LTC Survey Trends Report
February 2025

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VISITATION & SURVEY UPDATES

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The Regulatory Review article for this month reviewed F562, F563, & F564 regarding the immediate access to the resident and their visitation rights.

As a reminder, a revised QSO memo was released which delayed the effective date of the revised interpretive guidance until April 28, 2025. You can find more information on this topic here.

Survey Activity

District	Average Months for Providers with Recert	Number of Providers over 12 Months	Longest Survey Timespan
Statewide	10.7 months	6 nursing homes	16 months

Recertification:

- 33 total recertification surveys reviewed with 8.3 deficiencies on average per recertification survey with deficiencies.
    - Of the 27 recertifications with at least one deficiency, 8 providers received a fine (or 30%).
    - Of the 33 recertifications, 6 providers had deficiency free surveys (or 18%)

Complaint/Incidents:

- 60 providers with complaint/incident surveys reviewed with 2.9 deficiencies on average per survey reviewed with deficiencies.
    - Of the 26 complaint/incident surveys with at least one deficiency, 11 received a fine (or 42%).
    - Of the 60 complaint/incident surveys, 34 did not receive a deficiency (or 57%).

Congratulations to The Summit of Bettendorf and Mount Carmel Bluffs on deficiency free surveys!

Enforcement Actions

CY 2024	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVG NUMBER OF DEFICIENCIES
CY 2024 TOTALS	**$933,250**	**$3,119,389.65**	**39 Denials; 9 DPOC; 1 State Monitor; 1 Termination; 1 Voluntary Termination; 1 Temporary Management; 2 Mandatory Denials**	**$4,052,639.65**	**6.1 deficiencies**

CY 2025	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVG NUMBER OF DEFICIENCIES
JANUARY	**$69,750**	**0**		**$69,750**	**4.6 deficiencies**
FEBRUARY	**$85,000**	**0**		**$85,000**	**8.3 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.

CITATIONS WITH FINES

February Deficiencies with State Fining and Citation

F600; 58.43(1); E; $500. Staff took the residents' right to smoke away because of the behavior they had.

F600; 58.43(1); E; $500. Resident #4 had multiple incidents including scratching a resident, hitting residents, and kicking them. The residents' care plan lacked documentation of the altercations and interventions for staff to prevent further incidents.

F609; 58.43(9); D; $500. The nursing home did not report an allegation of abuse to DIAL when a staff member swore at a resident and when another male staff member stated something inappropriate to a female resident.

F609; 58.43(9); D; $500. The nursing home did not report suspected abuse to DIAL in a timely manner when a staff member witnessed another staff member tickle a resident's nipple while providing care.

F609; 58.43(9); D; $500. Did not report an allegation of abuse within a timely manner to DIAL when a staff member was accused of throwing something at a resident.

F609; 58.43(9); D; $500. The nursing home did not report allegations of abuse when a resident hit another resident.

F609; 58.43(9); D; $500. An allegation of potential abuse by a staff member was not reported to DIAL within a timely manner.

F609; 58.43(9); D; $500. An allegation of abuse was not reported within a timely manner. Staff members witnessed a nurse get upset when a resident came out late to smoke and was going to go outside without staff when the nurse grabbed the resident's arms as they tried to go out the door.

F610; 58.43(9); D; $500. A visitor reported a concern to the administrator about a staff member holding a resident's hands down and forcing them to take medications. The nursing home reported the incident to DIAL but failed to submit a thorough investigation of the incident. Following the incident the corrective action included that the staff member was placed on leave pending an abuse investigation. However, when the surveyor reviewed the schedule the staff member was on the schedule to work as a nurse.

F677; 58.19(1)g; G; $5,000. Resident #1's C.N.A. assignment sheet indicated that they required a Hoyer lift and assistance of two staff for transfers. A staff member attempted to transfer Resident #1 using a stand-pivot transfer by themselves and the resident sustained a fall in the shower room. Upon nurse's arrival, the resident was noted in a lot of pain and had a large laceration. The resident was transported to the ER and diagnosed with a hip dislocation, femur fractures, and patellar dislocation. The family elected comfort measures instead of surgical intervention. The resident returned to the nursing home and passed away two days later.

F684; 58.19(2)b; G; $5,000. Resident #1 was dependent with ADLs and according to the most recent MDS did not have skin issues. Per the care plan, the resident used an AFO on their right foot and staff were to inspect the skin before and after applying the AFO as well as skin observations weekly. The skin observations identified in the care plan were not documented in the resident's record. During an interview, Resident #1 reported that during a routine dermatology appointment, the dermatologist wanted to look at their legs. They pulled up their pant leg and noted a blackened area under the Velcro strap that had drainage

oozing out of the scab. The dermatologist identified significant white discharge, ordering an antibiotic and culture. The culture returned as MRSA.

F684; 58.19(2)b; G; $28,500 (Treble/Held in Suspension). Resident #12's record identified they possibly had as many as 10 falls during the day and complained of abdominal pain later. The staff sent the resident to the ER where they were diagnosed with a UTI. The resident's record lacked documentation of assessments prior to transferring to the ER. Resident #183 had several falls which resulted in a fracture to the resident's elbow and hip. However, the hospital discharged the resident back to the nursing home with WBAT orders to the hip and a brace to the elbow. The nursing home reported not receiving any orders from the ER upon return and did not assess or provide interventions for the resident's pain. Resident #11 had multiple falls, low oxygen saturation levels, was being treated for a UTI with antibiotics, changes in vital signs without thorough assessments being completed or follow up documentation. Resident #11 was admitted to the hospital with bacteremia as the bacteria was resistant to the ordered antibiotic.

F686; 58.19(2)b; G; $5,250. Resident #31's MDS indicated that they did not have a pressure ulcer upon admission and used a pressure reducing device. Their care plan lacked references to skin conditions or interventions. A weekly skin observation documented a reddened area to their bottom and that staff were to apply cream. During an interview, the resident indicated that they had discomfort from their buttocks and staff were not consistently applying the cream. Additionally, a pressure-reducing device was not in their chair. During a different observation, the resident had a saturated incontinent brief and the vinyl on their chair was soiled.

F686; 58.19(2)b; G; $5,750. Resident #3's hospital records from 12.23.24 included a diagnosis of malnutrition and recommendations for high-protein supplementation three times daily. Upon admission, the resident had skin tears and a surgical wound, but no pressure ulcers were noted. A dietary progress note included recommendations for a nutritional supplement and vitamins. The resident developed a pressure ulcer to their right gluteus on 1.10.25 and recommendations were received to go to the wound clinic. On 1.13.25, the resident's pressure ulcer had worsened, and their primary physician assessed the resident and ordered a transfer to the ER. The resident was diagnosed with a wound and urinary tract infections and returned to the nursing home with orders for treatment of the buttock wound. The treatment was not completed on 1.18 or 1.19. Additionally orders for repositioning, wedges, pressure-reducing devices, and supplements were not reordered.

F686; 58.19(2)b; G; $4,500 (Held in Suspension). Upon admission, Resident #54 did not have a pressure ulcer identified. An AFO splint was used to the resident's right ankle for support which caused a pressure ulcer. A Physical therapy evaluation did not include evaluation for the AFO to the right ankle.

F689; 58.19(2)j; G; $3,750. On 2.12.25, Resident #1 was heard saying "my hip" and found on the floor. Staff did not complete a thorough assessment prior to getting the resident up and when standing the resident expressed pain. They were transferred to the hospital and diagnosed with a hip fracture. Additionally, the staff did not complete root cause analysis for falls.

F689; 58.28(3)e; G; $4,500 The nursing home requested that a resident's cat be brought in to possibly help reduce behaviors as the resident was requesting their cat. While the cat was at the nursing home, it was unapproachable and hissed at staff and the resident. When the staff attempted to get the cat into the crate, the cat bit the resident. There was no documentation that the cat was current on their vaccines and the resident required antibiotics to treat an infection of the bite.

F689; 58.28(3)e; G; $6,000. Resident #39's care plan instructed staff to use 1-2 assistance with toileting and 2 assistance and a gait belt with transfers. However, staff attempted to use a mechanical lift during a transfer. During this transfer, a staff member was noted to be very rough with the resident including forcefully

placing their hands on the lift. When transferring the resident to the wheelchair, one staff member transferred, and their coworker reported that they “threw” the resident down in the wheelchair. Following a mechanical stand lift transfer, Resident #96 would not remove their hands from the lift. The staff forcefully removed their hands and later the resident’s thumb was noted to be discolored and swollen. An x-ray was completed, identifying a fracture. A nurse directed staff to use a mechanical stand lift to transfer Resident #11 when they were weaker than normal. During the transfer, the resident stated they couldn’t stand any longer and slid out of the lift. According to the user's manual for the lift, individuals using the stand lift must be able to support the majority of their own weight.

F689; 58.28(3)e; H; $10,000. Resident #33 was a high fall risk and had a care plan intervention of alarm use at all times. On 9.18.24, they had an unwitnessed fall in their room which resulted in a humerus fracture. The documentation indicated that the alarm did not sound which staff then implemented an intervention to check the alarm system and placement each shift. The new intervention was not documented in the resident’s record and during observations the surveyor noted the resident did not have an alarm in their recliner or bed. Resident #193 was identified as a high risk for falls, however, their baseline care plan lacked interventions to prevent falls or assist with transfers and mobility. During an interdisciplinary meeting, staff decided to remove the resident’s alarm and complete a speech therapy evaluation to address cognition. The record lacked documentation of the speech therapy evaluation or that any other interventions were implemented to prevent falls. The resident fell on 2.4.25 which resulted in a fractured hip.

F689; 58.28(3)e; G; $24,000 (Treble/Held in Suspension). Resident #4 had multiple falls including some with injury. The staff did not complete root cause analysis, implement new interventions based on the analysis, and document falls in the resident’s record. Review of the residents’ falls included several possibly related to toileting and incontinence, however, toileting needs were not revised based on the falls. Additionally, staff were observed without the use of a gait belt when transferring other residents and they did not follow the policy on completing neurological assessments following unwitnessed falls. Review of Resident #184’s record lacked documentation of the resident leaving the nursing home independently without signing themselves out, despite being at risk for elopement. Finally, staff did not include that a resident insisted on smoking, despite being unsafe to do so in their care plan.

F689; 58.28(3)e; K; $5,000 (Held in Suspension). Resident #1 was found outside of the nursing home on the grass by a visitor. The staff did not identify that the resident was at risk for elopement prior to this incident despite attempts to get out of windows and expressing they needed to leave the nursing home. Initially, the nursing home suspected that visitors allowed the resident to leave the building but when investigating the incident, it was identified the resident left independently without staff awareness. There were additional residents that were at risk of elopement in the same unit which did not have alarms present on the exit doors. When other exit doors were opened, an alert was sent to phones that the staff carried. However, when the surveyor attempted to open the door, the staff were not carrying the phones to receive the alarm notification.

F689; 58.28(3)e; J; $5,250 (Held in Suspension). A surveyor observed a resident with an oxygen tank on the back of their wheelchair smoking with four other residents. A smoking assessment for the resident indicated that supervision was necessary for safe smoking without subsequent assessments after the oxygen was ordered. Additionally, resident’s were pushed in wheelchairs without foot pedals on the chair.

F689; 58.28(3)e; J; $6,500 (Held in Suspension). Upon admission, Resident #61 had a physical therapy evaluation which recommended two staff assist the resident with transfers and mobility. Despite the recommendation, the nursing staff determined that they would use just one staff member for transfers and ambulation. The resident had a fractured hip as a result of a fall in the nursing home and due to complications from surgery, they passed away at the hospital.

F692; 58.19(1)n(1); J; $5,750 (Held in Suspension). Two residents had significant weight losses of 12-13% in 6 months. The resident's physicians were not notified of the weight loss and nutritional supplements were not implemented as recommended by the dietitian. The dietitian continued to recommend nutritional supplements for ongoing weight loss which were not communicated to the physician or followed.

F697; 58.20(2); J; $500 (Held in Suspension). Resident #183 was diagnosed with fractures of their elbow and hip due to a fall. Between the time of the fall and diagnosis, the resident's record lacked appropriate assessments or interventions related to pain. Upon returning to the nursing home from the hospital, the staff did not assess the resident or contact the physician for pain medication, despite the resident crying out in severe pain.

F757; 58.19(2)a; J; $9,000 (Held in Suspension). Resident #3 had an elevated INR level (6.7 on 1.17.25 with therapeutic range of 2.5 – 3.5). An order was received to hold the Coumadin on 1.17 and then decrease the dose from 5.5 mg to 5 mg daily with a recheck of the INR on 1.21.25. The residents' Coumadin was not held or decreased as prescribed by the physician and upon recheck the INR increased to 12.4. The resident was transferred to the hospital where they were admitted for a high INR, pneumonia and a UTI.

F760; 58.19(2)a; G; $6,000 (Held in Suspension). Antidepressant medications were not available for staff to administer from 1/1 to 1/6. Staff did not administer an antiseizure medication prescribed to be administered when the resident had a seizure.

F760; 58.20(1); G; $4,000. Resident #30 had orders for short and long-acting insulin with breakfast. During the night, the resident's blood sugar was noted to be low (52) with a recheck following a snack of 122. The following morning, the resident's blood sugar was 69, the nurse reported that the resident's blood sugar was fine and administered insulin as scheduled. After breakfast, another nurse reported that the resident was unresponsive and when the nurse got to their room and checked their blood sugar it was 34. The resident was served breakfast but the tray was sitting to the side of them and not in front of them and the resident did not eat anything. The resident was then sent to the ER. Administration educated the nurse that the resident's blood sugar should have been reported to the physician (per policy less than 70) and the resident's insulin should not have been administered unless they were eating.

TOP CITATIONS

F-TAG #	
F689	Accidents/Hazards/Supervision/Devices
F658	Services Provided Meet Professional Standards
F880	Infection Prevention & Control
F657	Care Plan Timing & Revision
F550	Resident Rights/Exercise of Rights
F684	Quality of Care

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

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

58.1(1) – Cited 1 time when a nursing home did not submit a veteran to the IDVA website in a timely manner.

F550 – Cited 12 times for failure to treat residents with respect, dignity, and privacy by:

- Residents were taken to meals in hospital gowns and not offered to get dressed.
- 2 times when staff swore at or in front of residents.
- 3 times when staff yelled at residents.
- 2 times when staff did not provide assistance with eating when necessary.
- Residents did not receive assistance with toileting needs which led to incontinence.
- Privacy was not provided when performing personal care.
- Staff refused to provide assistance the resident requested.
- A staff member repeatedly poked a resident in the chest in the middle of the night to try to wake them up when the resident was already awake.
- A resident reported that a staff member was washing their eyes when the resident asked them to stop because it hurt and the staff member would not stop.
- 2 times when staff were rough or aggressive when providing care.
- A nurse was rude to a resident when the resident woke the staff member up (who was sleeping in a recliner chair).
- A resident was forced to take medication according to a visitor that witnessed the incident.
- Staff turned off a resident's call light without offering assistance.

F552 – Cited 1 time when the resident's family was not notified of a fall that resulted in injury.

F553 – Cited 2 times when residents and/or their families were not invited to attend care plan meetings.

F561 – Cited 1 time when a resident's smoking privilege was taken away as punishment for behaviors.

F567 – Cited 1 time when resident funds were not accessible over the weekend.

F575 – Cited 1 time when contact information for state agencies was not posted in the nursing home.

F578 – Cited 2 times when the resident's code status did not match the signed forms throughout the resident's record.

F580 – Cited 2 times when notification of a change in condition was not provided to the residents' physician and/or family.

F582 – Cited 1 time when the resident was not provided at least 48-hour notice of discontinuing skilled services.

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

- There were an excessive number of items stored in the hallway making it difficult and hazardous for residents and staff to navigate.
- Loud noises were observed in the building.
- 2 times for strong urine odors.
- Residents' personal items were missing.
- The water coming from the sink in the bathroom was cold.
- The commode was not emptied and cleaned in a timely manner.

F585 – Cited 2 times for:

- 2 times for the grievance investigation results not reported to the individual reporting the grievance.
- Information on how to file a grievance was not available to the residents.

F600 – Cited 2 times for:

- The nursing home did not protect residents from resident-to-resident altercations.
- A staff member was rough when they provided care and refused to assist the resident with care they requested.

F606 – Cited 1 time when child abuse was indicated on the SING report, but the nursing home did not contact DHS for additional information.

F607 – Cited 1 time when background checks were not completed appropriate nor was annual abuse training.

F610 – Cited 1 time when the staff did not report an allegation of abuse to the management staff which resulted in the perpetrator continuing to work with residents.

F623 – Cited 2 times when the nursing home did not notify the LTC Ombudsman of a transfer or discharge.

F625 – Cited 2 times for not providing a bed hold notice prior to transferring to the hospital.

F636 – Cited 1 time when MDS' were not completed and submitted timely.

F637 – Cited 4 times when a significant change MDS was not completed based on admission or discharge from hospice services.

F638 – Cited 1 time for a quarterly MDS not being completed and submitted timely.

F640 – Cited 1 time when discharge, end of PPS, and death MDS' were not completed and submitted timely.

F641 – Cited 7 times when:

- 2 times when a resident was a Level 2, but the MDS was coded as a Level 1.
- Ozempic was coded as insulin.
- Medications were coded that the resident did not take.
- A pressure ulcer was coded on the MDS when the record did not indicate that the resident had a pressure ulcer.
- High risk medications were not coded including insulin and antianxiety.
- Falls, hospice status and restraint use were not coded accurately.
- The discharge location was incorrect.

F644 – Cited 3 times when:

- 3 times for a significant change Level 1 being completed for a new MI diagnosis.
- The care plan did not include specialized services identified in the Level 2.

F655 – Cited 3 times when:

- The baseline care plan was not completed within 48 hours of admission.
- The baseline care plan did not include initial discharge goals and use of therapy services.
- 2 times when a copy or summary of the baseline care plan was not provided to the resident or their representative.

F656 – Cited 9 times for:

- 2 times when staff did not follow the care plan.
- The care plan did not include:
    - 3 times – target behaviors for psychotropic medication use.
    - Non-pharmacological interventions to attempt when behaviors are present.
    - Accurate level of assistance required for bed mobility.
    - Oxygen
    - Restorative services
    - 7 times – High risk medications including antidepressants, anticoagulants, antipsychotics, diuretics, opioids, and antiplatelets.
    - CPAP use
    - Pain
    - History of UTIs
    - Catheter use
    - Hospice
    - Urostomy
    - Wounds

F657 – Cited 12 times for:

- The care plan was not followed.
- 3 times when the resident or their representative was not invited to the care plan meeting.
- The care plan was not updated to include:
    - 2 times – resident-to-resident altercations.
    - Rejection of care
    - Assistance with ADLs

- 2 times – behaviors
- Colostomy
- Catheter
- 2 times – transfer and mobility status changes.
- Smoking
- Use of a power wheelchair
- 2 times – pressure ulcers or wounds.
- Antipsychotic medications.
- 3 times for MI diagnosis including schizophrenia, anxiety, and depression.
- Hospice services.

F658 – Cited 17 times for:

- 10 times when the physician's orders were not followed.
- 2 times when residents had medication in their possession without staff supervision.
- There were not parameters established for notifying the physician of high or low blood sugars.
- An insulin pen was not primed.
- Orders were not transcribed timely.
- A resident with a catheter did not have a physician's order on changing the indwelling catheter.
- Narcotics were destroyed before the resident had an order to discontinue use.
- The physician was not notified when vital signs were outside of established parameter.
- Documentation was not included in the record as to why a resident did not attend scheduled appointments.

F676– Cited 1 time when a recommended restorative program was not implemented.

F677 – Cited 7 times for failure to provide/assist with:

- 4 times – bath/shower
- Nail care
- Hair washing
- Shaving
- Eating
- Oral care

F684 – Cited 12 times for:

- 4 times when neurological assessments were not completed per policy.
- 2 times when a resident was not assessed after a fall.
- 6 times when assessments were not documented for:
  - Acute respiratory illness (Influenza/COVID-19).
  - Returned from the ER following chest pain episodes.
  - Changes in condition
  - Use of a restraint
  - A cholecystostomy tube was pulled out.
  - Urinary status when a UTI was suspected.

F686 – Cited 2 times for:

- Treatments not completed as ordered to a pressure ulcer.
- Assessments were not consistently completed on a pressure ulcer.

F688 – Cited 4 times when restorative services were not provided as care planned.

F689- Cited 20 times for:

- Foot pedals were not used when pushing a resident in a wheelchair.
- 2 times – fall interventions not followed.
- A resident had a cigarette in their room that had a burnt end.
- There were excessive amounts of items stored in the hallway which presented hazards.
- The care plan for transfer assistance was not followed.
- 5 times – gait belts were not used when the resident required assistance with transfers.
- Mechanical lift safety steps were not completed according to the manufacturer's recommendations.
- Wanderguard placement and function were not routinely monitored.
- A TV was placed on the wall above a resident's bed. The resident routinely pulled on the cord to the TV believing it was the call light and there were concerns the resident would pull the TV off the wall on top of themselves.
- Fall interventions were not implemented upon admission when the resident was a high risk for falls.
- There was a marijuana pipe and medications in the resident's room.
- A change in transfer status for the resident was not communicated to the staff.
- Wheels were not locked during a transfer.
- The correct sling size was not used during a mechanical lift transfer.
- Smoking assessments were not completed.

F690 – Cited 4 times when:

- 2 times – catheter tubing and/or bag were on the floor.
- A resident with a diagnosed UTI was not treated with antibiotics timely.
- Gloves were not changed appropriately when providing perineal care.

F692 – Cited 4 times when:

- The physician was not notified of the dietitians' recommendations.
- A resident was allowed to sleep through meals and not offered items outside of mealtimes and resulted in weight loss.
- A nutritional assessment was not conducted for a resident who had cancer, nausea and vomiting.
- The policy was not followed for weight loss procedures.

F693 – Cited 1 time when staff did not place a barrier down underneath supplies, use Enhanced Barrier Precautions (EBP), or check placement of a feeding tube.

F695 – Cited 3 times when:

- The MAR did not include the order for oxygen use.
- The policy was not followed for changing oxygen tubing.
- Staff would not assist a resident to put water in their CPAP machine.

F697 – Cited 1 time when an order to increase the dose of morphine for a resident who was actively dying was not implemented timely.

F710 – Cited 1 time when the staff did not have an order to increase morphine or suction a resident when they were actively dying.

F725 – Cited 8 times for:

- Care was not provided according to the care plan.
- 5 times – call lights were not answered in a timely manner.
- The staffing plan in the facility assessment was not followed.
- 2 times – A licensed nurse was not on duty for a period of time.
- A nurse was sleeping in a recliner while on duty.

F726 – Cited 5 times for:

- Neurological assessments were not completed after a fall according to the policy.
- Nurses were not trained in checking wanderguard functioning.
- An administrator who was a licensed nursing in the 1970's sent a nurse home to take a nap before fulfilling their next shift and during this time a resident fell. The administrator completed an assessment of the resident and assisted the staff in lifting the resident off the floor.
- An assessment was not completed when a resident had a change in condition.
- An LPN administered IV medications and did not have an Expanded IV certification.
- A nurse communicated with the hospital staff (including receiving an order) via Snapchat.

F727 – Cited 3 times when there was not 8 consecutive hours of RN coverage, and an LPN was designated as the DON.

F728– Cited 1 time when a nurse aide was not verified on the registry before working as a nurse aide.

F732 – Cited 1 time when the posting with staff hours was not updated for more than two days.

F740 – Cited 1 time when the care plan did not include targeted behaviors for psychotropic medication use.

F741 – Cited 2 times for:

- Staff were not determined competent to provide care of major mental illnesses.
- The care plans did not include behaviors.

F755 – Cited 4 times when:

- 3 times – insulin was not discarded in a timely manner after exceeding manufacturer's recommendations for open dates.
- Insulin was not dated when opened.
- A staff administered morphine that another staff member drew up into a syringe.
- An insulin pen was not primed before administration.

F756 – Cited 1 time when a request for a GDR was not returned from the physician and there was not documentation of follow up.

F757 – Cited 2 times for:

- The care plan did not include target behaviors for psychotropic medication use.
- A resident did not have an appropriate diagnosis for antipsychotic medication use.
- Pain medication was administered without an indication of pain.

F758 – Cited 8 times when:

- PRN psychotropic medications were not limited to 14-day duration.
- Non-pharmacological interventions were not documented prior to administering PRN psychotropic medications.
- 3 times – target behaviors had not been care planned for psychotropic medication use.
- 2 times – a GDR was not completed or appropriate clinical rationale for declining documented.
- A GDR request from the pharmacy was not followed up on when the physician did not return it.
- A resident received PRN lorazepam when the order was not active as it was after the 14-day duration.

F759 – Cited 1 time when incorrect doses of medications were administered.

F760 – Cited 3 times when:

- Blood glucose levels and insulin administration was not completed 14 times in a month.
- One staff member had an excessive amount of medication errors for various reasons without intervention.
- MS Contin was administered every 8 hours instead of every 12 as the manufacturer recommends.

F761 – Cited 4 times when:

- 2 times – medication carts were unlocked and unsupervised.
- Medications were not secured following delivery from the pharmacy.
- Medications were not labeled correctly.
- Expired medications were not discarded.

F791 – Cited 2 times when the nursing home did not assist residents with scheduling dental appointments.

F800 – Cited 1 time when puree portion sizes were not accurate, and food temperature was not monitored prior to serving.

F801 – Cited 2 times when a qualified dietary manager was not employed.

F803 – Cited 2 times for:

- Mechanical soft portion sizes were not accurate.
- All items on the therapeutic menu were not served.
- Diets ordered by the physician were not served such as low sodium.

F804 – Cited 6 times for:

- 4 times when hot food temperatures were below 135 degrees.
- The food was not palatable including meats being hard and lacked flavor.
- Cold food was not 41 degrees or below.

F805 – Cited 1 time when mechanical soft portion sizes were not correct.

F811 – Cited 1 time when a paid feeding assistant helped a resident with a swallowing disorder.

F812 – Cited 9 times for:

- 3 times – kitchen cleanliness
- Kitchen environment in disrepair
- Gloves were not used appropriately.
- The food was touched with bare hands.
- 3 times – food was expired and not discarded.
- 3 times – items were not labeled and dated.
- The thermometer was not sanitized prior to checking food temperature.
- Sanitizer was not used when cleaning food preparation areas.
- Refrigerator temperatures were too low and freezing items.
- The refrigerator and freezer temperatures were not consistently monitored.

F835 – Cited 4 times when the nursing home did not have adequate administration as evidenced by:

- 2 times – A failure to respond to allegations of abuse.
- A vehicle used to transport residents did not have a current registration.
- Narcotics were not reconciled appropriately and unauthorized individuals had access to them.
- A licensed nurse was told to leave the building without coverage and the administrator completed duties that they were not licensed or certified to do.
- An LPN was appointed as the director of nursing.
- The call light system was not functioning appropriately and had to be manually reset frequently.
- Employee background checks and appropriate training were not completed.

F836 – Cited 1 time when a resident was not submitted to the IDVA website in a timely manner.

F842 – Cited 5 times when:

- Documentation was not completed for:
    - 2 times – incidents
    - 2 times – assessments
    - Positive COVID-19 and Influenza test results.
    - Physician communication.
    - Tests that were completed as ordered.
- Items were documented as completed that were not.
- Records were left open on a computer that was accessible to the public.

F849 – Cited 1 time when communication was not documented between the nursing home and hospice regarding psychotropic medication management.

F851 – Cited 3 times when staffing agency hours were not reported with PBJ records.

F865 – Cited 10 times when an effective QAPI process was not implemented based on repeat deficiencies.

F867 – Cited 3 times for:

- The nursing home did not have an effective QAPI process based on repeat deficiencies.
- The QAPI plan did not include all required elements.
- The nursing home did not have a QAPI plan.

F868 – Cited 2 times when the nursing home did not maintain documentation for quality assurance meetings.

F880 – Cited 13 times for:

- 7 times – EBP were not implemented when necessary.
- 4 times – hand hygiene was not completed.
- The laundry was not covered in the hall.
- Garbage bags were observed on the floor.
- Staff did not use source control during a respiratory illness outbreak.
- 4 times – gloves were not changed appropriately.
- 2 times – catheter tubing and/or bags touched the floor.
- A barrier was not used underneath supplies in the resident's room.
- Staff stepped on oxygen tubing.
- Alcohol wipes were not used when administering insulin and checking blood glucose levels.
- The hub on an insulin pen was not cleaned prior to placing a needle on.

F883 – Cited 2 times for:

- Pneumonia vaccination status was not assessed.
- Pneumonia vaccine was not administered when the resident consented to it.

F887 – Cited 1 time when a COVID-19 vaccine status was not assessed.

F908 – Cited 2 times for:

- The clothes dryer did not automatically enter a cool down cycle or shut off.
- Not having a functioning suction machine.

F919 – Cited 1 time when the call light system did not routinely work, and staff would have to manually reset the system.

F921 – Cited 2 times for:

- Several areas in the building were in disrepair.
- Hot water was above 120 degrees when tested.

F925 – Cited 1 times when sticky traps were observed throughout the building and residents expressed complaints about roaches.

F943 – Cited 2 times when:

- Staff did not complete dependent adult abuse training within 6 months of hire.
- Staff were not trained on activities that may constitute abuse.

F947 – Cited 2 times for:

- Nurse aides did not have 12 hours of inservice in the last 12 months.
- The nursing home did not ensure that nurse aides had appropriate training and competencies.

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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