LTC Survey Trends Report
December 2025

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LeadingAge Iowa

REGULATORY REVIEW & SURVEY UPDATES

by Kellie Van Ree, Vice President of Education and Clinical Services

A new regulatory review article on F575 – Posted Notices was included in the newsletter recently. The Department of Inspections, Appeals, & Licensing (DIAL) is trying to catch back up on recertification activity after the federal government shutdown. During the recent association update call, the long-term care unit indicated that their average of recertifications exceeds 12 months, but there are not any nursing homes that exceed the 15.9 month period as directed by the Centers for Medicare & Medicaid Services (CMS).

DIAL also emphasized that an immediate jeopardy cited under F880 (detailed later in this report) was cited due to systematic failures that resulted in significant transmission of COVID-19 between residents. The minimum expectation is that providers are using the Centers for Disease Control & Prevention (CDC) guidance for managing COVID-19 outbreaks. If your practices are not in line with the CDC guidance, you must be able to identify what national standards you're following and why.

Federal information in the QCor website still has not been updated since June, 2025, which includes information on federal fine activity and other enforcement action such as denial of payments or directed plans of correction. According to LeadingAge National, this relates to the transition from Aspen to iQIES for the survey agencies.

Survey Activity

District	Average Months for Providers with Recert	Time Since Last Survey	Longest Survey Timespan
Statewide	12.7 months	31 nursing homes currently exceed 12 months or more.	15 months

Recertification:

- 35 total recertification surveys reviewed with 5.2 deficiencies on average per recertification survey with deficiencies.
    - Of the 31 recertifications with at least one deficiency, 5 providers received a fine (or 11%).
    - Of the 35 recertifications, 4 providers had deficiency free surveys (or 11%)

Complaint/Incidents:

- 51 providers with complaint/incident surveys reviewed with 2 deficiencies on average per survey reviewed with deficiencies.
    - Of the 25 complaint/incident surveys with at least one deficiency, 8 received a fine (or 32%).
    - Of the 51 complaint/incident surveys, 26 did not receive a deficiency (or 51%).

Enforcement Action

CY 2025	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVG NUMBER OF DEFICIENCIES
JANUARY	$32,250	$301,215	2 Denials; 1 DPOC	$333,465.00	4.6 deficiencies
FEBRUARY	$50,250	$63,498.50	3 Denials; 1 DPOC	$113,748.50	8.3 deficiencies
MARCH	$64,000	$59,302.75	1 Denial	$123,302.75	5.6 deficiencies
APRIL	$22,000	$66,225.25	1 Denial	$88,222.25	6.2 deficiencies
MAY	$27,750	0		$27,750	5 deficiencies
JUNE	$53,500	0		$53,500	5.9 deficiencies
JULY	$86,740	0		$86,750	3.7 deficiencies
AUGUST	$122,500	0		$122,500	6.3 deficiencies
SEPTEMBER	$76,000	0		$71,000	5.4 deficiencies
OCTOBER	$176,000	0		$176,000	(see November)
NOVEMBER	$72,000	0		$72,000	3.8 deficiencies
DECEMBER	$74,250	0		$74,250	5.2 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 – Long Term Care on a deficiency free survey!

CITATIONS WITH FINES

December Deficiencies with State Fining and Citation

50.7; $500. The nursing home did not report an elopement when a resident was found outside and had fallen.

50.7; $500. The nursing home did not notify the state fire marshal when the nursing home's heating unit malfunctioned leaving portions of the building without heat from 11.26.25 through 12.3.25.

F600; J (no state citation report). Resident #34 reported that Staff A refused to suction their tracheostomy, and they felt neglected by them. During interviews the DON indicated they came into the building during the overnight hours as staff would frequently contact them about Staff A not suctioning the resident as requested to complete the task. Staff A reported that they completed the task multiple times during their shift but did not document it.

F607; 50.9(4); $500 (no scope and severity included in report). A criminal background check was completed on 1.31.25 but the individual was not hired until 4.14.25.

F609; 58.43(9); $500. The nursing home did not report an allegation of possible physical abuse within the required time frames.

F609; 58.43(9); $500. An allegation of possible abuse was not reported to DIAL in a timely manner when a staff member observed another staff member poking a resident in the chest while reprimanding them for falling.

F609; 58.43(9); $500. The maintenance supervisor reported allegations of possible abuse to the assistant director of nursing. The ADON did not inform the administrator of the allegations, initiate an investigation, or separate the staff member. The following day, the maintenance supervisor reported the allegations to the administrator. Additionally, the nursing home did not report the allegations to the police. The staff member worked full shifts the day of the initial report and the day after.

F610; J (no state citation report). The provider did not separate Staff A from residents when they were made aware that the staff member was not performing necessary care and service and did not investigate possible neglect.

F684; 58.19(2)h; G; $6,750 (Held in Suspension). Resident #29 was admitted with vascular wounds that lacked proper assessments and treatments ordered by the physician were not completed on multiple occasions. According to the vascular surgeon’s notes, the treatment was last completed 9 days ago due to lack of staffing, and an antibiotic was ordered for an infection. Resident #2 obtained skin tears that lacked completion of treatments on more than one occasion. Additionally, the surveyor observed the dressings not in place.

F684; 58.19(2)j; G; $5,750 (Held in Suspension). In early November, Resident #1 was found to have a urinary tract infection (UTI) and started an antibiotic. The resident continued to be febrile on and off throughout the month. Staff did not provide timely and consistent assessments including vital signs and did not contact the provider when the resident had a continued fever. On December 1, the resident was admitted to the hospital with urosepsis.

F684; 58.19(2)j; J; $10,000 (Held in Suspension). Another resident reported that Resident #1 vomited during their meal. Nursing staff checked on the resident and described labored breathing and "choking". They assisted the resident out of the dining room while they continued to spit out sputum. The resident was then assisted to the restroom and ready for bed when they applied the residents CPAP, elevated the head of their bed, and were left to sleep. Around 10:30 p.m. staff went to check on them, and they were described as having audible crackles, high blood pressure, and low oxygen saturation. The resident passed away before emergency services arrived at the building. The staff did not complete an assessment after the resident had the incident at the table and before the significant change in condition identified later.

F686; 58.19(2)b; J; $10,000 (Held in Suspension). Resident #14 was admitted on October 27 without pressure ulcers present and was assessed as being at risk. The resident developed a pressure ulcer that was noted on November 12 as a Stage 3 on their sacrum. The following day, the physician ordered treatments and prevention measures including an air mattress and every 2 hour repositioning. During surveyor observations, the resident did not have a dressing covering the wound, an air mattress on their bed, and was in the same position for more than 2 hours. The resident also developed another non-stageable pressure ulcer after the observations by the surveyor.

F689; 58.28(3)e; G; $6,000. Resident #1 was transferred using the Hoyer lift and only one staff member when they fell out of the lift. The resident was transported to the hospital where they were life flighted to a higher-level hospital. They were diagnosed with a skin tear of right and left elbows, closed fracture of the nose, complex laceration of the forehead, blunt head trauma, and superficial lacerations. The nursing home staff identified that the staff member who transferred did not follow their policy for requesting a second person to assist with the transfer.

F689; 58.28(3)e; G; $8,000 (Held in Suspension). Resident #3 was transferred to their bed on 7.25.25 around 7 p.m. when they fell out of the mechanical lift, landing on their knees and hitting their head. The resident had a hematoma to the left side of their head and a laceration to their face because of the fall. Resident #3 was sent to the ER for evaluation and returned in the middle of the night with a diagnosis of a sacrum and tibial plateau fracture. The resident started projectile vomiting later that day and was sent back to the ER where they were noted to have a crown from their tooth in their stomach. During investigation it was identified that staff placed the leg straps underneath both legs instead of an "X" shape. Additionally, while there were two staff in the room, one staff member was running the mechanical lift while the other finished assisting the resident's roommate and was not present to assist with the mechanical lift transfer. Resident #7 had a fall in the dining room and staff (including the nurse) failed to properly assess the resident prior to assisting them off the floor. Neurological assessments were not completed thoroughly and follow-ups were incomplete. Resident #15 sustained a fall, and the staff did not complete neurological assessments according to the policy. Resident #50 was transferred with assistance from staff that failed to use a gait belt during the transfer.

F689; 58.28(3)e; J; $2,500 (Held in Suspension). Resident #1 eloped on 11.2.25 at 7:20 a.m. when a housekeeper arrived at work and opened the front door. The resident was standing at the door, and the housekeeper held the door open for the resident to leave. Staff noted that the resident was not in their room and upon having the staff search the building, the housekeeper reported they let the resident out of the front door. The staff then called 911 and the family called the nursing home to report the resident called and stated they were downtown. The police brought the resident back to the building where they completed an assessment. The housekeeper was not aware that the person they let out of the building was a resident.

F689; 58.28(3)e; G; $6,500 (Held in Suspension). Resident #1 was transferred with assistance of two staff and a stand lift when the resident reported being dizzy and let go of the handlebars, falling backwards onto the floor and hitting their head. EMS was called and the resident was transported to the hospital where they were diagnosed with a femur fracture. During investigation it was identified that the second staff person was pulling the bed down while the other maneuvered the lift and the safety belt and leg straps were not used as. During an interview, the resident indicated they recall being transferred and then the fall but declined refusing to use the safety straps and the record lacked documentation of any refusals to use the safety belts.

F689; 58.28(3)e; J; $5,250 (Held in Suspension). Resident #1 was identified as a high risk for elopement with a history of elopement attempts. Review of camera footage showed on 12.8.25, Resident #1 walked to the front door when a staff member arrived at the front door shortly after, entered a code into the keypad, and both left out the front door walking away from the front door. Two minutes later (9:27 p.m.), the staff member walked back into the building without the resident. The following morning at 5:30 a.m. the staff reported the resident was not in the building. At 6:23 a.m. the nurse completed an assessment following the elopement incident and noted a low pulse oximetry and abnormal lung sounds. The resident was sent to the ER and returned the following day with a diagnosis of sarcoidosis. The resident was located approximately 1.7 miles away from the building. During an interview the staff member indicated that they leaving to go to their care, were unaware the person was a resident, and when the resident left the building they said they were going to visit their daughter and started walking away. The staff denied having new hire training or education on residents with elopement risk.

F695; 58.19(2)g; G; $5,000 (Held in Suspension). During an observation, Resident #22 was noted walking independently in the hallway with their oxygen e-tank. Upon returning to their room, the resident removed their oxygen and applied a nebulizer mask. After placing the mask on their face, they indicated that they did the procedure wrong and turned off the nebulizer, grabbed a vial of nebulizer medication from their bedside stand, squirted it into the nebulizer machine and then turned it on again. The resident expressed they were having more difficulty with shortness of breath and were hospitalized due to a COPD exacerbation. Upon reviewing the resident's record, there wasn't an assessment for self-administration of medications or identification that the resident self-administered medication or oxygen.

F880; 58.10(8); K; $5,500 (Held in Suspension). There were several concerns identified with infection prevention practices including, staff not wearing masks while at the nurse's station during a COVID-19 outbreak, not changing gloves between resident rooms, resident room doors open with COVID-19 positive residents inside, staff did not wear N95 masks while caring for residents with COVID-19, carried soiled linens with bare hands, residents were removed from transmission-based precautions following COVID-19 infection prior to 10 days after testing positive or developing symptoms. Additionally, residents remained in rooms with their roommates who had COVID-19 and were not tested based on exposure testing recommendations. During observations staff picked up a package of disposable wipes that fell on the floor during incontinent cares and held them in their hands. During interviews staff stated the wipes should have been thrown away if they fell on the floor.

TOP DEFICIENCIES

F-TAG #	
F880	Infection Prevention & Control
F689	Accidents/Hazards/Supervision/Devices
F684	Quality of Care
F658	Services Provided Meet Professional Standards
F812	Food Procurement, Store/Prepare/Serve - Sanitary

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

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

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

- Residents were not offered alternative menu items based on preferences.
- During observations there were areas of dried feces in the residents' rooms.
- A resident was placed in bed with their pants down around their ankles and a pillow covering them.
- A resident's soiled shirt was not switched in a timely manner.
- 2 times when staff yelled at residents.
- Care was not provided timely.
- Catheter drainage bags were not covered by dignity covers.

F552 – Cited 4 times when families were not notified for new or changing psychotropic medications prior to implementing including discussing risk vs. benefits.

F544 – Cited 1 time when resident did not have an assessment for self-administration of medications.

F557 – Cited 1 time when the nursing home discarded a resident's personal items by mistake.

F558 – Cited 2 times when the call light was not within reach and the resident was not provided with an adaptive call light.

F567– Cited 1 time when a staff member did not deposit a check into resident trust accounts, did not have an authorization to have funds in the account, or provide quarterly statements.

F578 – Cited 2 times when the staff did not ensure the code status form was accurate throughout records.

F580 – Cited 3 times when the physician was notified of medication errors, weight loss, and allegations of abuse.

F582 – Cited 1 time when residents did not sign a NOMNC or ABN upon discontinuation of Medicare services.

F584 – Cited 6 times for:

- Bathroom cleanliness
- The heating unit was not functioning appropriately which left two hallways without heat.
- General cleanliness of the environment.
- Excessive bird feces on the aviary.
- 3 times when equipment wasn't repaired.

F600 – Cited 2 times with:

- Resident-to-resident abuse.
- The staff yelled at the resident and poked them in the chest.

F604 – Cited 2 times when:

- The provider didn't follow procedures and remove a physical restraint every 2 hours.
- A staff member blocked a resident in with a chair and table to prevent them from tipping their wheelchair back.

F605 – Cited 6 times when:

- 2 times for PRN psychotropics not being discontinued after 14 days.
- Nonpharmacological interventions were not included on the care plan.
- 2 times when the clinical rational for not completing the GDR was not documented.

F606 - Cited 1 time when a staff background check was pending but the employee was already working.

F610 – Cited 3 times when abuse allegations were not investigated and/or they did not separate the staff from the resident.

F628 – Cited 3 times for:

- The long-term care ombudsman was not notified of a transfer.
- A discharge recapitulation and summary were not completed.
- The resident/representative was not notified of bed hold policies and rates in writing.

F636 – Cited 2 times for:

- The MDS was not coded correctly as restorative care was not provided.
- CAAs were not completed for triggered areas without an explanation of why.

F641 – Cited 5 times when:

- The MDS was not accurately coded by:
    - 4 times with PASRR level 2's.
    - Pressure ulcer
    - Discharge location
    - Elopement/wandering alarm
    - Bed rail was coded as a restraint and should not have been.

F644 – Cited 5 times when:

- 4 times when significant change Level 1 was not completed for a new mental illness diagnosis or psychotropic medications started.
- The level 2 recommendations were not included on the care plan.

F655 – Cited 1 time when the baseline care plan was not completed.

F656 – Cited 6 times when:

- The care plan was not individualized.
- The care plan did not include:
    - Behaviors
    - Non-pharmacological interventions to attempt prior to medication.
    - A diagnosis of dementia.
    - 2 times – oxygen use
    - Pressure ulcers.

F657 – Cited 4 times when the care plan was not updated to include:

- Restorative care was no longer provided.
- Sexual abuse incident between resident-to-resident.
- An intervention to elevate heels
- Cardiac diagnosis and diuretic medication use.

F658 – Cited 11 times for:

- Oxygen saturation levels were not monitored when the order read to maintain levels above 92%.
- Did not follow the dietitian's recommendations for intervention to prevent weight loss.
- 2 times when new orders were not transcribed.
- 4 times when physician orders were not followed.
- Orders were not clarified when necessary.
- 2 times when medications were not administered timely.

F677 – Cited 2 times when residents were not provided:

- 2 times with bathing/showers
- Incontinence care

F684 – Cited 11 times for:

- 2 times when an abnormal assessment was not reported to the physician.
- An assessment was not completed upon return from the hospital.
- AIMS testing was not completed per policy.
- Staff did not intervene timely when a resident reported symptoms of a yeast infection.
- Did not complete consistent and thorough assessments for residents with COVID-19.
- Skin assessments were not completed on non-pressure areas weekly.
- Neurological assessments were not completed according to the policy.
- Daily weights were not obtained according to the physician's order.

F686 – Cited 1 time for failure to complete pressure ulcer treatments and did not document refusals.

F688 – Cited 3 times when restorative programs were not provided according to the plan of care.

F689- Cited 13 times for:

- Foot pedals were not used when pushing residents in wheelchairs.
- 3 times when gait belts were not used during a transfer.
- 2 times when wheelchair brakes were not locked.
- A resident was allowed to leave the building with cognitive impairment.
- Smoking assessments were not completed.
- Medications were left with a resident and they were unsupervised by staff.

F690 – Cited 3 times for:

- Staff did not empty a catheter drainage bag.
- Catheter output was not consistently charted.
- Staff did not clean the drainage port when employing a catheter drainage bag.
- The washcloth side was not changed with each swipe during perineal care.

F692 – Cited 1 time when the physician was not notified of a weight loss.

F695 – Cited 3 times when oxygen tubing, nebulizer equipment, and humidification equipment was not changed routinely.

F698 – Cited 2 times when pre- and post-dialysis assessments were not completed.

F710 – Cited 1 time when staff didn't notify the physician for blood pressure results that were outside of established parameters.

F725 – Cited 5 times when:

- 3 times when call lights were not answered timely.
- 2 times when resident's expressed concerns about delayed care.
- A nurse left the building unattended.

F726 – Cited 1 time when staff did not have documentation of training and competencies in their files.

F727 – Cited 1 time when the building did not have 8 hours of RN coverage each day and there was a lapse in designation of a DON.

F730 – Cited 2 times when performance reviews were not completed annually.

F732 – Cited 2 times for:

- Nursing staff was not posted as required.
- The posted document did not include the census or the name of the provider.

F755 – Cited 2 times for:

- One resident had multiple as needed tramadol cards.
- There wasn't documentation of an incident when staff identified missing controlled substances.

F7576– Cited 1 time when staff didn't follow the drug regimen review recommendations to complete AIMS testing.

F759 – Cited 2 times for:

- Medications administered outside of established time frames.
- An insulin pen was not held in the skin for the required time after injection.
- A scopolamine patch was not removed prior to placing a new one.
- Staff didn't complete hand hygiene during medication administration.
- A thyroid medication was administered after the resident ate.
- The resident wasn't instructed to rinse their mouth following a steroid inhaler.

F760 – Cited 6 times for:

- 2 times when medications were not administered as ordered.
- Enoxaparin was administered via injection instead of glucagon.
- 2 times when residents were given another resident's medication.

F761 – Cited 3 times when:

- Medication carts were not locked and were unsupervised.
- Discontinued/expired medications were not discarded timely.
- Ativan and Clonazepam were not double locked with other controlled substances.

F791 – Cited 1 time when staff did not assist the resident in scheduling dental appointments to get dentures.

F803 – Cited 4 times when:

- 3 times when correct portion sizes for mechanically altered diets were not provided.
- All items on the menu were not served.
- The correct diet texture was not served (staff identified prior to the resident eating).

F804 – Cited 3 times when:

- 2 times when foot temperatures were served less than 135 degrees.
- Temperatures (pre- and after-meal) were not monitored.

F805 – Cited 1 time when a whole onion was served with a mechanical soft meat.

F812 – Cited 9 times for:

- 2 times for cleanliness of the kitchen.
- Equipment was not clean.
- 2 times when food was not covered in the hallway.
- 3 times when beard nets were not used.
- Staff touched the drinking surfaces of glasses.
- 4 times when staff did not appropriately use/change gloves.
- Utensils were placed on a potentially contaminated surface.
- 4 times for hand hygiene.
- Food was outdated and did discard.
- Meat was thanking on the refrigerator

F835 – Cited 1 time when a nurse's license was revoked in another state, but active in Iowa. Reference checks were not complete.

F842 – Cited 5 times when:

- There wasn't an indication for an antibiotic used.
- A laptop with resident records was open and visible to the public.
- An inventory was not completed as required
- Medication administration was not documented.
- Incidents including missing money and medication were not completed.

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

F867 – Cited 1 time when the provider did not document performance tracking to identify if problems were corrected.

F868 – Cited 2 times when the medical director, infection preventionist and/or DON were not present at quarterly meetings.

F880 – Cited 19 times for:

- 8 times when hand hygiene was not completed appropriately.
- 12 times when enhanced barrier precautions were not implemented/followed.
- Staff did not remove PPE when they left the resident's room.
- Catheter tubing touched the floor.
- Gloves were not used during insulin administration.
- Reusable equipment was not disinfected between resident use.
- Proper infection prevention techniques were not followed during a dressing change.
- Medications were touched with bare hands.
- The water management policy was not followed.
- Soiled linen was noted on the floor.
- A barrier was not placed under supplies.
- 2 times when gloves were not changed appropriately.

F882 – Cited 1 time when the nursing home did not have an assigned infection preventionist.

F883 – Cited 3 time when pneumonia and influenza vaccinations were not offered when they should have been.

F887 – Cited 1 time when COVID-19 vaccines were not offered when eligible.

F919 – Cited 1 time when an adaptive call light was not offered when the resident was unable to use a normal call light.

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

LeadingAge Iowa