LTC Survey Trends Report
September 2025

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LeadingAge Iowa

MEDICARE & MEDICAID CHARGES AND LATEST SURVEY UPDATES

by Kellie Van Ree, Director of Clinical Services

The Regulatory Review article for this month reviewed F571 related to charging fees for services covered under Medicare and Medicaid reimbursement.

Survey activity outside of actual harm or immediate jeopardy triaged complaints or incidents have stopped due to the Federal government shutdown. This includes processing surveys that were in process or completed but the reports were not processed prior to October 1. This led to several pending surveys in September that are not available to review outcomes.

Survey Activity

District	Average Months for Providers with Recert	Time Since Last Survey	Longest Survey Timespan
Statewide	11.5 months	14 months = 2 13 months = 7 12 months = 23 11 months = 27	14 months

Recertification:

- 22 total recertification surveys reviewed with 5.4 deficiencies on average per recertification survey with deficiencies.
    - Of the 17 recertifications with at least one deficiency, 5 providers received a fine (or 27%).
    - Of the 22 recertifications, 4 providers had deficiency free surveys (or 18%)
    - 11 pending recertification surveys.

Complaint/Incidents:

- 27 providers with complaint/incident surveys reviewed with 2.9 deficiencies on average per survey reviewed with deficiencies.
    - Of the 18 complaint/incident surveys with at least one deficiency, 9 received a fine (or 50%).
    - Of the 27 complaint/incident surveys, 9 did not receive a deficiency (or 34%).
    - 14 pending complaint/incident surveys.

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	**$71,000**	**0**		**$71,000**	**5.4 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 On With Life – Ankeny and Oaknoll Retirement Residence for deficiency free surveys!

CITATIONS WITH FINES

September Deficiencies with State Fining and Citation

50.7(1); $500. The nursing home did not submit a self-report when a resident had a fall with major injury.

F609; 58.43(9); D; $500. Allegations of possible abuse were not reported to DIAL in a timely manner, including when staff made inappropriate comments to residents.

F609; 58.43(9); D; $500. An incident between two residents was not reported to DIAL as possible abuse.

F678; 58.20(1); J; $10,000 (Held in Suspension). Resident #1 was a full code and was found without breathing or a heart rate. The staff were unaware of the resident's code status, so they went to the record but incorrectly read the resident's record and did not initiate CPR. Additionally, the staff were unaware of the location of the crash cart.

F684; 58.19(2)j; J; $24,750 (Treble/Held in Suspension). Resident #1 returned to the nursing home following partial amputation of the left foot, the staff did not consistently document assessments of the surgical incision. Additionally, other skin areas including the resident's coccyx were not assessed routinely. With the lack of assessments, the resident's wounds deteriorated including development of necrotic tissue to the surgical area on the left foot. A podiatry note stated a wound vac was ordered following debridement of the left foot wound with orders to change Monday, Wednesday, and Friday. Progress notes documented that the wound vac was applied. During subsequent podiatry appointments the wound vac was dead or not applied and the podiatrist directed the nursing home to send the supplies so they can change the dressing and charge the vacuum. The podiatrist reported during an interview that the deterioration in the wound was a direct result of a lack of care from the nursing home staff. Resident #4 had skin integrity concerns including diabetic ulcers to their feet, blisters to their buttocks which lacked routine assessments. Resident #5 had pressure ulcers to the right and left buttock that were not routinely assessed. During interviews, staff reported that Resident #2 fell, and a staff nurse instructed them to get the resident off the floor without first completing an assessment.

F684; 58.19(2)j; G; $9,500 (Held in Suspension). Resident #9 reported episodes of shortness of breath and was given an inhaler. The nurse documented vital signs when complained of shortness of breath but no additional notes, assessments or provider notification were completed. At 6:56 p.m. a progress note identified that the resident was not acting like themselves, they were lethargic most of the day, did not eat, drink or void, did not wake up to take medications and the nurse aide reported that the resident complained of chest pain. The residents' blood pressure was 168/82 and they were transferred to the ER where they were diagnosed as having a myocardial infarction.

F686; 58.19(2)j; G; $5,250 (Held in Suspension). Resident #10 was transferred to the ER on 6.27.25 and did not have any documented wounds. The hospital record included an image of the left heel which had an unstageable pressure ulcer. Resident #10 returned to the nursing home on 7.2.25 and the progress note included notes on dry eschar to the left heel but did not include measurements or an assessment including treatment and interventions. The resident again went to the hospital on 7.9.25, the MDS did not include coding of a pressure ulcer but the hospital record had an image of an unstageable pressure ulcer to the left heel. Similar circumstances happened during a subsequent hospitalization on 7.18.25. Upon readmission, the pressure ulcer was measured, but did not include any additional assessment, treatment, or interventions. Follow up assessments on 7.30, 8.10, 8.19, and 8.30 lacked documentation including measurements, characteristics of the wound and peri-wound, treatments, interventions, or identify if the wound was improving or deteriorating.

F686; 58.19(2)j; G; $5,000. Resident #1's wounds were noted to be deteriorating and was being treated in the wound center. The staff faxed the primary care physician an update on the wounds, indicating they would be seen on the following day, but there wasn't an appointment. A follow up was not completed until 5 days later and identified the wound was worse with a foul odor. The wound center physician changed the treatment until they could be seen in two days. The following day the resident was transferred to the ED with a fever, respiratory distress, and a large buttock ulcer that caused sepsis.

F689; 58.28(3)e; G; (Citation Not Posted). Staff did not complete an assessment to identify if the resident was safe to use an electric wheelchair. During observations Resident #1 was noted leaning significantly to the side and had a bruise on their arm due to getting it stuck in the chair.

F689; 58.28(3)e; J; $6,000 (Held in Suspension). Resident #1 had wandering behaviors and visual impairment (blindness) due to macular degeneration. On 8.19.25 at 3 a.m. Resident #1 was found outside the building by the dumpster lying on the ground. During investigation it was noted that the resident wanted to go to bed so a staff member assisted them to their bed at 1:45 a.m. and shortly after the CNA left the room the resident exited the room walking past several offices and eventually going into the maintenance office and outside of the building. The resident was outside from 2:12 a.m. until found at 3:03 a.m. During investigation of the incident, it was noted that the door did not lock because the electronic lock batteries died which allowed the resident to leave the building without the staff's knowledge.

F689; 58.28(3)e; G; $8,250. Resident #1's fall interventions included a pressure alarm. On 7.10.25, Resident #1 fell and sustained a fracture to their right elbow that required surgical repair and a laceration near their right eye which required 7 sutures. The pressure alarm did not sound at the time of the fall and staff did not determine why the alarm failed to sound. The resident returned to the nursing home because they required cardiac clearance prior to surgery. On 7.11.25 Resident #1 fell again resulting in a fracture of the left elbow which also required surgical repair and again, the alarm failed to sound.

F689; 58.28(3)e; J; $7,250 (Held in Suspension). Resident #54 fell from a mechanical lift when there was a kink in the sling, and the staff attempted to fix it while the resident was in the lift. The resident was sent to the hospital and diagnosed with bilateral sacral fractures. During investigation staff were unaware of how to determine the appropriate size lift sling for the residents. The staff did not follow the care plan for Resident #70 which resulted in additional falls and the staff did not use a gait belt when the resident was standing at the bathroom sink.

F689; 58.28(3)e; G; $5,500. A staff member did not use a gait belt during a transfer with Resident #1 which resulted in the resident falling and receiving a left arm and wrist fracture.

F697; 58.19(2)j; G; $5,250. Resident #14 had new onset and then increased pain after a fall. Despite the reports of pain, the provider did not administer pain medication or non-pharmacological pain measures. The staff later identified the increased pain was related to a fractured hip. The fall occurred on 9.13.25 and the resident was not transferred to the hospital until 9.16.25.

F697; 58.19(2)j; G; (Citation Not Posted). Resident #1 was noted to have chronic pain with increased acute pain related to an amputation. The resident had Oxycontin prescribed, but the notes stated that the medication was not available. The resident was eventually sent to the ER due to severe pain after they did not receive their pain medication for several days. The ER provided relief and sent an extra dose to the nursing home until the medications could be delivered. However, the resident was sent back to the ER the following night due to pain and again the medication was not available.

F812; 58.24(5); 58.32(9); L; $8,000 (Held in Suspension). The kitchen had signs of significant water damage including missing ceiling tiles, collapsing ceiling tiles, and others that showed significant damage. One tile in a food preparation area was moist and drops of water were beading from the tile. Odors of spoilage and dampness were noted. The floor was caked in sticky substances and food particles and there were numerous sticky traps around with signs of rodent droppings, light grey fur, and numerous insects near the dry storage area. Food that expired was served to residents the morning of the observation. The floor drains in the kitchen had small, worm-like insects and insect eggs. Rodent droppings were noted in front of the oven; a collection of coffee creamers and sponges were noted behind a sink with what looked like mold growing on it and the mold-like substance was also noted in the floor drains. The equipment throughout the kitchen was covered in a layer of grime and the flattop area on the stove appeared to not have been cleaned in some time. During subsequent observations new rodent droppings were identified in the kitchen and the staff reported seeing mice just minutes before. Cleaning logs for the kitchen were not completed since late April and May (survey conducted early September) with staff interviews stating that it is hard to clean the kitchen due to years of "crusted gunk" built up and issues with the kitchen flooding. Staff also report seeing mice and cockroaches that were reported to management staff. Staff also reported that when they ate the food they had vomiting and diarrhea after as were several residents recently.

TOP DEFICIENCIES

F-TAG #	
F880	Infection Prevention & Control
F684	Quality of Care
F689	Accidents/Hazards/Supervision/Devices
F550	Resident Rights/Exercise of Rights

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:

F550 - Cited 10 times for failure to treat residents with respect, dignity, and privacy by:

- Refused to provide care.
- Staff member told a resident with dementia they were going to the hospital to get their leg cut off.
- Residents body was exposed in the dining room.
- 2 times when staff did not knock on the door before entering the resident's room.
- Staff did not explain what they were doing before doing it.
- Did not have a dignity bag covering a catheter drainage bag.
- A resident was taken to a meal in their nightgown.
- Staff used double incontinent products on the resident.
- 2 times when staff swore at residents.
- Staff were too quick when completing care and caused the resident pain.
- Staff made disparaging comments about residents in front of other residents.

- Staff told a resident to leave the dining room.
- Removed a hearing processor from a resident's head so they couldn't hear.

F552 – Cited 1 time when staff did not document that a resident representative was notified prior to starting an antipsychotic.

F578 – Cited 1 time when a physician's signature was not on a code status form.

F580 – Cited 4 times when the physician and responsible party were not notified of:

- Weight loss.
- Change in tube feeding formula.
- Wanderguard placed.
- Worsening of wounds.
- Falls.

F583 – Cited 1 time when a resident's curtain was not closed during a transfer.

F584 – Cited 5 times for failure to provide a homelike environment by:

- 2 times for urine odors.
- 2 times for repairing items in the environment.
- Did not remove dirty dishes from a resident's room.
- Did not protect resident's property from loss or theft.
- Did not complete an inventory sheet.
- Air conditioning units had black mold-like substances.
- Sheets had brown and yellow staining.
- Urinals with urine left in them.
- Ceiling panels falling.
- 2 times when the building did not have adequate supplies.
- Stains were present on the walls.
- Resident rooms were not cleaned routinely.
- A cushion had foam coming out.
- Jagged edges in the environment.

F600 – Cited 3 times when:

- A staff member threatened a resident and pulled on their arm.
- There was an inappropriate relationship between a resident and staff member based on text message exchanges.
- A staff member shared a video on social media and referred to the resident as "crazy".

F605 – Cited 4 times when:

- 3 times when non-pharmacological interventions were not included in the care plan.
- 2 times when target behaviors were not identified in the care plan.
- A GDR that was declined by the physician did not have a clinical rationale for declining.
- Staff did not allow adequate time for effectiveness of a medication before administering another medication.

F607 – Cited 1 time when a criminal background check was not completed prior to hire.

F610 – Cited 1 time when the nursing home did not investigate allegations of staff pulling on the resident's arms.

F627 – Cited 1 time when a bed hold notice was not given to a resident due to them owing the nursing home money and the resident was not allowed to return to the nursing home following hospitalization.

F628 – Cited 6 times for:

- 2 times when the bed hold notice was not signed according to the policy and procedures.
- A bed hold notice was not provided.
- Accurate rules were not cited when they provided an involuntary discharge notice.
- 2 times when the LTC Ombudsman was not notified of transfer/discharge.

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

F641 – Cited 4 times when:

- The MDS was not accurately coded by:
    - Ozempic was coded as insulin.
    - Coded side rails as a restraint.
    - MDS' were not completed timely.
    - Coded pneumonia vaccines were up to date, but were not.
    - Did not code a Wanderguard.
    - A level 2 was not coded in the MDS.

F645 – Cited 1 time when a significant change Level 1 was not submitted for a bipolar diagnosis.

F656 – Cited 2 times for:

- The care plan did not include:
    - A diagnosis of edema
    - 2 times for the use of diuretic medications
    - Antidepressant
    - Skin impairment

F657 – Cited 1 time when the care plan was not updated to include hospice and there was not documentation supporting the resident or representative was included in the care planning process.

F658 – Cited 5 times for:

- 4 times when the physician orders were not followed.
- The resident did not rinse their mouth following use of an inhaler.

F676 – Cited 1 time when a restorative program was not provided and staff did not complete a review of the restorative program.

F677 – Cited 2 times for failure to complete incontinent care.

F679 – Cited 1 time when activity staff were working the floor and did not have scheduled weekend activities.

F684 – Cited 11 times for:

- 2 times when treatments for skin impairment were not administered timely and interventions were not followed.
- An assessment was not completed for a change in condition.
- Oxygen was not administered when oxygen saturation levels were low.
- Did not complete an assessment when a resident was given food they had allergies to.
- 2 times when skin impairment was not assessed.
- Staff did not document collaboration with hospice providers.
- Neurological assessments were not completed after falls per the policy.
- Therapy recommendations were not implemented.

F689– Cited 10 times for:

- The bed was not locked as staff repositioned residents in bed.
- 2 times when mechanical lift transfers were not completed safely. This includes when the sling caught on the chair, the staff rolled over power cords, and there was not a second staff member assisting.
- A resident eloped into the yard of the nursing home.
- A cognitively impaired resident was not supervised when they went outside.
- Staff did not ensure that a resident was strong enough to complete a mechanical stand lift transfer.

F690 – Cited 2 times for:

- Gloves were not changed appropriately.
- A catheter drainage bag was not emptied frequently enough that it caused an excessive amount of urine to be collected in the bag.

F692 – Cited 2 times when:

- Dialysis recommendations for special dietary restrictions were not followed.
- A weight loss was not identified and the physician notified.

F693 – Cited 3 times for:

- Placement was not checked for the feeding tube.
- Flush was not completed before and after medications were administered.
- Physician orders were not followed for flush amounts.

F695 – Cited 4 times when:

- 2 times when oxygen tubing and humidifier bottles were not changed.
- Oxygen flow rates were not documented.
- The order was not in accordance with the hospice records.

F725 – Cited 6 times when:

- 6 times for call lights not responded to timely.
- Did not provide assistance with toileting.
- A resident was left in bed all day due to lack of staffing.

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

F732 – Cited 1 time when the posting was behind the nurse's station and was not visible to residents and the public.

F755 – Cited 1 time when narcotics were not correctly reconciled which resulted in missing narcotics.

F759 – Cited 1 time when medications were omitted.

F760 – Cited 1 time when a resident received oxycodone instead of Ativan.

F801 – Cited 1 time when the nursing home did not have a CDM.

F803 – Cited 2 times when correct portion sizes were not served.

F804 – Cited 2 times when hot food was not maintained at or above 135 degrees.

F806 – Cited 1 time when a resident was served food they were allergic to.

F812 – Cited 6 times for:

- 2 times when food was not discarded timely.
- Food was not covered when stored.
- 2 times for general cleanliness concerns.
- The sanitizer levels in the dishwasher were not maintained.
- 2 times with food handling concerns.
- Cold food temperatures were not maintained at 41 or less.
- The garbage was not covered.
- Food was moldy.
- Equipment was not clean.
- Staff did not wear hairnets.

F835 – Cited 1 time when administration was not adequate based on having adequate supply inventory and concerns with pest control.

F838 – Cited 1 time when the facility assessment did not identify the number of nursing staff necessary based on the resident census.

F842 – Cited 2 times when:

- Medications were not documented appropriately on the MAR.
- Communication with an ENT physician was not documented in the record.

F865 – Cited 5 times when the nursing home did not have an effective QAPI process based on repeat deficiencies.

F868 – Cited 1 time when the medical director did not attend quarterly meetings.

F880 – Cited 14 times for:

- 9 times when staff did not use EBP.
- 2 times when reusable equipment was not sanitized between resident use.
- Gloves were not changed when necessary.
- A catheter bag touched the floor.
- 2 times when staff touched medication with their bare hands.
- 5 times when staff did not complete hand hygiene appropriately.
- The laundry room did not have a separate entrance for clean and soiled linens.

F883 – Cited 3 times when pneumonia vaccines were not offered to residents according to the CDC guidance.

F887 – Cited 2 times when COVID-19 vaccines were not offered to residents and staff.

F925 – Cited 1 time when flies were noted landing on food and dead flies were in the kitchen.

F940– Cited 1 time when a provider was missing several elements of staff training.

F943 – Cited 2 times when:

- Staff did not complete dependent adult abuse training within 6 months of hire.
- Staff did not complete dependent adult abuse within 3 years of last completion date.

F944 – Cited 1 time when staff were not trained on QAPI.

F945 – Cited 1 time when staff did not receive training on infection prevention and control programs.

F946 – Cited 1 time when staff did not have training on compliance and ethics.

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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