LTC Survey Trends Report April 2026

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LeadingAge® Iowa

REGULATORY REVIEW & SURVEY UPDATES

by Kellie Van Ree, Vice President of Clinical Services & Education Strategy

A new regulatory review article on [F688 Mobility and Range of Motion] was recently included in a newsletter.

Additional Resources on Restorative Care for your use:

- Restorative Nursing Program FAQ
- Restorative Nursing Plan Worksheet

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Survey Activity

District	Average Months for Providers with Recert	Time Since Last Survey	Longest Survey Timespan
Statewide	12.4 months	16 nursing homes are currently over 12 months	14 months

Recertification:

- 38 total recertification surveys reviewed with 4.8 deficiencies on average per recertification survey with deficiencies.
  - Of the 34 recertifications with at least one deficiency, 6 providers received a fine (or 18%).
  - Of the 38 recertifications, 4 providers had deficiency free surveys (or 10%)

Complaint/Incidents:

- 49 providers with complaint/incident surveys reviewed with 2.1 deficiencies on average per survey reviewed with deficiencies.
  - Of the 29 complaint/incident surveys with at least one deficiency, 9 received a fine (or 31%).
  - Of the 49 complaint/incident surveys, 20 did not receive a deficiency (or 40%).

Congratulations to LeadingAge Iowa members on a deficiency free survey:

- **Iowa Veteran's Home**
- **Story Medical Senior Care**
- **The Vinton Lutheran Home**
- **Titonka Care Center**

Enforcement Action

CY 2026	State Fines	Federal CMPs	Enforcement	Total	Avg number of deficiencies
January	$27,000	$50,568		$77,568	6.2 deficiencies
February	$55,500			$55,500	5.5 deficiencies
March	$103,250			$103,250	6 deficiencies
April	$64,000			$64,000	4.8 deficiencies

<u>Calendar Year 2025 Totals:</u>

State Fines - $592,250; Federal CMPs $2,175,610; Total $2,767,860; 14 Denials; 2 DPOCs; Average of 5.5 deficiencies per recertification survey.

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

April Deficiencies with State Fining and Citation

50.7; $500. Suicide attempts weren't reported to DIAL.

F600; 58.43; G; No citation issued. Resident #6 had a history of behaviors that significantly intruded on the privacy or activity of others. The care plan included a focus of psychotropic medications but lacked behaviors and interventions. There were many instances of aggressive behavior from the resident in the resident's record and during interviews other residents expressed concerns with the resident's behaviors that impacted their psychosocial well-being including anxiety, social isolation, decline in nutritional intake and fear.

F600; 58.43; G; No citation issued. While providing care to a resident they became agitated and a staff member became increasingly irritated, eventually swatting at the resident with an open hand and scratching their upper lift and cheek.

F607; 58.11(3); E; $500. A criminal background check wasn't completed prior to hiring a staff member.

F607; 58.11(3); D; $500. The nursing home didn't follow their policy for abuse by completing a criminal background check prior to employment for one staff.

F607; 50.9(4); D; $500. Staff H's background check wasn't completed prior to hire and information was not obtained from DCI for evaluation of criminal background. Staff I's nursing license wasn't verified prior to hire.

F609; 58.43(9); D; $500. Allegations of abuse weren't reported to DIAL within 2 hours when a staff member was witnessed hitting a resident's hand twice while performing care.

F609; 58.43(9); D; $500. An allegation of abuse wasn't reported to DIAL within 2 hours when a staff member was asked to take a resident to the restroom and told the resident to go in their pants.

F609; 58.43(9); D; $500 (Held in Suspension). The nursing home failed to report an allegation of abuse when a resident reported that they were being attacked by staff.

F609; 58.43(9); E; $500. DIAL wasn't notified within 2 hours of possible medication diversion including when staff noted that a blister card was taped together.

F609; 58.43(9); D; $500. Resident-to-resident abuse was not reported to DIAL in a timely manner or when a staff member was reported to slap a resident.

F609; 58.43(9); D; $500. An allegation of abuse wasn't reported to DIAL within 2 hours when staff witnessed a nurse tell a resident to shut up in the dining room and grabbed them by their arm to attempt to forcefully remove them from the dining room.

F684; 58.19(2)j; G; $27,750 (Treble/Held in Suspension). Resident #16 had a diagnosis of COPD. On 4.15.26 at 10:50 a.m. staff noted that the resident's oxygen saturation was abnormal and placed a call to their physician with call back number. At 12:04 p.m. the physician returned the call and was notified of stable vital signs with normal oxygen saturation due to the resident's BiPAP being on. At 10:41 p.m. the resident called 911 because they thought they were at another building and the person next to them had a stroke. EMS arrived and transported the resident to the hospital where they were admitted with an exacerbation of

CHF. The resident's record lacked documentation of a respiratory assessment. When EMS arrived the resident's oxygen saturation levels were high 60's to low 70's. Resident #41 had a diagnosis of COPD and used a blood thinner. On 3.30.26 at 8:05 a.m. the nurse faxed the physician indicating they had a cough with bloody sputum noted, low blood pressure and heart rate. The resident complained about not being able to take a deep breath. They had an appointment with the nurse practitioner later that day and were sent to the hospital at that time. During a bronchoscopy the hospital found a blood clot blocking their airway and an active bleed in the right upper lobe. During interviews it was noted that the resident had cups with bloody sputum in them that were not addressed by staff.

F689; 58.28(3)e; J; $8,250 (Held in Suspension). According to resident #1's record, on 4.2.26 at 5 p.m. when the nursing home was notified that during transport from a medical appointment to the nursing home the resident was involved in a motor vehicle accident and passed away. The incident investigation notes included at 2 p.m. on 4.2.26, the resident was involved in an accident in a company-operated vehicle. During the trip another vehicle turned in front of the company owned vehicle and the driver braked and swerved to attempt to avoid a direct impact. EMS were immediately contacted, and first responders arrived on scene. The resident's wheelchair was secured to the van, but they didn't have a seat belt secured which caused them to fly out of the wheelchair over a folded middle row seat where they landed face down and their head was near the floor between the second row and back side of the driver's seat. EMS attempted emergency measures, but the resident was declared deceased on site. During interviews the driver indicated they were educated to only use seat belts when a resident was in the seat and not necessary when in a wheelchair.

F689; 58.28(3)e; G; $4,000. Resident #2 had a fall in which staff saw them sliding out of a lift recliner chair and used the gait belt to assist them to the floor. The fall was not reported to the nurse before assisting the resident off the floor. The resident landed on their knees when they were lowered to the floor. The resident had an x-ray the following day due to reports of knee pain and was noted to have a fractured patella.

F689; 58.28(3)e; G; $5,000 (Held in Suspension). On 9.17.25 Resident #4 was attempting to turn an electric scooter around and exit the elevator independently when the door began to close and hit their leg. Later that day the resident's leg was swollen, and they complained of severe pain when they were transferred to the ED and diagnosed with a left lower leg hematoma. Therapy notes indicated the resident required assistance x 1 staff in the elevator. At the time of the incident the resident had a staff member with them, but they let go of the door to get out of the elevator for the resident to exit which caused the door to go into nudge mode.

F689; 58.28(3)e; G; $2,500 (Held in Suspension). During a mechanical lift, Resident #18 hit their head on the car causing a bruise. Staff implemented new interventions including approaching the wheelchair from the front and not the side, turning the resident away from the lift, and having them bend their right leg. During a subsequent transfer, the staff placed the lift on the side of the resident and when they began to lift, it tipped, causing the resident to be hit with the lift. The resident received a hematoma from the incident.

F760; 58.19(2)a; G; $6,500 (Held in Suspension). Resident #3 had orders for Tylenol, hydrocodone/acetaminophen, oxycodone for moderate to severe pain, and hydromorphone for severe pain rated at a level 10. Staff administered several hydromorphone without the resident's pain rating being documented as a 10 as indicated in the order. During record review, surveyors indicated that 76.5% of 17 pain medication administrations of hydromorphone there was no documentation of meeting the ordered parameters for administration. The resident was hospitalized during this time for acute hypoxic respiratory failure.

F760; 58.19(2)a; G; $5,000. Staff administered the resident's medications to them and then administered another resident's medications to the same resident. The resident's blood pressure went from 100/50 to

73/48 resulting in an order to transport the resident to the ER where they were admitted for drug overdose and monitored due to sinus bradycardia.

TOP DEFICIENCIES

F-TAG #	
F880	Infection Prevention & Control
F812	Food Procurement, Store/Prepare/Serve - Sanitary
F760	Residents are Free from Significant Medication Errors
F689	Accidents/Hazards/Supervision/Devices
F628	Discharge Process

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

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

F550 - Cited 6 times for failure to treat residents with respect, dignity, and privacy by:

- Allegations of staff to resident abuse.
- A staff member told a resident to go to the bathroom in their pants.
- The staff used two incontinent pads at a time on residents.
- A resident reported staff refused to change their incontinent pad when asked.
- Staff told a resident they can complete ADLs themselves.
- Staff didn't assist a resident in a timely manner which caused incontinence.

F552 - Cited 3 times when residents or their representatives weren't offered the opportunity for informed decision making related to psychotropic medications.

F554 - Cited 1 time when medications were left in the dining room without staff supervision.

F558 - Cited 1 time when transportation wasn't arranged for a resident to go to an appointment.

F561 - Cited 1 time when medications weren't administered when the resident requested and it interrupted their sleep.

F576 - Cited 1 time when residents were required to use the phone at the nurses station.

F578 - Cited 2 times when the resident's record for code status didn't match their IPOST.

F580 - Cited 2 times when the resident's physician and/or representative weren't notified of:

- A medication error
- A fall where a fracture was later identified

F582 - Cited 1 time when the notice wasn't issued timely and an ABN wasn't given when necessary.

F584 – Cited 7 times for:

- 3 times for room cleanliness
- Odors
- 3 times for disrepair in the resident areas
- Failure to provide clean linen
- Dead mice were noted in traps
- Privacy curtains weren't large enough to allow the resident full privacy.

F602 – Cited 2 times when:

- A staff member purchased items for a resident while purchasing something for themselves with the resident's money and they didn't give the resident the change back.
- Medications were diverted.

F604 – Cited 3 times when:

- Staff placed a seatbelt on a resident to prevent them from falling, but the seatbelt wasn't assessed for a physical restraint.
- Gait belts were used to restrain a resident to a recliner chair.
- A lap belt wasn't assessed to determine if it was a physical restraint.

F605 – Cited 1 time when staff didn't document non-pharmacological approaches prior to psychotropic medication administration.

F607– Cited 1 time when an incident of a visitor getting upset with a resident wasn't reported as an allegation of abuse.

F610 – Cited 1 time when an allegation of abuse wasn't investigated.

F628 – Cited 10 times for:

- 2 times when bed hold information wasn't provided.
- The discharge summary wasn't completed.
- The staff didn't document that the family requested the transfer to another building.
- 6 times when the long-term care ombudsman wasn't notified of the discharge or transfer.
- 2 times when the discharge recapitulation wasn't completed.
- The record didn't include a copy of the information provided to the hospital.

F637 – Cited 1 time when a significant change MDS wasn't completed when hospice discharged the resident.

F640 – Cited 2 times when MDS' weren't completed and submitted timely.

F641 – Cited 3 times when:

- PASRR Level 2 wasn't coded.
- Mounjaro was coded as insulin.
- Clopidogrel was coded as an anticoagulant.
- Grab bars were coded as a restraint.
- An antianxiety and antipsychotic medication wasn't coded on the MDS.
- The resident's smoking status wasn't coded.
- A sacral fracture wasn't coded as a major injury.

F644 – Cited 5 times when:

- 3 times when the level 1 was not completed with a new mental illness diagnosis.
- 2 times when the diagnoses were not accurate and complete on the level 1.

F645 – Cited 2 times when:

- There wasn't a level 1 completed prior to admission.
- Not all mental illness diagnoses were included on the level 1.

F655 – Cited 1 time when the baseline care plan didn't include that the resident used a BiPAP.

F656 – Cited 8 times when:

- When the care plan didn't include:
  - Smoking
  - Opioids
  - Anticoagulants
  - 2 times for antidepressants
  - Diuretics
  - Wandering/elopement risk
  - 2 times for target behaviors for psychotropic medication use
  - Diagnosis for antipsychotics
  - Non-pharmacological interventions to attempt to prior to psychotropic medication use
  - Assessing the dialysis site
  - Suicidal ideations
- Staff didn't follow the care plan.
- The care plan wasn't updated when the resident no longer received medications via g-tube.
- The CAAs were triggered by the MDS but weren't care planned and didn't have an associated worksheet identifying why they were not care planned

F657 – Cited 7 times when:

- Interventions weren't re-evaluated when they were not effective to prevent behaviors.
- A care conference wasn't offered prior to the first quarterly conference.
- The care plan was not updated to include:
  - Smoking and vaping status
  - Hospitalizations
  - PICC line
  - Exit seeking behaviors
  - Noncompliance with skin interventions
  - History of visitor to resident abuse

F658 – Cited 8 times for:

- Medications weren't administered timely.
- 5 times when physician orders weren't followed.
- 2 times when the resident's mouth wasn't rinsed following administration of a steroid inhaler.
- Staff didn't wait the appropriate time between a nebulizer treatment and administration of an inhaler.
- Adverse effects weren't monitored followed administration of a vaccine.
- Staff didn't remove the Fentanyl patch before applying a new one.

F675 – Cited 1 time when staff didn't sit a resident upright when trying to feed them.

F676 – Cited 2 times when bathing and restorative care wasn't provided as care planned.

F677 – Cited 8 times when residents were not provided:

- Incontinent care
- 2 times nail care
- 2 times shower/bathing
- Toileting assistance
- Food cut up
- 2 times shaving
- Oral care
- Feeding assistance

F684 – Cited 3 times for:

- Staff didn't intervene when medications weren't available to administer.
- A change in condition wasn't documented in the resident's record.
- Daily weights weren't obtained according to the physician's order.

F686 – Cited 3 times for:

- 2 times when treatments weren't completed.
- Weekly assessments weren't done.
- Care planned interventions for risk were not identified.
- Infection control concerns with the dressing change including:
    - Disinfecting the scissors between dirty and clean.
    - Glove changes.
    - Hand hygiene.
    - Cleansing the wound after a dressing was removed.

F688 – Cited 2 times when restorative wasn't provided as care planned.

F689– Cited 12 times for:

- The wheelchair brakes weren't locked during a transfer.
- Foot pedals weren't used.
- Gait belt wasn't used during transfer/ambulation.
- Staff failed to supervise a resident when using their vape device as care planned.
- A call light wasn't within reach of a resident.
- The manufacturer's recommendations for when to lock the wheels during a lift weren't followed.
- Failed to ensure alarms were functioning.
- Resident's weren't supervised during meal times as directed in their care plans.

F690 – Cited 3 times for:

- Catheter bags weren't changed according to the physician's order.
- Glove changes and hand hygiene weren't completed appropriately during toileting.
- There wasn't a physician's order for the catheter.
- The catheter bag was laying on the floor.

F695 – Cited 5 times when:

- 2 times when there wasn't a physician's order for respiratory equipment.
- 2 times when the record didn't include CPAP and/or BiPAP settings.
- 2 times when there wasn't a routine cleaning protocol for a CPAP and BiPAP.
- The oxygen flow rate wasn't in accordance with the order.
- The regulator for the e-cylinder wasn't placed correctly and the resident wasn't receiving oxygen.

F698 – Cited 2 times for:

- 2 times for pre- and post-dialysis assessments not being completed.
- Ongoing communication/collaboration wasn't documented.

F725 – Cited 5 times when:

- 5 times when the call lights weren't responded to in an appropriate time frame.
- Staff couldn't answer the door alarm in a timely manner resulting in an elopement.

F727 – Cited 1 time for failure to have RN coverage for 8 hours each day.

F732 – Cited 1 time for failure to post staffing.

F755 – Cited 3 times for:

- Controlled substances weren't documented on both the MAR and the log record.
- 2 times when medications weren't reconciled accurately.
- Discontinued medications weren't removed from the medication cart.
- OTC meds weren't stocked resulting in medication omissions.
- Administered duplicate doses of medications.

F759 – Cited 1 time when Fosamax wasn't administered according to manufacturer's recommendations.

F760 – Cited 13 times for:

- 3 times when medications weren't administered as ordered.
- 2 times when staff didn't leave the insulin pen in the skin for the period of time after the administration ended.
- The morphine strength wasn't verified which resulted in a medication error.
- 2 times when incorrect doses were administered.
- Staff failed to hold medications which resulted in surgery being cancelled.
- 2 times when a resident received another residents medications.
- Medications were left at bedside when they shouldn't have been.
- Incorrect medications were administered.

F761 – Cited 5 times when:

- 3 times when the cart was locked and unattended.
- Medications weren't removed when they were discontinued.
- Insulin wasn't dated when opened.

F803 – Cited 1 time when staff didn't provide the correct texture of food to the resident.

F804 – Cited 6 times when:
- 6 times when food wasn't maintained at or above 135 degrees.
- Food was dry.
- Cold food was above 41 degrees.

F805 – Cited 1 time when accurate portion sizes weren't provided.

F806: Cited 1 time when a resident was given food they were allergic to.

F812 – Cited 16 times for:

- 3 times when gloves weren't used appropriately.
- Beard net wasn't applied.
- 5 times for food handling concerns.
- 4 times when food wasn't dated when it was opened.
- Storage of food on the floor.
- 8 times when hand hygiene wasn't completed appropriately.
- 5 times when food wasn't discarded when expired.
- Hairnets were not applied.
- There wasn't any chemical sanitizer strips for testing concentrations.
- Food wasn't covered when it was stored.
- Kitchen cleanliness.
- Clean dishes weren't stored properly.
- 2 times when logs weren't completed consistently.

F842 – Cited 2 times when:

- 2 times when medical records weren't secure.
- Nurse's notes weren't completed when necessary.

F851 – Cited 1 time when PBJ hours weren't submitted correctly.

F865 – Cited 5 times when providers didn't have effective QAPI processes based on repeated deficiencies cited and to correct multiple medication errors.

F868 – Cited 1 time when the infection preventionist wasn't present at the quarterly QA meetings.

F880 – Cited 21 times for:

- 10 times when hand hygiene wasn't completed appropriately.
- 4 times when glove changes weren't performed.
- 2 times with infection control concerns related to dressing changes.
- The rubber stopper wasn't disinfected prior to drawing up insulin in a vial.
- There was black substance in the basement due to excessive water.
- 8 times when EBP wasn't followed.
- The glucometer wasn't disinfected between residents.
- Transmission based precautions weren't followed.
- Food handling concerns.
- 2 times when linens were uncovered.
- Staff didn't wear PPE to separate soiled laundry.

F883 – Cited 3 times when pneumonia and/or influenza vaccinations weren't offered or administered.

F887 – Cited 3 times when COVID-19 immunizations weren't offered or administered.

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