LTC Survey Trends Report November 2024

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LeadingAge Iowa

REASONABLE ACCOMMODATION & SURVEY UPDATES

by Kellie Van Ree, Director of Clinical Services

The Regulatory Review article for this month reviewed F558, the resident's right for reasonable accommodation and allowing for resident preferences.

LeadingAge Illinois/Iowa is hosting a webinar on the revised surveyor guidance on January 30, 2025. Members can register for this webinar for ***free***! I've also been working on several resources related to the revised guidance which you can find here.

Survey Activity

District	Average Months for Providers with Recert	Number of Providers over 12 Months	Longest Survey Timespan
Statewide	12.5 months	21 nursing homes	16 months

Recertification:

- 31 total recertification surveys reviewed with 5.8 deficiencies on average per recertification survey with deficiencies.
    - Of the 26 recertifications with at least one deficiency, 9 providers received a fine (or 35%).
    - Of the 31 recertifications, 5 providers had deficiency free surveys (or 16%)

Complaint/Incidents:

- 47 providers with complaint/incident surveys reviewed with 1.9 deficiencies on average per survey reviewed with deficiencies.
    - Of the 22 complaint/incident surveys with at least one deficiency, 8 received a fine (or 22%).
    - Of the 47 complaint/incident surveys, 25 did not receive a deficiency (or 36%).

Enforcement Actions

MONTH (2024)	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVERAGE NUMBER OF RECERTIFICATION DEFICIENCIES
JANUARY	$68,250	$248,974.88	4 Denials; 1 DPOC	$317,224.88	6.7 deficiencies
FEBRUARY	$26,500	$486,663.44	3 Denials	$513,163.44	9 deficiencies
MARCH	$36,250	$136,093.50	5 Denials; 3 DPOC	$172,343.50	5.3 deficiencies
APRIL	$131,250	$192,873	4 Denials	$324,123	5 deficiencies
MAY	$101,500	$311,975	6 Denials	$413,475	5.1 deficiencies
JUNE	$60,000	$536,751.50	6 Denials	$596,751.50	6.4 deficiencies
JULY	$142,250	$576,774	9 Denials; 1 DPOC; 1 State Monitoring	$719,024	6.1 deficiencies
AUGUST	$88,750	$258,354	6 Denials, 1 Termination	$347,104	5.4 deficiencies
SEPTEMBER	$140,000	0	2 Denials; 1 Voluntary License Termination	$140,000	6.9 deficiencies
OCTOBER	$130,000	0	1 Denial; 1 DPOC	$130,000	4.9 deficiencies
NOVEMBER	$113,750	0	0	$113,750	5.8 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

November Deficiencies with State Fining and Citation

50.7; $500. A fall with a major injury including a radius/ulna and pelvic fracture that resulted in hospitalization was not reported to DIAL.

F600; 58.43; K; $6,250 (Held in Suspension). There were several incidents of resident-to-resident abuse including Resident #19 touching another resident on the breast, buttock, along with documented grabbing and groping of Resident #12. Resident #22 hit Resident #77, grabbed and scratched Resident #12, slapped Resident #11, slapped and pinched Resident #13, and grabbed Resident #2's arm.

F600; 58.43; K; $5,750 (Held in Suspension). Resident #10 reported to staff that a CNA performed perineal care roughly and they felt like their buttocks was bruised. Another staff member was present in the room at the time when the resident stated "ouch", they reported that they stopped performing care on the other resident in the room and heard the staff member apologize to the resident. The CNA then asked the other aide why the resident said ouch when the CNA reported they were trying to wipe BM off their bottom. When finished, the CNA reported the incident to the nurse. Following the incident, the nurse spoke with the resident who denied pain, a skin assessment was completed and lacked evidence of injuries. An investigation was completed including interviewing several other residents and staff; however, the staff member was not removed from duty. Two staff members were caring for Resident #38 when one of the staff members used more than necessary strength to turn and reposition the resident. During the interaction the staff member stated that if the resident pinched or punched, they would do the same to them (this was the same staff member in previous incident). The incident was reported to the DON a couple days after the incident and the incident was investigated and reported to the police and state agency. The staff member was then suspended pending investigation. During investigation additional incidents of staff being rough with residents were identified.

F600; 58.43; D; $500. Staff took pictures and videos of residents and transmitted them over social media.

F607; 58.11(3); D; $500. A background check was not complete for one staff member.

F609; 58.43(9); K; $5,750 (Held in Suspension). Allegations of potential abuse were not reported to DIAL within a 2-hour time frame as required.

F609; 58.43(9); D; $500. An incident when a resident reported that a staff member was aggressive with providing perineal care was not reported as potential abuse.

F609; 58.43(9); D; $500. A resident reported being sexually assaulted and staff did not report the incident to management or DIAL in a timely manner.

F609; 58.43(9); D; $500. A staff member shared a video of a resident on social media and the Administrator was not made aware of the incident until four days later. Therefore, the allegation was not reported to DIAL in a timely manner.

F609; 58.43(9); K; $5,750 (Held in Suspension). Allegations of resident-to-resident abuse were not reported to the management and/or DIAL in a timely manner.

F609; 58.43(9); D; $500. An allegation of abuse was not reported to management or DIAL within the two-hour timeframe when a staff member stated they held the shower head with running water on a resident's face during a shower because they were combative.

F610; 58.43(9); K; $5,750 (Held in Suspension). The nursing home did not conduct thorough investigations into potential allegations of abuse including injuries of unknown origin, staff rough treatment towards residents which resulted in fear, and resident-to-resident abuse. The residents were also not separated from potential perpetrators when the nursing home became aware the abuse allegations.

F684; 58.19(2)j; G; $8,750. Resident #1 fell out of their wheelchair onto their face. The nurse did not complete a thorough assessment of the resident after they witnessed the fall including initiating neuro checks, notifying the provider or family of the fall. The nurse did not document the fall until the following day.

F684; 58.19(2)j; J; $8,500 (Held in Suspension). Resident #25 had a change in condition on 9.7.24 including difficulty transferring. A couple of hours later, the resident had a fall in another resident's room where they were found lying face down on the floor with a laceration to the left forehead. A fax was sent to the physician that was not responded to until two days later without staff follow up on the fax not being returned. The staff continued to notice a decline in the resident's condition as they required assistance and cueing with all meals when they were previously independent and were non-weightbearing to their left leg. On 9.17.24, the physician was notified of declining transfer status in which an x-ray of the hip was obtained that revealed no fracture. On 9.22.24, the resident was transferred to the hospital due to stroke-like symptoms and was diagnosed with a subdural hematoma and passed away on 9.29.24. In addition, the staff did not complete neurological assessments and post fall follow-up documentation for Resident #20 following an unwitnessed fall. Resident #226 had excessive coughing following consumption of the incorrect consistency of food at a meal and further assessment was not documented.

F684; 58.19(2)j; G; $15,000 (Treble). Resident #2 had a change in condition including slurring words, increased fatigue, change in ADLs and had orthostatic hypotension. The staff did not notify the physician of the change in condition until later in the evening when the resident's condition worsened.

F686; 58.19(2)b; G; $3,000 (Held in Suspension). Resident #27 was previously treated for a Stage 4 pressure ulcer to their heel with interventions for Prafo boots and heel protectors. The Stage 4 pressure ulcer was noted as healed on 9.23.24, however, on 10.14.24 a new pressure ulcer was identified to the same area. During observations, the resident was not wearing the heel protection devices included in the care plan to prevent pressure ulcers.

F686; 58.19(2)b; G; $5,000. Resident #50 was at high risk of pressure ulcer development and according to the resident's record they developed a right heel pressure ulcer on 11.1.24. The TAR lacked documentation of treatment during this time and the physician's order only stated to monitor the area. The resident's representative reported having a meeting on 10.30.24 and the pressure ulcer was discussed including hospice providing heel protectors for the resident (despite the area not being documented until 11.1.24). On 11.8.24, the pressure ulcer was assessed and noted to be larger. The resident expressed they did not want to use heel protectors because they made their feet hot and frequently removed them. There were no new interventions based on the residents' preferences. During observations a staff member did not complete hand hygiene or change gloves appropriately when completing wound care.

F689; 58.28(3)e; G; $4,000. Resident #37 had a history of falls including interventions that the resident's gripper socks were replaced. The resident had a fall on 11.6.24 at 10:25 p.m. when a staff member assisted the resident to the bathroom and did not use a gait belt. Upon assessment by the nurse after the fall they noted that only one gripper sock was on and was incorrectly positioned, while a regular sock was on the other foot. While reviewing the fall, the surveyor also noted that the nursing home did not implement new interventions for the 11.6.24 fall.

F689; 58.28(3)e; J; $6,000 (Held in Suspension). Resident #1's record identified they were at risk for wandering and elopement and used a wander/elopement alarm. The progress notes included instances of attempting to exit, increased confusion and delusions. On 10.31.24, staff last saw Resident #1 at 12:45 p.m. At 1:30 p.m., a CNA noted that a car was backed up against the curb blocking the parking lot. Which is when they noted that Resident #1 was in the driver's seat with the doors locked. Staff convinced the resident to unlock the door and they were able to put the car in park, remove the keys, and then called the building for help. During investigation it was noted that a CNA heard the door alarm sound. They responded to the door and took a couple steps outside but did not see anyone, so the alarm was cleared. The alarm was activated at 1:01 p.m. and deactivated at 1:06 p.m. on 10.31.24. The resident was assisted back to the building and no injuries were identified.

F689; 58.28(3)e; J; $5,500 (Held in Suspension). On 10.28.24 Resident #2 had a red area with blisters noted on their arm. The resident indicated it may have happened in the shower earlier that morning. According to interviews, the resident reported that they could feel discomfort on their arm (despite being quadriplegic) and the staff stated that the water was scalding hot. The resident was seen at urgent care and treated for a second degree burn to their arm. The surveyor tested the water temperature in the shower room where the resident took their shower and noted a water temperature of 145.2 degrees. Review of temperature logs lacked testing of the shower rooms.

F689; 58.28(3)e; H; $7,500 (Held in Suspension). Resident #5's four-wheeled walker had loose wheels on it and maintenance was unable to immediately repair. They provided the resident with a three-wheeled walker until their normal walker could be repaired. The following day the resident had a fall which resulted a transfer to the ER where they received diagnoses of a hematoma above right eye, distal right humerus fracture, and UTI. Resident #22 had several falls including a few that resulted in injury including hitting head, hip fracture, skin tears, and laceration. The resident's care plan lacked information on falls in August. Several falls occurred related to inappropriate footwear causing the falls. Resident #6's medications were left on top of the medication cart unsupervised. Resident #2 fell as a result of staff not using a gait belt during transfers. Another fall occurred which resulted a transfer to the ER for a laceration which required staples. The resident's care plan was not updated with interventions. The surveyor observed staff push resident #2 without wheelchair foot pedals on. Resident #3, who had dementia swallowed a robin's egg when a staff member brought it inside to show residents. Staff were directed to monitor the resident for potential salmonella. Resident #21 had falls which resulted in rib pain, laceration that required sutures, hematoma to the left side of their head, humerus and hip fracture. Resident #21's care plan lacked documentation of falls and interventions to prevent falls.

F689; 58.28(3)e; J; $4,500 (Held in Suspension). Resident #1 left a group while walking from an activity area to the memory care unit unbeknownst to the supervising staff. The resident walked through the front lobby and exited out an unlocked, unalarmed door to an unsecured courtyard area. A staff member saw the resident outside and assisted them back into the building. It was estimated the resident was outside, unsupervised for approximately 10 minutes.

F689; 58.28(3)e; G; $4,750. Resident #26's care planned interventions to prevent falls included having their bed in a position to allow the resident to safely stand (not in the low position) and their wheelchair at the foot of the bed to be accessible to use. The resident had a fall that resulted in a fractured wrist, and during investigation it was identified that the bed was in a low position and the wheelchair was in the bathroom behind a closed door.

F697; 58.19(2)j; G; $5,500 (Held in Suspension). Resident #1's care plan did not include information about dental care/services. Starting on 7.19.24, the resident was noted to have mouth pain which ultimately resulted in the resident requiring an emergency dental visit on 8.16.24. The dentist identified that the resident had non-restorable carious teeth and referred the resident to the University of Iowa for oral surgery.

The nursing home did not arrange an appointment for the resident which lead to ongoing pain. On 9.4.24, the resident again saw the dentist who noted that the resident had another tooth that needed extracted and had a potential yeast infection. The dentist contacted the University and reported the resident had severe mouth pain with the inability to eat. The University advised that the resident should go to the University ER where an on-call oral surgeon can advise. The resident was hospitalized on 9.8.24 for shortness of breath and diaphoresis, resulting in intubation and admission to the coronary care unit. Upon return to the nursing home, staff indicated the resident's teeth were in good condition when assessed. On 10.23.24 the resident again saw a local dentist due to significant pain in their mouth/teeth. The dentist indicated they made referrals to the University on two other occasions which were not followed through by the nursing home. The dentist recommended the resident be transferred to the University immediately, which was done the following day.

F805; 58.24(5)c; G; $4,000 (Held in Suspension). During observation of meal service, the cook provided a regular consistency diet to Resident #226 who had an order for pureed food. The cook recognized that they provided the incorrect texture but before they could remove the plate from the resident, items had already been consumed and the resident was noted excessively coughing. Staff also served coleslaw to a resident on a mechanical soft diet as they did not have extra cabbage to boil.

TOP CITATIONS

F-TAG #	
F689	Accidents/Hazards/Supervision/Devices
F880	Infection Prevention & Control Program
F812	Food Procurement – Store/Prepare/Serve Sanitary
F658	Services Provided Meet Professional Standards
F550	Resident Rights/Exercise Rights

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

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

F550 - Cited 8 times for failure to treat residents with respect, dignity, and privacy by:

- Staff swearing at or in front of residents.
- A staff member pushed a resident's forehead back when the resident was trying to bite them and used a demanding tone during the interaction.
- Residents were not provided privacy during incontinence care.
- The water in the shower rooms was cold which resulted in residents refusing to take showers for multiple months.
- Staff did not place a barrier when they provided incontinence care to a resident and the resident was laying on the blanket they routinely used to cover up with.
- Residents did not receive care in a timely manner.
- Staff were not kind to residents.
- A catheter drainage bag was not placed in a dignity bag.
- The nursing home tried to force a resident to change their code status or they had to go to the hospital.

F558 - Cited 1 time when a call light was not placed within a resident's reach.

F567 - Cited 1 time when a resident did not have access to their personal funds at all times.

F578 - Cited 4 times for:

- 3 times when the code status did not match in all areas within the resident's record.
- The code status form was not signed by the physician.

F580 - Cited 2 times for:

- The resident's guardian was not notified when the resident refused medical procedures and when they had a change in condition.
- The resident's physician was not notified when the resident's bowel pattern changed which resulted in a transfer to the hospital.

F582 – Cited 4 times when:

- 2 times when the SNF ABN was not completed.
- The cost was not included on the form as required.
- A NOMNC was not completed.
- The resident or representative were not notified of a discharge from skilled level care.

F583 – Cited 1 time when a resident's record was left open on a computer and visible to the public.

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

- A section of the dining room was blocked off due to a roof leak.
- Floor tiles were damaged or missing.

F600 – Cited 1 time when a resident had a fall and accused another resident of pushing them.

F610 – Cited 3 times when the nursing home did not complete thorough investigations into allegations of possible abuse and injuries of unknown origin.

F623 – Cited 5 times when the LTC Ombudsman was not notified of transfer out of the nursing home.

F625 – Cited 2 times for:

- A bed hold notice was not provided when a resident was transferred to the hospital.
- The bed hold form was not signed by the resident/responsible party.

F636 – Cited 2 times when:

- The quarterly MDS had sections that were not completed.
- A CAA was not completed when the resident was on an antipsychotic medication.

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

F641 – Cited 5 times for inaccurate MDS coding based on:

- Did not code when a resident smoked.
- 2 times when the discharge location was inaccurate.
- Wander/elopement alarms were not coded when present.
- Plavix was coded as an anticoagulant.
- Trulicity was coded as insulin.
- The MDS coded an external catheter was used when the resident had an indwelling catheter.
- The MDS coded a weight loss, however, the weight was identified as inaccurate.

F644 – Cited 3 times when a new PASRR was not completed for a new MI diagnosis.

F646 – Cited 1 time when a new PASRR was not completed for a new MI diagnosis.

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

F656 – Cited 7 times for:

- The comprehensive care plan was not completed within 21 days from admission.
- The care plan did not include:
    - MDRO
    - 2 times for enhanced barrier precautions.
    - Wandering and elopement
    - High risk medications including antiplatelets, opioids, antipsychotics, diuretics, antidepressants, anticoagulants.
    - Hospitalizations
    - Depression

F657 – Cited 4 times for:

- The care plan was not followed.
- The resident was not invited to the care conferences.
- The care plan was not updated to include:
    - Discontinuation of an antidepressant
    - Hospice services
    - Changes in ADL or mobility
    - Skin integrity changes
    - Diet or liquid consistency changes
    - Negotiated risk implemented

F658 – Cited 11 times for:

- A fall assessment was not completed and new interventions established.
- 5 times for not following physician orders.
- 2 times when residents were not supervised while taking medications.
- Orders were not transcribed accurately.
- The nursing home did not assist in arranging an appointment as necessary.
- A resident left the nursing home for an extended period during the day and the resident's insulin was not sent with them.
- The physician was not notified when a resident was transferred to the ER.
- Medications were administered to the wrong resident due to a medication aide training another when the trainer set up the medications for the trainee to administer.

F661 – Cited 1 time when the nursing home did not complete a discharge summary or document discharge planning efforts.

F677 – Cited 2 times for failure to provide/assist with:

- Toileting needs
- A resident was noted laying in bed without clothing under a blanket and the bed linens were soaked with urine.
- Assistance with eating

F679 – Cited 1 time when residents expressed concerns about not having individualized activity programming available.

F684 – Cited 7 times for:

- Staff did not reposition a resident in a timely manner.

F686 – Cited 1 time when the nursing home did not implement interventions to prevent a pressure ulcer when at risk.

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

F689– Cited 14 times for:

- Numerous items were stored in the halls causing hazards for mobile residents.
- 2 times when residents were pushed in wheelchairs without foot pedals.
- The care plan was not followed for transfer status.
- A smoking assessment was not completed.
- Fall interventions were not followed as care planned.
- A resident reported being left on the toilet for 2 ½ hours without a functional call light.
- During a mechanical lift the staff used a sling that was too large for the resident.
- A resident's smoking materials were not placed at the nurse's station as described in the policy and care plan.

F690 – Cited 3 times for:

- Catheter tubing on the floor.
- Gloves were not changed during catheter care.
- Enhanced barrier precautions were not used during catheter care.
- The nursing home did not follow up on signs/symptoms of a UTI, resulting in delayed treatment.

F692 – Cited 1 time when a weight loss was not identified and followed up on.

F695 – Cited 2 times for:

- Nebulizer equipment not being cleaned or changed.
- The nursing home did not send adequate oxygen supplies with a resident when they were out for an extended time for an appointment. This resulted in the resident's oxygen saturation decreasing and an ambulance being called.

F698 – Cited 5 times for:

- 3 times when pre- and post-dialysis assessments were not completed.
- The nursing home did not arrange for transportation to dialysis appointments resulting in the resident missing several treatments.
- The resident's record lacked documentation of communication to/from the dialysis center.

F700 – Cited 1 time when a resident had a transfer loop on their bed and the dimensions exceeded 4 ¾ inches which increases the risk for possible entrapment.

F725 – Cited 6 times for:

- 4 times when call lights were not answered in a timely manner.
- A staff member worked 23 consecutive hours due to a lack of staffing.
- The scheduled staffing did not match the facility assessment staffing plan.
- The nursing home did not have evidence of 24 hour licensed nurse coverage.

- Personal care was not provided in a timely manner.
- A lack of supervision lead to falls and resident-to-resident altercations.

F727 – Cited 2 times for:

- 2 times when there was not 8 consecutive hours of RN coverage each day.
- The nursing home did not have a DON.

F740– Cited 1 time when behavioral health services were not provided and the care plan lacked behavioral health needs.

F755 – Cited 1 time when staff did not document administration of narcotics on control sheets which lead to inaccurate inventories.

F756 – Cited 1 time when the physician did not respond to a GDR request.

F758 – Cited 2 times for:

- The care plan did not include targeted behaviors for psychotropic medications or non-pharmacological interventions.
- The diagnosis for an antipsychotic medication was listed as behaviors, which is not an appropriate diagnosis for use.

F759 – Cited 1 time when the medication error rate was 12% during observation including not priming an insulin pen, the medication dose was inaccurate, and insulin was administered more than 30 minutes before the scheduled meal time.

F760 – Cited 4 times for medication errors relating to:

- Manufacturer's instructions were not followed when administering insulin.
- Scheduled morphine and Ativan were not administered during end-of-life care.
- Namenda was not increased per a physician's order.
- Fast-acting insulin was administered more than 30 minutes before a mealtime.
- Medications were administered to the wrong resident while a medication aide was being trained.

F761 – Cited 3 times when:

- A medication cart was unlocked and unsupervised.
- Medications were set up in cups prior to med pass times.
- Medications were expired.

F791 – Cited 1 time when a dentist appointment was not made by the nursing home.

F800 – Cited 2 times when:

- Cold food temperatures were more than 41 degrees when tested.
- Portion sizes were not correct according to the therapeutic menu.
- Hot food temperatures were less than 135 degrees.
- Food was very dry and difficult to chew.

F803 – Cited 2 times for:

- Portion sizes were not followed according to the therapeutic menu.
- Items on the menu were not served to residents on a puree diet.

F804 – Cited 2 times when hot food temperatures were less than 135 degrees.

F805 – Cited 1 time when meat was cut up instead of being ground for mechanical soft diet.

F812 – Cited 12 times for:

- 2 times for not completing hand hygiene appropriately.
- 2 times when hair/beard nets were not used.
- 6 times when stored items were not labeled or dated.
- General cleanliness concerns in the kitchen.
- 3 times when stored items were not sealed/covered.
- Scoop handles were stored in the substance.
- No thermometer was present in the freezer/cooler.
- 2 times for food handling concerns.
- 4 times when dishwasher temperatures and sanitizer levels were not adequate to sanitize dishes.
- Items were stored on the floor.
- Inadequate sanitizer levels in cleaning buckets.
- The handwashing sink was used to fill water pitchers.
- Food was uncovered while transported in the hall.

F835 – Cited 2 times for the nursing home administration failing to:

- The nursing home did not have the equipment necessary to care for a bariatric resident and accepted for admission.
- The QAPI process was not effectively implemented based on repeat deficiencies.

F839 – Cited 1 time when staff performed CPR without being certified.

F842 – Cited 1 time when records indicated they were discharged from hospice level of care but notes and orders indicated they were on hospice and did not document a fall with a fracture.

F851 – Cited 2 times when PBJ data was not submitted accurately.

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

F868 – Cited 2 times when the infection preventionist and director of nursing were not present at quarterly meetings.

F880 – Cited 13 times for:

- 7 times when staff did not complete hand hygiene appropriately.
- 3 times when gloves were not changed.
- Catheter tubing was not secured to the resident's leg.
- A catheter drainage bag was lifted above the resident's bladder.
- Staff did not complete adequate perineal care including all areas that touched an incontinent product.
- A staff member removed their mask to talk to the surveyor in a resident's room who had COVID-19.

- 2 times when medications were handled with bare hands.
- Staff did not use clothing protection when handling soiled linens.
- 4 times for not implementing/using enhanced barrier precautions.
- A catheter bag was touching the floor.
- Clean laundry was transported without a cover.
- Clean linens touched staff's uniforms.
- Reusable equipment was not sanitized between use.
- Signage was not present on a resident's room indicating PPE use when a resident had COVID-19.
- Transmission-based precautions were not followed.
- Staff failed to place a barrier down on the floor when emptying a catheter drainage bag.
- A graduated cylinder was not rinsed following catheter drainage.

F882 – Cited 2 times when a certified infection preventionist was not employed.

F895 – Cited 1 time when a staff member forged another nurses signature and staff altered a narcotic control record.

F908 – Cited 1 time when shower water temperatures were too low resulting in resident's refusing.

F921 – Cited 1 time when mouse droppings were noted and staff never offered to assist a resident when they began collecting excessive items.

There are additional tools to assist with survey readiness on our website!

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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