LTC Survey Trends Report
July 2026

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REGULATORY REVIEW & SURVEY UPDATES

by Kellie Van Ree, Vice President of Clinical Services & Education Strategy

A new regulatory review article on F580 - Notification of Changes was recently included in a newsletter.

You can view this and other resources on our LeadingAge Iowa website.

Survey Activity

District	Average Months for Providers with Recert	Time Since Last Survey	Longest Survey Timespan
Statewide	13.2 months	48 nursing homes more than 12 months.	15 months

Recertification:

- 44 total recertification surveys reviewed with 5.6 deficiencies on average per recertification survey with deficiencies.
    - Of the 38 recertifications with at least one deficiency, 9 providers received a fine (or 24%).
    - Of the 44 recertifications, 6 providers had deficiency free surveys (or 14%)

Complaint/Incidents:

- 40 providers with complaint/incident surveys reviewed with 3.1 deficiencies on average per survey reviewed with deficiencies.
    - Of the 20 complaint/incident surveys with at least one deficiency, 10 received a fine (or 50%).
    - Of the 40 complaint/incident surveys, 20 did not receive a deficiency (or 50%).

Enforcement Action

CY 2026	State Fines	Federal CMPs	Enforcement	Total	Avg number of deficiencies
January	$14,750	$221,798	1 Denial	$236,548	6.2 deficiencies
February	$26,500	$75,498		$101,998	5.5 deficiencies
March	$46,750	$209,211		$255,961	6 deficiencies
April	$57,000	$65,510		$122,510	4.8 deficiencies
May	$50,000	$69,141		$119,141	6.2 deficiencies
June	$207,500			$207,500	5.1 deficiencies
July	$61,750			$61,750	5.6 deficiencies

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

CITATIONS WITH FINES

July Deficiencies with State Fining and Citation

50.7; $500. The nursing home didn't report when a resident was given the incorrect food texture and choked resulting in the resident's death.

50.7; $500. A major injury wasn't reported to DIAL which included a fractured hip that required hospitalization.

50.7; $500. Resident #28 had a fall that resulted in a hip fracture that wasn't reported to DIAL timely.

F600; 58.43(1); G; $6,500 (Held in Suspension). Resident #42 and #32 had a previous resident-to-resident incident with care planned interventions that staff were to monitor and maintain separation between both residents. On 6.14.26, Resident #32 sat in a Broda chair near a medication cart when Resident #42 was walking to their room. When Resident #42 walked past Resident #32, they struck Resident #32 in the head with their cane 4-5 times before staff could intervene. Resident #32 had bruising to their left hand, a skin tear and hematoma to the left eye as a result of the altercation.

F607; 50.9(3); D; $500. Staff K didn't have a background check or abuse registry verifications prior to starting employment.

F609; 50.7; D; $500. A resident death wasn't reported within 2 hours as an injury of unknown origin when an autopsy was performed due to the circumstances surrounding the death.

F609; 58.43(9); D; $500. An incident of possible financial abuse wasn't reported to DIAL or investigated by the nursing home when the former administrator was accused of taking resident funds for a resident they were POA for.

F609; 58.43(9); D; $500. An allegation of abuse wasn't reported timely to DIAL when a staff member witnessed questionable behavior including removing room identifiers (name plate/sign), unplugging their phone, and not allowing the resident to go to bed when they requested to do so.

F609; 58.43(9); D; $500. Allegations of possible staff to resident abuse weren't reported immediately for both verbal abuse and allegations of theft.

F609; 58.43(9); D; $500. An allegation of abuse wasn't reported to DIAL when a staff member reported during an interview that a dietary staff called a resident a b*tch.

F609; 58.43(9); D; $500. The nursing home didn't report to DIAL in a timely manner an allegation of abuse when a staff member made an inappropriate sexual comment to a resident that was overheard by another staff member.

F609; 58.43(9); D; $500. Incidents of resident-to-resident sexual contact weren't reported to DIAL when the resident had an unknown capacity to consent.

F684; 58.19(2)j; G; $6,250. Resident #4 was on several medications that have side effects of constipation and had an order for weekly weights. Since 4.13.26, there were only 2 weights documented that showed a 9 lb. weight gain. Review of bowel and bladder elimination records showed the resident only had a small bowel movement from 5.2 to 5.9. From 5.13 to 5.21 the resident had no recorded bowel movement. On 5.19 the physician was notified of protracted constipation and prescribed Senna Plus and Lactulose which were ineffective. On 5.20 the resident was given an enema which resulted in medium bowel movement. On 5.21.26 the resident was sent to the hospital for constipation and diagnosed with stercoral colitis caused by fecal impaction. The resident received a large volume fluid enema and manual disimpaction to remove the stool.

F688; 58.20(6)e; G; $7,250. Resident #37 developed a contracture to their left arm and wrist when one didn't exist based on the MDS from early 2025. During review the resident's record lacked documentation of a restorative program being completed and during interview staff indicated there wasn't a restorative program in place.

F689; 58.28(3)e; G; $4,500 (Held in Suspension). Resident #2's care plan identified that they are to use the full body mechanical lift with assistance of 3 staff. During the transfer, only 2 staff assisted and the resident shifted their weight sliding out of the sling. The resident complained of significant hip pain following the fall and was sent to the hospital where they were diagnosed with a hip fracture.

F689; 58.28(3)e; G; $9,500 Resident #3 didn't receive a complete investigation to determine the root cause of falls and failed to monitor and modify interventions. Additionally, during observation of transfers, staff failed to use gait belts. After the staff were notified of the concern, they placed gait belts on but still assisted to transfer with the use of the residents' arms and not the gait belts.

F689; 58.28(3)e; J; $5,000 (Held in Suspension). On 7.17.26 at 3:45 p.m. Resident #7 exited the building unattended. At 3:46 p.m. a dietary staff member entered the lobby and shut off both the door alarm and wander guard alarm without investigating the cause or checking the exit. Another resident asked if they were going to get Resident #7 who went outside and at 3:52 p.m. the resident was retrieved from the parking lot. review of the resident's records included a lack of elopement risk evaluation prior to the elopement, and a lack of documentation regarding wanderguard placement and function until 7.18.25.

F690; 58.19(1); K; $10,000 (Held in Suspension). Resident #9 had an indwelling foley catheter with interventions to monitor and document intake and output per policy, monitor for signs of a UTI including no urine output, altered mental status, change in eating patterns and record urine output. Review of documentation included that the resident had no urinary output recorded on 1.10.26 night shift and all three shifts on 1.11.26 with only 150 cc of fluid intake from 1.9 to 1.12.26. The staff attempted to irrigate the catheter without difficulty and changed the catheter on 1.12.26. The ambulance arrived a couple hours later. No additional entries or assessments were noted related to the situation. According to the ER notes, the resident's laboratory values were very abnormal and upon deflating the catheter balloon there was a large gush of blood. A CT was completed and noted the foley catheter was placed in the resident's prostate with a ruptured urethra, bladder wall thickening with bilateral hydroureternophrosis. The resident was admitted to ICU for sepsis and metabolic encephalopathy. The resident was subsequently placed on hospice and passed away. Review of other resident's with catheters revealed lack of documentation of urinary outputs on a consistent basis.

F695; 58.19(2)g; G; $7,000 (Held in Suspension). Resident #45 had an order for continuous oxygen between 2-5L to maintain saturation levels of 90% or greater. During observations the oxygen tank was empty until the staff were notified by the surveyor and then it was changed. Resident #67 had orders for oxygen between 2-5L continuously to maintain oxygen saturation levels at 90% or higher. During an observation Resident #67's oxygen cylinder was also empty. Resident #5's MDS identified that they received oxygen therapy, suctioning, and tracheostomy care. However, the physician orders lacked information on suctioning despite suctioning being indicated on the resident's care plan and documentation in the progress notes. During observations staff performed suctioning which should have been done using sterile technique, but staff touched multiple items with sterile gloves and failed to change their gloves appropriately.

F760; 58.19(2)a; G; $4,750. Resident #2 received incorrect medications which included amoxicillin, quetiapine, and levetiracetam which caused them to be unresponsive and resulted in a hospital stay. During investigation it was determined that the medications were administered during the morning medication pass when the staff reported that "everyone was coming at them with questions" and they couldn't safely administer medications.

F805; 58.24(5); J; $8,500. On 6.27.26 Resident #4 received a puree meal from the culinary staff of the nursing home which was the correct diet texture identified for the resident. A nurse aide prepared a second meal plate from the steam table including scrambled eggs, sausage and hash browns which was served in a regular texture. A short while later the resident began coughing and was taken back to their room and monitored until they went to bed. Prior to going to bed, the resident's oxygen saturation was 88% and their oxygen rate was increased. A couple hours later, staff again assessed the resident, and they were noted to have course lung sounds. At shift change, the night shift nurse was notified of a choking incident and went to assess the resident where they were noted to be anxious, short of breath, coughing, bluish in color with an oxygen saturation level of 75% with oxygen on. The resident was sent to the hospital and later passed away from aspiration pneumonia.

F805; 58.24(5); J; $8,000 (Held in Suspension). Resident #1's care plan directed staff to serve a puree diabetic diet with regular liquids. Resident #1 was served a peanut butter and jelly sandwich as a snack on 6.24.26 when the nurse heard the resident state they couldn't breathe and then grabbed their throat. The nurse started the Heimlich Maneuver and the resident eventually went unresponsive without a pulse when staff started CPR and called EMS. The resident eventually regained a pulse and breathing before EMS arrived and they transported to the ER where they were transferred to a higher acuity hospital and admitted for aspiration and fractured ribs.

TOP DEFICIENCIES

F-TAG #	
F812	Food Procurement, Store/Prepare/Serve, Sanitary
F880	Infection Prevention & Control
F689	Accidents/Hazards/Supervision/Devices
F725	Sufficient Nursing Staff

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

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

58.12 – Cited 2 times for not assessing and submitting veteran status to IDVA within 30 days of admission.

F550 – Cited 8 times for failure to treat residents with respect, dignity, and privacy by:

- 2 times when care wasn't completed timely.
- 2 times when staff yelled at residents.
- Staff were on their cell phone while providing care.
- Staff spoke rudely to the resident.
- The resident's request wasn't carried out.
- Residents were told to urinate in their brief.
- Resident exposed for prolonged period of time.
- Staff called the resident names.
- Made sexual comments to the resident.

F552 – Cited 6 times for:

- 5 times for not informing and obtaining consent for psychotropic medications.
- The resident or their representative wasn't included in decision-making about taking a non-psychotropic medication.

F554 – Cited 2 times when medications were left at the resident's bedside.

F558 – Cited 2 times for:

- Call light was not in reach of the resident.
- A shower chair was broken and had not been reordered which caused the resident to take bed baths.

F561 – Cited 3 times when:

- An intoxicated resident kept other residents awake.
- The care plan interventions weren't followed for a tracheostomy.
- A resident wasn't allowed to choose their bedtime.

F567 – Cited 2 times when resident funds weren't available 24 hours per day.

F575 – Cited 1 time when information on how to contact the state agency wasn't posted in an accessible location.

F578 – Cited 2 times for:

- The resident's IPOST wasn't signed by the physician.
- A resident changed their status to DNR but the IPOST was not revised.

F580 – Cited 5 times when the resident's physician and/or representative weren't notified of:

- CPAP wasn't working.
- 2 times for weight changes.
- Abnormal test results.
- Fall
- Medication error.

F582 – Cited 1 time when notices weren't provided at least 48 hours in advance of discharge.

F584 – Cited 2 times for:

- Beds weren't made timely.
- Odors
- Cleanliness of resident rooms.

F585 – Cited 1 time when residents weren't aware of what the grievance process is.

F600 – Cited 2 times for:

- Staff to resident abuse allegations.
- Resident to resident abuse allegations.

F602 – Cited 3 times for:

- 2 times for medication diversion.
- Staff took a resident's debit card.

F605 – Cited 3 times for:

- Behaviors weren't included in the care plan.
- 2 times when non-pharmacological interventions weren't attempted prior to administering as needed medications.

F607 – Cited 1 time when the staff didn't have a SING background check completed but had a different background check.

F610 – Cited 5 times when:

- 4 times when no investigation of allegations of abuse were completed.
- 2 times when victims weren't isolated from the alleged perpetrator.

F628 – Cited 7 times for:

- 3 times when bed hold notifications weren't provided.
- 4 times when the long-term care ombudsman wasn't notified of discharge/transfer.
- The discharge recapitulation wasn't completed.

F636 – Cited 1 time when the MDS was not completed timely.

F637 – Cited 5 times when a significant change MDS wasn't completed for:

- 5 times admission or discharge to hospice services.
- 1 time decline in ADL performance.

F638 – Cited 1 time when a quarterly MDS wasn't completed.

F640 – Cited 2 times when MDS' weren't submitted to CMS timely.

F641 – Cited 3 times when the MDS wasn't correctly coded by:

- Bedrails were coded as a restraint when they shouldn't have been.
- The level 2 wasn't coded on the MDS.
- Coded an antipsychotic medication when there wasn't one.
- Failed to code oxygen use.

F644 – Cited 5 times when a new Level 1 wasn't completed for:

- 3 times for a new MI diagnosis.
- New psychotropic medications.
- An intellectual disability wasn't included.
- New behaviors.

F645 – Cited 1 time when a new Level 1 wasn't completed prior to the short-term approval expiring.

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

F656 – Cited 5 times when:

- When the care plan didn't include:
    - 2 times for target behaviors.
    - Non-pharmacological interventions to use before administering psychotropic medications.
    - Level 2 recommendations.
    - High-risk medications including:
        - Psychotropic
        - Diuretic
        - Pain medication
        - Anticoagulant
        - Antibiotics
    - Oxygen

F657 – Cited 2 times when:

- The care plan was not updated to include:
    - Restorative program
    - CPAP
    - Dietary interventions
    - Fall interventions
    - Change in ADLs

F658 – Cited 8 times for:

- 7 times for following physician orders.
- An extended-release pill was crushed.
- Failed to notify the physician when a blood glucose was out of range according to the orders.

F677 – Cited 6 times when residents were not provided:

- 2 times bathing/showers
- 2 times incontinence care
- 2 times nail care.

F679 – Cited 2 times for:

- Planned activity programs weren't carried out.
- Residents expressed concerns about the lack of variety of activities.

F684 – Cited 7 times for:

- No assessments were completed for:
  - Safe use of an electric lift chair upon change in mental status.
  - When a resident reported that a pill was stuck in their throat.
  - Non-pressure skin concerns.
- Physician follow up wasn't completed as ordered upon discharge from the hospital.
- Staff administered glucose gel to a resident who was unconscious.
- Bruises weren't documented and followed up on after a fall.

F686 – Cited 1 time when weekly assessments lacked depth and stage of wounds.

F687 – Cited 1 time when a resident didn't receive requested podiatry services.

F688 – Cited 5 times when:

- 3 times when restorative services weren't provided according to the resident's care plan.
- The restorative program was discontinued without clinical rationale.

F689– Cited 14 times for:

- The care planned interventions weren't followed.
- A resident was found outside due to the door not fully latching and alarming.
- The wheelchair wasn't locked during transfer.
- Root cause analysis wasn't completed after falls.
- 2 times staff failed to use wheelchair pedals during transport.
- Residents were left in unsafe positions such as on the edge of the bed or in the bathroom.
- Smoking assessments weren't completed.
- 2 times when smoking materials were left with residents.
- Wanderguard system wasn't consistently monitored for functionality.
- The correct sling wasn't used for a transfer.
- 2 staff members weren't used during a lift transfer.
- The manufacturer's instructions for laundering lift slings wasn't followed.

F690 – Cited 2 times for:

- Failed to provide timely toileting assistance.
- The entire area that the incontinence pad touched was not cleaned.

F692 – Cited 3 times for:

- Fluid consumption wasn't monitored when the resident was on a fluid restriction.
- A significant weight loss wasn't identified and new interventions established.
- The staff failed to follow the recommendations from the dietitian.

F695 – Cited 3 times when:

- CPAP wasn't working and staff didn't intervene.
- No RN or Respiratory Therapist were on staff when residents used mechanical ventilation devices.
- Failed to change oxygen tubing.

F698 – Cited 1 time for failure to compete pre- and post-dialysis assessments.

F699 – Cited 1 time when the care plan lacked information on PTSD triggers for the resident.

F725 – Cited 9 times when:

- 9 times when call lights weren't answered in a timely manner.
- Staff failed to assist a resident in a timely manner with toileting.

F727 – Cited 3 times for lack of RN coverage for 8 consecutive hours.

F729 – Cited 1 time when the nurse aide registry wasn't checked prior to allowing a nurse aide to work on the floor as a certified nurse aide.

F730 – Cited 2 times when performance reviews weren't completed annually for nurse aides.

F732 – Cited 1 time when the posted staffing information wasn't accessible to everyone.

F740 – Cited 1 time when a referral to psychiatric services wasn't followed through on timely.

F755 – Cited 5 times for:

- A different resident's medication cards were sent home with a resident.
- Medications were punched out into the staff member's bare hand instead of a cup.
- Narcotic reconciliation wasn't completed according to professional standards.
- Medications weren't reordered timely.
- Narcotics weren't documented appropriately and consistently reconciled.

F756 – Cited 1 time missing a monthly drug regimen review and the nursing staff not following the recommendations on another.

F759 – Cited 2 times for observed medication error rates greater than 5%.

F760 – Cited 8 times for:

- An extended releases medication was crushed.
- 3 times when insulin pens weren't primed.
- Medications were administered from another resident's card.
- Medications were administered late.
- Medications were held without an order to do so.
- Administered an incorrect dose.
- Medications weren't available to be administered.
- An insulin pen was removed from the skin too quickly after administration.

F761 – Cited 3 times when:

- Medication cart was unlocked and unsupervised.
- Medications weren't dated when open.
- Narcotics weren't under double lock.

F803 – Cited 6 times when:

- 2 times when not all food items were served according to the menu.
- 2 times when food wasn't served in accurate portion sizes.

F804 – Cited 6 times when food wasn't maintained at or above 135 degrees.

F805 – Cited 4 times when:

- Not all items were served according to the menu.
- 2 times when portion sizes weren't correct when served.
- Peas were included in macaroni salad for mechanical soft.
- The incorrect texture diet was served.

F806: Cited 1 time when not all menu items were served to the residents.

F807: Cited 1 time when water wasn't offered or provided to residents at meals.

F809: Cited 1 time when residents didn't receive meals in a timely manner.

F810 – Cited 1 time when a divided plate wasn't used but was ordered.

F812 – Cited 18 times for:

- 4 times when hair and/or beard nets weren't used appropriately.
- 4 times when hand hygiene wasn't done properly.
- 5 times when gloves were used inappropriately.
- Utensils were placed on a contaminated surface.
- 3 times when logs weren't consistently completed.
- 6 times when items weren't labeled or dated.
- The thermometer wasn't cleaned between use on different food items.
- Artificial nails were worn by staff.
- 2 times when staff touched food with their bare hands.
- 2 times when foods were expired and not discarded.

- 5 times for general cleanliness concerns.

F814 – Cited 1 time when the garbage in the kitchen wasn't covered when necessary.

F842 – Cited 4 times when:

- A fall wasn't documented in the resident's record.
- The IPOST document didn't match the resident's record.
- Meal intake records were inaccurate.
- Staff signed medications out that were given by someone else.

F849 – Cited 2 times when:

- A hospice agreement wasn't present with a company providing service to a resident.
- The hospice agreement didn't indicate that the hospice administrator would be notified of abuse allegations against hospice staff.

F851 – Cited 1 time when PBJ data wasn't submitted accurately.

F865 – Cited 3 times when providers didn't have effective QAPI processes based on repeated deficiencies.

F868 – Cited 2 times when the medical director and administrator weren't present at quarterly meetings.

F880 – Cited 17 times for:

- 10 times when hand hygiene wasn't completed appropriately.
- 5 times when enhanced barrier precautions weren't used.
- Oxygen tubing was on the floor.
- 3 times when the glucometer wasn't disinfected between residents.
- Staff reached under their isolation gown to get scissors and hand sanitizer.
- Staff pushed a wheelchair through a puddle of urine.
- There wasn't a sign outside a room for a resident in transmission-based precautions.
- Medications were touched with bare hands.
- Staff used the same side of the wipe with incontinence care.
- Touched items with contaminated gloves.
- Failed to change gloves appropriately.
- Threw used lancets in the garbage instead of a sharps container.

F883 – Cited 4 times when pneumonia and influenza vaccinations weren't offered when appropriate and informed consents weren't obtained for those administered.

F887 – Cited 3 times when COVID-19 vaccinations weren't offered to residents and staff were not assessed for COVID-19 vaccination.

F908 – Cited 1 time when the lint filter of the dryer wasn't routinely cleaned.

F919 – Cited 1 time when the call light was not in the resident's reach.

F925 – Cited 1 time when there was evidence of a mouse infestation but the provider didn't have routine pest control services because of unpaid bills.

F943 – Cited 1 time when dependent adult abuse training wasn't completed within 3 years for recertifications.

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.