LTC Survey Trends Report
October 2021

Website:
www.leadingageiowa.org

Tel: (515) 440-4630
11001 Aurora Avenue,
Urbandale IA, 50322

LeadingAge Iowa

STAFFING DEFICIENCIES ON THE RISE

by Kellie Van Ree, Director of Clinical Services

During the month of October, there were more staffing deficiencies cited than noted throughout the entire year. These F-tags included F725 (Sufficient Nurse Staffing), F726 (Competent Nursing Staff), F727 (RN 8 hours/7 days per week, Full Time DON), and F802 (Sufficient Dietary Support Personnel). A total of 10 deficiencies were reviewed related to these 4 F-tags. LeadingAge Iowa understands the challenges providers are facing with workforce shortages. Workforce and a fair regulatory environment are some of the key items on our Legislative Agenda for 2022!

The following are examples of evidence of non-compliance cited in the 2567 reports:

- Failure to answer call lights appropriately (within 15 minutes). Multiple residents reported that call lights took an hour to two hours to answer, and staff were not assisting residents to change positions, causing wounds.
- During interviews, staff reported they are often the only one working as a CNA with two medication aides and the DON. It was reported during an interview that a housekeeper, who is not trained, helps assist with transfers. Staff are often completing mechanical lift transfers by themselves because there is no one to assist as the second person. Staffing sheets supported the CNA's statements related to the number of staff on duty.
- During resident interviews, there were multiple reports of call lights not being answered timely, some report waiting up to two hours for a mechanical lift. The residents report that staff members are utilizing mechanical lifts by themselves because there is no one else to assist. During staff interviews, the staff reported that they have been working with one nurse and two CNAs for a census of 56 residents. The staff report the only thing they can do is walk around the building to continuously monitor that residents are not on the floor (sustained a fall) based on the staffing levels.
- During surveyor observations, call lights were not answered within the 15-minute time frame. Upon review of the call light response time reports, there were call lights on that listed a response of 6 hours and 30 minutes, one with 3 hours 11 minutes, and several call lights with response times between 1-3 hours.
- The staff failed to answer call lights within the 15-minute requirement for 6 of 6 residents reviewed. During review of the printed call light response records, the call lights exceeded 3-4 hours on more than one occasion. **Note this deficiency resulted in a $500 Citation**.
- The staff did not have adequate competencies to assess residents following falls.
- The DON worked the floor to cover hours while the building had an average census over 60 residents.
- Upon interview, it was determined that the provider was without a DON for nearly a month. The administrator indicated that the DON had COVID-19 and had not returned to work in approximately a month. The administrator verbalized they did not anticipate that the DON was returning to work. Review of the daily staffing sheets also revealed the provider lacked RN coverage for 12 days from September 10 to October 5. The ADON reported that the DON had COVID-19 and during that time they had 2 RNs quit and have been unable to replace them.
- Upon review of the staffing sheets and schedule, it was noted that the provider failed to have RN coverage for 1 day during the days reviewed. (The deficiency did not indicate the number of days reviewed).
- The residents received meals on Styrofoam and plastic several times during surveyor observations. Upon interview, it was determined this was being done due to a lack of dietary staffing.

While reviewing the 2567 reports for survey trends, staffing deficiencies tend to be cited when there are significant concerns with resident care and treatment during the survey. Most of these deficiencies are clear violations of the regulatory guidelines. LAI encourages all members to review their emergency staffing plans and in the event that staffing shortages occur, ensure that documentation is supporting activation of the emergency staffing plan.

October LTC Survey Activity

Based on tracking data of completed recertification surveys the following statistics were noted:

District	% of Total Providers over 15 months since last recertification survey	Average length of time since last recertification for providers over 15 months
Northeast District	28.8%	22.1 months
East Central District	30.6%	23.6 months
Southeast District	43.7%	23.5 months
Northwest District	41.6%	23.7 months
West Central District	34.7%	22.8 months
Southwest District	41.4%	23.3 months

Fines for Calendar Year 2021

MONTH	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	F880	F884	ALL OTHERS
JANUARY	**$11.250**	**$719,694.30**	**7 DPOC**	**$730,944.30**	**$281,450.10**	**$25,700.71**	**$423,793.49**
FEBRUARY	**$12,000**	**$343,671.34**	**4 DPOC; 2 Denial**	**$355,671.34**	**$285,854.01**	**$27,305.08**	**$42,512.25**
MARCH	**$8,500**	**$483,654.29**	**7 DPOC; 3 Denial**	**$492,154.29**	**$92,732.02**	**$56,956.30**	**$342,465.97**
APRIL	**$27,500**	**$639,143.60**	**10 DPOC; 2 Denial**	**$666,643.60**	**$47,359.65**	**$32,251.13**	**$587,032.82**
MAY	**$25,750**	**$452,720.88**	**6 DPOC**	**$478,470.88**	**$117,858.25**	**$66,731.13**	**$293,881.50**
JUNE	**$22,750**	**$808,113.25**	**9 DPOC; 4 Denial**	**$830,863.25**	**$52,500**	**$65,875**	**$712,488.25**
JULY	**$41,250**	**$175,141.25**	**4 DPOC; 3 Denial**	**$216,391.25**	**$67,250**	**$79,600**	**$69,541.25**
AUGUST	**$55,750**	**$132,485**	**7 DPOC; 2 Denial**	**$188,235**	**$41,795**	**$78,325**	**$68,115**
SEPTEMBER	**$44,250**	**$562,931**	**11 DPOC**	**$607,181**	**$152,206**	**$95,900**	**$359,075**
OCTOBER	**$49,500**	**$666,600**	**2 DPOC**	**$716,100**	**$8250**	**$0**	**$707850**

Notes:

Fines are per the DIA (state) and QCor (federal) website. Total fine amounts may change based on appeal rights and reduction rules.

Other deficiency categories include those listed during the monthly survey trend report in the Citations with Fines section.

CITATIONS WITH FINES

October Deficiencies with State Fining and Citation

50.7(1); $500. The facility failed to report an accident causing a fracture. The resident initially had an x-ray that showed a lower leg fracture, and the physician completed a major injury form and determined it was not a major injury. The resident was later transferred to the hospital and underwent surgery, which required the incident to be reported.

F550/58.45(1); E; $500. During interviews with residents, it was noted that the staff failed to treat the residents with dignity and respect, including telling the residents they have an attitude, not cleaning up urine after the staff spilled the urine on the floor while emptying the catheter bag, residents reporting they have accidents (BM) in their beds because it takes 45+ minutes for staff to answer the call light. Another resident reported incontinence of bowel and bladder due to waiting 45 minutes to an hour for staff to respond to their call light. During a separate interview, another resident reported that they had an incontinence episode after waiting up to an hour for staff to answer their call light and assist with the restroom; the resident reported that the staff told them not to wait until the last minute to use the call light. Another resident reported that they had to wait for 45 minutes for the staff to answer their call light to request a portable phone. The resident indicated that the staff never brought the phone to him; the resident also reported the facility has been without phone service for several days, and the resident was without a way to contact their sick family member.

F600/58.43(1); 58.45(1); 58.41(1)(2); L; $500 (Held in suspension). The facility failed to provide residents an environment free of verbal and emotional abuse, retaliation, and intimidation. On 10/1/21 the administrative team discharged Resident #93 from the facility without proper documentation or cause because the resident reported care concerns related to other residents that depended on staff for care and/or could not speak for themselves. This caused the resident extreme stress, anxiety, and sadness. The resident reported they were "climbing the walls" and "was on the verge of a nervous breakdown". The administrative team also attempted to discharge Resident #4 for voicing concerns about their roommate's care (or lack thereof). Resident #4 reported this made them feel marginalized. A staff member reported the Administrator directed them not to assist Resident #35 with activities such as turning their magazine pages or helping with their television set. Resident #35 reported the administrative team always watched them and said that staff spent too much time with them. The resident stated that they were afraid they would get in trouble for using their call light and clarified they felt like a "dead man walking". The resident also told the volunteer ombudsman that they felt like the facility was trying to get rid of them.

F607/58.9(1)(2)a; L; $500 (Held in suspension). Facility failed to follow its policy related to preventing abuse. The facility hired 3 staff (the facility Administrator, Staff B LPN, and Staff F Social Worker). During the screening process, it was identified that these staff members were found to have emotionally and verbally abused residents, engaged in domestic assault, and committed forgery (respectively) prior to hire. The facility failed to develop and implement a plan to ensure corporate consultants, management staff, and/or human resources monitored the Administrator, Staff B, and Staff F to provide protections for the health, welfare, and rights of each resident residing in the facility as required. This failure led to an environment of abuse, fear, and retaliation which caused resident's psychosocial harm.

F622/58.40(1)(2)(3); G; $500 (Held in suspension). The facility told Resident #93's family they needed to be discharged from the facility and planned a meeting with the family on 9/13/21. On 9/13/21, the facility held a care conference with the family and reiterated to them the resident needed different placement. On 9/30/21 the family told the social worker they could not locate a place for the resident to live and would have to take them home. On 10/1/21 the facility completed a facility-initiated discharge to home with family. The facility failed to ensure they met discharge criteria; this caused the resident psychosocial harm.

failedF684/58.19(2)j; J; $9,000 (Held in suspension). Resident #7 sustained a fall on 6/27/21 at 5:12 p.m. The staff assisted the resident back into their wheelchair and then into bed. The incident report indicated the resident was yelling and screaming in pain with a pain assessment score of 6/10. The medication aide administered PRN lorazepam for anxiety. The staff did not administer pain medication to the resident until 22 hours after the fall, however, documented several entries of anxiety and terminal restlessness. The resident subsequently passed away. During interviews it was determined that the nurses failed to assess the resident following the fall. Resident #14

reported during an interview that they waited for assistance to get from their wheelchair to bed and that the staff were at the nurse's station on their phone. The resident reported that they transferred themselves to bed and during the transfer the resident fell. The resident indicated they got themselves into their bed and reported to the staff that they fell. The resident stated that no one assessed them following the fall. Staff reported that they were told by the resident that they fell and reported to the DON who directed them to get an ice pack and that they were not working on the floor so not to call anymore. A staff member reported to the Surveyor that Resident #15 fell while trying to get into a van to go to the bank. The staff reported that the staff member asked for help to assist the resident, but the DON told them to just let the resident go, so the resident left out the door and then slid out of their wheelchair onto the ground. When the staff tried to assess the resident, they started screaming to get away from them and wouldn't allow them to help. The resident reported during an interview that the staff told her that they were told not to assist, and the resident crawled to the taxi and got themselves into the taxi after falling. The resident indicated they would not allow the staff to assess them at the time but reported that no one had assessed them upon return to the facility and was having increased pain in their leg.

F684/58.19(2)j; J; $10,000 (Held in suspension). Resident #1 experienced several days of vomiting and complained of constipation. The facility administered laxative medications but failed to complete a thorough assessment of the resident until the resident was transported to the hospital. The resident was sent to the ER, their bowel sounds were absent, and abdomen was rigid. Upon x-ray the resident was diagnosed with probable ischemic bowel and a high bowel obstruction. The resident passed away approximately 10 hours after being sent to the hospital. The facility also failed to complete a thorough assessment, administer laxative medications as ordered, or notify the physician after Resident #3 had not had a BM for 3-4 days. The facility failed to complete any follow up physical assessments after 10/8/21, including on 10/13/21 when the resident was transferred to the local ER for constipation.

F686/58.19(2)b; G; $6,000 (held in suspension). Resident #16 was admitted to the facility on 5/28/21 with a stage 3 pressure ulcer to their right buttock, scattered superficial skin loss to the bilateral buttocks, wounds to bilateral heels, a right chest dialysis port, and right abdominal ileostomy. On 6/11/21 the resident began going to the wound center with bilateral heel wounds, wound to the right gluteus and left gluteus. The resident went to the wound center on 7/23/21 with a right gluteal fold pressure ulcer, left gluteal fold pressure ulcer, and the wounds previously listed. On 8/2/21 the resident missed their appointment due to transportation issues; the facility rescheduled, however, the resident subsequently missed all wound center appointments for various reasons until 9/10/21. The facility lacked assessments on the wounds since 6/3/21 and lacked additional information related to the resident's wounds.

F686/58.19(2)b; G; $4,000. Resident #14 developed a pressure ulcer on the Achille's tendon and heel bone from the resident's shoes not being adjusted properly. The pressure ulcer was first documented as a stage 2 and upon survey was identified as a stage 3.

F689/58.28(3)e; G; $5,000. Staff J (CNA) walked resident #1 toward the bed without a gait belt; as the CNA went to pull back the covers, the resident stumbled backwards and fell into a cabinet, sliding to the floor. The resident was subsequently admitted to the hospital with a right hip fracture. During observations, the surveyor witnessed a CNA transfer Resident #2 from a couch to a wheelchair by placing their hand/arm under the resident's arm and pulling up on the resident; the CNA did not use a gait belt to transfer the resident. Resident #3 was care planned to have a personal alarm; the resident sustained a fall, and the personal alarm was not sounding. Staff noted the alarm was in the chair but did not function appropriately.

F689/58.28(3)e; L; $6,750 (held in suspension). During an observation of the laundry room, the dryer tumbler was running with the front burner panel off the top of the dryer, exposing 5-inch flames running down the length of the burner, shooting out both sides of the unit. The tumbler contained a load of linens and the flames continued from the unit for 3 minutes and stopped while the tumbler continued to spin. Interview with the environmental service supervisor indicated the dryer runs better with the burner panel cover off. The panel cover was in the laundry room with a key in place. Another dryer in the laundry room that was not in use had a burner cover with a key in place. Within 12 feet of the dryer were several aerosol cans and plastic bottles of chemicals that were flammable. During a separate interview, a laundry staff member reported that when the burner panel cover was on, it would cause the pilot to go out and that the maintenance department was aware and looked at the dryer in the summer. During observations, the surveyor also noted the lint filter was completely full of a thick layer of lint along the back, top and sides of the compartment, extending out the back of the dryer.

F689/58.28(3)e; G; $7,000 (held in suspension). Resident #19 fell in their room with a fracture in April 2021; the intervention placed to prevent additional falls included having the resident go to the lobby area after getting up, and the care plan directed staff to lay down in between meals or place in recliner. The resident sustained another fall with fracture in July after staff left the resident unsupervised in their wheelchair in the room.

F725/58.18(4); E; $500. The facility failed to answer call lights timely for 6 of 6 residents reviewed. The residents reported during interviews wait times of 1 1/2 hours to 2 hours. During review of the printed call light records, call light times exceeded 3-4 hours on more than one occasion.

F742/58.19(2)j; J; $8,000 (held in suspension). Resident #39 was admitted on 8/16/21. The MDS indicated the resident had a high PHQ-9 score for depression. The resident received a 30-day exemption from the PASRR Level 2 process and on 9/17/21 received short term approval with specialized services identified for behavioral health. The Level 2 indicated the resident had a history of suicide attempts including an intentional car accident and an overdose on medications and alcohol. The resident's care plan lacked any PASRR recommendations or interventions; the resident received antianxiety and antidepressant medications, lacked information on previous suicide attempts and thoughts including interventions to keep the resident safe. On 9/12/21 the resident expressed to the staff that they wanted to kill themselves because of staff being mean to them. On 10/9/21 the staff found a butter knife tucked into the resident's leg while providing incontinent cares. The resident told the CNA that they were going to "end it all"; the CNA removed the knife from the room and reported to the nurse. The chart lacked documentation of interventions to keep the resident safe, or notification to the family or the physician of the incident.

F758/58.19(2)a; 58.43(3); G; $5,750. The facility failed to document medical symptoms for administration of PRN Xanax and hydroxyzine. The resident was sent to the ER for altered mental status, confusion, falls, worsened mental status and motor function. Upon workup at the ER, all diagnostic tests were normal, and the diagnosis was identified as polypharmacy from new medications prescribed at the facility.

F760/58.19(2)a; J; $8,000 (held in suspension). Resident #17 was admitted to the facility at approximately 1 p.m. on 8/31/21 from the hospital due to a hypertensive emergency. The pharmacy reported that the resident's medications were delivered around 10 p.m. on 8/31/21, and the facility could have requested an earlier delivery but did not. The resident's orders were not placed into the computer until 9/1/21. The medications were in the medication room in the package with no pills missing from the packaging. The E-kit documentation showed no medications removed from the E-kit on 8/31/21. The resident subsequently missed 4 doses of antihypertensive medications and was transferred to the ER on the morning of 9/1/21 with chest pain. The ER admitted the resident with high blood pressure and a diagnosis of a heart attack.

F886/58.10(8); K; $9,000 (held in suspension). The facility failed to appropriately test staff and residents per CMS QSO-20-38-NH-Revised upon identification of a COVID-19 positive person.

TOP 5 CITATIONS

F-TAG #	
F880	Infection Control
F689	Accidents/Hazards/Supervision
F684	Quality of Care
F686	Treatment/Services to Prevent/Heal Pressure Ulcers
F657	Care Plan Timing and Revision

These are the top six citations from Iowa surveys conducted in October 2021 per DIA 2567 reports.

F884 Reporting – National Health Safety Network

F884 is not currently listed on the QCor website for the month of October.

F880 Infection Control

F – Staff were noted wearing their mask below their nose, covering only their mouth. A staff member reported that they had never had their temperature checked prior to working, never been screened prior to working, and had not received education on screening. Another staff member was noted to have their mask around their chin standing at the dirty dish cart eating a bowl of salad, and residents were present. During an observation, a resident had a washcloth bunched up on the floor near their nightstand that was covered in brown substance like BM, also noted a urinal with 200 ml of urine on the tray table near the bed. The urinal was labeled with a different resident's initials that moved out of their room. Staff failed to change their gloves and complete hand hygiene while emptying an ileostomy and transfer with a mechanical lift. Another staff member was noted to be in the dining room with two residents, their face mask was down to their chin. Additional staff members were noted to have their facemasks down while in close vicinity to residents and failed to screen in prior to entry.

F – There were 4 COVID-19 screening forms for visitors that failed to have a temperature documented during the month of September. Staff A did not have a pre-employment physical completed prior to employment, and Staff D's last physical was nearly 5 years old, no physicals conducted within the last 4 years were in the employee's file. Staff A, B, and C failed to have a TB screening or test completed prior to hire.

E – Staff were assisting residents with COVID-19 and failed to always wear appropriate PPE when in the room, including gloves during cares. Staff failed to disinfect the Hoyer lift between resident use (different residents). Staff failed to wear shoe coverings when providing care to residents with COVID-19 (per facility policy). Staff had long acrylic fingernails on during cares for a resident; per facility policy they should not be worn by any person who provides direct hands-on resident contact.

D – During a dressing change, the nurse failed to wash their hands after removing their gloves.

E – During a urostomy appliance change for Resident #23, the nurse failed to wash their hands following glove removal. During care observation for Resident #2, the CNAs applied gloves without completing hand hygiene, failed to change their gloves when going from dirty to clean task, and failed to perform hand hygiene between glove changes when completed. During observation of cares for Resident #22, the staff failed to perform hand hygiene prior to and after glove use and failed to complete hand hygiene upon completion of the task. Resident #20's oxygen tubing did not contain a date when the tubing was changed and was not included in the resident's TAR. Resident #22 did not have a date on their oxygen tubing and was unsure when the last time it was changed.

D – During a dressing change observation, the nurse failed to appropriately disinfect the scissors used for the dressing change and failed to complete hand hygiene appropriately between glove changes. During a different dressing change observation, the same nurse failed to perform hand hygiene between glove changes.

D – During observation of a wound dressing change, the nurse failed to complete hand hygiene with all glove changes, failed to change gloves appropriately, and failed to disinfect scissors after using them to cut off the old dressing and cut the clean dressing supplies to be applied. During observation of perineal cares for Resident #33, the staff failed to complete hand hygiene when removing gloves. During observation of staff emptying a catheter bag, the surveyor noted the staff member touched the tip of the outlet valve on the graduate three times during the process. The staff member cleaned the valve before and after emptying the bag.

F – Upon initiation of the survey, the staff took the surveyors through the skilled nursing unit to a room to place their belongings prior to screening for COVID-19 signs or symptoms. The surveyors noted they were in the building approximately 5 minutes before being screened. During observation, the staff were not utilizing eye protection.

F – The facility failed to cover the clean laundry cart while passing linens to the residents.

E – The facility staff failed to wear eye protection when the county was in a high rate of community transmission.

E – During observation of a dressing change for Resident #27, the nurse failed to complete hand hygiene between glove changes. During observation, staff passed clean laundry from an uncovered basket.

E – During observations, the staff failed to use acceptable infection prevention standards by not performing hand hygiene between resident contact and after resident care. The staff also failed to use proper eye protection per CDC recommendations.

E – During medication administration, there were observations of staff touching residents' medication with a bare hand and placing the medications in the resident's mouth. There were several observations of staff not utilizing eye protection during resident care encounters.

F689 Accidents/Hazards Supervision

D – Resident #1 had a care plan that identified they were at risk for wandering and included interventions of a wander guard and to check placement twice daily. The resident eloped from the building on 6/13/21 by removing the air conditioner and eloping through the window. The resident was reported to be last seen at 8:30 a.m. when the staff checked on the resident and the resident declined breakfast. The resident was noted missing at 8:57 a.m., the elopement protocols were followed, and the sheriff notified. The resident was found by a local fireman and previous employee a few blocks away from the facility.

D – Resident #14 reported that they waited for over an hour for assistance to transfer from wheelchair to bed and then attempted to transfer themselves, resulting in a fall. The resident reported they were able to get themselves into bed and reported to the staff following the incident that they fell. The resident reported that the staff did not assess them following the fall. Resident #15 fell while attempting to get into a cab to go to the bank. The staff member reported that the DON instructed them to just allow Resident #15 to go to the cab; upon falling, the staff reported the resident screamed at them and would not allow an assessment to be completed. The resident returned to the facility and reported to the surveyor that the staff did not assess them following return to the facility. During observations by the surveyor, the staff were noted to push residents' wheelchairs without foot pedals.

D – Resident #1 was not identified as an elopement risk due to assistance of 1 required for ambulation and transfers. On 7/20/21 the staff went to assist the resident to supper, and the resident was unable to be located. The facility implemented elopement procedures and found the resident behind the nursing home. The resident was returned to the building, assessment complete without any injuries. During investigation, it was determined that another resident was noted silencing the alarm when sounding.

D – During observation of a transfer for Resident #12, Staff B attempted to have the resident stand by placing their arm under the resident's arm; however, the resident was unable to stand. A second staff member then came in to assist, and both staff placed their arms under the resident's arms and assisted the resident to stand. Neither staff used a gait belt to assist the resident. The resident's care plan indicated they were independent in their room and staff to assist as needed; the care plan did not indicate that a gait belt was necessary. The facility policy directed staff to use a gait belt on residents who require assistance with transfers and/or ambulation when mechanical lifting devices are not used.

D – Resident #4 was identified as outside of the facility by another resident and notified staff. Upon investigation, it was determined that the emergency door was unlocked, which caused the alarm not to sound.

D – Resident #2 had several falls. The resident had a note on their bathroom door indicating not to leave the resident alone in the bathroom. During surveyor observation, 2 staff transferred Resident #2 to the toilet, provided them the call light, and instructed to call when done. The resident was in the bathroom alone for approximately 3 minutes. Staff indicated that they were not aware the resident could not be left alone, and one staff thought that was for when the resident was walking. However, the resident had been using a sit to stand lift for approximately a month. Resident #4 had a fall when staff were transferring the resident with a sit to stand lift instead of a Hoyer lift. The resident was to use the Hoyer lift per therapy, and per the resident's care plan.

D – The facility failed to provide residents their call light within reach of the resident to promote their individual safety for 3 of 4 residents during observations.

D – During review of Resident #8's record, it was noted that the resident had a fall; the resident was care planned for assist x 2 with a mechanical lift. During an interview, the resident indicated at the time of the fall, staff transferred them alone with the mechanical lift and reported that staff transfer alone with the mechanical lift at times due to staffing. Resident #10 also was transferred without 2-assist while utilizing a mechanical lift. During observations, the surveyor noted the medication cart unlocked without staff present on multiple occasions.

D – Resident #13 was transferred by a CNA from their wheelchair to the lounge chair. The resident ambulated while the CNA held the back of the residents' pants. The staff member did not use a gait belt during the transfer.

E – Resident #1 was identified as a high risk for falls. Upon review, the surveyor identified from April through October 20, the resident had 17 recorded falls. Several of those falls lacked care planned interventions to mitigate fall risks. Resident #2 had 11 recorded falls from March through May 2021. Reviewing the care plan, 7 of 11 falls lacked care planned interventions to mitigate falls. Resident #3 had 3 falls reviewed by the surveyor, 2 of the 3 falls lacked care plan interventions.

F684 Quality of Care

E – Resident #3 developed a pinpoint open area on their coccyx on 9/13/20; upon review of skin assessments, the assessments were completed from March 2021 until April 14, 2021. No skin assessments were completed from 4/21 until 5/12 and then sporadically resumed on 5/18, 5/27, and 6/8. On 6/8 it was identified that the wound appeared infected; the facility failed to notify the physician of this assessment. Resident #4 had an unstageable pressure ulcer to heel; no weekly skin assessments were completed consistently. The resident subsequently developed osteomyelitis and was hospitalized 7/1/21 due to wound infection and had a below the knee amputation on 7/9/21. Resident #6 was being observed by the surveyor. During observations on 9/23/21, the resident was noted in bed at 6:33 a.m. with their sheet over their head. Throughout the morning, the resident appears to remain in bed untouched. At 11:45 a.m. staff entered the room to provide incontinence cares; the resident's brief was heavily saturated with urine and bowel movement. The staff identified the resident had a wound on their coccyx and placed on their left side with pillow support. A progress note dated 9/23/21 identified the wound and physician notification. The September and October TAR had no documentation of calmazine being added and provided as ordered; the resident's care plan post discovery of the wound lacked interventions for the wound or to mitigate risk of further ulcer development. During further observations, the surveyor noted that Resident #6 was first observed sitting in their wheelchair on 10/12/21 for 5 1/2 hours without incontinence care, repositioning, or any offloading supports for their pressure ulcer. On 8/3/21 Resident #6 was identified as having an acute fracture of the supracondylar region of the right femur; the nurse practitioner ordered a knee immobilizer and pain management, PT/OT to fit for immobilizer. During an interview with the nurse practitioner, they indicated that two weeks later during rounds they identified that Resident #6 had not been fitted for an immobilizer. The OT indicated that they evaluated and measured the resident on 8/16/21, which was the day they were notified of the order; the knee immobilizer was not delivered to the facility that they were aware of. The administrator indicated that they checked on the status of the knee immobilizer and indicated that it was at a medical supplier, and they would pick it up after leaving the facility. An interview with the medical supplier indicated they were notified of the knee immobilizer on 9/1, and it was in stock and picked up the same day; they were not aware of any other orders prior to that. Resident #10 was transferred to the hospital on 9/5/21 and diagnosed with right lower lobe pneumonia, elevated blood glucose levels, and the hospital identified 3 wounds, only one of which the facility had identified. The pressure sore on the coccyx measured 7 cm by 6 cm and was deep purple with suspected deep tissue injury as well as a suspected deep tissue injury on the resident's scrotum. In review of the MAR, the resident had no dressing orders on the TAR; during observations, the surveyor noted that the resident was in their wheelchair for long periods of time. They then transferred the resident into bed with incontinence care provided; there were 2 pressure areas identified and one that was closed, none of the areas have dressings, and the staff did not apply barrier cream during cares. The staff positioned the resident supine slightly on their left side without any pillows or off-loading devices to support their position.

D – Resident #3's care plan directed staff to conduct weekly skin assessments and to place soft cloths under the abdominal folds due to excoriation. Staff failed to complete skin assessments twice in August and once in September. Resident #6's care plan directed staff to complete a skin assessment weekly for risk of pressure ulcer development. Staff failed to complete skin assessments once in September. Upon observation of the area by the surveyor, it was noted there were 2 areas that the facility was documenting as one area. The staff failed to document measurements for the second area and failed to notify the physician of the second area. Resident #7's care plan directed staff to

complete weekly skin inspections to observe for redness, open areas, scratches, cuts, and bruises. The staff failed to complete skin assessments twice in September.

D – Resident #125 was discharged from the hospital following a toe amputation; the orders from the hospital were to keep the wound dressing clean, dry, and intact until their follow up appointment. The nurses' notes revealed that the resident's dressing bled through the gauze and onto the outer dressing, so the nurse changed the dressing. The resident did not have a physician's order for a dressing to the area.

E – Resident #48's chart indicated they were not eating or drinking (15 of 28 meals); the facility failed to notify the physician that the resident was not eating or drinking, and the chart lacked documentation of interventions. The resident was admitted to the hospital with acute kidney failure. Resident #46 was admitted to the hospital with shortness of breath, low oxygen saturation, nausea, and vomiting. A thoracentesis was performed, and 1200 ml of clear pleural fluid was evacuated. Review of the skilled nursing documentation for several days leading up to the hospitalization indicated that the resident's lung sounds were clear with no difficulty breathing, and the resident had a regular heart rate. During interview with the cardiologist, they indicated the staff would have noted shortness of breath, change in breathing, low oxygen saturation levels, and heard fluid around the resident's heart with a possible irregular rate leading up to the hospitalization. Resident #43 had allergies including Bactrim, betadine, iodine, and shellfish, in addition the physician transfer order report indicated an allergy to clindamycin. On 9/15/21 the facility received an order for clindamycin 150 mg three times daily for 21 days. The resident refused to take the medication and reported to staff they had an allergy; the record lacked documentation of physician notification of the allergy. On 9/29/21 the facility notified the foot surgeon of the resident's refusal to accept the oral medication, and an order was received to discontinue the clindamycin and initiate zyvox. During observation of wound care for Resident #11, the staff applied baza antifungal cream when the order was for lotrisone cream.

D – The staff failed to implement orders the ARNP ordered for Resident #3's buttock wounds.

D – Resident #1 had interventions for wound care to a rash; the facility completed an assessment when identified but failed to complete any further assessments on the areas. Resident #3 had a laceration identified to their right lateral calf that only contained measurements and that the laceration was scabbed without exudate; no further assessments or documentation were noted in the resident's chart.

D – Resident #1 was admitted on 9/13/21 with large, blistered areas that opened on the right leg. The RN reported the camera did not work and they did not assess or document the skin condition but notified the next shift, the DON, and MDS Coordinator of the need for assessment and treatment orders. During OT treatment on 9/15/21, the OTA reported they placed a dressing on the open wound and wrapped both legs with lymphedema wraps. No further assessments were completed until 9/19/21 when the resident requested the lymphedema wraps be removed. The nurse then obtained an order to send the resident to the ER where they were admitted with sepsis with septic shock from right lower extremity cellulitis with necrotic wound. Resident #3 was admitted to the facility on 9/10/21 post craniotomy. During an appointment, Resident #3 reported that the doctor noted an intact dressing to the surgical site on the back of their neck dated 9/7/21; the doctor reported the facility had not acknowledged or changed the dressing during their 10-day stay at the facility. Resident #6 had a wound drain placed in their left knee, which was removed; however, there were no orders for dressing changes to the area. There was an order to obtain a culture of the left knee drain removal site on 9/10/21 which showed MRSA present. The facility failed to complete any wound evaluations from 9/10 to 9/26.

F686 Treatment/Services to Prevent/Heal Pressure Ulcers

D – The resident had orders for a sacral wound dressing to apply calmoseptine to the peri wound with dressing changes. The staff failed to apply the calmoseptine as ordered during surveyor observation.

D – Staff failed to sign documentation of a treatment being complete to a left foot wound 5 times for the month of March and 4 times for the month of April.

D – A wound was discovered for Resident #45 on 7/17/20; the initial assessment lacked measurements and an appropriate assessment. The assessment on 8/5/21 lacked measurements or description of the wound. According to the resident's orders on 8/7/20, there was an order to apply betadine to the area on the right outer heel; there was no wound assessment completed for this area. The care plan lacked a focus area related to risk for pressure sore development and lacked interventions related to prevention of pressure wounds.

D – Resident #4 was identified as having pressure ulcers; the surveyor noted during incontinence cares for the resident that they had two open wounds on the right buttock and one on the left. The staff failed to provide repositioning for the resident from 7:30 a.m. until 2:40 p.m. During observation, the resident's wounds also lacked any intact dressings or visible creams, and when the resident was transferred out of their wheelchair at 2:40 p.m., there still were no visible dressings or creams on the wounds.

D – During review of Resident #1's TAR, it was noted the facility failed to administer treatment to pressure ulcers on the resident's buttocks on 12 occasions. During interview, the resident stated that upon admission, the areas were small, but since admission, the ulcers got larger and the staff failed to provide treatments. During review of Resident #2' s record, there were instances where the facility did not include orders on the TAR or document administration and several instances where treatments were not signed on the TAR as being completed.

D – Care plan interventions failed to address a pressure ulcer on the resident's heel and interventions to prevent worsening or further pressure ulcer development while the resident was sitting in their recliner chair.

F657 Care Plan Timing and Revision

D – Resident #10's care plan lacked revisions and interventions that were put into place after they physically assaulted another resident. Resident #7 was noted to have a fall without injury on 6/27/21; the following day, the resident began complaining of severe pain, which went on for several days. Progress notes for Resident #7 addressed calls to hospice to request increased pain medication; however, the care plan lacked additional pain interventions after March 2021.

D – Resident #20 had orders for Lexapro, Remeron, morphine sulfate concentration solution, and extended-release morphine. The resident's care plan lacked directives on administering psychotropic medications and pain medications. Resident #11 had orders for Lexapro and Remeron daily. The care plan lacked documentation pertaining to the usage and side effects with psychotropic medication administration.

D – Resident #23 was utilizing oxygen and the resident's care plan lacked documentation on oxygen use. Resident #6 had orders for mirtazapine daily; the care plan lacked interventions for mirtazapine.

D – Resident #1's care plan indicated that the resident eloped from the facility on 9/24, the care plan lacked documentation of the risk for wandering or elopements prior to the elopement. On previous elopement risk assessments, the resident was identified as a moderate risk for elopement. Resident #5 was identified as being at high risk for falls. The care plan included a low bed and fall mat; however, these interventions were not dated, so it is unknown when these interventions were implemented. Resident #7 was identified on their care plan as being at risk for pressure ulcer development; however, the care plan lacked documentation of a current wound to the resident's spine and interventions/treatment for the current wound.

D – The staff failed to update the residents care plan for a resident who was care planned to be walking to/from the bathroom and now no longer walked and utilized a mechanical lift for transfers.

D – During an interview with Resident #10, they indicated they had no idea what a care plan was or being involved in care plan conferences. The last documented care conference occurred in February 2021.

D – Resident #2 was noted to have a large open area on the coccyx with bruising and abrasions around the outer limits of the resident's buttocks at the upper thigh region at the lower gluteal crease. The resident's care plan lacked skin concerns and treatments. Resident #7 reported that the staff were providing meals on Styrofoam and that did not work very well for the resident as they were supposed to have a lip plate to enable the resident to feed themself. The care plan lacked interventions for a lip plate. Resident #8 had an incident report for a fall when a CNA was transferring them with a lift device by themselves. The resident's care plan indicated the resident is to be assist x 2 with assistive device for transfers.

D – During observations, Resident #18 utilized oxygen at 4L per nasal cannula. During record review, it was noted that the resident had an order for 3L of oxygen continuously and titrate for comfort. The resident's care plan stated that the resident was to have 5L of oxygen at all times.

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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