LTC Survey Trends Report
February 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 F576 - Access to Communication Devices was recently included in a newsletter.

As an FYI – during a recent meeting with other LeadingAge State Partners, many expressed that when nursing homes are cited in their state for F578 when the resident's code status does not match what they've elected on their decision-making forms that it is always cited at an immediate jeopardy level. This hasn't happened in Iowa unless the resident passes away and the advanced directive/physician order was not followed which is usually cited under F678 for CPR. To avoid this when/if it does happen, please ensure that you have a good process in place to update the code statuses timely and routine monitoring for accuracy.

The QCor website still hasn't been updated since June 2025, which provides limited data on federal enforcement action including civil monetary penalties, denial of payments, or directed plan of correction.

Survey Activity

District	Average Months for Providers with Recert	Time Since Last Survey	Longest Survey Timespan
Statewide	12.8 months	26 nursing homes currently exceed 12 months or more.	15 months

Recertification:

- 22 total recertification surveys reviewed with 5.5 deficiencies on average per recertification survey with deficiencies.
    - Of the 21 recertifications with at least one deficiency, 3 providers received a fine (or 14%).
    - Of the 22 recertifications, 1 provider had a deficiency free survey (or 5%)

Complaint/Incidents:

- 38 providers with complaint/incident surveys reviewed with 2.4 deficiencies on average per survey reviewed with deficiencies.
    - Of the 16 complaint/incident surveys with at least one deficiency, 3 received a fine (or 19%).
    - Of the 38 complaint/incident surveys, 22 did not receive a deficiency (or 58%).

Enforcement Action

CY 2026	State Fines	Federal CMPs	Enforcement	Total	Avg number of deficiencies
January	$55,250			$55,250	6.2 deficiencies
February	$55,500			$55,500	5.5 deficiencies

Calendar Year 2025 Totals:

State Fines - $862,000; Federal CMPs $490,241.50; Total $1,352,241.50; 7 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

February Deficiencies with State Fining and Citation

F550; G; No citation issued. Resident #1 asked the staff not to check and change them, but a staff member insisted on doing it including placing their hand between the resident's thighs to see if they were wet. The resident reported being fearful and having trouble sleeping. The nursing home corrected the situation and received past noncompliance for the deficiency.

F609; 58.43(9); D; $500. An incident of resident-to-resident abuse was not reported to DIAL.

F609; 58.43(9); E; $500. An allegation of abuse was not reported to DIAL within 2 hours when a staff member told a resident to shut up and be quiet and then pinched the resident's lips together.

F609; 58.43(9); D; $500. An allegation of abuse was not reported to DIAL when a resident was found to have a bruise on their eye with unknown origin.

F686; 58.19(2)b; G; $5,500 (Held in Suspension). Resident #26 developed a pressure ulcer on their heel and the resident's clinical record didn't include assessments of the wound after the initial assessment for several weeks. During observation of the wound dressing change, staff didn't change their gloves between cleansing the wound and applying the new dressing or between different wounds. Staff also didn't complete the dressing changes according to the order. Resident #23's admission notes failed to indicate skin integrity concerns on their buttocks despite the hospital notes stating there was a skin tear present on the buttocks. The progress notes also didn't include anything on the buttocks until 11.21.25 when they were transferred to the ER when the documentation indicated there were wounds on the left and right buttock. Upon return from the hospital, the resident was to follow up with the wound center which was not completed. Additionally, the nursing home notes lacked appropriate assessments of the wound(s). Staff didn't document consistently that treatments were completed.

F689; 58.28(3)e; G; $15,750 (Treble/Held in Suspension). Resident #4 used a full body mechanical lift for transfers according to their care plan. During a transfer using the lift one of the hoops came unattached from the lift causing the resident to slide out of the sling with complaints of rib pain after the fall. During a transfer of Resident #2, staff didn't use a gait belt and lifted the resident under their shoulders causing the resident pain.

F689; 58.28(3)e; G; $8,250 (Held in Suspension). Resident #80 received a burn when they were laying on their side with their knee against the heater. Staff moved the resident's bed away from the heater to prevent it from recurring. Resident #80 also had care plan interventions to prevent falls including not leaving the resident in their wheelchair while in their room and placing a star on their wheelchair to alert staff the resident is at high risk for falls. During observations the star wasn't on the resident's wheelchair. Resident #11 required a stand lift with assistance of 2 staff for transfers. On 8.1.25, a staff member transferred the resident by themselves with use of a pull up bar. The resident wasn't able to hold themselves up at the bar and fell. Additionally on 12.15.25 the resident told a CNA that they could walk, so the aide elevated the recliner chair causing the resident to slide out of the chair and the aide helped lower to the floor. The following day the resident's ankle was swollen, bruised and painful and they were transferred to the ER and diagnosed with a mildly displaced ankle fracture. Resident #13 had a fall when interventions were not in place including shoes or gripper socks being on the resident's feet and the wheelchair pedals were attached when they shouldn't have been. Observations during the survey also noted the residents' fall interventions not being followed. Staff were also observed transferring Resident #13 without a gait belt and the antilock brakes were not functioning on their wheelchair.

F689; 58.28(3)e; G; $5,000. Resident #1's care plan directed staff to use a full-body mechanical lift and assistance of 2 staff for transfers. On 12.11.25, the resident complained of pain to their right ankle along with noted swelling and inability to weight bear. The physician was notified and gave an order to complete an x-ray which showed a questionable right ankle fracture without dislocation. During staff interviews they reported that Resident #1 sat on the commode and when finished staff attempted to put the lift sling under them but were unable to. Two staff members then assisted the resident to stand/pivot transfer to their recliner in which staff reported it was difficult and the resident's legs got twisted up.

F690; 58.20; G; $19,500 (Treble/Held in Suspension). Resident #11 used a urinary catheter and the care plan directed staff to empty the bag every shift with a physician's order to record output every shift. During review, several output entries were not documented. Resident #1 also had a urinary catheter but their care plan lacked directives for frequency and provision of catheter care. Resident #1's record lacked documentation of catheter care on several dates as well as urinary output. Resident #1 had an order for Amoxicillin for a UTI that was not administered for the appropriate duration which resulted in the resident being transferred to the hospital.

TOP DEFICIENCIES

F-TAG #	
F880	Infection Prevention & Control
F689	Accidents/Hazards/Supervision/Devices
F684	Quality of Care
F760	Free from Significant Medication Errors
F812	Food Procurement, Store/Prepare/Serve - Sanitary

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:

F550 – Cited 5 times for failure to treat residents with respect, dignity, and privacy by:

- Staff didn't assist with care according to the resident's preference including providing shaving for facial hair and combing their hair.
- A catheter drainage bag wasn't covered with a dignity bag.
- Staff were rude to resident's in how they spoke to them.
- Call lights weren't within resident's reach.
- Staff entered a resident's room while they were receiving care.
- Staff told a resident to urinate in their incontinent brief.

F552 – Cited 2 times when:

- The record lacked documentation that the resident or their representative was notified of increasing psychotropic medications.
- The resident or their representative wasn't able to have informed decision making with starting psychotropic medication.

F554 – Cited 3 time when:

- 2 times when medications were left with a resident without observation of them taking the medication.
- A resident had an inhaler in their pocket and didn't have an assessment for self-administration of medication.

F578 – Cited 1 time when the record stated the resident was a DNR, but the IPOST indicated they wanted CPR.

F580 – Cited 5 times when the physician and/or family were not notified of condition changes, refusal of treatments, and the staff were unable to complete wound vac treatment.

F582 – Cited 1 time when an ABN form was not provided to a resident when required.

F584 – Cited 5 times for:

- Missing clothing.
- Cleanliness
- Cockroaches
- Areas of disrepair
- 2 times for strong odors.

F602 – Cited 1 time when a staff member took Fentanyl patches from the wrapper and then placed back in the box.

F605 – Cited 2 times when:

- GDRs weren't requested as required.
- Staff didn't attempt/document non-pharmacological approaches before using a PRN psychotropic.

F607 – Cited 2 times when:

- Staff didn't complete dependent adult abuse training within 6 months of hire.
- Another staff member completed the competency examination for the dependent adult abuse training due to the staff member not being able to pass it.

F610 – Cited 2 times when:

- No investigation was completed for allegations of abuse.
- Abuse wasn't reported immediately which allowed the staff member to continue working with residents.

F627 – Cited 1 time when the staff didn't re-evaluate a resident's status prior to discharge from the hospital before issuing an involuntary discharge notice.

F628 – Cited 1 time when the ombudsman's office wasn't notified of a transfer.

F636 – Cited 1 time when an admission MDS wasn't completed within 14-days of admission.

F637 – Cited 1 time when a significant change MDS wasn't completed upon hospice admission.

F640 – Cited 1 time when discharge MDS' weren't completed timely.

F641 – Cited 5 times when:

- Smoking assessments weren't completed
- The MDS wasn't coded accurately including:
    - 4 times for PASRR Level 2.
    - A urinary catheter was coded that wasn't present.

F644 – Cited 3 times when:

- A behavior management plan identified in the Level 2 services and supports wasn't care planned.
- 2 times when Level 1s weren't submitted with new MI diagnosis.

F645 – Cited 1 time when a new Level 1 wasn't submitted prior to a short-term approval ending.

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

F656 – Cited 3 times when the care plan didn't include the following:

- PASRR Level 2 recommendations
- Anticoagulant
- Diuretic

F657 – Cited 5 times when:

- The care plan was not updated to include:
  - Switched from smoking cigarettes to vaping.
  - The resident had a vehicle at the nursing home and could leave the building unsupervised.
  - Suicidal thoughts/statements.
  - Antipsychotics
  - Antianxiety
  - Diuretics
  - Antidepressants
  - Enhanced barrier precautions
  - Transmission-based precautions
  - No longer smoked.

F658 – Cited 4 times for:

- 3 times when physician's orders weren't followed.
- A heart monitor wasn't sent back to download results.

F677 – Cited 3 times when residents were not provided:

- Oral Care
- Fresh water
- 2 times showers/baths
- Perineal Care

F684 – Cited 7 times for:

- Assessments/interventions were not completed:
  - An elevated temperature
  - Edema and shortness of breath
  - No bowel movements for 6 days.
  - Large bruise
  - 3 times post-fall
  - Skin/wound

F686 – Cited 3 times for:

- Pressure ulcer treatments weren't completed as ordered.
- Assessments were not completed.
- Hand hygiene wasn't completed during observation of a treatment.

F688 – Cited 1 time when restorative programs were not provided according to the plan of care.

F689- Cited 12 times for:

- The nursing home didn't have evaluations to ensure that a resident with cognitive impairment was safe to drive and leave the building unsupervised.
- When a resident expressed suicidal thoughts, items that could possibly be used for self-harm were not removed.
- 2 times when staff didn't apply pedals as they pushed residents in their wheelchair.
- 3 times when gait belts weren't used during a transfer.
- A resident was left alone in a shower room and fell (the resident required assistance with ADLs).

F690 – Cited 1 time when staff providing incontinence care failed to remove their gloves and complete hand hygiene appropriately.

F692 – Cited 3 times for:

- 2 times when interventions weren't implemented to prevent additional weight loss.
- The physician wasn't notified of a weight gain according to the established parameters.

F693 – Cited 2 times when:

- The placement of the feeding tube wasn't checked prior to administering a flush and medications.
- The head of bed wasn't elevated during continuous feeding.

F695 – Cited 2 times when:

- The nursing home failed to routinely clean a bipap.
- The oxygen rate was not set at the physician ordered rate.

F698 – Cited 1 time when post-dialysis assessments were not completed.

F725 – Cited 2 times when:

- Call light response times were greater than 15 minutes.
- Staff were reported sleeping while on duty.
- The DON worked the floor as a charge nurse when the average census was greater than 60 residents.

F727 – Cited 2 times for:

- Not having RN coverage every day during the review period.
- The DON worked as a charge nurse when the census was greater than 60 residents.

F732 – Cited 2 times for:

- Staffing was not posted daily.
- The staffing report failed to include the census and actual hours worked per category.

F755 – Cited 2 times for:

- Medications weren't wasted or returned on discharge or death.
- Ambien wasn't correctly reconciled leading to missing tablets.

F757 – Cited 1 time when the staff didn't follow up on an INR lab to ensure the resident had orders for Warfarin.

F760 – Cited 6 times for:

- 2 times when insulin pens were not primed.
- 2 times when insulin open dates weren't verified prior to administering.
- A medication was administered without an order.
- 2 times when medications were omitted.
- An incorrect dose was administered.
- An antibiotic wasn't started until 2 days after the order was received.

F761 – Cited 2 times when:

- Eye drops weren't discarded timely.
- An inhaler didn't have an open date.
- The narcotic lock box keys were left in the lock of the medication cart.

F774 – Cited 1 time when transportation wasn't arranged to a wound center appointment.

F804 – Cited 2 times when food wasn't maintained above 135 degrees or below 41 degrees for room trays.

F809 – Cited 1 time when resident's didn't receive meals timely or at all in some instances.

F812 – Cited 6 times for:

- Failure to monitor food temperatures.
- Didn't maintain logs for refrigerator and freezer temps and dishwasher sanitation/temp levels.
- 2 times for food handling concerns.
- Meat was thawing over ready-to-eat food.
- Hairnets didn't cover the employee's entire head of hair.
- Cleanliness of the kitchen.
- Staff wore excessive jewelry.
- Food items were not labeled and dated when opened.

F842 – Cited 3 times when:

- Staff backdated documentation.
- An incident of abuse wasn't documented.
- Medication orders weren't transcribed accurately.

F865 – Cited 5 times when providers didn't have effective QAPI processes based on repeated deficiencies cited.

F868 – Cited 2 times when the infection preventionist and/or director of nursing weren't present at the quarterly meetings.

F880 – Cited 17 times for:

- 9 times when EBP wasn't implemented/followed.
- Isolation linens weren't laundered separately or last.
- Urinals weren't replaced routinely.
- 9 times when hand hygiene wasn't completed appropriately.
- Catheter drainage bag and/or tubing touched the floor.
- There was duct tape present on the housekeeping cart.
- 4 times when staff failed to change their gloves appropriately.

- Staff touched medications with their bare hands.
- During catheter care, staff wiped towards the urinary meatus instead of away from it.
- A box of gloves was sat on the floor without a barrier underneath.
- A roll of gauze was dropped on the bed and used to cover a wound.
- Insulin pens were used on multiple different residents or from residents that had been discharged or passed away.
- Staff failed to remove PPE prior to exiting the isolation room.
- Laundry was uncovered while transporting.

F883 – Cited 2 times when pneumonia and influenza vaccinations weren't offered or administered.

F887 – Cited 1 time when COVID-19 vaccines were not offered to staff and residents when eligible.

F919 – Cited 1 time when call lights were not consistently functioning.

F926 – Cited 1 time when the administrator indicated the campus was non-smoking but there were numerous cigarette butts on the ground and a resident was observed smoking.

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.

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