LTC Survey Trends Report
January 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 F690 - Incontinence & Urinary Catheters was included in the newsletter recently.

DIAL is making progress towards nursing home recertification surveys to be caught up again. The number of surveys more than 12 months since their last recertification reduced from 31 in December to 20 in January. However, the longest recertification period has exceeded 16 months.

The average number of deficiencies is abnormally high this month as one provider received an abnormally high number of deficiencies (43) which skewed the results slightly. If this survey was removed from the statistics, the average deficiencies per survey would be 4.9, which is less than the CY 2025 average.

I also tried to include examples of past noncompliance cited during investigations when there was an associated fine.

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. LeadingAge National recently asked CMS about this and CMS indicated there may be additional information released about the QCor Website.

Survey Activity

District	Average Months for Providers with Recert	Time Since Last Survey	Longest Survey Timespan
Statewide	12.9 months	20 nursing homes currently exceed 12 months or more.	16 months

Recertification:

- 40 total recertification surveys reviewed with 6.2 deficiencies on average per recertification survey with deficiencies.
    - Of the 31 recertifications with at least one deficiency, 3 providers received a fine (or 10%).
    - Of the 40 recertifications, 9 providers had deficiency free surveys (or 23%)

Complaint/Incidents:

- 42 providers with complaint/incident surveys reviewed with 1.7 deficiencies on average per survey reviewed with deficiencies.
    - Of the 22 complaint/incident surveys with at least one deficiency, 6 received a fine (or 27%).
    - Of the 42 complaint/incident surveys, 20 did not receive a deficiency (or 48%).

Enforcement Action

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

Congratulations to The Village, a WesleyLife Community on a deficiency free survey!

CITATIONS WITH FINES

January Deficiencies with State Fining and Citation

50.7; $500. A fall with a fracture of the resident's ankle was not reported to DIAL as a major injury when the resident required assistance of a staff member for transfers and mobility.

F600; 58.43; G (no state citation report). Several residents expressed fear of a staff member due to their actions while providing care including being verbally mean, throwing personal care items at the residents, being bossy, and a resident with bruising to their legs. During investigation the staff member was removed from the building and terminated which led to a past noncompliance finding.

F609; 58.43(9); D; $500. Resident #4 reported to staff that they were raped which was not reported within the required two hour time frame to DIAL.

F609; 58.43(9); D; $500. The provider didn't notify DIAL in a timely manner or law enforcement when a staff member reported slapping a resident across their face when they stuck their hand down the staff members' shirt and grabbed their breast.

F609; 58.43(9); D; $500. The nursing home didn't report an allegation of abuse and complete a thorough investigation when a resident reported that a C.N.A. threw their legs into their bed and hit their upper leg.

F609; 58.43(9); D; $500. An allegation of abuse was not reported to DIAL within two hours as required when an x-ray technician placed their gloved hand over a resident's mouth as they coughed.

F686; 58.19(2)b; K; $7,750 (Held in Suspension) Resident #29 was at risk for developing pressure ulcers. During skin checks, the nurse documented an open area on the resident's coccyx without measurements or a description more than once. Documentation on 11.28.25 identified that the wound was worsening. Additional entries on 12.16, 12.18, 12.25, and 1.1 lacked measurements or description of the wound. The physician was notified on 12.23.25 of the wound condition with an order for wound care appointments and on 12.29.25 prescribed an antibiotic for infection. On 1.3.26, the assessment indicated significant worsening and was now unstageable due to slough or eschar with light drainage and a strong odor noted. On 1.6.26 the resident went to have the wound surgically debrided including a bone biopsy and expressed concerns about returning to the nursing home due to lack of repositioning. Resident #2 had pressure ulcers that did not include intervention for several days, reported concerns with staff repositioning them, did not have a pressure reducing mattress, or appropriate repositioning devices in their room. Resident #9's pressure ulcer assessments lacked measurements. Resident #30's care plan lacked identification of pressure ulcers. Resident #22's assessments were not thoroughly documented. Resident #23's record lacked documentation after initially noting the wound, was prescribed antibiotics due to infection which was not administered due to being unavailable. Resident #21's care plan did not include interventions for skin concerns including what pressure relieving devices were installed. During observations residents were not repositioned appropriately.

F689; 58.28(3)e; G; $7,250. Staff did not provide adequate supervision when a resident fell in the dining room and staff were not present in the dining room at the time of the fall.

F689; 58.29(3)e; G; $21,000 (Treble/Held in Suspension). On 12.7.25 at 3:52 p.m. Resident #1 was walking to the bathroom with staff assistance when they felt like their legs were giving out and staff lowered them to the floor. The resident complained of pain in their left ankle with swelling identified. The resident was sent to the ER where they were diagnosed with a tibia fracture. They had a splint placed and could not bear weight to that leg. During investigation it was noted that the staff didn't use a gait belt when they assisted the resident with ambulation. Additionally, the intervention of non-skid strips were not in place. The nursing home corrected the deficiency prior to on-site survey resulting in past non-compliance.

F689; 58.28(3)e; G; $7,250 (Held in Suspension). On 11.23.25 a C.N.A. transferred a resident from their bed to the commode without the use of a gait belt. During the transfer the residents' legs went out from under them causing them to fall to the floor. The staff reported hearing the residents' arm make a cracking noise and the resident complained of right arm pain. An x-ray obtained later in the day revealed a mildly displaced fracture of the humeral neck.

F689; 58.28(3)e; G; $4,500 (Held in Suspension). Resident #4's care plan directed staff to use two assistance and a full body lift to transfer to the shower chair. During the transfer, the lift tipped over and the bar hit the resident above their eyebrow causing a small laceration and bruise. During investigation of the incident, the lift was removed from service, and a new lift was rented until an inspection could be completed. It was determined that the opening of the legs takes a long time and the staff failed to make sure the legs of the lift were open wider than the resident, which caused it to tip. Due to the corrections implemented, the nursing home was noted in past noncompliance.

F880; 58.10(8); G; $5,000. During the entrance conference the administrator stated Resident #17 tested positive for Influenza A. During observation the resident's room door was open, they didn't have a sign on the door indicating any special precautions were required and there wasn't a PPE cart nearby. The resident's roommate was in the room with the privacy curtain pulled. The same day, the roommate went to the dining room without being offered a mask and sat with other residents. Staff didn't wear PPE when entering the room and didn't complete hand hygiene upon exiting. The staff was then observed touching four other residents' trays and a cart. Resident #17's roommate later developed symptoms of influenza. During observations of staff monitoring blood glucose levels, staff placed items on a barrier but set the barrier down in the resident's room and then brought it back out, placing it on top of the cart. Staff donned gloves prior to touching medications but touched the medication cart and computer multiple times with the gloves on and then touched the medications.

TOP DEFICIENCIES

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

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

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

58.12 – Cited 1 time when a veteran resident was not included on the IDVA website.

F550 – Cited 7 times for failure to treat residents with respect, dignity, and privacy by:

- Staff stood by residents while assisting them with eating.
- Staff went through residents belongings without permission.
- Rude to residents in the way they were speaking.
- 2 times when residents were exposed to the public.
- 2 times when staff failed to knock and be acknowledged before entering a resident's room.
- Staff were aggressive when providing care.
- Staff to resident abuse allegations.
- The ER reported that a resident came to the hospital in three heavily saturated incontinent products.
- Staff did not respond to resident requests in a timely manner.
- 2 times when staff were not interacting with residents as they assisted them with eating.

F551 – Cited 1 time when a social services staff member assisted a cognitively impaired resident to cash out a life insurance policy instead of allowing the resident's legal representative to handle.

F552 – Cited 3 times when families were not notified for new or changing psychotropic medications prior to implementing including discussing risk vs. benefits.

F554 – Cited 1 time when medications were left with a resident who did not have the appropriate measures in place to self-administer medications.

F561 – Cited 1 time when staff did not accommodate the resident's request for showering preferences.

F568 – Cited 1 time when quarterly statements were not provided to the resident on their fund balances.

F572– Cited 1 time when the nursing home didn't provide ongoing education to residents on their rights.

F577 – Cited 1 time when survey reports were not accessible.

F578 – Cited 1 time when the latest IPOST was not in the resident's record according to resident and representative interviews.

F580 – Cited 5 times when the physician and family were not notified of the resident refusing physician orders, significant weight loss, worsening of wounds, allegations of abuse, and medications being held.

F582 – Cited 3 times when the resident or their representative were not provided notice or the appropriate forms upon discontinuing skilled care.

F584 – Cited 2 times for:

- Cleanliness of resident rooms.
- Residents personal property wasn't protected from loss or theft.
- Areas throughout the building in disrepair.

F585 – Cited 2 times when staff didn't complete the grievance process with resident concerns.

F600 – Cited 1 time when the resident wasn't protected from resident-to-resident abuse.

F602 – Cited 3 times for:

- Staff using a resident's EBT card for personal grocery items.
- Pain medication diversion.
- A resident's bank card was stolen and used to pay for a staff member's personal bills.

F605 – Cited 3 times when:

- A GDR was not attempted.
- Non-pharmacological interventions and target behaviors were not included on the resident's care plan.
- PRN psychotropic medications were ordered for longer than 14 days.

F606 - Cited 1 time when a background check directed the nursing home to conduct further research into the person's criminal history and this was not completed.

F607 – Cited 1 time when the abuse policy was not followed based on a criminal background not being completed and staff concerns were not thoroughly investigated.

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:

- 2 times when bed hold notification was not provided upon transfer.
- A discharge recapitulation was not completed.

F641 – Cited 6 times when the MDS was not coded accurately by:

- 2 times for the Level 2.
- The discharge location
- 3 times for medications
- Bed rails were coded as a restraint
- An MDRO diagnosis was not included.

- The resident was not coded as a current smoker.
- The MDS coded a ventilator when the resident was not on a ventilator.

F644 – Cited 3 times when a significant change Level 1 was not completed for a new mental illness diagnosis

F645 – Cited 1 time when the Level 1 didn't include all mental illness diagnoses.

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:

- Oxygen
- Glucose monitoring
- Fall interventions
- Psychotropic medications
- The resident placed themselves on the floor

F657 – Cited 5 times when:

- Care plan meetings were not held and/or the residents and their representatives were not invited to attend.
- The care plan was not updated to include:
    - Homicidal statements
    - ADL changes
    - Restorative care
    - Use of a mechanical lift
    - Fall interventions.

F658 – Cited 10 times for:

- 5 times when physician orders were not followed.
- Medications were touched with bare hands.
- Staff did not verify medication accuracy as the pill was obtained from a medication cup and not a medication bottle.
- Did not document completion of treatments.
- The physician wasn't notified when the blood pressure was outside of established parameters.
- Compression socks were applied without a physician's order.
- Staff drew insulin out of a pen with an insulin syringe instead of placing a pen needle on the hub, which was not in accordance with manufacturer's recommendations.

F676 – Cited 1 time when restorative care was not offered to the resident.

F677 – Cited 8 times when residents were not provided:

- 2 times for toileting assistance
- Oral care
- Repositioning
- Feeding
- 3 times for bathing/showers
- 2 times for incontinence care
- Nail care

F678 – Cited 1 time when CPR certified staff members were not scheduled/present at all times.

F679 – Cited 1 time when a resident was placed in a common area without any stimulus such as a TV or radio.

F684 – Cited 7 times for:

- Physician's orders for wound care were not followed.
- The bowel protocol was not followed to alleviate constipation.
- Assessments were not completed:
    - 2 times when residents had influenza A
    - For a head injury.
    - 3 times for wounds/skin assessments.

F686 – Cited 1 time when the ordered treatment was not completed and during observations of wound care, staff did not follow infection control standards.

F688 – Cited 4 times when restorative programs were not provided according to the plan of care.

F689– Cited 15 times for:

- Root cause analysis was not completed with new interventions identified to prevent falls.
- 2 times when smoking assessments were not completed.
- The legs on a mechanical lift were not open during the transfer.
- Residents were pushed in a wheelchair without foot pedals.
- 2 times when only 1 staff member assisted during a full-body mechanical lift transfer.
- Hot water temperatures exceeded 120 degrees Fahrenheit.
- Gait belts were not used during transfers.
- A commode broke causing a resident to fall.
- Residents were vaping inside the building.
- 2 times when fall interventions were not followed.
- Post-fall neurological assessments were not completed according to policy.
- The mechanical lift sling was not raised high enough which caused the residents' ankles to drag across the bed.
- A resident was smoking unsupervised when their care plan directed supervised smoking only.

F690 – Cited 2 times for:

- The catheter tube touched the floor.
- The drainage spout touched the inside of the graduated cylinder.
- The catheter tubing was not cleaned appropriately during perineal care.

F692 – Cited 1 time when residents were not offered drinks with their meal.

F693 – Cited 3 times when:

- Feeding was delivered via push instead of gravity methods.
- Flushes were not completed before and after medication administration.
- The head of bed was not elevated during tube feedings.

F695 – Cited 3 times when:

- 3 times when the flow rate was not in accordance with physician's orders.
- The e-tank was empty causing the resident shortness of breath.
- The oxygen tubing change policy was not followed.
- Oxygen was not identified in the resident's care plan.

F697 – Cited 1 time when pain medications were not provided as the resident requested.

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

F725 – Cited 6 times when:

- 2 times when care and services were not provided.
- The staffing was not in accordance with the facility assessment.
- 4 times when call lights were not answered in a timely manner.

F726 – Cited 2 times for:

- Orientation was not provided for new staff as well as agency staff.
- Staff did not educate a resident (or notify the nurse) when a resident refused to wear an immobilizer during a transfer.

F727 – Cited 2 times when the nursing home did not have RN coverage at least 8 consecutive hours in a 24-hour period.

F730 – Cited 1 time when performance reviews were not completed.

F732 – Cited 3 times for:

- Nursing staffing was not posted as required.
- The posted document did not include the name of the nursing home or the date.

F755 – Cited 4 times for:

- Did not have established parameters for notifying the physician of hypo/hyperglycemia.
- Lorazepam and Clonazepam were not stored under double lock.
- Medication carts were not locked.
- Medications were not available for administration.

F760 – Cited 7 times for:

- 4 times when insulin pens were not primed.
- 2 times when medications were not dated when opened.
- Insulin was going to be administered more than 30 days since it was opened.
- Diclofenac gel was not measured according to the dose and manufacturer's recommendations.
- The insulin pen hub was not cleaned with alcohol prior to putting the pen needle on.
- A resident received another resident's medication.
- Medications were omitted.

F791 – Cited 1 time when staff didn't assist a resident with scheduling an appointment to have teeth extracted according to the dentist's recommendation.

F801 – Cited 1 time when the dietary manager was not a CDM or have other allowable credentials.

F802 – Cited 3 times for:

- Meals were not served timely.
- Staff were not competent in completing the puree process to ensure the residents received accurate portions.
- Staff did not have competencies to monitor the dishwasher temperature.

F803 – Cited 3 times when:

- 2 times when the staff didn't serve all items on the menu.
- Inaccurate portion sizes were served.

F804 – Cited 8 times when:

- 8 times when food temperatures were not maintained at 135 degrees or more.
- Chicken was not fully cooked.

F805 – Cited 3 times for concerns identified with the texture and consistency of altered texture diets.

F808 – Cited 1 time when the physician ordered a constant carbohydrate diet which was not followed.

F812 – Cited 12 times for:

- Cleanliness of equipment in the kitchen.
- Scoops were stored in the items.
- 3 times for cleanliness of the kitchen.
- Meals were not served timely.
- Food temperatures were not checked.
- Staff touched food with their hands.
- 5 times when food was not labeled or dated when opened.
- 2 times when food was not discarded timely.
- There weren't thermometers in the refrigerator and/or freezer.
- 2 times when logs were not completed.
- Dishes were not washed timely.
- Cooked food was noted in the kitchen from the previous meal and was not discarded.
- 2 times when food was not covered appropriately.
- 3 times when staff touched food with possibly contaminated gloved hands.
- The dishwasher was not reaching a high enough temperature during the rinse cycle.
- 2 times when clean dishes were not stored appropriately.
- Hair and/or beard nets were not used appropriately.
- Bowls of food were placed on a plate that touched other food.

F814 – Cited 1 time when room trays were not picked up and food discarded timely.

F842 – Cited 6 times when:

- 2 times when documentation was not accurate.
- Incidents were not documented in the resident's record.
- 2 times when resident records were accessible/visible to the public.
- Logs were falsified.
- An end date was not included on the order when the physician ordered a specific stop date.
- Documentation of a completion of an assessment and intervention was not documented timely.

F851 – Cited 2 times when PBJ reports were not accurate when submitted.

F865 – Cited 6 times when:

- 5 times when providers had repeat deficiencies due to lack of effective QAPI processes.
- The nursing home did not make good faith efforts to correct identified deficiencies.

F867 – Cited 1 time when the provider did not track or monitor performance to ensure sustained improvement.

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

F880 – Cited 18 times for:

- 9 times when hand hygiene was not completed when necessary.
- 9 times when enhanced barrier precautions were not implemented.
- Staff failed to remove their PPE prior to exiting the room.
- Staff didn't sanitize reusable equipment.
- Catheter tubing touched the floor.
- Oxygen tubing touched the floor.
- Infection control policies were not reviewed/updated annually.
- Laundry was not covered when transported.
- Staff did not use PPE when sorting soiled laundry.
- Residents with influenza A and other respiratory symptoms were not isolated.
- Staff failed to change gloves appropriately.
- A catheter bag was held above a resident's bladder.

F881 – Cited 1 time for lack of an antibiotic stewardship program.

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

F883 – Cited 1 time when pneumonia vaccinations were not offered when they should have been.

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

F925 – Cited 1 time when there was evidence of mice infestation.

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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