Compliance Tips from IHCA's Survey Results Committee

August 2018

Survey composition: 29 annual surveys (1 deficiency free), 37 complaints (15 unsubstantiated), 6 self-reports (4 unsubstantiated), 15 complaint/self-report (3 unsubstantiated) and 2 mandatory reports (0 unsubstantiated) reviewed by the IHCA Survey Results Committee are listed below with the most common citations. There were 151 total deficiencies.

The following is a breakdown of severity level:

A =	0.00%	D =	66.23%	G =	4.64%
B =	3.31%	E =	17.89%	H =	0.00%
C =	0.00%	F =	3.97%	I =	0.00%
				J =	2.65%
				K =	0.00%
				L=	0.00%

Total # of Reports: 77
Total # of surveys/reports deficiency free or unsubstantiated: 24
Avg. # of deficiencies

- All = 2.85
- Annual = 3.73
- Complaints = 4.07
- Self-reports = 3.40
- Complaint/Self-Reports= 1.83
- Mandatory = 2.00

Total fines = $10,350 ($69,950 held in suspension)

Deficiencies and Fines (sorted ascending by f-tag number)

F 550—Resident Rights/Exercise of Rights

- Resident who had episodes of frequent incontinence was escorted to doctor's appointment wearing an incontinence brief and no pants, but had a blanket wrapped around her in 30-degree weather. Facility said resident often sits in room in only brief with blanket wrapped around her. Transport arrived for appointment and transferred her without pants. Facility said they did not know there was an appointment scheduled (D)

- Staff member flicked, pulled, and swatted a resident's ear and after another staff told her to stop she did it again. Another staff put whipped cream on a resident's face and held resident's hands back. Right for residents to be treated with dignity and respect (D)
- Nurse was unkind to a resident when resident became agitated with nurse for not leaving residents at the bedside. Staff reported that nurse called the resident "stupid" and stated "that is why nobody likes your fat ass". Same nurse reportedly called a resident a "bitch" and was rough with her (reported by resident) and tore her gown while repositioning her (D)

F 561—Self Determination

- Right to self-determination-facility failed to ensure one resident's needs were met as they desired. Resident reports putting call light on and CNA told her to go (to the bathroom) in brief/bed. Same res (who had to be at work at 6:30am) asked to get up at 5 am and was told to wait until 6 a.m. (D)

F 567—Protection/Management of Personal Funds

- Facility failed to ensure residents had access to personal funds on weekends for one of two residents. Facility did not give access to a resident's fund on the weekend (D)

F 578—Advance Directives/Discontinuation of Treatment

- Resident's chart had a document which stated the resident was a full code, care plan indicated they were a DNR (D)
- Facility failed to document for one of three resident's preference regarding Advanced Directives and Planning. Facility didn't have a Physician Order, no IPOST (D)
- Facility failed to ensure the residents choice for resuscitation was documented correctly (D)

F 580—Notification of Changes Injury/Decline

- Facility failed to immediately consult with physician for significant change for 3 of 5 residents. Two residents with weight losses and other changes and 1 resident with condition change to hospital and nurse sent fax to physician. One resident with weight loss and not eating meals was also documented in pain and hollering with movement, receiving Tylenol for pain but ineffective x4 days. Nurse charted unable to hear BP or palpate pulse, family wanted hospitalized, resident wasn't transferred for 2.75 hrs. ED physician documented abnormal labs, acute renal failure and dehydration. Res subsequently admitted to hospice, returned to facility and died. Another resident with weight loss and little oral intake for 8 days and died, physician reported unaware of condition change. Physician did state resident had been failing over a long period of time due to dementia. There were several notifications to physician, but none since intakes changed (D)

F 582—Medicaid/Medicare Coverage

- Two residents were not given proper notice of right to appeal Medicare non-coverage decisions (Record contained a SNFABN/10055 but form did not include NOMNC/10123) (D)

F 583—Personal Privacy/Confidentiality of Records

- Staff member took picture of resident on Snapchat. Failure to follow policy (E)
- Facility failed to protect resident privacy when employees posted pictures of 2 residents on social media (E)

F 584—Safe/Clean/Comfortable Homelike Environment

- Resident hallway temps measured 83.7, 82.4, 82, and 80 degrees F. Residents and families complaining of heat. No effective way at present to provide efficient cooling of these resident care areas (E)
- Surveyor observed facility preparing to transfer a new resident into bed that had a fitted sheet with a large yellow stain (D)
- Facility failed to maintain the resident lunge area of the Chronically Confused and Demented Illness (CCDI) unit in a sanitary and homelike manner (D)

F 609—Reporting of Alleged Violations

- Facility did not report missing narcotics to DIA (did report to BON and law enforcement) and did not report that a charge nurse failed to assess a resident after a fall nor report the fall to subsequent charge nurse when leaving duty (E)
- Failed to report res-to-res altercation or suspicion of abuse to DIA. CNA reported during interview they witnessed a resident grab another resident's arm and twisted about a month ago. One of the res involved confirmed allegation. Nothing documented in either chart. nurses & DON reported no knowledge of incident (E)
- Facility failed to report all allegations of resident to resident abuse for 2 residents (E)
- Facility did not report allegation of resident to resident abuse in a timely manner (D)
- Facility did not report a resident's missing Fentanyl patch (D)
- Failure to report abuse timely (D)
- Facility did not notify DIA of allegation of misappropriation of resident medications which included 17 doses of hydrocodone (D)

F 610—Not Employ Staff with Adverse Actions

- Failure to report abuse timely (F)
- Facility did not investigate a resident's missing Fentanyl patch (D)

F 625—Notice of Bed Hold Policy

- Facility did not provide behold notice for 2 residents upon transfer from the facility (D)

F 636—Comprehensive Assessments & Timing

- Care plan did not accurately reflect all medications administered (D)

- MDS did not properly code 2 residents falls on their MDS's (D)
- Facility failed to complete a comprehensive and accurate assessment using the Resident Assessment Instrument (RAI) specified by the Centers of Medicare and Medicaid for one of 12 residents (D)

F 637—Comprehensive Assessment After Significant Change

- Staff did not complete a significant change in condition MDS when resident was no longer independent in transfers and bed mobility, and needed full assistance to dress, toilet and perform personal hygiene (D)

F 640—Encoding/Transmitting Resident Assessment

- Facility failed to complete a discharge MDS and transmit as required (D)

F 645—PASRR Screening for MD & ID

- Failure to keep current PASRR in chart for 1 of 7 residents (D)

F 655—Baseline Care Plan

- Facility failed to provide the resident or resident representative with a written copy/summary of the initial/baseline care plan after admission to the facility (E)
- Staff did not provide a summary of the baseline care plan to resident or resident representative as required for 2 residents (D)

F 656—Develop/Implement Plan of Care

- Failure to update care plan so staff knew how to intervene with resident behaviors (D)
- Facility failed to follow care plan and failed to develop and implement a comprehensive care plan that included residents decline in bowel continence (D)
- Staff did not update care plan with the addition of an anti-coagulant (D)

F 657 Care Plan Timing & Revision

- Facility failed to review and revise resident's care plan (D)
- Facility failed to update care plans to reflect the status of 3 residents (D)
- Failure to provide adequate interventions on the care plan for seizure activity. Failure to use non-pharmacological interventions prior to giving a PRN anti-anxiety. Failure to have information on care plan related to special instructions for feeding assistance (C)

F 658—Services Provided Meet Professional Standards

- Staff did not flush resident's G tube after administering meds with appropriate amount of water as ordered by physician (D)
- Failed to follow physician orders-res returned to facility 3/17 with new amp. No orders for dressing change until 3/20 (D)
- Resident was self-administering Albuterol with no assessment or plan identified in the Care Plan. She told surveyors "some nurses let me, and some follow the rules" (D)

- Failure to meet professional standards by not observing resident ingest medication (D)
- Resident was using O2 via concentrator during survey - records indicated the O2 had been discontinued due to non-use (D)
- Facility failed to follow physician orders as directed (D)
- Facility policy review failed to follow physician's orders for 1 to 5 residents (D)

F 660—Discharge Planning Process

- Facility failed to develop a discharge plan for the resident's current discharge needs, goals, and treatment preferences while considering care giver support for one resident (D)

F 661—Discharge Summary

- Failure to complete a recapitulation of a resident's stay when discharged to another facility (D)

F 675—Quality of Life

- Quality of life-facility failed to provide incontinent supplies in quantities enough to meet resident needs. CNAs reported a shortage of incontinent supplies since new management took over facility (E)
- Facility did not provide incontinent supplies in quantities enough to meet resident needs. Direct care staff complained that often there were not enough large and extra-large supplies available to meet resident needs (E)

F 677—ADL Care Provided for Dependent Residents

- Several residents presented with long, unkept, dirty fingernails during survey. One resident with hand contracture had open wound in palm from long nails (E)
- Resident had long oily hair, beard that was long and full of dried food and was wearing soiled clothing. Documentation showed that resident did not have a bath for two weeks (D)
- Facility failed to complete incontinence cares in a manner to prevent the spread of infection, odors, and skin breakdown (D)

F 678—Cardio-Pulmonary Resuscitation

- Failure to possess a current code status for a resident. When resident coded, crash cart had no ambu bag or suction and computer stated resident was DNR but a signed form could not be located (D)

F 684—Quality of Care

- Quality of care-facility failed to assess and address condition changes for 2 residents who died and 1 resident with loose stools x2 weeks. See corresponding deficiency F580. Abated IJ by providing education to nurses which included assessment, family and physician communication, change of condition detection and s/s of dehydration. IJ lowered to a D (J-D) **$29,250** (**$9,750 fine trebled) in suspension**

- Failure of professional standards of practice. Did not properly monitor a resident with history of swallowing difficulties and failed to carry out appropriate procedures to assist a choking resident whom later died. Also, failure to follow bowel protocol on another resident (J) **$10,000 fine in suspension**
- Physician orders called for trimming nails each bath day, to use Optifoam dressing to contracted resident palms and to use an inflatable hand splint to prevent pressure as tolerated. Facility was using rolled wash clothes at times instead. Resident was being assisted in therapy room by PTA and COTA to stand and walk at parallel bars. Residents legs gave out and was assisted to the floor by these staff members. Knee popped and had swelling. Uncertain if nurse assessed the resident before the resident was moved to wheelchair. Resident with PICC line was admitted to facility on 5/11/2018. No physician orders were obtained to PICC line dressing changes. Order was received to change dressing on 5/23/18. No dressing change was documented until 5/30/18. Last known dressing change was 5/8/18 in hospital (D)
- Facility did not follow physician's recommendation following pharmacy review. No dx for Neudexta and did not document periods of emotional lability as physician recommended (D)
- Facility failed to follow the physician's orders (D)
- Facility failed to identify, assess and place interventions for an area of altered skin integrity for one of four residents (D)
- Failure to ensure assessment and intervention of bruising no skin sheets done-failure to provide quality of care (D)
- Facility did not document lung sound assessment or respirations for resident presenting with a productive cough (D)
- Nurse returned a resident to bed after a fall without assessment of potential injuries and transferred resident without a gait belt and the assistance of two as care planned. (possible tag stacking?) (D)
- Facility failed to follow the physician's orders (D)
- Facility failed to assess a resident change of condition and provide appropriate interventions for a case of herpes zoster until it was significantly advanced (D)

F 686—Treatment to Prevent Pressure Ulcers

- Failed to provide interventions to prevent and care for pressure ulcers for 2 of 7 res. Res with stage 3 ulcer on buttock developed ulcer over Achilles-several observations by surveyor of resident without boots, lying on back. Another resident with pressure ulcers on coccyx, heel and bilat great toes. On 5/25 coccyx wound present on 5/29 blister on heel, by 6/12 others had developed. Several observations by surveyor of no boot in place, feet directly on foot pedals (G) **$3,100 fine**
- Facility failed to ensure completion of initial and/or ongoing assessments and intervention to identify, prevent or promote healing of areas of altered skin integrity for two of two residents (G) **$2,000 fine**
- No weekly documentation of pressure ulcer on buttocks (D)
- Failure to complete weekly pressure ulcer checks and failed to prevent pressure ulcer from developing and/or worsening (D)

- Failed to identify the risk factors to prevent a pressure area from developing for 1 res. Resident with spinal cord injury and paralysis of leg developed pressure ulcer on heel possibly from screw on foot pedal (which was removed) (D)

F 688—Prevent Decrease in Range of Motion

- Facility failed to provide regular ROM exercises for 1 of 21 residents. Res reported did not receive any exercises and previously was on a ROM program but no longer (D)

F 689—Free from Accidents and Hazards

- Failed to provide adequate nursing supervision, assistance devices and individualized interventions for a resident that had multiple falls that resulted in a hip fracture. Resident had fallen 15 times within a three-month time frame (G) **$7,000 fine in suspension**
- CNA left resident standing and did not use a gait belt, turned around to grab the wheelchair, resident fell and sustained cervical spine fracture (G) **$5,350 fine in suspension**
- Staff did not use gait belt when transferring and ambulating resident who subsequently fell and received head laceration and cervical fracture (G) **$5,350 fine in suspension**
- Resident fell and sustained a fractured hip in December - this resident had numerous falls in the months preceding the fractures. Another resident was transferred in the wheelchair without foot pedals - he held his feet up during the transfer via wheelchair (G) **$4,750 fine**
- Resident exited building and was in parking lot for 9 minutes before returning to the facility when guest arrived and let the resident into the facility. Video cameras at facility recorded elopement. Staff did not respond to audible door alarms and pager alerts (J) **$3,750 fine in suspension**
- Resident exited the building at 6:39PM per surveillance cameras. Resident wandered around the parking lot before re-entering the building around 6:47 PM. When tested by the surveyor, the alarm was only audible very faintly down the hallway from the door. 2 agency nurses were working the night of the elopement - they stated they had not been trained on the pagers or door alarms. The resident had a history of exit seeking. The resident was not injured (J) **$3,750 fine in suspension**
- Staff did not provide wheelchair assistance in a safe manner - propelled resident in wheelchair without pedals in place (D)
- Agency staff transferred a resident with a gait belt instead of EZ stand as directed in the Care Plan. Resident was lowered to the floor (D)

F 690—Bowel, Bladder Incontinence, Catheter Care

- Facility failed to provide complete incontinence care - did not turn resident to right side to clean (D)
- Facility failed to provide treatment and care in accordance with professional standards of practice, a resident comprehensive, person centered care plan and the residents choice to restore bowel function to the extent possible (D)

- Incontinence care not done thoroughly missing buttocks and hips (D)

F 692—Nutrition/Hydration Maintenance Status

- Facility failed to assess a resident for dehydration and another for continued significant weight loss (D)

F 693--Tube Feeding/Management/Restore Eating Skills

- CNA transferred resident to bed while tube feeding was running. Resident was laid flat in bed and head of bed not elevated. CNA told surveyor she was not trained in elevating bed or pausing tube feeding during transfers (D)

F 697—Pain Management

- Pain mgmt.-Res on Tylenol in uncontrolled pain. Several employees reporting resident screaming, moaning, making sounds like a sheep and couldn't be touched without being in pain. Res sometimes wouldn't take Tylenol. Nurse reported MDS nurse told her she didn't know what she was doing and when physician rounded MDS nurse told physician she didn't witness any pain. Went not addressed about 2 weeks, res admitted to hospital in acute renal failure, returned on hospice and died (G)

F 698--Dialysis

- Full assessments of resident were not consistently completed prior to and after dialysis treatments (D)

F 725—Sufficient Nurse Staffing

- Residents' call lights were not answered in a timely manner. Residents stated it took 45 minutes to get call lights answered. A resident stated she was left on the commode for an extended period of time and self-transferred off when no one answered the call light. Slow call light response time was addressed in numerous Resident Council Meetings. LPN interviewed stated they were "short staffed" resulting in the delayed response to call lights (D)
- Facility failed to answer resident call lights in a timely manner. Facility must have sufficient nursing staff (D)
- Two residents waited an hour for call lights to be answered (D)
- Multiple resident complaints about lack of response to care needs such as changes of ostomy bags and appliances which created a large stain and odor (D)

F 729--Nurse Aide Registry, Verification

- Failure to verify CNA on registry (D)

F 730—Annual Nurse Aide Review

- Facility failed to ensure CNA's received regular in-service education (D)

F 732—Posted nurse Staffing Information

- Facility failed to post daily nurse staffing for public and resident information (B)

F 755—Pharmacy Services/Procedures/Records

- Facility failed to ensure the medication room was secure from unauthorized personnel (D)

F 757—Drug Regimen/Freedom from Unnecessary Drugs

- Facility did not attempt a gradual dose reduction for a resident taking psychotropic medication (D)
- Facility failed to offer alternative interventions prior to the administration as needed anti-anxiety medication (D)
- Failure to document non-pharmacological interventions implemented prior to administration of PRN anti-anxiety medication (D)
- Unnecessary drugs-no documentation of interventions prior to administration of several doses of PRN medication for 1 resident (D)

F 758—Free from Unnecessary Psychotropic Medications

- Staff did not ensure an appropriate diagnosis or document indications that warranted the continued use of an antipsychotic medication for one resident (D)
- Staff failed to limit the prn use of an anti-anxiety medication to 14 days or provide physician rationale for continued use (D)
- Resident with PRN anxiety medication extended beyond 14 days with no documentation by physician. Pharmacist included in their review, not addressed (D)
- Facility failed to ensure psychotropic meds reviewed had a clinical rationale or a GDR for 1 resident. Pharmacy review recommended to consider possible GDR for Zoloft & Seroquel; no documentation that it was done (D)
- Facility failed to ensure psychotropic medication was not ordered for greater than 14 days and failed to ensure the use of non-pharmacological approaches was attempted prior to administration of a psychotropic medication (D)
- Facility failed to limit the use of anti-anxiety medication as needed (prn) to 14 days or to provide physician rationale for continued use (D)
- Facility failed to ensure staff attempted alternative interventions prior to the administration of a psychotropic medication for one of six residents (D)

F 759—Freedom from Medication Error Rate of 5% or More

- Facility failed to ensure professional staff administered resident medication as physical ordered resulting in a 6.45 percent medication error rate (D)

F 761—Label/Store Drugs/Biologicals

- Facility did not assure that drug carts & cabinets were always secured and that only authorized personnel had keys. CMA did narcotic count at end of shift by herself without nurse and then gave keys to another CNA to give to nurse who had not yet arrived. This CNA in turn gave keys to another CNA to give to nurse. Later it was discovered that 30 doses of hydrocodone were missing (D)

F 791—Routine/Emergency Dental Services

- Facility failed to provide dental service in timely manner and failed to document or have policy for dental services (D)

F 803—Menus Meet Residents' Needs/Preparation in Advance/Followed

- Facility failed to ensure all residents, identified to receive pureed texture, received the proper portion size based on the planned menu (E)
- Facility failed to obtain dietitians signature on menu changes prior to serving substitute meal. Menu is not posted prior to meals (E)
- Staff failed to follow plans for residents on renal diet, heart healthy diet, and low sodium diet (D)
- Facility did not follow menu for residents receiving pureed diet by omitting pureed garlic bread (B)

F 804—Nutritive Value/Appearance/Palatability/Temp

- Facility failed to serve foods at palatable temperatures. Facility foods were too cold (E)

F 805—Food in Form to Meet Individual Needs

- Resident received a mechanical soft diet instead of pureed as ordered. Staff told surveyor that Dietitian had changed the diet to mechanical soft, but Dietitian denied that she had changed the order (D)

F 808—Therapeutic Diet Prescribed by Physician

- Facility failed to serve food in correct ordered diet to meet nutritional needs of 1 of 1 resident observed during meal time (D)

F 809—Frequency of Meals/Snacks at Bedtime

- Facility failed to ensure meal service was at regular times with no more than a 14-hour lapse between the evening meal and the breakfast meal (E)

F 812—Food Procurement, Storage, Preparation, Sanitization

- Food temperature problems - rice 146, Pork chops 106.8, Asparagus 111.1. Roast beef temped at 61 and cauliflower at 101.3 (F)
- Facility failed to maintain clean and sanitary kitchen, failed to properly sanitize the dinning rom tables and failed to ensure foods were maintained at or above 140 degrees Fahrenheit (F) to reduce the risk of food borne illness (F)
- Facility failed to prevent contamination of baked goods by placing commercially packaged plastic hamburger bun container on top of the tray of rolls during meal service (F)
- Food items were not sealed dated and labeled when stored in refrigerator, refrigerator had dirty handles, a scoop was stored inside flour bin, unsantizable cutting boards (E)
- Dietary employees & CDM failed to have hair under hairnets during food prep (E)
- Dish machine did not test appropriately for chlorination. (required 50 - 100 parts, tested negative on testing strip for chlorine) (E)

- No thermometer in refrigerator used to store resident food. Staff failed to discard leftover food within 3-5 days (E)
- Improper use of bare hands when handling items that touched food (E)
- Cans of powdered supplement stored with scoops inside, no handwashing before donning gloves by dietary staff, touching non-food items with gloved hands and then returning to serving food (E)
- Improper glove use during dining room meal service which included touching steam table and plugging in table and then touching buns with same gloved hand (E)
- Facility did not serve milk at safe temperature (D)

F 839—Staff Qualifications

- Failure to verify nurse licensure(D)

F 842—Resident Records—Identifiable Information

- Facility did not keep complete medical records on 3 residents which included falsification of records related to finding a resident on the floor without pulse or respirations. No incident report was completed (E) **$1,000 fine ($500 x 2)**
- Documentation in res chart found cool to touch, cyanotic and absence vital signs. During interview surveyor determined res was found on floor. Nurse later told surveyor was untruthful and administrator instructed her to return to bed and chart res was found in bed. CNA interviewed initially reported res was in bed, later confirmed res was found on floor. Another CNA confirmed res was on the floor. Administrator reported not knowing res was on floor at time of death, reviewed the res record and could not find an incident report. Administrator adamantly denied telling the nurse to falsify records and further stated the first time she knew res was on floor was when surveyor told them. Physician also stated was notified of death but not that res was on floor. Interview of mortician indicates res had some bruising on face, but nothing suspicious or concerning (E)
- Resident record did not reflect accurate representation of med administration necessity and response to intervention. Pain medication records on the narcotic sheet and E-mar did not match. Resident family complained of resident lethargy and poor assessment by nurses (D)
- Failure to ensure medical records maintained in accordance with professional standards and practices that were complete and accurate for residents with significant changes. See corresponding deficiency F580 (D)

F 843—Transfer Agreement

- Facility failed to have a current transfer agreement with the hospital (D)
- The facility did not have a current transfer agreement with the hospital (B)
- Facility did not have a current transfer agreement with the local hospital (B)

F 849—Hospice Services

- Facility failed to document coordination of Hospice services with the facility (D)

F 868—QAA Committee

- Failed to have a quarterly QA meeting in Dec 2017 (D)

F 880—Infection Prevention and Control

- Facility failed to utilize proper infection control technique during resident care, failed to complete the Step 2 tuberculosis testing and failed to track staff infections and compute infection rates (F)
- Facility failed to ensure catheter bags were not in contact with the floor and failed to utilize proper infection control procedures (E)
- Facility failed to utilize proper infection control technique for two of two residents in contact isolation (E)
- Nurse did not perform Hand washing between glove changes during wound care (D)
- Facility failed to pass infection control measures during med pass (staff touched pills with bare fingers), perineal cares (covered resident with blanket that had fecal matter on it), and dressing change (did not disinfect scissors during dressing change) (D)
- Tubersol vials not discarded after 30 days. Nurse did not do hand hygiene before putting gloves on and administering eye drops. Another nurse also did not do hand hygiene before and after gloving (D)
- Facility failed to follow infection control procedures for one resident on transmission based on precautions (D)
- Infection control: during ambulation res almost stepped on catheter tubing and it was hitting the floor. Also, observations of catheter bag hooked onto bottom of wheelchair, tubing dragged on floor (D)
- Resident with active open herpes zoster lesions who was significantly cognitively impaired wandered from his room to common areas. A late diagnosis of herpes zoster allowed this resident to wander freely about the unit for several days with significant lesions when no isolation precautions were taken. Staff member providing pericare to this resident touched multiple items in resident room prior to removing the gloves used during pericare. Isolation precautions not implemented in a timely manner for resident who had MRSA in foot wound (D)

F 883—Influenzas, Pneumococcal Immunizations

- Failure to have records that flu and influenza vaccines were offered to 2 residents during flu season (D)
- Facility failed to determine if one of 26 residents had received pneumonia vaccination (B)

F 908—Essential Equipment, Safe Operating Condition

- Facility failed to maintain the kitchen and environment in a clean manner. Items were greasy, grimy, and had food debris on them (F)

F 921—Safe/Sanitary/Functional/Comfortable Environment

- Cracked and missing floor tiles in kitchen (D)

N 101—Reporting

- Documentation in res chart found cool to touch, cyanotic and absence vital signs. During interview surveyor determined res was found on floor. Nurse later told surveyor was untruthful and administrator instructed her to return to bed and chart res was found in bed. CNA interviewed initially reported res was in bed, later confirmed res was found on floor. Another CNA confirmed res was on the floor. Administrator reported not knowing res was on floor at time of death, reviewed the res record and could not find an incident report. Administrator adamantly denied telling the nurse to falsify records and further stated the first time she knew res was on floor was when surveyor told them. Physician also stated was notified of death but not that res was on floor. Interview of mortician indicates res had some bruising on face, but nothing suspicious or concerning (E) **$500 fine**

[MORE]

Nursing Facility Survey Frequency-August 2018

Name of Entity	Exit Date	City	Previous Date	Months
ACCURA HEALTHCARE OF PLEASANTVILLE	6/28/2018	Pleasantville	5/4/2017	13.5
ACCURA HEALTHCARE OF AMES	6/14/2018	Ames	4/27/2017	13.8
ACCURA HEALTHCARE OF BANCROFT	6/28/2018	Bancroft	4/20/2017	14.4
ACCURA HEALTHCARE OF MILFORD	5/17/2018	Milford	4/6/2017	13.3
BLACKHAWK LIFE CARE CENTER	6/21/2018	Lake View	4/13/2017	14.3
CALVIN COMMUNITY	6/7/2018	Des Moines	4/6/2017	14.1
CASA DE PAZ HEALTH CARE CENTER	6/21/2018	Sioux City	4/20/2017	14.0
COMMUNITY CARE CENTER	6/21/2018	Stuart	4/13/2017	14.3
COMMUNITY MEMORIAL HEALTH CENTER	6/7/2018	Hartley	3/23/2017	14.5
EAGLE POINT HEALTH CARE CENTER	6/14/2018	Clinton	4/6/2017	14.4
ELKADER CARE CENTER	6/21/2018	Elkader	4/20/2017	14.0
EMBASSY HEALTH CARE COMMUNITY	6/28/2018	Sergeant Bluff	4/13/2017	14.5
GOOD SAM - DAVENPORT	5/17/2018	Davenport	3/9/2017	14.3
GOOD SAM - LEMARS	6/14/2018	Le Mars	4/6/2017	14.3
GRANDVIEW HEIGHTS	6/14/2018	Marshalltown	4/6/2017	14.3
HERITAGE CARE & REHAB	6/28/2018	Mason City	4/20/2017	14.2
LENOX CC	6/7/2018	Lenox	3/16/2017	14.8
MANORCARE HEALTH SERVICES - UTICA RIDGE	6/28/2018	Davenport	4/13/2017	14.5
MANORCARE HEALTH SERVICES	6/28/2018	Cedar Rapids	4/20/2017	14.2
NEWALDAYA LIFESCAPES	6/28/2018	Cedar Falls	4/13/2017	14.5
PREMIER ESTATES OF MUSCATINE (2)	6/19/2018	Muscatine	3/23/2017	14.8
THE SUITES OF WESTERN HOME COMMUNITIES	6/7/2018	Cedar Falls	First survey	
THE VILLAGE AT LEGACY POINTE NURSING FACILITY	6/28/2018	Waukee	4/27/2017	14.1
VISTA WOODS CARE CENTER	6/7/2018	Ottumwa	3/16/2017	14.5
WESLEY PARK	6/14/2018	Newton	4/13/2017	14.1
WEST BEND HEALTH AND REHABILITATION	6/21/2018	West Bend	4/12/2017	14.3
WEST RIDGE SPECIALTY CARE	6/14/2018	Knoxville	4/6/2017	14.3
WILLOW DALE WELLNESS VILLAGE	6/14/2018	Battle Creek	3/30/2017	14.4
ZEARING HEALTH CARE	6/7/2018	Zearing	4/6/2017	14.1
			Average	14.2