LTC Survey Trends Report
November 2025

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REGULATORY REVIEWS & NUMEROUS COMPLAINTS REVIEWED

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With the delay in survey trend reports over the last couple months due to the government shutdown, there are a few new Regulatory Review articles available for your review.

F572 – Information and Communication
F573 – Access to Residents Medical & Personal Records
F574 – Required Notices and Contact Information

This report includes several months of activity as there were several surveys from late September that were not processed because of the government shutdown. As the government re-opened, these reports flooded in. Additionally, the survey agency was only able to investigate complaints for a period of time. As you'll see from the survey activity report below, there were a record number of complaint and incident surveys reviewed.

Federal information in the QCor website still has not been updated since June, 2025, which includes information on federal fine activity and other enforcement action such as denial of payments or directed plans of correction.

Survey Activity

District	Average Months for Providers with Recert	Time Since Last Survey	Longest Survey Timespan
Statewide	12.3 months	59 nursing homes currently exceed 12 months or more.	15 months

Recertification:

- 33 total recertification surveys reviewed with 3.8 deficiencies on average per recertification survey with deficiencies.
    - Of the 29 recertifications with at least one deficiency, 4 providers received a fine (or 14%).
    - Of the 33 recertifications, 4 providers had deficiency free surveys (or 12%)

Complaint/Incidents:

- 264 (typically 20-30) providers with complaint/incident surveys reviewed with 1.7 deficiencies on average per survey reviewed with deficiencies.
    - Of the 111 complaint/incident surveys with at least one deficiency, 36 received a fine (or 32%).
    - Of the 264 complaint/incident surveys, 153 did not receive a deficiency (or 58%).

Enforcement Action

CY 2025	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVG NUMBER OF DEFICIENCIES
JANUARY	$32,250	$301,215	2 Denials; 1 DPOC	$333,465.00	4.6 deficiencies
FEBRUARY	$50,250	$63,498.50	3 Denials; 1 DPOC	$113,748.50	8.3 deficiencies
MARCH	$64,000	$59,302.75	1 Denial	$123,302.75	5.6 deficiencies
APRIL	$22,000	$66,225.25	1 Denial	$88,222.25	6.2 deficiencies
MAY	$27,750	0		$27,750	5 deficiencies
JUNE	$53,500	0		$53,500	5.9 deficiencies
JULY	$86,740	0		$86,750	3.7 deficiencies
AUGUST	$122,500	0		$122,500	6.3 deficiencies
SEPTEMBER	$76,000	0		$71,000	5.4 deficiencies
OCTOBER	$176,000	0		$176,000	(see November)
NOVEMBER	$72,000	0		$72,000	3.8 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.

Congratulations to Fellowship Village on a deficiency free survey!

CITATIONS WITH FINES

September, October, & November Deficiencies with State Fining and Citation

50.7; $500. Resident #5 was found to have a cord wrapped around their neck following a mental health change and was stabbing themselves with a pen. The incident was not reported to DIAL until 22 days later.

50.7; $500. Resident #2 was found on the floor with blood surrounding them along with a nail file and clippers. The staff attempted to wrap a towel around the resident's arm, but the resident kept pulling it off. The resident was sent to the ER and then for a psychiatric evaluation because the resident reported they had thoughts of harming themselves by cutting their wrists. The provider did not report the incident as a suicide attempt because the cuts on their arm were to the upper arm and not their wrist area and they were not aware of a note the resident wrote indicating that a staff member told them they called the police and wanted them dead.

F600; G (no state citation report). They did not ensure residents were free of abuse when a resident was found masturbating while touching another resident's face along with a separate incident when staff refused to administer pain medication to a resident and yelled at them.

F600; J (no state citation report). Staff were providing care for Resident #4 when one of the staff started arguing with the resident. The resident said that they did not want the staff to come back into their room to care for them and then both staff placed the resident in bed without changing their incontinent product or removing the lift sling from under them. The resident activated their call light, but no staff responded for more than an hour. During this time the resident reported that their bedside stand was pushed into the bathroom, and they had no access to their cell phone or a way to call for help other than the call light. The resident was soaked with urine, and the air conditioner was blowing on them which made them cold and frantic. When the staff finally responded, the resident asked to speak to the DON, but the DON indicated they didn't want to deal with it so they didn't speak to the resident. The following morning the resident asked to speak to the administrator to report the abuse. The resident also expressed concerns about the staff member still working to which the employee told the resident to shut their door, so they don’t have to see them.

F600; 58.28(3)e; G; $5,250. Resident #1 used their walker to strike Resident #2 in the face in the dining room. According to staff they did not hear any yelling or altercations prior to the incident. Resident #2 was transported to the hospital immediately and diagnosed with a nasal fracture while Resident #1 was also sent to the hospital for psychiatric evaluation. During investigation, staff reported that Resident #1 previously attempted to strike other residents with their walker. When questioned about interventions that were implemented following the previous incidents, they stated that the resident was placed at a table across from the nurse's station for close supervision which did not happen when Resident #1 hit Resident #2.

F600; 58.43; D; $500. Staff did not protect a resident when another resident hit them in the back while in a common area. The resident had a known history of resident-to-resident abuse and the staff also failed to evaluate the effectiveness of interventions to prevent harm to other residents.

F600; 58.43; G; $500 (Held in Suspension). Resident #64 had a note in their record that indicated the hospice nurse completed an assessment due to increased pain. Throughout the day, the resident continued to complain of pain and hospice was called again due to a golf ball sized lump protruding from the right arm. Hospice refused an x-ray and family requested to wait until the next day to pursue anything. The following day an x-ray was obtained and the medical director recommended sending the resident to the ED but family declined. The following morning the resident was sent to the ER where they were diagnosed with a fracture of the radius and a displaced fracture of the humerus. During an interview, staff L recalled that they heard the resident scream and staff Q asked for assistance as the resident was violently resistive. Staff L noted the

resident was fearful of Staff Q and was resistive to them but not others when providing care. Following the task, the staff reported concerns to the nurse and expressed that other residents reported concerns with Staff Q. During interviews with the medical director, they indicated that they couldn't say that the fracture was intentional but in their opinion the injury would have been dramatic to cause the fractures.

F600; 58.43; G; $5,000. Staff A assisted resident #1 with a shower. Staff B and C reported that when they went to assist Staff A, Staff A said "Watch this", turned the water to cold and sprayed resident #1 with the cold water for 5 seconds. Resident #1 then took the shower head and smacked it against the wall and it almost broke. Staff A denied intentionally spraying the resident stating that they maybe accidentally did it while putting the shower head back.

F609; 58.43(9); D; $500. The nursing home did not report allegations of abuse to DIAL within a timely manner.

F609; 58.43(9); D; $500. Allegations of abuse were not reported to DIAL within 2 hours as required.

F609; 58.43(9); D; $500. An incident of resident-to-resident abuse was not reported to DIAL when a resident reports pulling another resident's hair.

F609; 58.43(9); D; $500. The nursing home was aware of an incident where a nurse aide was accused of “slamming” a resident and making them not feel safe. After hearing the allegation, the nursing home told the nurse aide not to help Resident #1 but allowed them to work with other residents.

F609; 58.43(9); D; $500. An allegation of abuse was not reported to DIAL within 2 hours of the incident when an allegation was reported to the DON that a staff member forcefully put a spoon into the residents mouth and hit the spoon on their teeth. The staff member also forcefully shook the resident attempting to wake them up.

F609; 58.43(9); D; $500. Did not report an allegation of abuse to DIAL when a resident reported that a nurse threw a flashlight at them. The resident's son called law enforcement, and they reviewed the camera footage and determined that the nurse was not close enough to the resident for the allegation to be valid.

F609; 58.43(9); D; $500. An allegation of abuse was not reported to DIAL when resident #2 was found in resident #1's room, masturbating while touching resident #1's face. As well as when a staff member refused to provide resident #3 with pain medications and yelled at them.

F609; 58.43(9); D; $500. The nursing home did not report possible abuse allegations to DIAL when a resident reported they were missing money from their room.

F609; 58.43(9); D; $500. A staff member entered the shower room while another staff member was providing a shower to a resident and the staff member thought the other staff member was recording the resident receiving a shower. The incident was reported to leadership, and they investigated but did not find any evidence of wrongdoing. The incident was not reported to DIAL within 2 hours as required.

F609; 58.43(9); D; $500. An incident when two residents fought which resulted in a resident hitting another resident in the face was not reported to management staff in a timely manner.

F609; 58.43(9); D; $500. Allegations of staff being rough with a resident were not reported to DIAL.

F609; 58.43(9); D; $500. An allegation of abuse was not reported when a resident reported that a staff member pushes, yells, and gets into shouting matches with them.

F609; 58.43(9); D; $500. An allegation of abuse was not reported to DIAL timely when a resident expressed concerns that a staff member elevated the foot of their bed and then took their bed remote away. The staff member later threw the bed remote towards the resident striking their wound vac. Additionally, an allegation of a staff member forced a resident to take a shower including forcefully removing their clothes while the resident resisted was not reported.

F609; 58.43(9); D; $500. Staff did not report an allegation of neglect when a staff member left a resident after they fell and did not tell staff that they fell.

F658; 58.19(2)a; G; $7,000 (Held in Suspension). The staff did not follow the physician's directive to notify them if a resident's blood glucose level was outside of the established parameters when a resident had a blood glucose over 400 and resulted in hospitalization due to hyperglycemia.

F658; 58.19(2)a; G; $5,000 (Held in Suspension). Resident #1 returned from the hospital on 6.25.25 with orders for blood glucose checks before meals and at bedtime. Following the order and through July, no documentation of blood glucose monitoring was completed. On 7.11.25 the resident was sent to the hospital as they were unresponsive, clammy to the touch, and had a temp of 99.0. They returned on 7.18.25 with sepsis from a UTI and an abscess in the retroperitoneum space. The discharge medication included IV antibiotics daily for 42 days. Antibiotics were not given the day of hospital discharge and the following day the staff noted that the IV was not in place and notified the physician to which they stated to place a peripheral IV and they would send someone on 7.21.25 to insert a PICC. On 7.20 the resident removed the IV and the staff attempted to contact the physician. On 7.22 it was documented that there was no IV access and no documentation of physician notification. On 7.24 the resident returned to the hospital. Additionally, staff did not follow the physician's orders for notifying of high or low blood glucose levels.

F684; 58.19(2)a; G; $20,250 (Treble). On 8.18.25, Resident #2's family arrived at the nursing home to find them unresponsive at approximately 6:40 p.m. The family member yelled out for assistance when staff arrived, they checked the resident's blood sugar, which was 27. The family member asked the nurse to call 911, but the nurse indicated she needed to take other steps first. The family then called 911 and the police arrived and initiated CPR (it is unclear if CPR was indicated). When the paramedics arrived, they stopped CPR and administered IV medications to bring the resident's blood sugar back up and transported them to the hospital. During investigation it was noted that the day shift nurse was to check the resident's blood sugar, administer insulin and Mounjaro at 4 p.m. but reported upon arrival of the night nurse at 6 p.m. that they did not have time to do so. The night shift nurse did not monitor the blood sugar for Resident #2 until the family member arrived. It was noted that the resident previously had blood sugars below 70. Measures were not documented to bring the blood sugar level up. Additionally, the nursing home did not have glucagon on site or orders for it for any diabetic residents.

F684; 58.19(2)j; G; $8,750. Resident #1 returned from a hospital stay with orders for duplicative laxatives that staff were not aware of for 5 days after readmission. Resident #2 also had a fall with complaints of pain, and the staff did not complete a thorough assessment.

F684; 58.19(2)j; G; $9,500 (Held in Suspension). On 5.29.25 at 1 p.m. Resident #4 was observed on the floor on their stomach. Upon initial assessment, vital signs were checked, no injuries or pain were noted. There was no further investigation or follow-up completed, and the physician was not notified of the fall. On 6.2.25 at 7:15 p.m. the progress notes indicated the family took the resident to the hospital as they were not acting right. On 6.3.25 there was a progress note that the resident was admitted to the hospital with a brain bleed and passed on 6.15.25 with the death certificate indicating the cause of death was blunt force trauma to the head. Resident #3 had a fall on 8.8.25 at 12:30 a.m. where they were sitting on the ground by their bed, with no injuries initially identified. On 8.11.25 an x-ray was completed and identified a mildly displaced

right hip fracture which required surgery. The nursing home completed daily follow-up notes that did not indicate an injury until mild pain was documented on 8.11.

F684; 58.19(2)j; J; $8,750 (Held in Suspension). Resident #1 was admitted to the nursing home on 10.2.25. During an interview, the resident reported that the staff did not complete an assessment, check their blood glucose level, or weight. The staff asked if they had lunch to which the resident responded no, but reports the staff did not bring the resident lunch. They fell asleep and reported waking up to an alarm sounding on their portable oxygen machine as it was out of oxygen. The resident reported “feeling different” but was unsure if that was because of diabetes or the oxygen running out. They asked the nurse to test their blood sugar and reported it was high to which the resident requested insulin, but the staff reported they did not have orders for insulin, despite resident being a type 1 diabetic. The resident reported that the staff again checked their blood sugar at 8 p.m. which was high but still did not administer insulin. The resident commented to the nurse about being a type 1 diabetic and requiring insulin. The following morning the resident woke up with signs of hyperglycemia, to which the physician ordered labs. Later that morning the resident was sent to the ER due to blood glucose of 701 and diabetic ketoacidosis. During review of the incident, the pharmacist indicated that they missed putting the insulin orders into the record and there was no documentation that the physician was notified of not having the order.

F684; 58.19(2)j; G; $10,000. During observation of Resident #3 on security camera footage, the surveyor noted that on 10.17.25, the resident was seated in a common area in a recliner. The resident stood up and attempted to walk toward a dining room table when they tripped on their catheter tubing causing them to fall onto their left side and hit their head. In the video, Staff A and B were both present at the nurse's station. Staff A casually approached the resident while another staff member arrived and the two sat the resident up on their buttocks and then assisted the resident off the floor without the use of a gait belt. In the video, the surveyor could identify that the resident was dragging their foot, the leg was internally rotated, and the resident would not apply pressure to the leg. The resident was later placed back into the same recliner. The surveyor noted that when in the recliner, the resident held their leg, appearing to be in pain. The resident was later transferred to a dining room chair, again not bearing weight and appearing to be painful until the staff ultimately called the ambulance, and they were taken to the ER where they were diagnosed with a mildly displaced hip fracture. The nurse later charted an assessment, but staff are unsure where they information came from as it wasn't able to be corroborated as there wasn’t an assessment completed on the camera footage. Resident #8 was readmitted to the nursing home and during an assessment a blister was noted on the right trochanter without additional assessments of the area.

F684; 58.19(2)j; G; $5,500. On 10.26.25 at 4:47 p.m. Resident #1 was transferred to the hospital due to altered mental status and was admitted for possible infection. The resident became hypoxic and required 6L of oxygen and was subsequently diagnosed as septic. During investigation staff reported that they noted a change in condition the day prior to the hospitalization which was reported to a nurse who did not assess the resident. Resident #8 was on Depakote, Seroquel and Trazadone. The initial orders for medications lasted for 30 days and upon the expiration of the order, another order was not obtained.

F686; 58.19(2)b; G; $9,250. Resident #1's care plan included a focus of actual skin impairment and directed staff to use EBP based on open wounds to bilateral heels and buttock but did not include interventions related to prevention of pressure ulcers such as repositioning and elevating heels. A nurse-to-nurse report from the hospital on 6.24.25 indicated that the resident had bilateral buttock and labia treatments. Upon review of the MAR and TAR, the left buttock treatment was not included in the TAR for June, July or August. On 7.1.25 the resident developed a blister to their heel, and their family was not notified of the area. Assessments were not always thoroughly documented, subsequent wounds lacked physician and family notification. Throughout the following months the resident continued to develop new skin areas and others worsened, which caused the resident significant pain. Review of skin sheets frequently lacked thorough assessments of the areas or physician notification when the wounds worsened. The resident was transferred

to the hospital and the critical care unit progress note documented on 8.25.25 included that the resident had necrotizing infection, septic shock, possible osteomyelitis from chronic sacral and bilateral heel/decubitus ulcers, metabolic encephalopathy and multiple chronic pressure ulcers. Resident #2's progress notes included documentation on 10.3.25 that the resident summoned the nurse due to pain in their ankle where the nurse noted a Mepilex dressing on the ankle covering a yellow open area with red and warm surrounding skin. The record lacked documentation regarding when and why the Mepilex dressing was applied. The resident was treated by wound care, but the clinical record lacked documentation that the nursing home staff followed up with the physician or dietitian based on wound nurse recommendations.

F686; 58.19(2)b; G; $7,250. Resident #6 had a left heel pressure ulcer and staff were directed to float the heel or apply heel protectors while in bed. As of 10.16.25, the resident was receiving end of life care due to a terminal prognosis and anticipated being admitted to hospice. Ongoing assessments showed the left heel wound measuring larger over a few weeks without physician notification. The staff noted worsening of the wound along with swelling and warmth in which staff obtained an antibiotic order and change in treatment. Subsequent skin assessments lacked measurements and description of the wound until approximately 10 days after the antibiotic started when the resident was sent to the ER due to increased lethargy, odor noted from the wound, and increased pain. Resident #71 was noted to have moisture associated skin damage with orders to apply barrier cream as needed and follow wound care orders. The MAR/TAR lacked treatment orders and during observations the staff did not apply barrier cream. The surveyor noted a reddened area to the resident's buttock with a slit that was open.

F689; 58.28(3)e; J; $4,500 (Held in Suspension). Resident #38 was noted standing by the front door on 7.20.25 between 4:30 - 4:40 p.m. and visitors were exiting at the time. The door alarm sounded and staff A responded but didn't locate anyone and went back to their job tasks. At 5 p.m. Staff B observed the resident walking outside on the sidewalk near a creek traveling towards a busy highway. During investigation it was noted that the door alarms were not checked consistently. The policy indicated that when staff respond to the door and don't see anyone, they must account for all residents but that didn't happen.

F689; 58.28(3)e; G; $5,250 (Held in Suspension). Resident #3 required assistance from 2 staff for transfers. On 8.31.25, a staff member assisted the resident from the toilet and lost their balance, resulting in a fall with a strained ankle. The resident required the use of a mechanical lift due to the injury from the fall.

F689; 58.28(3)e; G; $7,000. Resident #1 had a history of falls related to self-transferring. On 10.9.25 at approximately 7 p.m. Resident #1 attempted to stand from their wheelchair while in the dining room unsupervised and fell. They were transferred to the ER via ambulance and later was life flighted to a larger hospital due to multiple fractures including nasal and cervical. The resident also sustained a head injury from the fall.

F689; 58.28(3)e; G; $5,750 (Held in Suspension). Staff did not use the correct size lift sling for a resident which resulted in the resident falling from the lift and receiving a T12 compression fracture.

F689; 58.28(3)e; G; $4,500 (Held in Suspension). When staff were rolling a resident in bed, the locking mechanism failed which caused the resident to hit their head on a concrete wall. This resulted in the resident having a laceration to their forehead and was sent to the ER for treatment and evaluation. The resident was admitted to the hospital due to receiving 4-5 sutures and had a small subdermal hematoma.

F689; 58.28(3)e; G; $5,000. Resident #1 had a history of falls from their recliner. After a fall on 5.27.25, an intervention was implemented to unplug the resident's recliner so they would be unable to put the footrest up. On 6.7.25, Resident #1 was observed during rounds with their feet up in the recliner and later was found on the floor. The recliner was not unplugged at the time, allowing the resident to put the footrest up, later tripping on the footrest and hitting their head resulting in a hematoma. During investigation of a complaint, it

was identified that the memory care unit did not have adequate staffing based on several residents sitting in a common area that was unsupervised, residents were observed getting up without assistance when they needed assistance and opening the memory care doors without staff assistance.

F689; 58.28(3)e; G; $6,750 (Held in Suspension). Resident #1 required a full body lift and assistance from two staff for transfers. A staff member attempted to transfer the resident independently with the lift resulting in the resident falling from the lift. The resident was transferred to the ER due to hitting their head and they received five staples to a head laceration on the left side of their scalp. Additionally, due to taking anticoagulant medication, the resident developed a significant bruise and a hematoma. During other observations of lift transfers, staff were unaware of how to appropriately determine the sling size for residents to be safe in using the lift.

F689; 58.28(3)e; G; $5,250. Resident #1's care plan directed staff to assist with transfers by using a walker and gait belt with 1 assist. On 10.20.25, Staff A assisted the resident using a stand pivot transfer instead of the walker and the resident's lower leg scrapped the lever on the wheelchair causing a laceration. The resident takes Eliquis as a blood thinner and the resident required transfer to the hospital due to the size of the laceration and extent of bleeding. The ER notes included that it took a prolonged time to repair the laceration including figure of eight sutures to tie off arteriolar bleeds resulting in 20 sutures total to repair. Additionally, the resident received a blood transfusion due to a low hemoglobin from the amount of blood lost.

F689; 58.28(3)e; G; $9,250. Resident #2 was in the shower with staff when they grabbed onto a bar in the and pulled themselves onto the floor. The resident was subsequently taken to the ER where they had diagnoses of slightly elevated blood pressure and abnormal lab values. Additionally, images revealed a femoral fracture with medial displacement. During interviews staff expressed concern that the resident requires two staff assist to shower because of behaviors, which did not happen. Resident #2 also had another fall in which they complained of pain and staff administered Tylenol and noted that it was effective. Staff reported the incident to the daughter and decided to ask for an x-ray to rule out a fracture. The staff obtained the order, and the resident received a mobile x-ray that showed a suspected fracture. The family expressed concerns about the lack of assessment skills of the nurses and did not have the resident return.

F689; 58.28(3)e; G; $7,750. Resident #1 had several falls from their wheelchair, and a new intervention was implemented to not have the resident in their wheelchair alone in their room. The resident had subsequent falls from their wheelchair while in their room, resulting in a fractured hip that required surgical repair.

F689; 58.28(3)e; J; $2,500 (Held in Suspension). Resident #1 was at risk for elopement with interventions to prevent wandering and elopement identified in the resident's care plan. On 10.17.25 at approximately 8 p.m. the door alarm sounded on the B wing. Dietary staff stepped outside the door and looked both ways but did not see anyone and silenced the alarm. Approximately 15 minutes later, the hospital/EMS staff phoned the nursing home as the resident entered the ambulance area of the hospital across the street.

F689; 58.28(3)e; G; $8,500. Resident #1 had a history of repeat falls including 8 falls from January to August. On 6.1.25, the resident had a fall in their room after attempting to self-transfer resulting in a head laceration and staple repair during an ER visit. On 8.8.25, the resident again fell in their room after attempting to self-transfer resulting in a head injury and hip pain. The resident was transferred to the hospital and diagnosed with a hip fracture that required surgical repair. The resident subsequently developed pneumonia and passed away following surgery.

F689; 58.28(3)e; G; $7,750. Resident #4 was at high risk of falls with several interventions identified on the care plan. Multiple falls required transfer out of the nursing home for treatment including a hospital stay due to hematoma. Upon returning to the nursing home, the physician ordered to limit polypharmacy and complete routine assessments of cognition, discontinuing medications that increase fall risk such as gabapentin and duplicative medications. The transcription of discharge orders lacked following these recommendations and new orders were initiated for additional medications that increased the risk of falls. After this, the resident fell 7 more times and two of those falls resulted in hospitalizations for various injuries.

F689; 58.28(3)e; K; $26,260 (Held in Suspension). Resident #1's care plan directed staff to transfer using a full body mechanical lift with two staff assistance. The care plan did not direct staff which lift to use or the type and size of sling to use. Resident #1 had a fall on 9.26.25 that resulted in a head laceration. According to statements from the staff, they provided incontinence care to the resident, placed the full-body sling under them, and used the lift to lift them up. However, during the transfer the resident hit a wedge cushion, and the resident fell out of the sling. It was noted in the statements that the hook has a gap where the rubber closure part of the lift does not meet the hook and staff believe the lift sling strap slid out of the hook. A CT of the resident's head revealed a subdural hemorrhage with a small amount layering in the back horn of the right lateral ventricle. Further diagnostic studies showed worsening of the brain bleed, and the resident was placed in hospice. During interviews staff were unaware of what size or type of slings to use based on the resident’s size or lift type.

F697; 58.19(2)j; G; $6,750. Resident #1 had a witnessed fall in which the nurse completed an assessment and the resident reported increased pain to their leg but was able to complete range of motion. The staff assisted the resident back to their bed where the resident reported an increase amount of pain "worse ever". The nurse gave the resident Tylenol and faxed the physician instead of calling to report the change in condition. The resident continued to report pain and yell out. The next shift arrived at 7:15 a.m. (3 hours 15 min after the fall) and sent the resident to the ER where they were diagnosed with a left acetabular fracture with protrusion of the femoral head in the pelvis.

F725; 58.20(1); K; $5,250 (Held in Suspension). A staffing agency nurse was scheduled for a shift at the nursing home during the overnight hours. The nurse left the building at 2 a.m. after leaving the keys unattended and did not count narcotics with another individual. This left two of four units without nurse coverage. Three residents had scheduled medication during this time and Resident #3's pain was so severe because of not being administered scheduled medications that they called 911. At approximately 6 a.m. EMS responded and the 911 dispatcher also sent a police officer as they could hear people laughing in the background. Upon review of the body camera footage the resident could be heard screaming and crying in the background in pain. The nurse that was left on duty refused to enter the cart until the narcotics were counted, which finally happened when another nurse arrived at the building. The medications were administered along with other scheduled medications around 7 a.m. During investigation, staff reported that the staffing agency nurse told the other nurse that they had a family emergency and spoke to the nurse manager on call who was going to cover the shift and then they gave the nurse the keys. However, staff reported that the nurse that was left in the building was acting strangely and would not help the residents because the cart wasn't counted and kept telling the staff that the nurse coming in would take care of it. The nurse manager on call reported that the agency nurse sent them a text message that they didn't hear until they awoke in the morning and no one else from the building attempted to call them or the DON about coverage. During this time another resident with significant anaphylaxes reactions to medications reported symptoms of allergies and asked for an EPI pen. The staff that reported this to the nurse that was on duty stated that the nurse did not assess the resident or provide the medications requested and just deferred to when the other nurse comes in. The resident took selfies during this time and showed the surveyor which showed facial swelling. The resident also reported significant itching and that they used an EPI pen they had in their purse, which they self-administered since no one came to assess or assist them.

F760; 58.19(2)a; J; $7,250 (Held in Suspension). On 10.3.25 at 8 a.m. Resident #1 received their medications without incident and then Staff A got Resident #3's medications ready and tapped Resident #1 on the shoulder but said Resident #3's name. Resident #1 then opened their mouth, and the staff gave them Resident #3's medications also. Approximately 5 minutes later, they realized they gave Resident #1 both resident's medications. Upon calling the nurse practitioner, they stated to monitor vital signs every hour and if they become lethargic or unable to rouse, send to the ED. Approximately 15 minutes later, the nurse practitioner called back and indicated the physician stated to administer 1 liter of fluids at 75 ml per hour to flush the medications out of the residents system or push oral fluids every 15 minutes. When the nurse went to check the resident, they were not responding and the nurse called 911. The staff gave Narcan and then EMS arrived and transported the resident to the ER. The resident was evaluated and sent to another hospital to the ICU with a diagnosis of toxic encephalopathy, cardiogenic shock, hypotension, and bradycardia.

F760; 58.19(2)a; G; $4,250. Resident #1 had an order for Exelon patches including an order to remove the old patch prior to placing a new patch. There was a note on the MAR that indicated the patch was not on the resident but then in further charting, the staff noted that they had two Exelon patches on. The staff assessed the resident and then administered their HS medications. A while later, the resident had low blood pressure and was transferred to the ER where they were admitted to the hospital for acute encephalopathy and the Exelon patch was discontinued.

F760; 58.20(1); J; $8,000 (Held in Suspension). Resident #5 was hospitalized on 6.24.25 due to hyperglycemia and the medications were not placed on hold. Upon readmission, medications were not reconciled and the nursing home did not administer metformin in the correct dosage. Additionally, the resident had 2 long-acting insulins (Tresiba and Lantus) ordered. The day after readmission, the staff reported to the physician that insurance would not cover Tresiba and asked for clarification as they were on Tresiba and Lantus to which the physician stated there shouldn't be 2 long-acting insulin medications ordered and discontinued Tresiba. Later in the day the resident's blood sugar was low and despite glucagon and juice, the blood sugar would not increase causing the resident to go to the hospital.

F760; 58.20(1); G; $5,000 (Held in Suspension). Resident #1 received Resident #2's morning medications including medication to lower their blood pressure. Resident #1 was transferred to the hospital following the medication error and admitted to the intensive care unit. During interviews the staff member who administered the medications incorrectly was an agency nurse and asked the resident if their name was Resident #2, to which they shook their head yes, so the nurse administered the medications later learning that the resident was incorrect. Resident #3 received two blood pressure medications as one was supposed to be discontinued. During investigation, the nurse administering the incorrect medication indicated that they thought the error was related to transcribing the order. However, the DON believed that the medication was changed and the old medication card was not pulled from the cart. Resident #4 received insulin that was intended for another resident and Resident #4 does not receive insulin injections. During interviews, staff expressed this error was related to having two new residents close in proximity that looked similar and had similar names.

TOP DEFICIENCIES

F-TAG #	
F689	Accidents/Hazards/Supervision/Devices
F684	Quality of Care
F550	Resident Rights/Exercise of Rights
F600	Free from Abuse & Neglect
F609	Reporting of Alleged Abuse

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

Comprehensive List of Deficiencies (in addition to Fines) Cited in September, October, & November:

58.10(8) – Cited 1 time when a barrier was not placed under a graduated cylinder when emptying a catheter drainage bag and in the process urine was spilled on the floor that was not cleaned appropriately. Additionally, the provider was not using an EPA registered disinfectant when mopping.

58.12 – Cited 1 time when VA status was not assessed within the first 30 days of admission.

F550 – Cited 16 times for failure to treat residents with respect, dignity, and privacy by:

- Staff pulled resident's pants down around their ankles and covered them with a blanket in their bed between meals.
- 3 times when staff did not treat residents with kindness and respect.
- Staff swearing at or in front of residents.
- The staff made a resident with behaviors go to their room for "quiet time"
- Rough when providing care.
- Plates were left on trays in the dining room for meals.
- Stood by residents when assisting them with eating.
- Gait belts were not removed from the resident's waists when not using for a transfer.
- Call lights were not within reach of the resident.
- Call lights were not answered in a timely manner.
- Residents were not allowed to receive phone calls on the facility phone.
- Staff did not knock on the resident's room door prior to entering.
- Staff did not explain what they were doing to the resident.
- Assistance was not provided with care when requested by the resident.
- Medical records were displayed on a computer that was accessible to the public.
- During an assessment, a nurse stuck their hand down a resident's pants in a common area to palpate their hips.
- Staff walked into the residents' room as other staff were assisting with personal care (these staff were not necessary for the care provided).
- Residents were pulled backwards in their wheelchairs.
- Residents were waiting in the hallway for showers with a blanket wrapped around their unclothed bodies.

- Perineal care was not provided when a resident was incontinent.
- Staff did not change linens when they were wet with urine.

F561– Cited 2 times when:

- Dementia residents were forced to get dressed at 4 a.m.
- The staff did not follow the resident's preference for VA medications.

F569 – Cited 1 time when resident funds were not refunded within 30 days from discharge as required.

F578 – Cited 3 times when:

- 2 times when code status documents were not included in the resident's record.
- The chart indicated the resident was a full code, but the document signed by the resident indicated a DNR.
- The IPOST was not given to EMS when transferring a resident.

F580 – Cited 6 times when the physician and responsible party were not notified of:

- Pressure ulcers
- Medication errors
- Weight loss
- Suicidal thoughts with a plan.
- Falls
- Wounds

F582 – Cited 1 time when residents did not sign a NOMNC upon Medicare discharge.

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

- Bathroom cleanliness
- Laundry placed on the floor in the laundry room.
- Items were not repaired timely in the resident's room.

F600 – Cited 15 times with:

- Possible staff to resident verbal abuse.
- 3 times for resident-to-resident abuse.
- Possible verbal and physical abuse by staff.
- Multiple residents were missing credit/debit cards and cash.
- A resident paid a staff member for personal services.
- Staff forced a resident to complete care.
- A resident was left on the floor when they fell and the staff member left the room and building without telling anyone about the fall.

F602 – Cited 4 times when:

- Staff asked a resident for money to complete car repairs.
- 3 times for diverted narcotics.

F607 – Cited 1 time when the resident was not separated from another resident with resident-to-resident abuse.

F609 - Cited 1 time without an associated fine/citation when a staff member didn't report an allegation of abuse to a management staff to report to DIAL (per policy).

F610 – Cited 7 times when:

- 2 times when staff were not separated from the alleged perpetrator
- 5 times when abuse allegations were not thoroughly investigated when reported.

F627 – Cited 2 times for:

- An emergency involuntary discharge notice was issued when a resident was transferred to the ER for behaviors.
- A resident was not educated on their discharge options prior to requesting the resident to sign an AMA form and discharging to a homeless shelter without medications.

F628 – Cited 5 times for:

- 2 times when the discharge summary was not completed.
- 1 time when the resident did not have a discharge care plan.
- 2 times when the LTC Ombudsman was not notified of discharge or transfer.
- The bed hold notice did not include the rate of the bed hold or the representative's signature as indicated in the policy.

F635 – Medication orders were not transcribed, resulting the resident not receiving medications.

F637 – Cited 2 times when significant change MDS' were not completed for:

- ADL changes.
- Admission to hospice

F640 – Cited 1 time when MDS' were not transmitted in a timely manner.

F641 – Cited 4 times when:

- The MDS was not accurately coded by:
    - An antianxiety medication, was not coded on the MDS.
    - A siderail was coded as a restraint by it should not have been.
    - Hospice was not coded.
    - Clopidogrel was coded as an anticoagulant.
    - A Level 2 was not coded.

F644 – Cited 4 times when:

- 3 times when significant change Level 1 was not completed for a new mental illness diagnosis or psychotropic medications started.
- 2 times when short-term approval expired and a new Level 1 was not completed.
- The Level 2 supports were not included on the care plan.

F655 – Cited 1 time when the baseline care plan was not provided to the resident or their representative.

F656 – Cited 5 times when:

- The care plan was not followed.
- The care plan did not include:
    - A PICC line
    - Diuretic medication
    - Pain
    - Wounds

F657 – Cited 7 times when the care plan was not updated to include:

- Changes in ADL assistance
- Wounds
- Weight loss
- 2 times for resident-to-resident abuse.
- A new level 2 supports
- 2 times for fall interventions.

F658 – Cited 12 times for:

- 2 times when discharge medications were not started following hospitalization.
- 4 times when physician orders were not followed.
- Medications were left unattended in a resident room.
- Allergies were not included in the chart.
- The physician wasn't notified of an abnormal glucose level.
- Medications orders were not clarified when there was a significant change in dosages.
- Medication errors occurred.

F676 – Cited 1 time when a restorative program was not completed.

F677 – Cited 4 times when residents were not provided:

- 3 times with bathing/showers
- Repositioning

F684 – Cited 21 times for:

- 4 times when skin was not assessed appropriately.
- 3 times when treatment orders were not followed.
- A resident was not assessed after they had a seizure.
- Staff moved a resident after a fall and before a physical assessment.
- The staff did not report that a resident ate food they are allergic to.
- UTI symptoms were not followed up on.
- An assessment was not completed after a resident vomited and they later were septic.
- Staff did not follow established bowel protocols.
- Nurses did not intervene when vital signs were abnormal.
- The podiatrist was not notified of changes to a wound on the resident's foot.
- Fall follow-up assessments were not completed.
- Urine output was not assessed.

F686 – Cited 2 times when staff did not complete pressure ulcer assessments.

F688 – Cited 4 times for:

- 3 when an RA program was not established.
- A palm splint was not placed as ordered

F689– Cited 34 times for:

- 4 times for elopements
- Fall interventions were not care planned.
- Did not evaluate if fall interventions were appropriate and/or effective.
- 3 times when foot pedals were not used on wheelchairs during transportation.
- 5 times when care planned fall interventions were not followed.
- 3 times when residents were not appropriately supervised to prevent resident-to-resident
- A sling to the mechanical lift was not used.
- Did not position a lift sling appropriately causing the resident to fall.
- A hazardous cart was in the hallway with tools that were unlocked.
- A key was left in the doorknob of a possibly hazardous room.
- Wheelchair brakes were not locked during a transfer.
- Staff did not ensure that alarms functioned properly.
- Gait belts were not used during transfers.

F690 – Cited 4 times for:

- 2 times when staff did not complete adequate incontinent care.
- Staff did not follow orders to get a urinalysis timely.
- Urinary output from a foley catheter was not documented.

F692 – Cited 1 time when a nutritional supplement was not provided for weight loss.

F693 – Cited 3 times for:

- Staff did not maintain patency of a j-tube.
- Placement was not checked prior to feeding, flushes, and medications.
- Water flush orders were not followed.

F694 – Cited 1 time when staff did not follow standards of practice as a resident had a PICC line that was not assessed routinely.

F697 – Cited 4 times when staff did not administer pain medications when residents expressed pain.

F698 – Cited 1 time when staff did not assess bruit and thrill in a resident with a fistula.

F699 – Cited 1 time when the resident did not have a trauma care plan with a documented history of trauma.

F710 – Cited 1 time when the resident's physician did not respond to multiple calls on blood pressure changes and medications.

F725 – Cited 14 times when:

- 12 times for lack of call light response in a timely manner.

- Staff were not supervising the memory care unit allowing for residents in common areas to stand unsupervised and wander.
- Residents were not served meals.
- Residents reported they had to shower independently due to a lack of staff.
- Did not provide care in a timely manner when requested.

F726 – Cited 1 time when staff were not competent on the use of an AED as they placed it on a conscious resident and the AED shocked them while still responsive.

F732 – Cited 1 time when staffing was not posted daily as required.

F741 – Cited 2 times when:

- Staff did not have dementia training but provided care to several individuals with dementia.
- Staff were not competent on dressing change procedures.

F742 – Cited 1 time when a resident's care plan did not have a focus or interventions on trauma with a noted trauma history.

F755 – Cited 2 times for:

- Medications not available to administer.
- Safeguards were not in place to prevent diversion of narcotics and controlled substances.

F757 – Cited 1 time when a GDR was not attempted on a psychotropic medication.

F760 – Cited 12 times for:

- The incorrect medication administered.
- 2 times when medications were administered to the wrong resident.
- 2 times when incorrect doses were administered.
- 2 times when insulin was administered past the 28-30 days that it was good for after opening.
- A Fentanyl patch was not removed prior to applying a new one.
- Treatment orders were not followed as written by the physician.

F761 – Cited 4 times for:

- Narcotics were not secured under double lock.
- 2 times when medication carts were unlocked and unattended.
- Insulin was not dated when opened.
- Medications were given to the resident's family to administer.
- Medication was not dated in the med cart when opened.

F803 – Cited 5 times when:

- All menu items weren't served with meals.
- A resident who was NPO was given food and ate it.
- Pre-made pureed products were given to the residents that did not match what was on the menu.
- 3 times when altered texture portion sizes were not correct.

F804 – Cited 2 times when:

- Hot food items were not maintained at or above 135 degrees.
- Residents expressed concerns that the food was overcooked and served cold.

F805 – Cited 3 times for:

- Having chunks of meat in puree consistency.
- Food was not cut up for the resident according to their diet.
- Diet orders were not followed.

F806 – Cited 2 times when:

- A resident was given food they had an allergy to.
- When residents expressed that they didn't care for the food, they were not provided alternative options.

F812 – Cited 10 times for:

- 3 times for kitchen cleanliness.
- 2 times when meat was not thawing appropriately.
- 2 times when dishwasher logs were not completed consistently.
- There were outdated/expired foods present in storage.
- 2 times when scoops were placed in the food or ice.
- 2 times when food temperature logs were not consistently documented on.
- Refrigerator and freezer temperature logs were not consistently completed.
- 3 times when staff failed to complete hand washing appropriately.
- A utensil was placed on a potentially contaminated surface.
- 3 times when food was not labeled or dated.
- Staff had artificial nails on.
- Food was touched with bare hands.

F825 – Cited 1 when therapy orders were not followed in a timely manner.

F842 – Cited 7 times when:

- 3 times when incident reports were not completed.
- Wounds were not documented.
- No documentation of vaccination declination.
- Medications from discharged residents were given to another resident instead of being discarded.
- Neurological checks were not documented.
- Power of attorney paperwork was not in the resident's medical record.

F865 – Cited 5 times when providers had repeat deficiencies and did not have an effective QAPI process.

F868 – Cited 1 time when the infection preventionist did not attend quarterly meetings.

F880 – Cited 14 times for:

- Infection control concerns with dressing change practices.
- 2 times when PPE was worn outside of the resident's room.
- 6 times when hand hygiene was not completed appropriately.
- Gloves were not changed when necessary.

- 9 times when enhanced barrier precautions were not implemented when necessary.
- A catheter drainage bag was placed on a garbage can.
- The water management policy was not followed.
- Did not follow contact precautions procedures.
- N95 and eye protection were not used with active COVID-19 infections.
- 2 times when supplies were not cleaned between different resident use.
- Clothing was not protected when sorting soiled linens.

F883 – Cited 1 time when pneumonia vaccinations were not offered when they should have been.

F908 – Cited 1 time when plastic areas were not repaired on equipment and could have caused skin tears.

F923 – Cited 1 time when there were reports that floors had excessive water in areas where residents wandered frequently.

F925 – Cited 2 times when residents expressed concerns with excessive flies.

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

LeadingAge Iowa