LTC Survey Trends Report
May 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 F577 - Right to Examine Survey Results was recently included in a newsletter.

Additional Resources on Examining Survey Results for your use:

- F577 – Guidance for quality assurance
- F577 – Spreadsheet for quality assurance

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Survey Activity

District	Average Months for Providers with Recert	Time Since Last Survey	Longest Survey Timespan
Statewide	12.2 months	37 nursing homes are currently over 12 months	14 months

Recertification:

- 22 total recertification surveys reviewed with 6.2 deficiencies on average per recertification survey with deficiencies.
    - Of the 18 recertifications with at least one deficiency, 2 providers received a fine (or 11%).
    - Of the 22 recertifications, 4 providers had deficiency free surveys (or 18%)

Complaint/Incidents:

- 40 providers with complaint/incident surveys reviewed with 4.3 deficiencies on average per survey reviewed with deficiencies.
    - Of the 29 complaint/incident surveys with at least one deficiency, 14 received a fine (or 48%).
    - Of the 40 complaint/incident surveys, 11 did not receive a deficiency (or 28%).

Congratulations to LeadingAge Iowa members on a deficiency free survey:

Deerfield Health Care Center

Enforcement Action

CY 2026	State Fines	Federal CMPs	Enforcement	Total	Avg number of deficiencies
January	$27,000	$50,568		$77,568	6.2 deficiencies
February	$55,500			$55,500	5.5 deficiencies
March	$103,250			$103,250	6 deficiencies
April	$64,000			$64,000	4.8 deficiencies
May	$68,250			$68,250	6.2 deficiencies

Calendar Year 2025 Totals:

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

Fines identified in this report are per the Iowa Department of Inspections and Appeals website (state) and QCor (federal). Total fine amounts may change based on appeal rights and reduction rules.

CITATIONS WITH FINES

May Deficiencies with State Fining and Citation

F600; 58.43; G; No citation on website. On 4.19.26, Resident #1 was observed standing over Resident #2 while in a Broda chair and Resident #1 hit Resident #2 in the face with the handle of a cane 3-4 times before staff could reach the resident to intervene. The resident had a slightly swollen eye with a bruise on the cheekbone. The staff corrected the incident and was issued past noncompliance.

F600; 58.43; G; No citation on website. Resident #18 reported that they were lying in bed and asked a staff member to help change their incontinent product following urination. The staff refused to change the resident's incontinent product despite being in their room 4-5 times that day. The resident summoned the nurse who assisted the aide in cleaning the resident however, the nurse had to leave during the procedure and then the aide began yelling at the resident. The resident couldn't remember the exact quotes but said that they remembered the "f" word being used as well as accusing the resident of lying and stating they will get even.

F606; 50.9(3); D; $500. Staff A's SING report indicated further research was required under criminal history but there wasn't a criminal record included or evaluation in the file.

F607; 50.9(3); F; $500. The SING report indicated that further research was required for possible child abuse history, however, there wasn't any follow up completed based on the SING report.

F607; 50.9(3); D; $500. A SING report was completed on 2.12.25 and indicated further research was required by DCI. The file contained a record check evaluation form signed by the staff member and a criminal history record check request form from their prior employer which contained the criminal history results as of 2.14.25. The Personnel file lacked documentation of DCI's final criminal history response from the prior employer to ensure they had been cleared to work.

F607; 50.9(3); D; $500. Staff J didn't have a criminal background check completed prior to hire.

F609; 58.43(9); D; $500. Staff failed to report multiple allegations of abuse to DIAL within the required time frame.

F609; 58.43(9); D; $500. A resident reported that staff yelled at their roommate while they assisted them in the bathroom. The resident didn't report it to a staff member until the following morning. The staff member reported that they told the ADON about it as well as completing a grievance form, but it wasn't reported to DIAL.

F609; 58.43(9); D; $500. A staff member took a video of a resident urinating in a chapel trash can and posted it on Snapchat. The incident wasn't reported immediately.

F609; 58.43(9); D; $500. Resident #6 was in their bed, unclothed, when resident #7 came into their room and kissed them twice on the face. Resident #6 told the resident no and to get out which they did. Resident #6 got dressed and walked to the nurse's station where staff were present and when they told them about the incident they laughed and said they would watch the other resident. The incident was not reported to management or DIAL immediately. Resident #3 reported an incident when the night nurse opened the resident's door and yelled at them "let's go" and aggressively pulled their legs to move them out of bed. The resident reported the incident to an outside care provider who reported the incident, but it was not reported within 2 hours.

F609; 58.43(9); D; $500. A resident reported that during the night a staff member went in to check a resident for incontinence and the nurse aide pinched their vaginal lips. During investigation it was reported that another staff member was present, and the staff member didn't do anything inappropriate, but the incident wasn't reported to DIAL within 2 hours.

F609; 58.43(9); D; $500 (Held in Suspension). A nurse became ill while working and took a resident's Zofran tablet for nausea. The facility failed to report the incident to DIAL because the medication wasn't a controlled substance.

F609; 58.43(9); D; $500. Failed to report to DIAL injuries of unknown origin including bruises to the face and bruises to the wrist.

F610; 58.43(9); D; $500. The staff didn't complete a thorough investigation of an allegation of abuse when they didn't interview all staff working on the night that the allegation was made.

F627; J; No citation on website. Resident #1 was upset when staff reminded them that there was a no smoking policy at the nursing home. The resident stated that they wanted to sign out and leave. Staff then assisted the resident with signing an AMA discharge form. The resident left the facility via cab to a homeless shelter. The resident didn't have any medication and was unable to tell the staff at the shelter where they came from, or how they arrived.

F678; 58.19(2)j; J; $10,000 (Held in Suspension). Resident #1 requested CPR and was found without breathing or a pulse. Staff performed some chest compressions but did not provide any type of rescue breathing and stopped performing compressions before EMS arrived to take over CPR efforts. Additionally, there was a crash cart and backboard available that were not used when needed. According to an interview the nurse reported that the CNAs indicated the resident was having loose stools and was cleaned up several times and then requested to go to the hospital due to difficulty breathing. The nurse reported that the staff then reported the shortness of breath so they went to find oxygen but couldn't find all the working parts, so they were in the basement trying to locate them when the staff called them urgently to the room. When they noted the resident was not breathing and didn't have a pulse, they sent one CNA to call 911 while the other took care of the other residents and the nurse started chest compressions but stopped when the ambulance arrived.

F684; 58.19(2)b; G; $7,750. Resident #9 had wounds identified on their MDS including a diabetic foot ulcer. During review of the TAR multiple treatments weren't signed out as completed to the area. Assessments lacked documentation of measurements of the wound. On 4.24.26, the wound to the 1st interdigital space was listed as healed or closed. A podiatry note on 4.27.26 documented an amputation of a gangrenous toe on the right foot and then on 5.1.26, the resident was noted at a high risk of below the knee amputation due to the wound. Surgical follow up assessments continued to lack a thorough assessment including measurements. On 5.17.26, the resident was transferred to the ED with sepsis, acute renal failure and their right foot was necrotic and gangrenous requiring amputation of the leg.

F684; 58.19(2)b; G; $2,500. Resident #5 received a skin tear during a fall to their right shin on 4.6.26 and it initially measured 2 cm x 2 cm. On 4.13.26, the skin tear was dark pink with surrounding red tissue and was 3 cm x 1 cm with a macerated area of 2.6 x 0.7 cm. Review of the TAR lacked documentation of the order to change the bandage daily and the dressing didn't get started until 4.16.26.

F684; 58.19(2)b; G; $3,000. Resident #18 had moisture associated skin damage due to obesity. The staff failed to transcribe a physician's order for wound care to the wounds and didn't complete weekly skin assessments on the wounds. When a new wound was found, the staff applied a treatment that they didn't have an order for.

F689; 58.28(3)e; G; $6,250. Resident #1 had a history of falls and was found lying on the floor on 5.3.26 complaining of pain 10/10 in the left hip as well as redness to the area and mild swelling. Despite the assessment findings, staff transferred the resident from the floor to their bed with a mechanical lift. Upon being transferred to the ED, the resident was diagnosed with a hip fracture.

F689; 58.28(3)e; G; $7,750 (Held in Suspension). Resident #1 suffered a fall from a full body mechanical lift. Upon the nurse's entering the room the resident was noted to have a laceration and a bump to the crown of the resident's head. The resident refused to allow staff to assess them and insisted that EMS come to help lift them off the floor, later agreeing to be checked out at the hospital. At the hospital, the resident was diagnosed with a subdermal hemorrhage, subarachnoid hemorrhage, a right clavicle fracture, and a left femur fracture. The resident was admitted to the ICU. During investigation staff reported hearing the lift sling snap before the resident fell.

F697; 58.19(2)j; G; $7,750. Resident #1 had incident reports on both 4.18.26 and 4.19.26 in which the resident was found on the floor. The first fall on 4.18 no injury was noted, but on 4.19 the resident had signs of pain when the staff touched their right leg. Staff gave the resident Tylenol and Ativan for pain and anxiety. The following shifts, staff documented continued pain and agitation including both verbal and non-verbal signs of pain. On 4.20.26 at 7:48 am. a nurse told another nurse they had concerns about the resident and expressed that they needed transported to the hospital. The nurse communicated to the physician on the assessment findings and the physician gave an order to transfer to the ED where they were diagnosed with a hip x-ray. During multiple interviews staff reported the resident expressed pain, cried during transfer and while staff performed care.

F697; 58.20; G; $4,500 (Held in Suspension). Resident #68 was hospitalized from 10.26 to 10.28.25 and upon return the care plan wasn't updated to include right leg pain which led to the hospitalization. The care plan was updated to include non-weight bearing status and the use of a knee immobilizer. The resident was also admitted to hospice on 11.3.25. Review of the resident's record indicated they had pain daily at a moderate level since their return from the hospital however the pain level was not monitored on 11.3 and 11.4 and no as needed medications were administered for pain. During a family interview, they expressed concerns during their visit that the resident expressed nonverbal signs of pain and asked the staff for pain medication that was not administered. During investigation it was noted that the resident's pain medications were not delivered from the pharmacy but that the emergency kit had morphine available that staff could have used.

F760; 58.19(2)a; G; $4,240. When applying a Fentanyl patch, the staff failed to remove the plastic backing from the patch before placing it on the resident. This led to the resident not receiving any pain medication from the patch and resulted in increased use of as needed morphine.

F760; 58.20(1); K; $9,000 (Held in Suspension). Resident #4’s medications weren't accurately reconciled from a hospitalization which led to medications being inappropriately discontinued including blood pressure medications, diuretics, diabetes, cholesterol and depression. The resident was subsequently hospitalized for hyperosmolar hyperglycemic state when their A1C was 17.3, sepsis, kidney injury, metabolic encephalopathy, and metabolic acidosis. Resident #2 and #6’s medications were not accurately reconciled either, which led to medications for blood pressure and insulin not being administered as well as discontinuing metformin. Also, Resident #6 received double the dose of hydromorphone.

TOP DEFICIENCIES

F-TAG #	
F880	Infection Prevention & Control
F689	Accidents/Hazards/Supervision/Devices
F684	Quality of Care
F725	Sufficient Nursing Staff

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

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

58.12(1) - Cited 1 time when the provider didn't add the veteran to the IDVA website within 30 days of admission.

F550 - Cited 10 times for failure to treat residents with respect, dignity, and privacy by:

- Staff yelled at the resident's roommate and when the resident attempted to intervene the staff member was rude to the resident.
- Staff refused to provide the resident with their call light.
- Refused to provide the correct incontinent product size for the resident.
- Staff wouldn't let the resident go outside and smoke during designated smoking times.
- Staff took a cigar from a resident when the resident wanted to go outside and smoke.
- A resident asked a staff member to stop doing something and the staff member wouldn't quit.
- Staff asked residents about using the bathroom in the dining room.
- The resident's room door wasn't closed when providing care.
- Blood stained sheets were left on the bed.
- Staff refused to provide care when requested.
- Staff wouldn't listen and follow resident's requests.
- Medications weren't administered according to the resident's preferences.
- Staff weren't nice to the residents when providing care.
- Care wasn't provided timely.

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

F553 - Cited 1 time when care conferences were not documented.

F554 - Cited 3 times when medications were left with the resident and no self-administration assessment was completed.

F557 - Cited 1 time when staff failed to follow up on a report that the resident had missing items.

F558 – Cited 4 times when:

- The nursing home didn't order the correct size of incontinent product for the resident.
- 2 times when the call light was not within the resident's reach.
- Staff refused to wear a mask when the resident asked them to.

F578 – Cited 3 times when:

- The code status was not included in the care plan or record.
- The code status was not identified and the resident was admitted more than 10 days prior.
- The incorrect color of magnets (according to their policy) were placed on the door frames for residents based on their code status.
- The code status wasn't accurate in all locations.

F580 – Cited 8 times when the resident's physician and/or representative weren't notified of:

- Medications were omitted.
- Continued pain with use of pain relief.
- Medication changes.
- Weight changes.
- Change in conditions.
- The vital signs were outside of established parameters.
- Adverse effects of medications.
- Incidents.

F584 – Cited 4 times for:

- 2 times for cleanliness and repair of the building.
- Urine odors.
- Missing belongings.
- Equipment cleanliness.

F585 – Cited 1 time when staff didn't report grievances.

F600 – Cited 4 times for:

- Videos were taken and posted to social media without resident consent.
- 3 times when resident's weren't protected from other residents to prevent resident-to-resident incidents.

F602 – Cited 2 times for medication diversion.

F607– Cited 1 time when staff didn't separate residents during verbal altercations.

F610 – Cited 2 times when:

- Injuries of unknown origin weren't investigated.
- An allegation of possible abuse wasn't investigated.

F627 – Cited 3 times for:

- No discharge recapitulation, summary, or medication reconciliation.
- A notice of discharge/transfer wasn't provided.

F628 – Cited 5 times for:

- Hospital transfers weren't documented in the resident's record.
- Notice's weren't provided before discharge/transfer.
- Transfer notice didn't include all required elements.
- 2 times when bed hold notifications weren't provided.
- 3 times when the long-term care ombudsman wasn't notified of discharge/transfer.
- No discharge recapitulation or summary.

F637 – Cited 2 times when significant change MDS' weren't completed with changes in ADLs and admission to hospice.

F641 – Cited 6 times when the MDS wasn't correctly coded by:

- 2 times when the PASRR Level 2 wasn't coded.
- A urinary catheter wasn't coded in the MDS.
- Hypnotics and antidepressants weren't coded.
- Feeding tube wasn't coded.
- The diagnosis for antipsychotic medications weren't coded.
- No BIMS test was completed.

F644 – Cited 4 times when:

- Not all diagnoses were included in the PASRR Level 1.
- 2 times when a new Level 1 wasn't completed before the short-term approval expired.
- A new Level 1 wasn't completed with a new mental illness diagnosis.

F655 – Cited 1 time when the baseline care plan wasn't completed timely.

F656 – Cited 5 times when:

- When the care plan didn't include:
  - Diuretics
  - Catheters
  - Wounds
  - Antipsychotics medications
  - Antianxiety medications
  - Antidepressant medications
  - The level 2 recommendations.
- Staff didn't follow the care plan.

F657 – Cited 4 times when:

- The care plan was not updated to include:
  - Resident-to-resident incidents.
  - Antipsychotics
  - UTI and antibiotics
  - Pain

F658 – Cited 4 times for:

- 2 times when physician orders' weren't followed.
- Established protocols weren't followed.
- Hospital discharge orders were not followed.

F677 – Cited 7 times when residents were not provided:

- 4 times for bathing.
- Shaving
- Nails
- Perineal care
- Oral care.

F684 – Cited 12 times for:

- 2 times when urine samples weren't collected timely.
- 4 times when post fall assessments and neurological assessments weren't completed according to policies and procedures.
- 3 times when assessments weren't completed with changes in condition.
- Abnormal lab values weren't followed up on.
- The treatment for a wound wasn't completed.
- A wound vac wasn't changed per the order.
- Staff didn't respond to an alarm on a wound vac.

F686 – Cited 2 times for:

- Pressure reducing interventions weren't implemented.
- Assessments and treatments weren't completed.

F688 – Cited 3 times when restorative wasn't provided as care planned.

F689– Cited 13 times for:

- Staff weren't supervising when residents wandered into other rooms.
- Residents were sharing alcohol with other residents.
- A smoking assessment wasn't completed.
- A resident ingested pain relief ointment.
- Staff left a resident on the bed pain for a prolonged period of time.
- A gait belt wasn't used during a transfer.
- The wheelchair wasn't locked during the transfer.
- 2 times when the correct sling wasn't used for a mechanical lift.
- Foot pedals weren't on the wheelchair.
- 2 times when staff weren't supervising to prevent resident-to-resident altercations.
- Storm procedures weren't followed causing a resident to fall trying to get out of their room during a tornado warning.
- Fall intervention's weren't followed.

F690 – Cited 2 times for:

- Glove changes and hand hygiene weren't completed appropriately during toileting.
- The catheter bag was laying on the floor.

F692 – Cited 1 time when a significant weight change wasn't followed up on.

F695 – Cited 2 times when:

- Oxygen flow rate wasn't correct according to the order.
- Non-licensed staff were adjusting the oxygen flow rate.
- The humidifier and tubing wasn't changed according to the policy.

F697 – Cited 1 time when pain medications weren't administered when a resident reported pain.

F698 – Cited 5 times for:

- 2 times when staff failed to complete pre-and post-dialysis assessments.
- 2 times when the fistula wasn't assessed.
- Dialysis competencies weren't assessed.
- Staff were not competent on performing peritoneal dialysis onsite when a resident required it.

F700 – Cited 1 time when staff failed to obtain informed consent prior to use of bed rails.

F725 – Cited 12 times when:

- 11 times when call lights weren't answered in a timely manner.
- Non-certified staff performed care that weren't competent in doing so.
- Agency staff trained new facility staff.
- The staffing wasn't sufficient to provide the care necessary for residents based on several factors.

F726– Cited 3 times when:

- Non-certified staff transferred residents without the use of gait belts.
- Staff without dementia education provided care in a dementia specific unit.
- Nursing competencies weren't maintained to ensure transcription errors were prevented.
- Multiple examples of evidence that staff competencies weren't maintained based on a failure to complete safe and appropriate care.

F728 – Cited 1 when a nurse aide/medication aide certification wasn't checked to ensure it was valid.

F741 – Cited 2 times when:

- There wasn't documentation of staff competencies for behavioral health.
- The care plan didn't include PTSD, triggers, signs of distress, and interventions.

F742 – Cited 1 time when the care plan didn't include Level 2 recommendations.

F744 – Cited 1 time when the care plan lacked dementia services.

F745 - Cited 1 time when the social worker didn't assist with Medicaid applications or obtaining a power of attorney.

F755 – Cited 3 times for:

- A nurse took a bottle of liquid morphine home in their pocket.
- Medications weren't available to administer.
- A nurse forged another nurse's signature when they didn't reconcile narcotics.

F759 – Cited 1 time for medication error percentage over 10% due to administration times.

F760 – Cited 3 times for:

- Medications omitted.
- 2 times when insulin pens weren't primed.
- The correct medication wasn't administered.

F761 – Cited 2 times when:

- Medication carts were unlocked and unsupervised.
- Narcotic medications weren't destroyed timely.

F800 – Cited 1 time when a diet wasn't served as ordered.

F801 – Cited 1 time when the dietitian didn't complete a nutritional assessment.

F802 – Cited 1 time when staff lacked competencies on proper dishwasher procedures to ensure correct sanitation.

F803 – Cited 1 time when the incorrect portion size for puree diets was served.

F804 – Cited 4 times when:

- 3 times when food wasn't maintained at or above 135 degrees.
- Cold food was above 41 degrees.

F806: Cited 1 time when a resident the resident's food preferences weren't followed.

F812 – Cited 10 times for:

- 4 times for kitchen cleanliness
- 4 times when hand hygiene wasn't completed when necessary during food preparation and serving.
- 5 times when gloves weren't changed when necessary.
- 3 times when food temperatures were less than 135 degrees.
- 3 times for equipment cleanliness.
- Food items were stored on the floor.

F825 – Cited 1 time when OT services weren't provided timely when a resident requested them.

F838 – Cited 1 tie when staffing needs weren't evaluated on each shift in the facility assessment.

F842 – Cited 5 times when:

- 2 times when incidents weren't documents.
- Signed items weren't completed.
- Items were not transcribed on the MAR correctly.
- 3 times for repeat deficiencies.

F865 – Cited 3 times when providers didn't have effective QAPI processes based on repeated deficiencies cited and to correct multiple medication errors.

F868 – Cited 1 time when quarterly meetings weren't held.

F880 – Cited 17 times for:

- 4 times when hand hygiene wasn't performed.
- 10 times when EBP wasn't followed.
- 4 times when glove changes weren't completed as necessary.
- Used the same side of a washcloth during wound cleansing procedures.
- 3 times when the glucometer wasn't disinfected appropriately.
- The policies and procedures weren't reviewed/updated annually.
- Disinfectant wasn't used that would kill c-diff when necessary.
- Didn't use a barrier device for clean equipment.
- COVID-19 guidance wasn't followed which led to transmission of the virus.
- A used lancet was placed in a staff member's pocket.

F882 – Cited 3 times when pneumonia and/or influenza vaccinations weren't offered or administered.

F887 – Cited 1 time when a staff member wasn't screened or educated on COVID-19 vaccine.

F909 – Cited 1 time when bed rail inspections weren't completed for residents requiring the use.

F919 – Cited 1 time when call lights were not in reach.

F921 – Cited 1 time for not covering heating elements and there wasn't trim on a windowsill.

F943 – Cited 1 time when dependent adult abuse training wasn't completed within 6 months of hire.

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.