LTC Survey Trends Report
October 2024

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LeadingAge Iowa

ENFORCEMENT ACTION REVIEW & SURVEY UPDATES

by Kellie Van Ree, Director of Clinical Services

The Regulatory Review article for this month reviewed F557, the resident's right regulation regarding allowing the resident to retain and use their personal property. This regulation also includes requirements for conducting searches of the resident's personal property.

In case you missed it, CMS recently released a new QSO memo, significantly revising several regulations in Appendix PP. You can review the in-depth article LeadingAge Iowa sent to members here.

Survey Activity

District	Average Months for Providers with Recert	Number of Providers over 12 Months	Longest Survey Timespan
Statewide	15.1 months	28 nursing homes	15 months

Recertification:

- 47 total recertification surveys reviewed with 4.9 deficiencies on average per recertification survey with deficiencies.
    - Of the 39 recertifications with at least one deficiency, 4 providers received a fine (or 10%).
    - Of the 47 recertifications, 8 providers had deficiency free surveys (or 17%)

Complaint/Incidents:

- 47 providers with complaint/incident surveys reviewed with 2.7 deficiencies on average per survey reviewed with deficiencies.
    - Of the 30 complaint/incident surveys with at least one deficiency, 9 received a fine (or 30%).
    - Of the 47 complaint/incident surveys, 17 did not receive a deficiency (or 36%).

Congratulations to Highland Ridge on a deficiency free survey!

Enforcement Actions

MONTH (2024)	STATE FINES	FEDERAL CMPS	ENFORCEMENT	TOTAL	AVERAGE NUMBER OF RECERTIFICATION DEFICIENCIES
JANUARY	**$104,000**	**$155,502.93**	**3 Denials**	**$259,502.93**	**6.7 deficiencies**
FEBRUARY	**$26,500**	**$575,447.62**	**3 Denials**	**$601,947.62**	**9 deficiencies**
MARCH	**$36,250**	**$153,429**	**5 Denials; 3 DPOC**	**$189,679**	**5.3 deficiencies**
APRIL	**$131,250**	**$192,873**	**4 Denials**	**$324,123**	**5 deficiencies**
MAY	**$101,500**	**$324,680**	**6 Denials**	**$426,180**	**5.1 deficiencies**
JUNE	**$75,750**	**$495,510**	**6 Denials**	**$571,260**	**6.4 deficiencies**
JULY	**$214,500**	**$284,397**	**9 Denials; 1 DPOC; 1 State Monitoring**	**$498,897**	**6.1 deficiencies**
AUGUST	**$121,000**	**$63,690**	**6 Denials, 1 Termination**	**$184,690**	**5.4 deficiencies**
SEPTEMBER	**$140,000**	**0**	**1 Denial; 1 Temporary Management/License Revoked**	**$140,000**	**6.9 deficiencies**
OCTOBER	**$129,000**	**0**	**0**	**$129,000**	**4.9 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

October Deficiencies with State Fining and Citation

F600; 58.43(1); J; $500 (Held in Suspension). Resident #47 reported an allegation of abuse regarding a Dietary staff member. The resident reported that the staff member entered their room to deliver their meal and visited with them for a moment. When the staff member left, they kissed the resident on the neck. The incident was not reported to the DON until 7 days later when they initiated an investigation. The resident was interviewed by the DON and indicated they felt safe and that the staff member kissed them on the cheek when they went to leave their room. The incident was reported to law enforcement, who interviewed the resident and the alleged perpetrator. Law enforcement concluded that the resident was of sound mind and the staff member did not appear to have sexual intent or intent to harm. During an interview by the surveyor, the resident reported that the staff member decreased their interaction with them for a brief period, but since they have been in their room 6-8 times per day, rubbing their back and arm, sits in their recliner uninvited and makes them feel uncomfortable. The resident stated that they tried to tell the staff member that it made them uncomfortable without success. The resident reported they started making excuses to get them to leave their room. During the interview the resident was tearful and expressed that they didn't want staff to know what was said during the interview. Observations by the surveyor included the same staff member entering the resident's room to deliver a meal tray. During interviews with other staff members, they expressed that they frequently see the staff member in and out of the resident's room. Resident #316 required staff supervision and during an incident a staff member reported that another staff member spoke very mean to the resident including telling them to sit their f***** a** down. The incident was not investigated until 4 days later, despite staff telling the nurse on duty at the time.

F609; 58.43(9); D; $500 (Held in Suspension). A staff member took a resident out of the nursing home approximately every other week to go for a car ride, have dinner and watch TV at their house. Both the resident and the staff denied any relationship or sexual acts. The staff member indicated the resident was a friend of their brothers, but they did not have a previous friendship prior to admission. The nursing home was notified by another staff member that felt it was inappropriate and indicated they initiated an investigation, however, there was no record of this. The staff member denied ever being questioned regarding the situation. The allegation was not reported timely to DIAL. A resident received money from social security and refused to deposit it into the resident trust account. Instead, they gave it to the dietary manager who would purchase things for the resident or provide cash. The Administrator was told that the dietary manager had the resident's money, and they were told to return the money. This situation was also not reported as potential abuse.

F609; 58.43(9); K; $500 (Held in Suspension). The nursing home did not report allegations of abuse to DIAL within the required timeframe.

F609; 58.43(9); D; $500 (Held in Suspension). Staff did not follow the nursing home policies when a narcotic was missing.

F610; 58.43(9); K; (Included in Another Fine). The nursing home did not separate staff members accused of alleged abuse from dependent residents.

F658; 58.20(1); G; $5,250 (Held in Suspension). Resident #49 had lab work completed that revealed a high sodium level and low potassium with new orders and follow up labs scheduled for 8.15.24. The labs were not completed until 8.20.24 without notifying the physician of the delay in lab work. On 8.22.24 the physician again provided new orders and a follow-up lab in a week. A progress note on 8.27.24 indicated the resident was tired and lethargic and had a critical sodium level which required a transfer to the ER.

F684; 58.19(2)j; G; $8,750 (Held in Suspension). Resident #10's daughter expressed concern about a decline in the resident's condition and expressed that every time the resident experienced similar signs they needed to be hospitalized for a UTI. The nurse reported that the resident seemed more tired than usual, and their white blood count was elevated. However, the resident's vital signs were normal. The daughter also obtained vital signs during one of their visits and noted a high pulse and respiratory rate that was reported to the nurse but not to the physician. The following day the resident required a transfer to the ER due to a loss of consciousness. During observations the surveyor noted that Resident #4's wound vac was alarming for nearly an hour with several staff entering the resident's room while the alarm beeped, none addressing the alarm. When the surveyor went into the room with staff members the wound vac screen was dark and was not plugged into an outlet. Resident #8 had orders for continuous oxygen. During several observations the resident did not have their oxygen on. Resident #9 was using an empty oxygen tank and had low oxygen saturation levels of 85-89%.

F684; 58.19(2)j; G; $3,750. A resident with a history of scratching themselves had care plan interventions to monitor skin weekly, administer treatments as ordered, keep fingernails short, and document changes. An order for Benadryl cream was received on 5.21.24 that was not applied for 8 days. There were weeks that the skin assessments were not completed by staff. The resident was admitted to the hospital on 5.29.24 due to cellulitis of the lower extremities, delirium, pneumonia, abnormal urinalysis and was placed on antibiotics. The resident returned to the nursing home with hospice services. During interviews it was determined that the resident's family attempted to provide treatments the resident used when they were at home, but no orders were obtained by the staff.

F686; 58.19(2)b; G; $9,000. Resident #3 was identified as having a stage II pressure ulcer on the MDS, however, their care plan did not address skin breakdown/pressure ulcers. The baseline care plan indicated the resident turned and repositioned themselves, however, a functional abilities form indicated the resident required maximum assistance with transfers and ADLs. The pressure ulcer initially identified on 10.4.24 measured 0.7 cm x 0.3 cm x 0.1 cm and deteriorated over the next week which included documented measurements of 8 cm x 2 cm x 0.01 cm deep. On 10.15.24 the resident presented to the ER when staff reported to the primary physician the area was odorous, and concerns were present for possible infection. The resident passed away later that morning due to sepsis from the ulcered area and worsening renal failure.

F689; 58.28(3)e; J; $4,000 (Held in Suspension). Resident #1 had severely impaired cognition, and the care plan included a focus on elopement/wandering risk due to a history of attempts to leave the building. Notes included in the resident’s record documented exit seeking and elopements. On 10.21.24 at 6:30 a.m., an incident note documented the resident was found outside in the back parking lot. Following the elopement, the doors were checked, and it was identified the front door alarm was turned off and the nurse re-armed the door alarm. During investigation of the incident, they were unable to identify exactly how the alarm was turned off but speculated that a staff member inadvertently turned it off when trying to alarm it after they let a visitor outside.

F689; 58.28(3)e; G; $8,250 (Held in Suspension). Resident #2 had falls from their wheelchair that staff did not implement interventions in the care plan to address wheelchair positioning concerns. The resident had a fall from their wheelchair that resulted in a right fibular and tibial fracture. During observations, the surveyors observed staff pushing a resident with their foot off the pedal and dragging on the floor.

F689; 58.28(3)e; J; $20,750 (Treble/Held in Suspension). Resident #4 was a high risk for elopement and their care plan included a focus and interventions related to elopement including a Wanderguard device on their wheelchair. A visitor was outside of the nursing home front entrance when they noted Resident #4 in their wheelchair outside, talking on the phone. The visitor began walking towards Resident #4 when they began propelling themself down the sidewalk and gained speed as they went down a slope, tipping their

wheelchair over and landing on the grass. During investigation the cameras showed the resident leaving the front entrance and then fell approximately 11 minutes after leaving the building. The Wanderguard alarm did not sound to alert staff.

F689; 58.28(3)e; G; $23,250 (Treble/Held in Suspension). Resident #2 had a fall on 6.26.24 and the intervention to prevent additional falls was to have the resident wear gripper socks. On 6.27.24 the resident experienced another fall and did not have gripper socks on. The resident complained of right hip pain with external rotation noted which resulted in a transfer to the ER and was diagnosed with a hip fracture.

F689; 58.28(3)e; J; $24,750 (Treble/Held in Suspension). Resident #1 had diagnoses of dementia, hip fracture, and a history of falls. The resident's BIMS score indicated severe cognitive impairment, and the resident used a wander/elopement alarm. The resident had numerous entries in their nurses notes about elopement attempts. An EMS report from 10.21.24 at 1:55 p.m. indicated that they were dispatched to a private residence for a fall. Resident #1 was found by bystanders on the ground approximately 2 blocks from the nursing home. The resident had pain in their neck and was transported to the ER by ambulance. At the ER the resident was diagnosed with a fracture of C1 and C2 vertebrae and an abrasion on their scalp. During the investigation all alarms were functional, and no staff reported hearing the alarm sound, so it was not determined how the resident left the building.

F690; 58.19(1)j(4); G; $2,750. Resident #1 had an indwelling foley catheter which was routinely replaced on 10.19.24 with bloody urine returned. The following day the resident's intake decreased and they developed a fever. The physician was notified on 10.21.24 without new orders. On 10.23.24, the staff again notified the NP due to ongoing concerns and the NP discontinued use of aspirin. The resident was sent to the ER later that day due to an ongoing change in condition. The resident was diagnosed in the ER with a massively distended urinary bladder with air within the bladder lumen, extensive emphysematous changes to the bladder, and foley catheter with balloon inflated in the urethra.

F760; 58.19(2)a; J; $7,000 (Held in Suspension). Resident #25 had an order for Revlimid 5 mg daily on days 1-21 every 28 days. An oncology report indicated the nursing home was unsure if the medication was administered as the medication was still available in the building. The cancer center wanted the medication to start that day. The medication was again not administered from April 17 on. Review of the resident's lab results indicated they had elevated M Protein IgG Lambda levels when they did not receive the medication, and the levels consistently decreased since receiving the medication beginning in June. The nursing home did not have documentation on an investigation as to why the medication was not administered or medication error reports. Resident #2 and Resident #10 shared a room. Resident #2 was given Resident #10's medications including opioids, muscle relaxers, antidepressant, and anticonvulsants.

F805; 58.25(5)c; J; $4,500 (Held in Suspension). Resident #23's care plan directed staff to provide nectar thickened liquids. A Speech Therapy evaluation completed 10.4.23 indicated the resident was at risk for aspiration and needed to remain on nectar thickened liquids. During observation a medication aide administered the resident's medications with regular consistency water. Following administration, the resident began coughing significantly.

F881; 58.10(8); G; $5,000 (Held in Suspension). Resident #14 complained of urinary frequency, the nursing home obtained an order for a UA which was positive, and the resident was started on Cipro. The urine culture returned identifying the bacteria was resistant to Cipro, however, the nursing home did not notify the physician of the resistance. Approximately a month later the resident again complained of frequency with urination, a UA was obtained, and Cipro was ordered. The culture again showed the same bacteria and resistance to Cipro. Due to the resistant bacteria, there was an increased presence of bacteria in the second culture.

TOP CITATIONS

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

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

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

50.9(9)d – Cited 1 time when a staff member was convicted of a new crime and a background check was not completed.

58.12(1) – Cited 1 time when a veteran was not submitted to the IDVA website.

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

- A resident was not allowed to leave the nursing home with a friend.
- 3 times when incontinent care/toileting was not provided in a timely manner.
- 2 times when staff were swearing in front of or at residents.
- Meals were not served timely.
- Residents were provided with plastic utensils for meals.
- 3 times when staff were rude to residents.
- A resident had food on their clothing and were not assisted in changing clothes.
- Staff refused to provide care to a resident.
- Staff spoke in a foreign language while providing care to a resident.
- There was not a privacy curtain in a semi-private room to allow for full visual privacy for each resident.
- Staff provided care in a common area visible to other residents and the public.
- A resident was pulled backwards down the hallway in a shower chair.

F551 - Cited 1 time when staff did not follow a power of attorney's request to transfer the resident to the ER.

F557 – Cited 1 time when a notice was not posted that survey results were available, and the survey results were not in a readily accessible area.

F558 – Cited 1 time when a call light was not placed within a resident's reach.

F561 – Cited 1 time when a power of attorney declined an influenza vaccine, but staff administered anyways.

F567 – Cited 2 times for:

- 2 times when resident funds were not accessible at all times.
- Quarterly statements were not provided to residents/responsible parties.

F568 – Cited 1 time when quarterly statements were not provided to residents/responsible parties when they deposited funds with the nursing home.

F569 – Cited 1 time when a power of attorney was not notified that a resident's funds were nearly the maximum threshold for Medicaid eligibility.

F578 – Cited 5 times for:

- 3 times when the code status form was different than what the resident's record indicated (such as care plan, orders, etc).
- 2 times when the code status form was not signed.

F580 – Cited 5 times for:

- 3 times when the physician was not notified of weight loss, urine culture results, and a choking incident.
- 3 times when family was not notified of falls, new orders, and COVID-19 infection.

F582 – Cited 3 times when:

- There was not a signature on the required form(s).
- The NOMNC was not given at least 48 hours in advance of skilled discharge.
- An ABN was not provided when required.

F584 – Cited 2 times for failure to provide a homelike environment by:

- General cleanliness concerns in the resident's room/bathroom.
- A resident's wheelchair had food debris present and appeared that it had not been regularly cleaned.

F600 – Cited 1 time when the nursing home did not implement interventions to prevent abuse when they were aware of a potential inappropriate relationship between a resident and staff member.

F602 – Cited 2 times for:

- Interventions were not implemented by the nursing home when they were notified that a staff member had a resident's money at their house and were managing it for the resident.
- A nurse took Ozempic pens from a resident.

F607 – Cited 1 time when a background check was not completed prior to hire for a staff member.

F610 – Cited 3 times when the nursing home did not complete thorough investigations into allegations of possible abuse.

F623 – Cited 3 times when the LTC Ombudsman was not notified of transfer out of the nursing home.

F625 – Cited 1 time for failure to provide bed hold notices to residents.

F635 – Cited 1 time when a resident admitted for respite care did not have admission orders, code status paperwork, physician contact information, assessments, or their hospice provider information in their record.

F637 – Cited 1 time when a significant change MDS was not completed when a resident was discharged from hospice services.

F638 – Cited 1 time for not completing a quarterly MDS.

F640 – Cited 3 times when MDS' were not submitted timely according to the RAI manual.

F641 – Cited 7 times for inaccurate MDS coding based on:

- A diuretic not being coded.
- A fall with a major injury was inaccurately coded.
- 3 times when anticoagulants were coded inaccurately.
- A level 2 was not coded.
- Hospice services were not coded.

F642 – Cited 1 time when physician's orders were not followed.

F644 – Cited 5 times for:

- 3 times when a new Level 1 was not completed with a new MI diagnosis.
- 2 times when a new Level 1 was not completed with new psychotropic medications.
- The resident did not receive services identified in the Level 2.
- A short-term approval expired and a new Level 1 was not completed.

F656 – Cited 7 times for:

- The care plan did not include:
    - Oxygen
    - Diuretics
    - COVID-19
    - 3 times for anticoagulants
    - Hospice
    - PICC line
    - Culturally competent care – the resident's primary language was Spanish and this was not addressed throughout the care plan, such as cultural activities of interest, preventing isolation due to the language barrier, etc.

F657 – Cited 7 times for:

- The care plan was not updated to include:
    - Diuretics
    - Hospice
    - 3 times for new fall interventions.
    - Changes in ADL assistance
    - Antianxiety medication
    - Catheter discontinued
    - Anticoagulants
    - 2 times for behaviors.

F658 – Cited 16 times for:

- 11 times when physician's orders were not followed.
- An order to self-administer medications was not present.
- Staff did not hold the insulin pen in the skin for the time indicated per manufacturer's instructions.
- Did not complete hand hygiene during medication administration.
- 2 times for not transcribing orders timely.
- Did not document medication administration.
- Staff did not check placement of a feeding tube prior to initiating feeding/medications.
- A flush was not completed between administration of each medication via g-tube.

F660 – Cited 1 time when the nursing home discharged a resident and did not arrange for services upon discharge or ensure they obtained medications.

F676 – Cited 1 time when restorative care was not provided which caused a resident's function to decline with ADLs.

F677 – Cited 8 times for failure to provide/assist with:

- Proper perineal/incontinent care (technique).
- 3 times for bathing/showers.
- 2 times for incontinent cares (timeliness).
- Feeding
- Shaving
- Changing clothes

F679 – Cited 1 time when the only activities provided to the residents were bingo and music therapy.

F684 – Cited 19 times for:

- 4 times for failure to follow physician's orders
- A wound vac was not applied properly.
- Orders were not transcribed in a timely manner.
- 2 times when neurological assessments were not completed following a fall when a head injury was noted or per policy.
- 2 times for completing assessments when an infection was present.
- 5 times for completing skin assessments.
- Cares were not provided to prevent pressure ulcer development.
- An assessment was not completed when a resident had a change in their vital signs.
- A resident was given the wrong medications.
- 2 times for assessments not being completed following an incident with possible injury.

F685 – Cited 1 time when a resident reported desire to see an eye doctor and an appointment was not made.

F686 – Cited 2 times for:

- A wound vac was not turned on to function appropriately.
- A blister on a resident's heel was not identified and the policy followed when staff noted the blister.

F688 – Cited 2 times for:

- A splint being applied according to therapy recommendations.
- Failure to complete restorative per the resident's care plan.

F689– Cited 16 times for:

- New interventions were not implemented following falls.
- A safety belt was not used when a resident was in the shower chair which caused the resident to slip out of the chair.
- A call light was not placed within reach of the resident.
- 2 times when staff did not use foot pedals while pushing residents in a wheelchair.
- A resident was not supervised while they took a shower and they slipped and fell.
- Staff did not use another person to assist with a mechanical lift transfer.
- A lack of supervision of residents in the dining room when a resident fell.
- Staff turned away from a resident while they were ambulating and the resident fell.
- Wheelchair brakes were not locked during transfers.
- 3 times when the care plan was not followed to prevent falls.

F690 – Cited 5 times for:

- Catheter drainage bags were not covered by a dignity bag.
- Catheter drainage bags were touching the floor.
- A catheter was inserted without a physician's order.
- 2 times when urine specimens were not obtained timely or followed up on when a resident showed symptoms of a UTI.

F692 – Cited 1 time when a nursing home did not provide a resident with fresh water in their room.

F693 – Cited 2 times when:

- Staff did not follow the physician's order for tube feeding.
- Staff did not use gloves when they hooked a bag with formula to a g-tube and did so in a public area.

F695 – Cited 2 times for:

- A resident had oxygen in use and the cylinder was empty.
- There were no emergency trach supplies available at the resident's bedside.

F710 – Cited 1 time when staff did not clarify admission orders for a resident taking Coumadin and there were not directions on checking the resident's INR levels.

F725 – Cited 11 times for:

- 9 times when call lights were not answered in a timely manner.
- 3 times when cares were not provided timely.
- 2 times for PBJ reports indicating low staffing levels.

F726 – Cited 2 times when staff were not competent to provide care/services including wound vacs and enemas.

F727 – Cited 3 times for failure to have RN coverage on several days.

F744 – Cited 1 time when a resident's care plan did not include a dementia diagnosis and interventions.

F755 – Cited 1 time when a medication cart was unlocked and unsupervised.

F756 – Cited 1 time when a gradual dose reduction was not addressed by the pharmacist.

F758 – Cited 1 time when a GDR was not addressed by the physician.

F760 – Cited 5 times for medication errors relating to:

- The medication did not get discontinued according to the physician's order.
- An extended-release medication was crushed.
- 2 times when the correct dose of medication was not administered.
- A transdermal patch was not removed before applying a new one.

F761 – Cited 3 times when:

- A medication room door was propped open.
- Medications were stored in a cup instead of in the pharmacy package.
- A refrigerator with narcotics was not locked.
- Insulin pens were not dated when opened.
- Medications bottles were not dated when opened.

F803 – Cited 4 times for:

- 2 times when incorrect portion sizes were served.
- The puree food was not the appropriate texture.
- The cook did not grind the food for mechanical soft diets.

F804 – Cited 4 times when:

- Food items were not maintained at least 135 degrees.
- Food items were cooked too long making them tough, not palatable, and difficult to chew.

F805 – Cited 1 time when staff attempted to serve a whole fish patty to a resident on a mechanical soft diet.

F806 – Cited 1 time when a resident's preference for a vegetarian diet was not followed.

F808 – Cited 1 time when a resident did not have a physician's order to upgrade from a puree diet texture.

F809 – Cited 1 time for not offering bedtime snacks.

F812 – Cited 15 times for:

- 6 times when hand hygiene was not completed appropriately.
- 7 times for concerns with food handling.
- Utensils were not placed on a clean surface.
- 2 times when all of the staff's hair was not restrained in a hair net.
- 2 times for not discarding food timely.
- 2 times for not covering food/drinks when transporting in the hall.
- 3 times when food was not labeled or dated.
- A box of food in the freezer had several freezer burnt items inside.

- 3 times when sanitizer levels were not high enough in sanitizing buckets.
- Logs with dishwasher temperatures/sanitation levels were not completed.
- Garbage cans were overflowing with trash.
- The hand washing sink was used to fill water glasses.

F835 – Cited 3 times for the nursing home administration failing to:

- 2 times for ensuring that allegations of abuse were thoroughly investigated.
- The plan of correction was not implemented to correct previous deficiencies.
- Documentation of incidents were incomplete.

F838 – Cited 1 time when the facility assessment did not include information on the resident's needs and how that was used to establish staffing needs.

F842 – Cited 2 times for:

- A nurse to nurse report sheet with resident specific information was visible to the public as it was left on a table.
- A laptop was left open and unsupervised with resident information present.

F849 – Cited 1 time when a resident's record lacked hospice services provided to the resident.

F851 – Cited 3 times when PBJ data was not submitted accurately.

F865 – Cited 2 times for:

- 2 times when repeat deficiencies were cited, implying the QAPI process was not effective.
- Grievances related to staff treatment of residents were not incorporated into the QA program.

F868 – Cited 1 time when the infection preventionist was not present in meetings.

F880 – Cited 19 times for:

- 7 times when hand hygiene was not completed appropriately.
- 4 times when gloves were not changed appropriately.
- Barriers were not placed before items were set down in a resident room.
- Reusable equipment was not properly sanitized between residents.
- PPE was not discarded appropriately.
- 4 times when staff touched medications with their bare hands.
- 7 times when enhanced barrier precautions were not implemented appropriately.
- 2 times when catheter drainage bags were touching the floor.
- Staff did not complete TB testing as required.
- The water management plan was not followed.
- No water management plan developed.
- The infection control policies were not reviewed/updated annually.
- Transmission-based precautions were not implemented for the duration recommended by the CDC.

F881 – Cited 1 time when a bacteria was resistant to the prescribed antibiotic according to the culture and sensitivity report and the physician was not notified.

F883 – Cited 2 times for:

- Pneumonia vaccines were not administered according to CDC recommendations.
- An influenza vaccine was administered when the power of attorney declined consent.

F887 – Cited 1 time when consents were not obtained prior to administering COVID-19 vaccines.

F912 – Cited 1 time when a room licensed for 4 individuals did not have at least 80 square feet of living space.

F913 – Cited 1 time when a resident could not exit their room without entering the roommates private space.

F914 – Cited 1 time when a privacy curtain was not present in a semi-private room.

F919 – Cited 1 time for a call light not being available in a resident room.

F921 – Cited 1 time for general cleanliness concerns throughout the building.

F925 – Cited 2 times for:

- Presence of excessive flies in the kitchen, dining room, food storage areas.
- Signs of mice were noted throughout the building.

F943 – Cited 1 time when a staff member did not have a current dependent adult abuse training.

F946 – Cited 1 time when staff did not check the functioning of door alarms.

There are additional tools to assist with survey readiness on our website!

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

LeadingAge Iowa