DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165562	A. BUILDING _____ B. WING _____	C 05/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE CARE CENTER	120 NORTH THIRTEENTH STREET ALBIA, IA 52531

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F 000	INITIAL COMMENTS Correction Date: 5-30-18 Complaints 75162-C, 75201-C and 75847-C were investigated May 10-22, 2018. Complaints 75162-C and 75847 were substantiated. Complaint 75201-C was not substantiated. The following deficiencies relate to the Federal Code of Regulations (42-CFR) Part 483, Subpart B.	F 000	**Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because the provisions of federal and/ or state law require it.**	
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609	It is the practice of the facility to report alleged violations. 1. Facility reports all known allegations in 2 hours after allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events cause the allegation do not involve abuse and do not result in serious bodily injury. 2. Staff G was required to retake the dependent adult abuse class on 05/30/2018. 3. In-service education was provided to facility staff on 05/24/2018 by Administrator and Director of Nursing.	05/30/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Admin 7-3-2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	Continued From page 1 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interview, the facility failed to notify the Department of Inspections and Appeals in accordance with Federal reporting requirements regarding allegations or suspicion of resident-to-resident abuse. (Residents #5 and #7). The facility reported a census of 52 residents. Findings include: In an interview on 5/17/18 at 2:20 p.m. Staff G, certified nurse aide, stated about a month ago she witnessed Resident #7 grab Resident #5's right arm and twist it while in the green hallway. Resident #5 yelled, "Hey, hey, and both residents brought up their fist, but neither struck at one another. As Resident #5 was trying to move on with his wheel walker, but Resident #7 attempted to trip him. Staff G stated she reached the residents, separated them, and then informed the charge nurse, who assessed the resident. Staff G stated she could not remember the date, but thought it was late in the week on Resident #5's shower day (Thursday). Staff G reviewed her shower sheets and noted on 4/5/18, Resident #5 had three bruises on the top of his right hand and behind his right arm. Staff G stated she believed that was the day it happened; she recalled Resident #5 mentioned the altercation during his shower. Staff G stated the treatment nurse was Staff H and the charge nurse was Staff I that day.	F 609	Continued From page 1 4. Dependent adult abuse training will be provided upon hire and annually. Compliance will be monitored by the QAPI committee.	

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F 609	Continued From page 2 In an interview on 5/17/18 at 3:45 p.m., Resident #5 stated over a month ago he was walking out of his room and Resident #7 was in the hallway. Resident #5 asked Resident #7 how he was doing and Resident #7 immediately grabbed his hand and arm and was squeezing it. Resident #5 stated he wanted to fight back, but was told he just needed to let it go. Resident #5 stated staff was aware of what happened. Review of both Resident #5 and Resident #7's nurse's notes revealed neither record contained any documentation of the altercation on 4/5/18, or any altercation in April 2018. The record also failed to contain an incident report that documented the altercation reported by Staff G . In an interview on 5/17/18 at 2:57 p.m. Staff H, LPN, stated she knew nothing about a physical altercation between Resident #5 and Resident #7 on 4/5/18 and nobody had reported anything to her. In an interview on 5/17/18 at 2:50 p.m. Staff I, RN stated she was did not serve as charge nurse on 4/5/18 and knew nothing about a physical altercation between Resident #5 and Resident #7. Review of the work schedule revealed Staff I scheduled as the charge nurse on day shift on 4/5/18. In an interview on 5/17/18 at 4:15 p.m., the Director of Nursing, stated she was unaware of a physical altercation occurring between Resident #5 and Resident #7. The DON was then asked if she had a conversation with a family member regarding an altercation between Resident #5 and Resident #7. The DON stated a family member	F 609	Continued From page 2	

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F 609	Continued From page 3 came in and questioned whether an altercation had occurred and the DON stated not that she knew of. The DON reviewed the charting and asked the nurses who stated they knew nothing about an altercation. The DON stated sometimes residents get verbal with one another.	F 609	Continued From page 3	
F 675 SS=E	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to provide incontinent supplies in quantities sufficient to meet resident needs. The facility reported a census of 52 residents. Findings include: In an interview on 5/21/18 at 12:00 p.m. Staff J, certified nurse aide, stated the facility had problems with keeping enough incontinence briefs in the facility, especially the brown (large) and gray (extra large). Staff J stated two weeks ago they completely ran out of brown and gray incontinent briefs and were forced to use purple (medium) briefs and pull ups. Staff J reported the supply truck did not deliver until Tuesdays .	F 675	It is the practice of the facility to provide incontinent supplies in quantities sufficient to meet resident needs. 1. Facility provides incontinent supplies to meet all resident's needs. 2. Facility provides disposable incontinent products to all residents, supplies are delivered once a week and can be delivered overnight if necessary. The facility incontinent product representative from Tena sized facility residents on 02/27/2018 and provided staff education and facility with ordering guide and sizing chart. 3. In-service education was provided to facility staff on 05/24/2018 by Administrator and Director of Nursing.	05/24/2018

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F 675	Continued From page 4 In an interview on 5/21/18 at 12:10 p.m. Staff E, certified nurse aide, stated there had been a shortage of supplies since new management took over the facility. Incontinence briefs often run out by Tuesday. They usually had plenty of purple (medium), but currently had no brown (large) and only a few grays (extra large) left. Staff E stated when she saw a shortage she tried to use a size larger to avoid skin issues from being too tight, but sometimes has had to use purple if they are all that was available. In an interview on 5/21/18 at 3:35 p.m., Staff K, certified nurse aide, stated they often run out of some incontinent brief sizes; the facility currently had no brown (large) sizes. Staff K stated they tried to fit the resident with the next closest size. Staff K identified 4 residents on her hall today who were currently using incontinent briefs that were not their size. In an interview on 5/21/18 at 4:12 p.m. Staff L, certified nurse aide, stated they run out of incontinence briefs toward the end of each week. They run out of the brown (large) size and have to use an alternative size until they get another delivery. Staff L identified one resident on her hall that uses brown incontinent briefs, but is out and using the purple (medium) brief. Staff L stated they have also on occasion run low or out of incontinent wipes. An observation on Monday 5/21/18 at 12:05 p.m. revealed the supply room and supply carts void of any brown (large) incontinent briefs and few gray (extra large) briefs available.	F 675	Continued From page 4 4. Facility provides disposable incontinent products and washable incontinent products for all residents.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

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F 842	Continued From page 5 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842	Continued From page 5 It is the practice of the facility to maintain medical records which are complete and accurately documented. 1. Facility maintains medical records that are complete and accurately documented. 2. Staff A was provided education on 05/11/2018. Staff A resigned 06/29/2018. 3. In-service education was provided to facility staff on 05/24/2018 by Administrator and Director of Nursing. 4. In-service training will be provided to facility staff upon hire and annually. QAPI committee will monitor compliance.	05/24/2018

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F 842	Continued From page 6 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interview the facility failed to maintain medical records which are complete and accurately documented. (Residents #1, #5 and #7). The facility reported a census of 52 residents. Findings include: According to Resident #1's Minimum Data Set (MDS) assessment tool dated 11/17/17, Resident	F 842	Continued From page 6	

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#1 had a brief interview for mental status (BIMS) score of 10 indicating moderately impaired cognitive skills for daily decision making. Resident #1 required limited assistance with bed mobility, transfers, dressing, eating, toilet use and personal hygiene. Resident #1's diagnosis included non-Alzheimer's dementia, congestive heart failure and a fractured cervical vertebrae. Resident #1 was 101 years old.

Nurse's notes dated 12/31/17 at 4:20 a.m. written by Staff A indicated Staff A was summoned to Resident #1's room by Staff B. Resident #1 was without respirations or heartbeat. Resident #1 appeared very cyanotic (blue as a result of a lack of oxygen) and cool to the touch. Staff B had just been down that hallway and Resident #1 was resting in bed with her head towards her roommate at that time.

In an interview on 5/10/18 at 11:30 a.m. Staff A, Registered Nurse, stated she was worked the overnight shift on 12/30/17. At around 4:20 a.m., Staff B reported Resident #1 was on the floor, on her left side with her back toward her bed. Resident #1 was without respirations or heartbeat. She was cyanotic and cool to the touch. Staff A stated Resident #1 may have gotten up unassisted, tried to get to the bathroom, and fell. Staff A stated there was no blood or injuries noted. Staff A stated Resident #1 required assist of one staff with transfers, but would often get up unassisted, two to three times a shift. Staff A stated Resident #1 would not use her call light. Staff A stated she was uncertain when Resident #1 was last seen, but assumed at 2:00 a.m. rounds. Staff A stated Resident #1's neck collar was in place when discovered on the floor that morning. When asked why Staff A did

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not include the fact that Resident #1 was found on the floor in her documentation, Staff A responded I don't know. Staff A asked if she had ever been instructed by anyone to change or alter her documentation and Staff A responded no. Staff A stated she was uncertain if she had filled out an incident report related to Resident #1's fall. (The record failed to contain an incident report).

In a follow up interview on 5/25/18 at 11:07 a.m., Staff A stated she had not been truthful in her earlier statement regarding Resident #1's fall and death. Staff A stated Staff B summoned her to Resident #1's room. Resident #1 lay on the floor in fetal position, had no pulse or respirations, and appeared dark blue all over. Resident #1's neck collar lay on her recliner. Staff A stated she called the Administrator to inform her of Resident #1's passing and that staff found the resident on the floor. According to Staff A, the Administrator stated, "Are you (expletive) kidding me?" Staff A stated she was caught off guard by the Administrator's reaction and asked her "How do you want me to chart this?" Staff A reported the Administrator instructed her to return Resident #1 to bed and chart staff found her in bed, deceased. Staff A stated she knew better, but followed the Administrator's instructions anyway.

In a telephone interview on 5/10/18 at 11:05 p.m., Staff B, certified nurse aide, when asked was asked about finding Resident #1 on the morning of 12/31/17. Staff B stated he walked in the room and found Resident #1 in her bed unresponsive. When asked why the nurse reported Resident #1 was found on the floor, Staff B stated it's been a while ago. Staff B asked if Resident #1 was wearing her neck collar when found and Staff B hesitated before stating yes. Staff B then

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F 842	Continued From page 9 excused himself to answer a call light. Surveyor made a return call about 5 minutes later and Staff B answered. Staff B stated Resident #1 was found on the floor with her neck collar on and she had no injuries. Staff B stated he and the nurse, Staff A lifted Resident #1 back into bed. Staff B stated Resident #1 was last seen in bed at 2:00 a.m. when he was passing ice. Staff B excused his initial comment regarding Resident #1 being in bed unresponsive as being caught off guard with the question. In an interview on 5/20/18 at 10:41 p.m. Staff C, certified nurse aide, stated she worked the overnight shift on 12/30/17 assigned to the pink and blue halls, but noted Resident #1 was on the green hall. Early on the morning of 12/31/17 staff summoned her to Resident #1's room. Resident #1 lay on the floor, deceased. Staff C stated she and two others (Staff A and Staff B) lifted Resident #1 into her bed. Staff C stated Resident #1 wore her neck collar. In an interview on 5/10/18 at 12:15 p.m., when asked if staff completed an incident report when staff found Resident #1 on the floor the morning of her passing. The Administrator stated I didn't know she was on the floor. The Administrator reviewed Resident #1's record and could not locate an incident report. In a follow up interview on 5/24/18 at 9:00 a.m. the Administrator was informed that additional information had been obtained regarding the death of Resident #1 and The Dept of Inspections and Appeals wanted to give her an opportunity to clarify her knowledge of what occurred. The Administrator stated she received a phone call from Staff A informing her Resident #1 had	F 842	Continued From page 9	

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F 842	Continued From page 10 passed away. The Administrator stated she had first learned that Resident #1 was on the floor when notified by the surveyor during the investigation (5/10/18 - 5/22/18). The Administrator stated she disciplined Staff A related to her failure to document completely and failure to complete an incident report. The Administrator was informed there was an allegation she had instructed Staff A to falsely document the incident involving Resident #1 to make it appear as if she had passed away while in bed. The Administrator stated, "Why would I do that?" The Administrator also stated, "I always report falls." The Administrator reported she trusted and relied on nurses to be professional and properly report incidents and pertinent details as they occur. The Administrator adamantly denied she instructed Staff A to falsify the details related to Resident #1's death. In an interview on 5/10/18 at 1:42 p.m., Resident #1's physician stated he had no record of being notified at 4:30 a.m. on 12/31/17 of Resident #1's death. The physician stated he was informed, but doesn't recall being told staff found Resident #1 on the floor. The physician stated Resident #1 had diagnoses of congestive heart failure, chronic kidney disease, and dementia that may have contributed to her death. In an interview on 5/21/18 at 12:00 p.m. Staff D, certified nurse aide, stated she worked the morning of 12/31/17 and had been told Resident #1 passed away in her sleep. Staff D stated she was not aware Resident #1 was found on the floor. In an interview on 5/21/18 at 12:05 p.m. Staff E, certified nurse aide, stated she worked the	F 842	Continued From page 10	

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F 842	Continued From page 11 morning of 12/31/17 and was aware of Resident #1 passing. Staff E stated she was not provided any details and didn't ask. Staff E stated she was not aware Resident #1 was found on the floor. In an interview on 5/22/18 at 12:14 p.m. Staff F, Registered Nurse, stated on the morning of 12/31/17 she arrived to work and the overnight nurse (Staff A) informed her Resident #1 had passed away that morning. Staff A stated Resident #1 was found on the floor in a fetal position without her neck collar and was entirely blue. Staff A stated she called the Administrator who told her to get Resident #1 in bed and to document Resident #1 was found in bed deceased. Staff F stated she was shocked to hear this and questioned Staff A whether she complied with the Administrators instructions. Staff A stated she had because she's the Administrator. In an interview on 5/23/18 at 10:59 a.m., Resident #1's mortician stated he recalled Resident #1 had some bruising on the left side of her face and remembers he informed the family of the bruising. The mortician stated the bruising wasn't suspicious or concerning.	F 842	Continued From page 11	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE CARE CENTER	120 NORTH THIRTEENTH STREET ALBIA, IA 52531

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 675	Continued From page 4 In an interview on 5/21/18 at 12:10 p.m. Staff E, certified nurse aide, stated there had been a shortage of supplies since new management took over the facility. Incontinence briefs often run out by Tuesday. They usually had plenty of purple (medium), but currently had no brown (large) and only a few grays (extra large) left. Staff E stated when she saw a shortage she tried to use a size larger to avoid skin issues from being too tight, but sometimes has had to use purple if they are all that was available. In an interview on 5/21/18 at 3:35 p.m., Staff K, certified nurse aide, stated they often run out of some incontinent brief sizes; the facility currently had no brown (large) sizes. Staff K stated they tried to fit the resident with the next closest size. Staff K identified 4 residents on her hall today who were currently using incontinent briefs that were not their size. In an interview on 5/21/18 at 4:12 p.m. Staff L, certified nurse aide, stated they run out of incontinence briefs toward the end of each week. They run out of the brown (large) size and have to use an alternative size until they get another delivery. Staff L identified one resident on her hall that uses brown incontinent briefs, but is out and using the purple (medium) brief. Staff L stated they have also on occasion run low or out of incontinent wipes. An observation on Monday 5/21/18 at 12:05 p.m. revealed the supply room and supply carts void of any brown (large) incontinent briefs and few gray (extra large) briefs available.	F 675	Continued From page 4 4. Facility provides disposable incontinent products and washable incontinent products for all residents.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

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F 842	Continued From page 5 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842	Continued From page 5 It is the practice of the facility to maintain medical records which are complete and accurately documented. 1. Facility maintains medical records that are complete and accurately documented. 2. Staff A was provided education on 05/11/2018. Staff A resigned 06/29/2018. 3. In-service education was provided to facility staff on 05/24/2018 by Administrator and Director of Nursing. 4. In-service training will be provided to facility staff upon hire and annually. QAPI committee will monitor compliance.	05/24/2018

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F 842	Continued From page 6 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and otherlicensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interview the facility failed to maintain medical records which are complete and accurately documented. (Residents #1, #5 and #7). The facility reported a census of 52 residents. Findings include: According to Resident #1's Minimum Data Set (MDS) assessment tool dated 11/17/17, Resident	F 842	Continued From page 6	

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F 842	Continued From page 7	F 842	Continued From page 7	

#1 had a brief interview for mental status (BIMS) score of 10 indicating moderately impaired cognitive skills for daily decision making. Resident #1 required limited assistance with bed mobility, transfers, dressing, eating, toilet use and personal hygiene. Resident #1's diagnosis included non-Alzheimer's dementia, congestive heart failure and a fractured cervical vertebrae. Resident #1 was 101 years old.

Nurse's notes dated 12/31/17 at 4:20 a.m. written by Staff A indicated Staff A was summoned to Resident #1's room by Staff B. Resident #1 was without respirations or heartbeat. Resident #1 appeared very cyanotic (blue as a result of a lack of oxygen) and cool to the touch. Staff B had just been down that hallway and Resident #1 was resting in bed with her head towards her roommate at that time.

In an interview on 5/10/18 at 11:30 a.m. Staff A, Registered Nurse, stated she was worked the overnight shift on 12/30/17. At around 4:20 a.m., Staff B reported Resident #1 was on the floor, on her left side with her back toward her bed. Resident #1 was without respirations or heartbeat. She was cyanotic and cool to the touch. Staff A stated Resident #1 may have gotten up unassisted, tried to get to the bathroom, and fell. Staff A stated there was no blood or injuries noted. Staff A stated Resident #1 required assist of one staff with transfers, but would often get up unassisted, two to three times a shift. Staff A stated Resident #1 would not use her call light. Staff A stated she was uncertain when Resident #1 was last seen, but assumed at 2:00 a.m. rounds. Staff A stated Resident #1's neck collar was in place when discovered on the floor that morning. When asked why Staff A did

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F 842	Continued From page 8	F 842	Continued From page 8	

not include the fact that Resident #1 was found on the floor in her documentation, Staff A responded I don't know. Staff A asked if she had ever been instructed by anyone to change or alter her documentation and Staff A responded no. Staff A stated she was uncertain if she had filled out an incident report related to Resident #1's fall. (The record failed to contain an incident report).

In a follow up interview on 5/25/18 at 11:07 a.m., Staff A stated she had not been truthful in her earlier statement regarding Resident #1's fall and death. Staff A stated Staff B summoned her to Resident #1's room. Resident #1 lay on the floor in fetal position, had no pulse or respirations, and appeared dark blue all over. Resident #1's neck collar lay on her recliner. Staff A stated she called the Administrator to inform her of Resident #1's passing and that staff found the resident on the floor. According to Staff A, the Administrator stated, "Are you (expletive) kidding me?" Staff A stated she was caught off guard by the Administrator's reaction and asked her "How do you want me to chart this?" Staff A reported the Administrator instructed her to return Resident #1 to bed and chart staff found her in bed, deceased. Staff A stated she knew better, but followed the Administrator's instructions anyway.

In a telephone interview on 5/10/18 at 11:05 p.m., Staff B, certified nurse aide, when asked was asked about finding Resident #1 on the morning of 12/31/17. Staff B stated he walked in the room and found Resident #1 in her bed unresponsive. When asked why the nurse reported Resident #1 was found on the floor, Staff B stated it's been a while ago. Staff B asked if Resident #1 was wearing her neck collar when found and Staff B hesitated before stating yes. Staff B then

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F 842	Continued From page 9 excused himself to answer a call light. Surveyor made a return call about 5 minutes later and Staff B answered. Staff B stated Resident #1 was found on the floor with her neck collar on and she had no injuries. Staff B stated he and the nurse, Staff A lifted Resident #1 back into bed. Staff B stated Resident #1 was last seen in bed at 2:00 a.m. when he was passing ice. Staff B excused his initial comment regarding Resident #1 being in bed unresponsive as being caught off guard with the question. In an interview on 5/20/18 at 10:41 p.m. Staff C, certified nurse aide, stated she worked the overnight shift on 12/30/17 assigned to the pink and blue halls, but noted Resident #1 was on the green hall. Early on the morning of 12/31/17 staff summoned her to Resident #1's room. Resident #1 lay on the floor, deceased. Staff C stated she and two others (Staff A and Staff B) lifted Resident #1 into her bed. Staff C stated Resident #1 wore her neck collar. In an interview on 5/10/18 at 12:15 p.m., when asked if staff completed an incident report when staff found Resident #1 on the floor the morning of her passing. The Administrator stated I didn't know she was on the floor. The Administrator reviewed Resident #1's record and could not locate an incident report. In a follow up interview on 5/24/18 at 9:00 a.m. the Administrator was informed that additional information had been obtained regarding the death of Resident #1 and The Dept of Inspections and Appeals wanted to give her an opportunity to clarify her knowledge of what occurred. The Administrator stated she received a phone call from Staff A informing her Resident #1 had	F 842	Continued From page 9	

DEPARTMENT OF INSPECTIONS AND APPEALS

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	IA0495	A. BUILDING: _____ B. WING _____	C 05/22/2018

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MONROE CARE CENTER	120 NORTH THIRTEENTH STREET ALBIA, IA 52531

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N 101	50.7(1) 481- 50.7 (10A,135C) Additional notification. 5/24/18 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(1) Of any accident causing major injury. a. " Major injury " shall be defined as any injury which: (1) Results in death; or (2) Requires admission to a higher level of care for treatment, other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a " major injury " based upon the circumstances of the accident, the previous functional ability of the resident, and the resident ' s prognosis. b. The following are not reportable accidents: (1) An ambulatory resident, as defined in rules 481-57.1(135C), 481-58.1(135C), and 481-63.1(135C), who falls when neither the facility nor its employees have culpability related to the fall, even if the resident sustains a major injury; or (2) Spontaneous fractures; or (3) Hairline fractures. This Statute is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the Department of Inspections and Appeals of a fall that resulted in	N 101	**Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because the provisions of federal and/ or state law require it.** It is the practice of the facility to notify the Department of Inspections and Appeals of a fall that resulted in death. 1. Facility reports all known accident causing "major injury" defined as any injury which: Results in death; or Requires admission to a higher level of care for treatment, other than for observation; or Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a " major injury " based upon the circumstances of the accident, the previous functional ability of the resident, and the resident ' s prognosis.	05/24/2018

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7/3/2018

DEPARTMENT OF INSPECTIONS AND APPEALS

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N 101	Continued From page 1 death in accordance with State reporting requirements. (Resident #1). The facility reported a census of 52 residents. Findings include: In an interview on 5/25/18 at 11:07 a.m., Staff A, Registered Nurse, stated on the morning of 12/31/17 Resident #1 was discovered on the floor deceased. Staff A contacted the Administrator and reported the fall and death. Nurse's notes dated 12/31/17 at 4:20 a.m. written by Staff A indicated Staff A was summoned to Resident #1's room by Staff B. Resident #1 was without respirations or heartbeat. Resident #1 appeared very cyanotic (blue as a result of a lack of oxygen) and cool to the touch. Staff B had just been down that hallway and Resident #1 was resting in bed with her head towards her roommate at that time. The resident's medical record did not contain any documentation related to the resident's fall. In an interview on 5/24/18 at 9:00 a.m., the Administrator reported she received a phone call from Staff A on 12/31/17 informing her Resident #1 had passed away. The Administrator stated she was not informed Resident #1 had fallen and was discovered on the floor, therefore did not report the fall as required. The Administrator stated she had first learned Resident #1 had been found on the floor when brought up by the surveyor during the investigation (5/10/18 - 5/22/18). The Administrator stated she trusted and relied on nurses to be professional and to properly report incidents and pertinent details as they occur.	N 101	Continued From page 1 2. Staff A was provided education on 05/11/2018. Staff A resigned 06/29/2018 3. In-service education was provided to facility staff on 05/24/2018 by Administrator and Director of Nursing. 4. In-service training will be provided to facility staff upon hire and annually. QAPI committee will monitor compliance.	