LTC Survey Trends Report
September 2024

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ENFORCEMENT ACTION REVIEW & SURVEY UPDATES

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For the regulatory review this month I reviewed Chapter 7 in the State Operations Manual (SOM) regarding enforcement action. As you will note there are several types of enforcement actions being imposed throughout the State. This article includes descriptions of each enforcement action and what category they fall into with examples of scope and severity ranges.

September 30 ended the Federal Fiscal Year (FY), and DIAL indicated they met their goals with recurrent recertification averages. While we don't anticipate that providers will continue experiencing recertification surveys within those short time frames (such as four months for some of our members), providers may continue to experience recertification surveys in shorter time frames than we've seen historically.

Survey Activity

District	Average Months for Providers with Recert	Number of Providers over 12 Months	Longest Survey Timespan
Statewide	10.2 months	60 nursing homes	16 months

Recertification:

- 40 total recertification surveys reviewed with 6.9 deficiencies on average per recertification survey with deficiencies.
    - Of the 31 recertifications with at least one deficiency, 5 providers received a fine (or 16%).
    - Of the 40 recertifications, 9 providers had deficiency free surveys (or 23%)

Complaint/Incidents:

- 50 providers with complaint/incident surveys reviewed with 2.8 deficiencies on average per survey reviewed with deficiencies.
    - Of the 25 complaint/incident surveys with at least one deficiency, 10 received a fine (or 40%).
    - Of the 50 complaint/incident surveys, 25 did not receive a deficiency (or 50%).

Enforcement Actions

MONTH (2024)	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVERAGE NUMBER OF RECERTIFICATION DEFICIENCIES
JANUARY	**$104,000**	**$155,502.93**	**3 Denials**	**$259,502.93**	**6.7 deficiencies**
FEBRUARY	**$26,500**	**$656,855.02**	**3 Denials**	**$683,355.02**	**9 deficiencies**
MARCH	**$36,250**	**$165,085.75**	**5 Denials; 3 DPOC**	**$201,335.75**	**5.3 deficiencies**
APRIL	**$131,250**	**$244,401.75**	**4 Denials**	**$375,651.75**	**5 deficiencies**
MAY	**$170,000**	**$119,500**	**4 Denials**	**$289,500**	**5.1 deficiencies**
JUNE	**$181,500**	**$18,535**	**3 Denials**	**$200,035**	**6.4 deficiencies**
JULY	**$228,250**	**$120,995**	**5 Denials; 1 DPOC; 1 State Monitoring**	**$349,245**	**6.1 deficiencies**
AUGUST	**$125,000**	**0**	**5 Denials, 1 Termination**	**$125,000**	**5.4 deficiencies**
SEPTEMBER	**$140,000**	**0**	**1 Denial; 1 Temporary Management/License Revoked**	**$140,000**	**6.9 deficiencies**

Congratulations to Faith Lutheran Home & MercyOne Centerville on deficiency free surveys!

Fines identified in this report are per the Iowa Department of Inspections and Appeals website (state) and QCor (federal). Total fine amounts may change based on appeal rights and reduction rules.

CITATIONS WITH FINES

September Deficiencies with State Fining and Citation

50.7(5); $500. A suicide attempt was not reported to DIAL.

F600; K; Temporary Management/Licensed Revoked. According to resident interviews, staff often refused to allow them to use the phone and when they were only allowed, they could only use it for a couple of minutes with staff supervision. Staff also make them wait a long time before they answer their call light. Another resident reported that staff make them wait over an hour to go to the bathroom and some turn the call light off saying they will return and do not. Staff reportedly yelled at other residents and refused to allow them to brush their hair before going to meals. Another resident reported that staff refuse to assist them to the bathroom which causes them incontinence to the point that they want to commit suicide and made to feel worthless. A resident reported during an interview that staff would yell "they pissed the bed again" when they were incontinent. Other staff members reported their concerns to the DON but nothing was changed.

F600; 58.43(2); J; $8,000 (Held in Suspension). Staff members witnessed another staff member grab a resident by their feet, swing them over in bed and pull them up by their arms roughly. The staff member was also noted flinging the resident's legs out of bed aggressively and calling the resident a "f***** ahole". Another staff member witnessed the same staff member pull a resident down in their chair from the shoulder area and a bruise was later identified on their chest. The staff member was also heard telling the resident “Don’t f-ing hit me or I'll never take care of you again."

F600; 58.43(2); G; $500. Resident #1 was heard yelling from the shower room telling the staff they were hurting him. The CNA that was assisting with the shower stated, "I'm just washing your f****** face". At the time the staff overhearing the event did not think anything of it as the resident commonly yells out that staff are hurting him when they are just touching him. However, following the shower the resident was noted to have a swollen face and discolored area by their nose, there was a sore under the right and left eye, and the resident reported pain in their left pinky finger. The resident was sent to the ER for assessment and no acute fractures were noted. During investigation the resident reported that the staff member hit them; however, at a later time stated that the staff member just washed their face too hard.

F606; 58.11(3); D; $500. Staff B's SING report had a criminal history indicated with CCH record faxed, however, the employee's file did not have documentation of the record or evaluation that they could work.

F609; K; Temporary Management/Licensed Revoked. The administration did not report allegations of abuse within two hours to DIAL based on several allegations of staff mistreating multiple residents in the building.

F609; 58.43; J; $8,250 (Held in Suspension). The nursing home did not report allegations of abuse to DIAL within two hours of the incident occurring when a staff member was witnessed being physically aggressive with multiple residents and swearing at them.

F609; 58.43(9); J; $500 (Held in Suspension). The nursing home did not report an allegation of abuse to DIAL until four days after the incident occurred.

F610; Temporary Management/License Revoked. The residents were not protected from abuse when the staff and residents reported concerns with allegations of abuse to multiple residents from staff members.

F610; 58.43(9); L; Included in Above Citation. Staff B witnessed another staff member tell a resident "f*** you too" and slap the resident on the forearm and leg. The staff member reported it to a nurse the following day, but the report was not given to the Administrator or DON until four days after the incident occurred. This delayed the separation of the staff member from residents and initiation of an investigation.

F610; 58.43(9); J; $8.250 (Held in Suspension). The nursing home did not separate an alleged abuser from residents and complete a comprehensive investigation immediately.

F658; G; Included in Citation under F760. The nursing home did not follow physician orders when they gave two residents each other's medications which resulted in one resident being hospitalized and the other reporting a headache and anxiety.

F658; 58.19(2)a; G; $3,500 (Held in Suspension). Resident #2 went to the ER on 7/29/24 with acute hypoxic respiratory failure and returned to the nursing home with new orders for albuterol, prednisone, Spiriva, and increased furosemide. On 8/1/24 the nurse practitioner saw the resident and stated that new prescriptions had not been received, the resident was short of breath, lethargic, and oxygen saturations while on 5L were 84%. The nurse practitioner wanted the resident sent to the hospital. The resident returned to the nursing home on 8/6/24 and was sent back to the hospital on 8/10/24 for decreased oxygen saturation levels and increased lethargy. The resident passed away the following day at the hospital. During investigation by the nursing home, it was noted that the orders were not put into the resident's record which delayed them being started.

F686; J; Temporary Management/License Revoked. An open area was observed on a resident's inner buttocks on 9/17/24, but was not assessed or documented until 9/18/24 when the DON assessed the area and notified the physician. A treatment order was received but was not completed appropriately during surveyor observations. The wound deteriorated which included observation of slough tissue and oozing when a dressing was not covering the wound.

F686; 58.19(2)b; G; $5,000 (Held in Suspension). Resident #8 was at risk for developing pressure ulcers and the care plan identified interventions for skin integrity but was not updated after 3-6-24. On 2-14-24, a new order for calmoseptine as needed was received. From 2-14 to 2-19 the calmoseptine was only administered one time. On 2-19-24 the staff identified a pressure ulcer to the right ischium, another to the left buttock on 2-28-24, and another on the right buttock on 3-6-24. Subsequent skin assessments did not include elements of a thorough assessment including measurements and descriptions of each wound.

F689; 58.28(3)e; G; $5,000. Resident #1 required assistance from one staff member for personal hygiene and ambulation. A CNA assisted the resident to the bathroom and then left them alone. While in the bathroom the resident lost their balance and fell to the floor, which resulted in a hip fracture. Resident #2 went to an appointment without staff accompaniment and fell while at the appointment. The resident was taken to the emergency room where they noted a couple chipped teeth. The resident's care plan identified that they will have a staff person or family member go to appointments with them, which did not occur.

F689; 58.28(3)e; G; $6,000. Resident #3 is independent with ambulation and was walking back from the dining room when they slipped on ice in front of the ice machine. The resident was heard yelling and complaining of hip pain. Staff sent the resident to the ER where they were diagnosed with a hip fracture.

F689; 58.28(3)e; J; $16,500 (Treble/Held in Suspension). Resident #1 had a history of exit-seeking and was missing from the nursing home on 8/25/24 at approximately 9 p.m. Staff identified they were last seen around 8:30 p.m. and the resident was found at Walmart around 10 p.m. Upon investigation it was identified that the Wanderguard system was not functioning properly. During an observation by the surveyor, Resident #14 who had a moderate risk for elopement entered the code to open the main door and exited the building. Resident #9 also at a high risk for elopement was near the door when the alarm began sounding. Staff did not respond to the door for approximately 1.5 minutes. Following the incident, staff did not update the code to the door based on the resident at risk for elopement entering the code and leaving.

F689; 58.28(3)e; G; $5,750 (Held in Suspension). Resident #1's care plan indicated they required staff assistance of one for ADLs and transfers and the resident was on a blood thinner. On 8/13/24 Resident #1 sustained a fall in the bathroom in which they obtained a head laceration. A transfer to the ER was initiated due to the use of blood thinners. The resident was admitted to the hospital due to an intraventricular hemorrhage, scalp laceration, and closed head injury without loss of consciousness. During investigation it was determined the resident did not have a gait belt on and the staff turned away to obtain the resident's glasses from the counter when the resident fell.

F689; 58.28(3)e; G; $6,000 (Held in Suspension). Resident #87's care plan directed the use of two staff members during transfers. A staff member assisted the resident to transfer without a second person when the resident lost strength in their knee and it gave out. The resident sustained a left distal femur periprosthetic fracture that required surgical intervention due to the fall.

F689; 58.28(3)e; G; $20,500 (Treble). A C.N.A. assisted Resident #4 to the bathroom without applying a gait belt. When the resident reached the bathroom door the staff member removed their oxygen and turned away to place the oxygen tubing in the resident's recliner when they fell. The resident complained of pain and was transferred to the ER where they identified a fracture of the right greater trochanter, and it was determined the fracture was non-operable. The resident returned to the nursing home in a non-ambulatory status.

F689; 58.28(3)e; G; $3,000 (Held in Suspension). Resident #11 had cognitive impairment, and their care plan failed to address hot liquids. On 7/9/24 at 8:58 a.m. a CNA noted a reddened area to the resident's thigh. When asking the resident what happened, they thought they may have spilled hot tea on themself the night before. The area was tender according to the resident but overall no complaints. A treatment order was received until the area was healed. The incident report included a new intervention that the resident will not have Styrofoam cups in their room and the kitchen will dilute hot tea with ice or tap water. A progress note indicated that the resident continues to be provided cups with lids but the resident removes the lids at times, which was also observed by the surveyor. During another observation, the resident had a beverage with a lid; however, a short while later the resident was noted with a puddle under them, and it was determined the resident spilled hot tea. An assessment revealed a reddened area to lateral posterior thigh, without blisters.

F689; 58.28(3)e; J; $6,000 (Held in Suspension). Resident #21 was found by a staff member with the bed remote cord wrapped around their neck. The resident expressed frustration with the routines at the nursing home and had suicidal intentions. The nursing home sent the resident to the ER and the resident returned later that day. The nursing home implemented 15-minute checks upon return but did not remove cords in the room that the resident could again use for self-harm. In addition, the 15-minute check records were not completed from 6:45 p.m. - 9:45 p.m. that evening.

F689; 58.28(3)e; G; $6,500. Staff A assisted Resident #8 onto the weight chair from the side of their bed. The staff member unlocked the wheels to move the resident to the bathroom. While the staff turned the chair, the resident's body weight shifted, and the resident fell to the floor. The staff member found a wheel from the weight chair on the ground that had come off while pushing. Staff indicated they recently provided routine preventative maintenance on the weight chair and did not note any problems. Staff did not engage the stability legs on a mechanical lift during a transfer and were supposed to perform a time out to ensure safe strap placement but did not. Resident #4 was transferred with a Hoyer lift when the right sling strap slipped off the hook which caused the resident to fall out of the lift and hit their head. During interviews the staff indicated they did not appropriately use the lift, including performing a time out and engaging stability legs during the transfer.

F692; 58.19(1)n(1); G; $4,250. Resident #16 had a weight loss of 10.4% over approximately three months. The care plan included a nutritional supplement, but did not identify additional weight loss interventions as the resident's weight continued to decrease. During observations the resident's tray was left at their bedside and staff reported the resident liked to sleep late, but did not keep the tray warm until the resident woke up. The resident also expressed they liked Bosnian food, which was not addressed by the staff.

F725; 58.18(4); G; $5,000 (Held in Suspension). Resident #9 had a fall during the night and was not found until approximately 8:30 a.m. The resident had a large bruise on the right side of their face. Resident #9 reported yelling for help all night and nobody checked on them until the morning. During investigation it was identified that staff did not complete rounds or check on Resident #9 from 3:30 AM until the resident was found on the floor at 8:30 a.m. Another resident reported waiting up to 30 minutes for staff to answer their call light.

F757; 58.19(2)a; J; $5,000 (Held in Suspension). On April 1, Resident #19 received an order for Warfarin dosing changes due to an INR of 3.7 with a follow up INR scheduled for April 8. On April 8, the INR was rechecked and was again high. An order was obtained to hold the Warfarin on the 8th and 9th and recheck the INR on April 10. The staff administered Warfarin on both days and the next INR on April 10 was 9.3. An order was again received to hold the Warfarin from April 10 - 14th. On April 13, staff found the resident in bed with blood on their arms and legs, their blood

pressure was low at 80/40 with oxygen saturation at 88%. The resident was placed on oxygen and sent to the ER where they were admitted due to the elevated INR and a gallbladder infection.

F760; 58.19(2)a; K; $7,750 (Held in Suspension). A medication aide gave medication for Resident #2 to Resident #1 and Resident #1 to Resident #2. Resident #1 became lethargic and difficult to arouse. Staff noted the resident was pale, unable to feed themselves, and their blood pressure was low. The resident was sent to the ER where they noted that medications were administered in error including multiple diabetic medications, multiple hypertension medications, antipsychotic, antidepressant, antianxiety, and gabapentin. The resident was diagnosed with toxic metabolic encephalopathy due to multiple sedating medications, hypotension, and risk for hypoglycemia. Resident #2 reported a headache and anxiety related to the medication error.

F802; K; Temporary Management/License Revoked. There were not enough dietary staff resulting in the nursing home using untrained housekeeping staff to assist with dietary services. This resulted in six residents receiving regular texture food who required mechanical soft diets which presented a choking hazard.

F805; K; Temporary Management/License Revoked. Residents on mechanical soft diets were served shredded pork as the housekeeping and laundry supervisor was working in the dietary department due to staff shortages. The supervisor thought the pork would turn into a mushy consistency so they did not grind it up as they should have. In addition, residents on mechanical soft diets were observed with chunks of pineapple on their plates when they should have been served strawberries.

F880; 58.10(8); K; $8,000 (Held in Suspension). Residents #9 and #16 tested positive for COVID-19 and staff reported not having available PPE including gowns, N95 masks, and eye protection until the surveyors entered the building. In addition, Resident #9 came out for meals from the date they tested positive (9-15) until 9-22 when surveyors entered the building. Staff reported they tested positive for COVID-19 and were told to wear an N95 mask and continue working, others reported N95 masks were not available. Staff also failed to wear gowns during EBP for catheter care.

TOP CITATIONS

F-TAG #	
F880	Infection Prevention & Control Program
F689	Accidents/Hazards/Supervision/Devices
F658	Services Provided Meet Professional Standards
F812	Food Procurement – Store/Prepare/Serve Sanitary
F725	Sufficient Nursing Staff

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

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

58.12(1) – Cited 3 times for:

- 2 times when VA eligibility was not assessed within 30 days of admission.
- The nursing home did not have access to the IDVA website, so the task was not completed at all.

F550 – Cited 9 times for failure to treat residents with respect, dignity, and privacy by:

- Staff were mean to residents including inappropriate comments and slamming doors.
- The staff member refused to comply with the resident's preference when they asked for medications to be provided one at a time.
- 2 times when staff did not provide care in a timely manner leading to incontinence.
- The resident did not want to get out of bed to take a shower due to pain, but the staff forced them to get up by using a mechanical lift and take a shower.
- Staff used profanity in front of residents.
- Beds were not being made.
- A resident requested to not have a specific caregiver and the nursing home did not accommodate the request.
- A nurse did not address a resident's catheter leaking which left the resident in a urine soaked bed throughout the night.
- A staff member recorded a staff and resident interaction and sent to other staff via social media.
- A resident was taken to the dining room with just a blanket covering their lower half (no pants) and was partially exposed.
- The staff transported a resident backwards in a Broda chair.

F552 – Cited 2 times when:

- A family member was not notified of a resident being transferred to the emergency room.
- A resident requested their diet be reevaluated and the nursing home did not follow through.

F553 – Cited 1 time when a resident reported they did not have a care conference since their admission care conference. This resident's record lacked documentation for care conferences.

F557 – Cited 2 times when:

- A resident's record was visible on a computer monitor.
- Staff searched through a resident's belongings while they were at an appointment for the roommate's remote and did not seek consent to search.

F558 – Cited 1 time when a resident reported they were unable to access the sink in the bathroom because they were in a wheelchair.

F567 – Cited 1 time when resident's reported not having access to their personal funds at all times.

F578 – Cited 5 times for:

- 3 times when the code status in the resident's record did match the code status form.
- A physician's order for a DNR was not obtained.
- There was no code status form in the resident's record.

F580 – Cited 3 times for:

- 2 times for failure to notify the resident's family for a new bruise and pressure ulcer.
- 3 times for failure to notify the resident's physician when a resident was sent to the emergency room, and another had a change in condition.

F582 – Cited 3 times when:

- Skilled discharge notices were not signed.
- 2 times when advanced discharge notice was not provided according to Medicare guidelines.

F583 – Cited 1 time when a privacy curtain did not provide full visual privacy when a resident used a commode.

F584 – Cited 4 times for failure to provide a homelike environment by:

- 2 times when there were not sufficient linen supplies available.
- Beds were unmade and had sheets with visible staining on them.
- A mechanical lift did not have the required safety tabs.
- The dining room was not cleaned as dried eggs and other food items were noted on the floor for multiple days.

F585 – Cited 1 time when a residents reported to surveyors they filed grievances against staff members and the nursing home did not have record of grievances or follow up.

F600 – Cited 2 times when:

- A staff member threw a box of gloves at a resident.
- Staff cursed when speaking to residents.

F604 – Cited 1 time when a body pillow was tucked into a fitted sheet and it was not identified as a physical restraint.

F610 – Cited 1 time when a staff that threw a box of gloves at a resident was not removed from resident care pending an investigation.

F623 – Cited 2 times when the LTC Ombudsman was not notified of transfer out of the nursing home.

F625 – Cited 3 times for failure to provide bed hold notices to residents.

F636 – Cited 1 times when an admission MDS was not completed timely per the RAI manual.

F638 – Cited 1 time for not completing a quarterly MDS.

F640 – Cited 3 times when MDS' were not submitted timely according to the RAI manual.

F641 – Cited 4 times for:

- Behaviors not coded on the MDS.
- Physical restraints were coded on the MDS but not used according to staff interview and record review.
- 2 times when medications were coded on the MDS without evidence of being used.
- Hospice was not coded on the MDS.

F644 – Cited 2 times for:

- 2 times when a PASRR was not submitted prior to expiration of the short-term approval.
- Level 2 recommendations were not followed.

F655 – Cited 1 time when a baseline care plan was not developed within 48 hours.

F656 – Cited 11 times for:

- The care plan did not include:
    - History of GI bleed.
    - Wandering
    - UTIs
    - 5 times for high-risk medications.
    - Behaviors
    - 2 times for transfer assistance required
    - Enhanced Barrier Precautions
    - Oxygen use
    - Smoking
- Not following interventions included in the care plan.

F657 – Cited 7 times for:

- The care plan was not updated to include:
    - Elopements
    - Pressure ulcers
    - 4 times for high-risk medications.
    - Behaviors
    - Hot liquid spills
    - Diabetes
    - Overall change in condition

- Falls
- Weight loss

F658 – Cited 16 times for:

- Medications being unattended.
- Medications were not documented as administered.
- 8 times for not following physician orders.
- 2 times for failure to prime insulin pens.
- Orders were not transcribed.
- Medication error
- Medications were administered outside of established parameters.
- Did not check placement of a feeding tube prior to medication administration or feeding.
- A high blood glucose level was not reported to the physician.
- A weight gain was not reported to the physician.
- Failure to discard insulin after manufacture's recommended duration from opening.

F660 – Cited 2 times when:

- A resident expressed that they wanted to be discharged but the nursing home did not complete discharge planning.
- A resident was in the process of being transferred to another nursing home and upon discharge was sent to the wrong nursing home.

F676 – Cited 1 time when staff did not follow safety measures with a mechanical lift.

F677 – Cited 8 times for failure to provide:

- 7 times for showers/bathing
- Perineal care
- Repositioning

F679 – Cited 1 time when the activity calendar only had pictures on it and lacked any scheduled activities. The nursing home only employed part-time activity staff and did not have documentation of the last six months of activities provided to the residents.

F684 – Cited 9 times for:

- Weekly skin assessments were not completed.
- Medications were documented as administered, but the medication was not in the medication cart.
- Physician's orders were not followed.
- An abnormal lab value was not followed up on by staff.
- A nurse did not assess or notify the family or physician when a resident complained of symptoms consistent with possible heart attack.
- A resident's change in condition was not assessed.
- Hospice was not notified when a resident fell and was transferred to the ER.
- 2 times for lack of documentation on pressure ulcer and skin injury.
- Failure to transcribe physician's orders.

F686 – Cited 2 times for:

- Failed to follow the care plan for pressure ulcer prevention.

- Physician's orders for dressing changes/treatments were not followed.

F688 – Cited 5 times for:

- 4 times for failure to complete the restorative program.
- Failure to reposition a resident.

F689– Cited 16 times for:

- The fall policy and procedure was not followed.
- Treatment carts were unlocked during observations.
- Did not routinely check on a resident resulting in a resident laying on the floor yelling for help for multiple hours.
- Smoking materials were kept in resident rooms.
- A wheelchair was replaced or repaired when the brakes were not functioning.
- A resident who smoked did not have a physician's order to allow smoking.
- A van driver tipped a resident's wheelchair over causing them to fall when removing them from a transportation van.

F690 – Cited 3 times for:

- Residents did not receive assistance with toileting needs in a timely manner.
- 2 times when catheter sizes did not match the physician's orders.

F692 – Cited 3 times for:

- Did not follow care planned diet interventions.
- 2 times for not implementing new interventions for weight loss.

F695 – Cited 2 times for:

- Orders were not followed for oxygen use.
- Oxygen cylinders were not available.

F698 – Cited 3 times for not completing pre- and post-dialysis assessments.

F710 – Cited 1 time when edema was not addressed by the physician.

F712 – Cited 1 time when several routine physician's visits were not completed.

F725 – Cited 12 times for:

- 6 times when the call lights were not answered in a timely manner.
- 3 times when resident care was not provided due to insufficient staffing.
- Did not have sufficient staffing to ensure safety due to delayed response to door alarms.
- Admission assessments were not completed due to lack of staffing.
- 2 times when he nursing home did not follow the staffing patterns identified in the facility assessment.

F726 – Cited 1 time when family reported they provided activities of daily living due to concerns identified with staff not completing them.

F727 – Cited 1 time for failure to have RN coverage on several days.

F740 – Cited 1 time when the nursing home did not facilitate telehealth psychiatric visits due to lack of staff to assist and the Wi-Fi was not functional.

F755 – Cited 3 times for:

- 2 times when narcotics were not destroyed when discontinued or residents discharged.
- 2 times when narcotics were not accurately reconciled.

F756 – Cited 1 time when medication regimen reviews were not completed for all residents one month.

F757 – Cited 1 time when the nursing home did not follow up on a gradual dose reduction (GDR) request.

F758 – Cited 3 times for:

- Diagnoses were not identified when a resident had psychotropic medications.
- An order for a GDR was not followed.
- A clinical rationale for declining a GDR was not documented.

F759 – Cited 1 time when a surveyor noted 13 cups of medications in the medication cart with multiple medications in each. The nurse indicated that they set up over-the-counter medications prior to the medication pass.

F760 – Cited 2 times when residents received another resident's medication.

F761 – Cited 1 time when liquid morphine was not stored under a double locking system.

F800 – Cited 2 times for:

- A puree diet was not provided when ordered.
- Correct portion sizes were not served for residents on a pureed diet.

F801 – Cited 3 times for not having a qualified dietary manager.

F803 – Cited 4 times for:

- Items served to residents for meals were not identified on the approved menu.
- All items on the menu were not served.
- Substituted items were not documented or approved.
- Incorrect portion sizes served.

F804 – Cited 4 times when temperatures for hot food were not maintained at or above 135 degrees.

F805 – Cited 2 times when:

- Puree portions were not accurately measured.
- Residents on altered texture diets were served a regular texture diet.

F809 – Cited 2 times for:

- Food was not served at the established mealtimes.
- A resident was not routinely served meals that were missed when returning from dialysis.

F812 – Cited 13 times for:

- 5 times for cleanliness concerns in the kitchen or with equipment.
- 4 times when items were not labeled or dated when opened.
- Refrigerator and freezer temperatures were too high when observed.
- Hair nets were not applied when entering the kitchen.
- Food delivery items were left outside on a warm day for a prolonged period of time.
- 3 times when hand hygiene was not completed appropriately.
- Garbage cans were uncovered.
- Sanitation levels were not high enough to be effective in solutions.
- Food temperatures were not checked prior to serving.
- 5 times when food handling concerns were identified including touching food with bare hands and touching food with contaminated gloves.
- 2 times for not discarding expired food.
- A thermometer was not present in the refrigerator.
- Dishwasher logs were not completed for temperature monitoring.

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

- Provide adequate staffing levels and not following up on incidents and investigations.
- Six immediate jeopardy deficiencies were identified during the on-site survey, there were issues with the internet, fax and printers that disrupted communication.

F837 – Cited 1 time when the facility assessment was not completed and the governing body did not ensure effective administration.

F838 – Cited 2 times when:

- The facility assessment did not include the name of the building, the number of certified beds, average census, capabilities, and resident needs.
- The facility assessment indicated the average census was 45-59 when it was actually 92, two resident halls were not included in the acuity section, and staffing was not adequate based on resident interviews revealing lapses in care.

F839 – Cited 1 time when an RN was working with an expired license.

F842 – Cited 8 times for:

- 2 times when items were documented that were not actually completed.
- 2 times when resident records were stored in boxes in the basement of the building, the records had signs they were previously wet, and the areas were not secure.
- 2 times when electronic records were visible to the public.
- A diagnosis of schizophrenia was added without adequate supporting documentation.
- An assessment was not documented.

F847 – Cited 1 time when a resident with severe cognitive impairment signed a binding arbitration agreement.

F851 – Cited 5 times for:

- 2 times when PBJ reporting was not accurately reported.
- 1 time when agency staff hours were not reported.
- 2 times when PBJ data was not submitted at all.

F865 – Cited 7 times for not implementing an effective QAPI program as evidenced by repeat deficiencies.

F868 – Cited 1 time when the infection preventionist, DON, and medical director were not in attendance at quarterly meetings.

F880 – Cited 19 times for:

- 6 times when hand hygiene was not completed appropriately.
- A barrier was not placed under supplies in a resident room.
- 10 times when EBP were not followed for residents with indwelling devices or wounds.
- The nursing home only had expired COVID-19 tests on site.
- 2 times when gloves were not used/changed appropriately.
- Transmission-based precautions were not followed.
- A catheter drainage bag was held above the bladder level during a transfer.
- Water in the basement led to mold development which possibly exacerbated respiratory conditions.
- Adequate PPE was not available.
- Sanitation supplies were not available for reusable equipment.
- Laundry carts were uncovered in the hallway.
- A dusty fan was blowing on the clean linen area in the laundry room.
- 3 times when staff did not wear protection over their uniform while handling soiled linens.
- Failed to have a water management plan.
- The IPCP policy and overall program was not reviewed/updated annually as required.
- Food was uncovered when transported through the halls.
- Medications were touched by staff with bare hands.
- Residents in transmission-based precautions did not have a sign or PPE placed by their door.

F883 – Cited 2 times when a influenza and pneumonia vaccines were not offered to residents.

F887 – Cited 1 time when the nursing home did not have documentation assessing a resident's COVID-19 vaccination status.

F908 – Cited 1 time when a mechanical lift was missing a button to control the lift and the batteries would not stay charged.

F921 – Cited 2 times for:

- Water in the basement with mold on various items.
- Multiple boxes were stored at the nurses station.

F925 – Cited 1 when mosquitos were noted in the building due to standing water in the basement.

F943 – Cited 2 times when mandatory reporter training for dependent adult abuse was not completed every three years as required.

F944 – Cited 1 time when QAPI education was not provided.

F947 – Cited 1 time for nurse aides not having dependent adult abuse education as required or completion of 12 hours in-service training in the last 12 months.

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.