F602; 58.43; D; $500. Resident #7 was notified by their bank of an overdraft charge from paying a cellular telephone bill in the amount of $417. The resident did not use that cellular phone service and notified the police department of fraud. The resident reported during an investigation that they resided in the nursing home in October and November and gave their card to staff to purchase pop from the vending machine for the resident. It was determined during the investigation that a staff member used the card to pay for their cell phone bill.

F607; 50.9(4); D; $500. Two staff members had background checks completed more than 31 days prior to being hired.

F607; 58.11; D; $500. A staff member completed dependent adult abuse training within 6 months of hire.

F609; 58.43(9); D; $500. An allegation of verbal abuse was not reported to DIAL within the required time frame when a staff member told a resident that they soiled themselves and they needed to clean it up themselves.

F609; 58.43(9); D; $500. The nursing home did not report allegations of possible verbal abuse by a staff member in a timely manner.

F609; 58.43(9); D; $500. The nursing home did not report missing money to DIAL or law enforcement.

F609; 58.43(9); D; $500. Concerns with staff refusing to answer call lights and perform resident care during the overnight shift were not reported in a timely manner.

F609; 58.43(9); D; $500. Abuse allegations were not reported to DIAL within the required time frame when a resident accused a staff member of rushing during their shower, pinching them with the gait belt, and jamming a toothbrush in their mouth.

F658; 58.19(2); G; $3,000. Resident #2 had an order for morphine sulfate 15 mg twice a day for pain with nurse practitioner review every 30 days for continued ordering. During a visit on 3.20.25, the NP provided an order to continue with the scheduled and as needed morphine doses. On 3.31.25 the nursing home notified the nurse practitioner that the resident had not received their morphine since 3.18.25. During this time the resident experienced withdrawal symptoms including high blood pressure, trembling, diarrhea, nausea, and vomiting which resulted in a transfer to the ER. The resident returned to the nursing home with a hospice referral order. When the hospice evaluated the resident, they noted that the morphine order was not on the resident's MAR which is how it was identified they had not received the morphine. The resident passed away on 4.1 and their death certificate indicated the resident had withdrawn from opioids the week leading up to their death with likely physiological damage.

F684; 58.19(2)j; G; $8,000. The nursing home did not assess a resident's lung sounds before and after administering a nebulizer treatment and did not intervene when the resident had shortness of breath when laying down and on exertion. The lack of assessment delayed treatment which resulted in the resident being hospitalized for parainfluenza infection and passed away.

F689; 58.28(3)e; G; $5,000 (Held in Suspension). Resident #61 required the assistance of one staff member for transferring. On 4.20.25, Resident #61 reported they were taken to the shower room and tried to transfer themselves into the shower chair when they fell. The resident indicated that a staff member was present in the room and aware that they were transferring but did not assist them. The fall resulted in an impacted proximal left fibular fracture. The fall report also indicated the resident did not have footwear or a gait belt on at the time. During observations of transfers with a full body mechanical lift staff did not spread the lift legs while moving the residents around.

F689; 58.28(3)e; G; $2,750. Resident #1 was not able to be located, which prompted staff to begin searching for them. After a while, the resident was found at the bottom of the basement steps. During investigation it was determined that locked door which required a code was able to be unlocked by turning a deadbolt lock on the backside of the door or the resident figured out the code and was able to access the basement steps. As a result of falling down the steps, the resident had a hematoma to their face, arm, an abrasion and a bruise to the left hand but did not suffer any broken bones.

F690; 58.19(2)j; G; $4,000. A resident had blood-tinged urine in their catheter drainage bag. For several days, the progress notes indicated that the resident had a foley catheter but lacked an assessment of urine characteristics or physician notification of the blood-tinged urine, which resulted in the resident requiring hospitalization.

F760; G; (No Citation on Website). A resident who previously used two antipsychotic medications for schizoaffective disorder did not receive their medications for a two-week period which resulted in the resident being hospitalized and developing a Stage III pressure ulcer. During an interview, it was identified that the resident had two different sets of orders, the one without the antipsychotic medication was not the correct resident’s information.

TOP DEFICIENCIES

F-TAG #	
F880	Infection Prevention & Control
F812	Food Procurement, Store/Prepare/Serve - Sanitary
F689	Accidents/Hazards/Supervision/Devices
F684	Quality of Care

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

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

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

- A staff member called a resident outside of their name.
- The staff told the resident to complete their own perineal care.
- Staff used a vape pen in a common area inside the nursing home.
- A staff member jerked on a resident's arm to assist them in rolling over to provide care.
- Staff did not assist with changing an incontinence product when asked.

F552 – Cited 1 time when a POA was not notified of medication orders.

F554 – Cited 2 times when residents had medication and ointments at bedside without proper procedures for self-administering medications.

F557 – Cited 1 time when staff did not provide privacy to the resident while performing care.

F558 – Cited 2 times for:

- Not assisting a resident make an appointment to obtain new glasses when they were wearing glasses that were not theirs.
- A resident could not reach their clothing when sitting in their wheelchair.

F561 – Cited 2 times when staff did not aid a resident when needed/asked.

F578 – Cited 1 time when the code status order did not match the resident's desires on the IPOST form.

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

- A resident-to-resident altercation.
- A skin alteration.
- An allegation of staff mistreatment.

F582 – Cited 3 times when staff did not issue a NOMNC and ABN (when needed).

F584 – Cited 2 times for failure to provide a homelike environment by:

- Not protecting resident's clothing as they reported it missing.
- Cleanliness of the resident's room.

F600 – Cited 1 time when staff yelled and cussed at residents.

F605 – Cited 3 times for:

- 3 times when non-pharmacological interventions to attempt instead of psychotropic medications were identified on the resident's record.
- 3 times when target behaviors were not identified on the care plan.
- 2 times when staff did not complete a GDR.
- There was no clinical rationale documented when a PRN was extended past 14-days duration.

F607 – Cited 2 times when:

- An allegation of abuse was not investigated and the staff continued working.
- The policy was not followed when staff did not report concerns they had related to staff members refusing to answer lights and provide care during the middle of the night.

F609 – Cited 2 times when resident-to-resident abuse and allegations of misappropriation were not reported to DIAL.

F610 – Cited 5 times for:

- 3 times when investigation of abuse allegations was not completed.
- 2 times when the alleged perpetrator was not separated from their victim.

F628 – Cited 6 times for:

- 3 times for not completing a bed hold notice.
- The amount of the bed hold was not identified on the form.
- 2 times when the LTC ombudsman was not notified of transfer.
- A discharge recapitulation and summary was not completed.

F636 – Cited 1 times when entry tracking and discharge MDS' were not completed timely.

F637 – Cited 1 time when a significant change MDS was not completed when a resident was admitted to hospice.

F640 – Cited 3 times when MDS' were not transmitted to CMS in a timely manner.

F641 – Cited 5 times when:

- There was no level 2 coded in the MDS.
- Hospice was not coded.
- The diagnosis of dementia was not coded.
- Two times when an anticoagulant was not coded and Plavix was coded as an anticoagulant.
- Medications were coded that were not included on the MAR for the lookback period.
- A UTI was not coded when the resident was on antibiotics for a UTI during the lookback period.
- A foley catheter was not coded.

F644 – Cited 3 times when a new Level 1 was not submitted after a resident received a new possible MI condition was diagnosed, or new psychotropic medication prescribed.

F655 – Cited 1 time when the baseline care plan did not have pain or an antipsychotic medication.

F656 – Cited 6 times for:

- The care plan did not include:
  - Skin breakdown
  - Opioids.
  - Edema
  - Stomatitis
  - Hospice
  - A strap used for an immobile resident.
  - An anticoagulant.
  - Insulin

F657 – Cited 10 times for:

- Residents and/or family were not invited to the care plan meeting.
- The care plan was not updated to include:
  - 2 times for ADL assistance.
  - 2 times for hospice care.
  - Discontinuation of a cast.
  - Fall interventions.
  - Elopement risk.
  - Level 2 recommendations.
  - Antipsychotic medications.

F658 – Cited 10 times for:

- Staff did not notify the physician of tests outside of parameters.
- 5 times when staff did not follow the physician's order.
- Did not follow the rights of medication administration.
- Did not instruct the resident to rinse their mouth after use of an inhaler.

F676– Cited 1 time when recommended restorative programs were not implemented.

F677 – Cited 4 times for failure to provide/assist with:

- Eating.
- 2 times for bathing.
- 2 times for toileting.
- Perineal care.

F684 – Cited 11 times for:

- Assessments were not completed on the following:
  - 2 times skin breakdown.
  - After a fall.
  - When the resident did not have a BM per policy.
  - The resident returned to the building after an outing and acted erratic with a history of SUD.

    - A resident reported they had a seizure (with a history of seizures).
- Edema wear was not applied per order.
- A change of vital signs outside established parameters was not reported.
- Signs of eye infection were not assessed or reported.
- A central line was present on a new admission that was not identified on the admission assessment or addressed.

F686 – Cited 1 time when staff did not assess or intervene when a nurse practitioner identified a pressure ulcer and reported to staff.

F688 – Cited 1 time for not completing restorative programming.

F689– Cited 14 times for:

- 2 times when staff pushed a resident in a wheelchair without foot pedals.
- A resident was smoking while using oxygen.
- Did not follow the care planned transfer assistance.
- 3 times when fall interventions were not followed.
- An incident report was not completed following a fall or identified a new intervention.
- A resident received a bruise on their face, likely from a mechanical lift bar.
- Staff did not raise the head of bed for a resident who was eating and previously had a stroke.
- A staff member grabbed a resident's wrist to assist them in standing instead of the gait belt.
- Staff did not respond appropriately when a door alarm sounded.

F690 – Cited 3 times for:

- 2 times when catheter tubing/drainage bags touched the floor.
- A foley catheter was not identified on the care plan.
- When the catheter was discontinued, a toileting plan was not attempted to try to restore bladder function and continence.
- A catheter drainage bag was hung on a garbage can.

F692 – Cited 3 times for:

- A recommendation from a dietitian for a nutritional supplement was not followed.
- 2 times when the physician was not notified of weight loss.

F693 – Cited 2 times for:

- Staff did not check placement before administering a flush.
- The residents' orders did not include the amount of water flush.

F695 – Cited 7 times when:

- 2 times when oxygen was not included in the care plan.
- Oxygen tubing sat on the floor.
- There was not an order for a CPAP.
- 3 times when oxygen and nebulizer tubing was not changed per policy.
- CPAP settings were not documented.
- Oxygen saturation levels were not monitored when the oxygen flow rate was titrated based on levels.

F698 – Cited 1 time for not completing pre- and post-dialysis assessments.

F710 – Cited 1 time when a physician was not notified of a weight loss.

F725 – Cited 5 times for:

- 4 times for call lights not answered timely.
- Did not have adequate staff to complete bathing.
- There were not enough staff to provide toileting to residents.

F727 – Cited 2 times when there was not 8 consecutive hours of RN coverage each day.

F740 – Cited 1 time when target behaviors and non-pharmacological interventions were not outlined in the care plan for psychotropic medication.

F741 – Cited 2 times when staff did not receive adequate training for caring for residents with substance use disorders.

F744 – Cited 1 time for not having individualized interventions for dementia related behaviors.

F755 – Cited 3 times when:

- Narcotics were not accurately documented on both the MAR and the reconciliation sheets.
- Medications were not administered timely.
- Medications were not available to be administered.

F757 – Cited 1 time when the resident's care plan did not include target behaviors and side effects of psychotropic medications.

F759 – Cited 3 times for medication errors greater than 5% including:

- Crushed Extended-Release tablets.
- Insulin pens were not held in the skin for a long enough period.
- Incorrect doses were administered.

F760 – Cited 1 time for not priming an insulin pen.

F761 – Cited 4 times for:

- Expired medications were not discarded
- Medication carts were unlocked and unsupervised.
- Did not reconcile narcotics.

F800 – Cited 1 time when staff did not provide the diet as ordered by the physician.

F802 – Cited 2 times when staff were not adequately trained to complete functions of their role.

F803 – Cited 9 times for:

- 3 times when not all items on the menu were served.
- Alternate options were not available.
- Menus lacked the dietitian's signature.
- There was no alternative for baked beans when residents had mechanical soft diets.
- 2 times when staff did not serve the accurate portion size for puree diets.

- The diet orders were not followed as ordered.

F804 – Cited 5 times for:

- 4 times when hot food temperatures were not maintained at least 135 degrees.
- Ice cream was soft and melted when served.
- The staff did not serve the correct portion size for mechanical soft diets.
- The correct diet texture was not served.

F805 – Cited 1 time when staff did not serve the correct portion sizes for puree diets.

F812 – Cited 15 times for:

- 6 times for cleanliness concerns.
- 3 times when food was not discarded and was outdated.
- A freezer was not maintaining appropriate temperatures and had food in it.
- 4 times when items were open and not labeled or dated.
- Meat was thawing over lettuce.
- 3 times for not completing hand hygiene appropriately.
- 2 times when food temperatures were not being checked or documented.
- The staff did not know how to check the functioning of the dishwasher (chemical/temperature).
- 2 times when hair nets were not used appropriately.
- 2 times for food handling concerns.
- Food was transported without being covered.

F825 – Cited 1 time when OT services were not provided according to a physician's order.

F826 – Cited 1 time when staff were not trained on appropriate use and care for CPAP machines.

F842 – Cited 3 times when:

- Documentation of why residents refused multiple showers was not included in the records.
- Documentation was not completed in a timely manner.
- A resident's private information was accessible to the public.

F851 – Cited 3 times when PBJ data was not submitted accurately.

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

F868 – Cited 2 times for:

- Not having an adequate QAPI process based on repeat deficiencies.
- The medical director did not attend QAPI meetings.

F880 – Cited 20 times for:

- 7 times when hand hygiene was not performed appropriately.
- 3 times when gloves were not changed appropriately.
- 3 times when reusable equipment was not disinfected between residents.
- 14 times when EBP was not used.
- 2 times when catheter tubing touched the floor.
- Dirty items were placed on a clean barrier.

- Garbage with potentially contaminated waste was not removed from the resident's room.
- A humidifier was not routinely cleaned.
- Eye drops were placed on a resident's equipment without a barrier.

F881 – Cited 2 times when:

- An antibiotic did not meet criteria, and the nursing home did not address it.
- There was not a process to monitor long-term use of an antibiotic.

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

F887 – Cited 1 time when the resident did not sign a declination for COVID-19 vaccine.

F919 – Cited 1 time when a call light was not within reach for the resident.

F925 – Cited 1 time when residents expressed concerns about ants and mice in the building.

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

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.

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