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	355115	A. BUILDING _____ B. WING _____	C 08/30/2012

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid survey and complaint survey started on 08/27/12 and completed on 08/30/12, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000	F Tag 224 It is the intent of Garrison Memorial Long Term Care Facility to comply with F Tag 224 Mistreatment / Neglect / Misappropriation of resident property.	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and procedure, record review, information submitted by the complainant, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #5) found unattended on the toilet remained free from neglect; and failed to ensure staff reported and investigated the incident. This failure placed Resident #5 at risk for skin breakdown, falls, and a loss of dignity; and placed all residents at risk for future neglect. Findings include: Review of the facility policy titled "Abuse Prohibition Program / Grievance" occurred on 08/28/12. This policy, revised May 2011, stated,	F 224	#1) An Abuse investigation was completed by Nursing Administration during the survey and submitted to the health dept. #2) All residents who go on an outing can potentially be at risk. A report process will be initiated in which the off going CNA staff reports to the on coming CNA staff the status of the residents. #3) As part of the corrective plan for all residents who go on an outing, the list that is compiled by the activity department, noting who is going on the outing, the Activity Aide will mark off on the list who actually has left the unit, and will give this to the charge nurse on duty at the time. As part of the corrective plan we will conduct a Lean Six Sigma, value analysis on this issue. (*Exhibit 1*) The staff involved in	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dean Matter — TITLE: administrator — (X6) DATE: 9/25/12

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 224	Continued From page 1 "It is the policy of [facility name] to maintain the environment free of abuse and neglect. . . . IDENTIFICATION: . . . 2. The department supervisor and/or charge nurse shall then report the suspected occurrence to the Director of Nursing or designee. . . . INVESTIGATION: . . . 1. Any investigation of any . . . neglect . . . will always be conducted . . . and are to be thoroughly investigated, the purpose of the investigation is to determine the circumstances surrounding the alleged incident and the evidence available to make a final determination. The investigation researches the who, [sic] what, [sic] where, when, how, and why of the incident. . . . 3. The charge nurse on duty will conduct a physical examination of any alleged victim(s) immediately, and address any medical needs. . . . The Charge nurse will continue to investigate the alleged incident, which may include but not limited to: * Identify all staff, residents or others . . . involved in the alleged incident * Interview all staff, residents and/or family in person when ever possible. (Use interview form) * Have the individual who is being interviewed sign and date the interview documentation when ever possible. * Obtain written statements of events that occurred from the staff/individual reporting the incident * All written documentation of investigation, findings and interviews with staff and residents will be given to the Director of Nursing . . . REPORTING 2. The reporter of the incident completes the Incident Form. . . ."	F 224	this, will be involved in developing and improvement process. This process will generate changes in procedure and may change policies. These changes will be approved by administration. This meeting of Lean Six Sigma will be held October 4, 2012. The staff will be educated of changes to be made at the next nursing staff meeting in October. Education with staff will be completed at a staff meeting held on Sept 24, 2012, a review of the policy Incident Reporting and Incidents of Unknown Origin will be reviewed. (***Exhibit 2 abc***) #4) The date of correction will be October 4, 2012. done by DON #5) A QA study will be conducted on this issue for 3 months weekly and then randomly for 3 months. Looking at incident reports and incidents of unknown origin reports to determine if proper documentation has been completed according to policy, (***Exhibit 3***) All QA information will be submitted to the hospital QA committee for any further corrective actions as appropriate. (***Exhibit 4***)	and ADON via telephone c both DON 10/2/12 10:56AM CT

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F 224	Continued From page 2	F 224		

- Written information submitted by the complainant identified facility staff left Resident #5 on the toilet in a standing lift for three hours on 08/10/12. Resident #5's roommate discovered and reported the incident upon return from an outing.

Resident #5's nursing notes failed to include documentation on 08/10/12 regarding staff leaving the resident on the toilet unattended for an extended period of time.

During an interview on 08/28/12 at 1:05 p.m., an administrative activity staff member (#11) stated an activity outing occurred on 08/10/12 . The scheduled outing occurred from approximately 1:30 - 3:30 p.m. This activity staff member (#11) stated Resident #5 "did not attend" the outing but her roommate (Resident #3) did.

During an interview on 08/28/12 at 1:10 p.m., a nursing staff member (#6), who worked a 12 hour day shift on 08/10/12, stated Resident #3 returned from the outing and came to the nurse's station and the social worker's office and stated "someone is going to have to get [Resident #5's name] out of the bathroom."

The nursing staff member (#6) stated she reported the incident to her supervisor and to administrative nursing staff. This staff member (#6) assessed Resident #5, identified no injuries, and stated she failed to document the incident in Resident #5's medical record or complete an incident report. The nursing staff member (#6) stated she received information later that evening that a Certified Nurse Assistant (CNA) (#12) utilized the stand lift to transfer Resident #5 to the

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F 224	Continued From page 3 bathroom at approximately 1:00 p.m. on 08/10/12 and "forgot her." An interview occurred, on 08/28/12 at 2:10 p.m., with administrative nursing staff members (#1 and #2) and the nursing staff member (#6). The administrative nursing staff members (#1 and #2) stated they were informed of staff finding Resident #5 in the bathroom, but were not informed of the three hour time frame. During an interview on 08/29/12 at 1:30 p.m., an administrative nursing staff member (#1) stated she found no incident report regarding staff leaving Resident #5 unattended on the toilet for three hours on 08/10/12.	F 224		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225	F-Tag 225 It is the intent of Garrison Memorial Long Term Care Facility to comply with F-Tag 225 Investigation /Report Allegation. #1) Correction for Resident # 11, Staff person #4 was monitored while caring for this resident by nursing staff. There were no further confrontations between resident #11 and Staff #4, and at this time appear to be able to get along, resident #11 is satisfied with the cares she receives from staff #4. Correction for an alleged incident that occurred on 5/20 and 5/21, an investigation was completed and submitted to the State Health Department on Sept 30th, 2012.	

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F 225	Continued From page 4 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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, review of facility policy and procedures, and staff interview, the facility failed to report 3 of 3 alleged incidents of neglect and/or abuse to the administrator and to the State survey and certification agency upon receiving notification of the allegations, failed to complete a timely and thorough investigation of all the allegations, and failed to report the results of the investigations within 5 working days to the administrator and the State survey and certification agency. Failure to report and thoroughly investigate all alleged violations involving mistreatment, neglect, or abuse has the potential to place all residents at risk of possible neglect and abuse. Findings include:	F 225	Staff person #4 was spoken to by the Director of Nursing on July 11, 2012, concerning lack of care provided by staff #4 and what the consequences would be if this behavior continued. #2) All residents can potentially be affected by this type of incident. #3) See ***(Exhibit 2 abc)*** "Incident Reporting and Incidents of Unknown Origin" policy, has been updated. Inservice for all LTC Staff will be held on ***Sept 24th***, 2012 where review of this policy and Abuse Prohibition" will be done. #4) The date of correction will be October 4, 2012. completed by DON or ADON via telephone Both Day 10/2/12 10:58 AM CT #5) A QA study will be conducted on this issue for 3 months weekly and randomly for the next 3 months. A review of all incident reports, chart documentation, Investigations of Injuries of Unknown origin, Staff reporting, and resident complaints, will be studied to determine if appropriate steps have be taken according to the "Abuse Prohibition Policy" and "Incident Reporting." Staff person #4 will be monitored during this time also for	

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F 225	Continued From page 5 Review of the facility policy titled "Abuse Prohibition Program / Grievance" occurred on 08/28/12. This policy, revised May 2011, stated, "It is the policy of [facility name] to maintain the environment free of abuse and neglect. . . . IDENTIFICATION: 1. Any staff witnessing or possessing reliable knowledge of any act , [sic] or suspect act, involving mistreatment, neglect or abuse . . . must notify their department supervisor or charge nurse on duty. . . . INVESTIGATION: 1. Any investigation of any allegations of abuse, neglect . . . will always be conducted, all complaints are taken seriously and are to be thoroughly investigated, the purpose of the investigation is to determine the circumstances surrounding the alleged incident and the evidence available to make a final determination. The investigation researches the who , [sic] what , [sic] where, when, how and why of the incident. . . . 4. The Director of Nursing /designee will also conduct an investigation. * A notification of incident will be made to the Administrative designee as soon as appropriate * A preliminary report to the State Health Dept. will be done by the Director of Nursing/designee within the next working day, * A final resolution to the investigation , [sic] is completed and sent within five working days to the State Health Department . . . REPORTING 1. The reporter immediately reports the incident to the nurse in charge of the resident's care. 2. The reporter of the incident completes the Incident Form 3. The Charge nurse shall notify the Director of	F 225	performance and care concerns, any continued concerns may lead to termination. All QA information will be reviewed by the hospital QA committee for further recommendations. *(Exhibit 5)*	

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F 225	Continued From page 6 Nursing/designee, once the resident(s) are safe. 4. The Director of Nursing / designee shall inform the Administrator of incident and findings from investigation, report to the State Health Department within 24 hours of impending investigation. . . . C.) . . . All allegations will be reported to the department [State survey and certification agency] within 24 hours by telephone . . . The report of the investigation and results will be mailed or faxed within five working days . . . to the ND Department of Health. D.) The Facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, . . . are reported immediately to the administrator of the facility and to other officials in accordance with State Law. . . ." - Review of facility's investigations of alleged neglect and/or abuse, within the past year, occurred on the morning of 08/28/12. These allegations included the following incidents: * A "Patient Complaint Form," identified Resident #11 complained about how a staff member (#4) talked to her and the "parties (apparently) argued." The complaint form identified the incident occurred on 04/30/12, was reported on 05/07/12, and administrative staff members (#2 and #3) spoke to the resident on 05/10/12 (3 days after being reported to staff). The complaint form lacked any specific information as to what the staff member (#4) said to the resident during this incident and the section of the form titled "Results" was dated 05/23/12 (16 days after being reported). * A confidential written document alleged a staff member (#4), on 05/20/12, failed to provide services to a resident by entering the resident's	F 225		

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F 225	Continued From page 7 room on two occasions, turning off his/her call light, and then leaving the room. Review of the staff schedule showed the staff member (#4) continued to work in the facility the next day (05/21/12). * A confidential written document, dated 05/21/12, alleged a staff member (#4) failed to toilet residents which resulted in one resident's bed being "soaked" with urine; failed to ensure the accessibility of a call light to the resident; and assisted the resident back into a bed wet with urine. Review of the facility's documents pertaining to the above alleged violations of neglect and/or abuse showed no evidence the facility staff notified their administrator and the State survey agency immediately after receiving notifications of the allegations; completed a timely and thorough investigation of the allegations, including documenting the information obtained through interviews; and notified their administrator and the State survey agency of the results of the investigations within 5 working days of the incidents. During an interview, on 08/28/12 at 9:45 a.m., the surveyor requested additional information regarding the alleged incidents from an administrative staff member (#1). The administrative staff member identified no additional information was available. On 08/29/12 at 1:30 p.m., this administrative staff member (#1) further identified the lack of Incident Forms, as per facility policy, by the reporters of the above-stated allegations.	F 225		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	F Tag 323 It is the intent of Garrison Memorial Long Term Care Facility to comply with F Tag 323 to ensure that the residents environment remains as free of accident hazards as is possible. And each resident receives adequate supervision and assistive devices to prevent accidents.	

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F 323	Continued From page 8 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, record review, information submitted by the complainant, confidential staff interview, resident interview, and staff interview, the facility failed to provide adequate supervision and assistive devices to enhance/promote safety and prevent accidents for 3 of 4 sampled residents (Resident #1, #5, #6) identified with falls. Failure to use appropriate transfer aids resulted in Resident #6 experiencing pain during the transfer. Failure to provide supervision during toileting of dependent residents, use appropriate transfer aids, and consistently implement fall prevention measures may result in avoidable falls and/or injuries for all residents. Findings include: Review of the facility policy titled "Abuse Prohibition Program / Grievance" occurred on 08/28/12. This policy, revised May 2011, stated, "It is the policy of [facility name] to maintain the environment free of abuse and neglect. . . . Training of Employees . . . VII. Reporting . . . 2. The reporter of the incident completes the Incident Form. . . ."	F 323	#1) Abuse investigation completed for resident #5 during survey, submitted to State Health Department. Care plan and orders updated to reflect current transfer status, *(exhibits 6&7)* addressing documentation of incidents in F tag 225 Care Plan updated to reflect current transfer status and use of lift with resident #6 *(exhibit 8)*, PT evaluation of 9/5/2012 *(exhibit 9 a&b)* PT order of 9/5/2012 *(exhibit 10)* Care Plan (*exhibit 11)*of resident #1 reviewed and updated to reflect any new orders *(exhibit 12)* concerning transfers and alarm usage. #2) All residents that have a history of falls, and have orders to have alarms on, use assistive devices for transfers have the potential to be affected. #3) The "Fall Event Form" does not address the issue of use of alarms on it, will be changed, also the "Physical Therapy Notification Form" changed *(exhibit 13)* to	

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F 323	Continued From page 9 Written information submitted by the complainant identified concerns that staff failed to consistently implement fall prevention measures, such as bed and chair alarms. - Observation during the initial tour on 08/27/12 at 10:40 a.m. showed Resident #6 seated in a wheelchair with a clip alarm and a pad alarm in place. Observations throughout the survey showed these two alarms in place. Review of Resident #6's medical record occurred on all days of survey. Diagnoses included osteoarthritis, lumbago (low back pain), osteoporosis, and dementia. The current Minimum Data Set (MDS), dated 07/11/12, identified moderately impaired cognition, delusions, physical and verbal behaviors, and extensive assistance from two or more staff for transfers and toilet use. The current care plan stated, ". . . I am forgetful [and] need help with my cares . . . Approaches . . . DO NOT leave W/C [wheelchair] in room. Use EZ stand [a mechanical sit-to-stand lift] for ALL transfers . . . I don't want to fall, as I have fallen before . . . Approaches . . . Clip alarm on @ all times . . . DO NOT leave W/C in B.R. [bathroom] when resident toileting . . ." A previous care plan, dated 08/09/11, also stated, "Do Not leave W/C in B.R. when resident on toilet." During an interview on 08/28/12 at 1:05 p.m., a nursing staff member (#7) stated she was unsure as to when the facility implemented the pad alarm to Resident #6's wheelchair, but that it had been "over six months at least. Alarms aren't new to	F 323	address alarms, how resident got into bathroom if fall occurred there, floor surfaces, something impeding walkway, Education on this new form and proper completion of Fall Event Form and Physical Therapy Notification Form done at all staff meeting on Sept 24th, 2012 , Physical Therapist will also attend this education session. Will review care plans of resident # 1, 5, 6 to address transfers and alarms. #4) The date of correction will be October 4, 2012. done by DON and ADON via telphone call & both DON 10/2/12 & losiyn CT #5) A QA study will be conducted for 3 months weekly and then randomly for 9 more months doing observations of appropriate transfers, use of alarms as per order, on all shifts, will monitor all fall event forms and physical therapy notification forms, along with documentation by nursing and therapy to note consistency in documentation and identify if all issues are addressed the same and as appropriate. ***(Exhibit 14)*** Following the QA results we will determine any changes that need to	

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F 323	Continued From page 10 her." During a confidential interview, a certified nursing assistant (CNA) expressed concerns related to a lack of staff. She stated, "Sometimes I leave people alone in the bathroom that I know I shouldn't. But another light goes off and I have to go help that person [resident]. There just aren't enough people [staff] to get all the work done." Medical record review identified Resident #6 experienced the following falls: * Facility Event Report, dated 06/06/12 at 8:30 p.m.: ". . . Resident found sitting on floor by CNA - Resident states 'I got down on my knees to look under my bed for a card that dropped [and] then sat down on the floor.' . . ." The report failed to identify if alarms were in place at the time of the fall. * Physical Therapy (PT) Progress Note, dated 06/08/12: ". . . Notification of fall slip received. Patient fell on 06/60/12 [sic] at 2030 hours [8:30 p.m.]. . . . Call light was within reach. Wheelchair was locked. Patient's bed alarm and chair alarm were placed properly. . . . We will continue to work on maintaining the clip alarm, but we do have to pin it to her bra in the back because she will take it off otherwise. So, we do continue to encourage staff to maintain that policy. . . ." * Facility Event Report, dated 06/13/12 at 7:45 p.m.: ". . . Resident's alarms sounding off - CNA found Res [resident] sitting on floor in BR - Res states 'I tried to stand up [and] sit in the W/C [and] missed it.' . . ." * PT Progress Note, dated 06/15/12: ". . . Notification of fall slip received. Patient fell at	F 323	be made and do retraining/reviewing of the procedures at least twice a year. Will review care plans for new approaches as identified. QA studies will be submitted to the hospital QA committee for further recommendations	

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(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
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19:45 hours [7:45 p.m.] on 06/13/12. Resident's alarms were sounding and CNA found resident sitting on the floor in the bathroom. Resident indicated to CNA that she was just trying to get in the chair after toileting. . . . At this point patient was trying to transfer herself from toilet to wheelchair. We have indicated to nursing staff that patient's wheelchair should not be left in front in [sic] her in the bathroom as she does try to get herself into the chair if she sees it. . . . We'll recommend that nursing staff remove wheelchair from toilet during toileting, if at all possible to stick around or near when resident is toileting. . . ."

* Facility Event Report, dated 07/09/12 at 12:40 p.m.: ". . . Resident found on floor in BR by nurses station. Was attempting to transfer self back to W/C from toilet. Alarm was not on. . . ." The report failed to identify if the pad alarm was in place, how the resident got into the bathroom, and reason the clip alarm was not in place.
* PT Progress Note, dated 07/12/12: ". . . Notification of fall slip received. Patient fell on 07/09/12 at 1240 hours [12:40 p.m.]. Resident was found on the floor in the bathroom by the nurses' station. She was attempting to transfer herself back to the wheelchair. Alarm was not on. . . . We do have a pin that we use and we have to have that fastened to her bra or patient will take off her alarm. Unfortunately, patient has been sneaking into the bathroom herself . . . and she did transfer herself to the toilet, but was unable to get herself back to the wheelchair. Apparently, patient did take the clip alarm off at this point. . . ."

Because inconsistencies exist between the Facility Event Report and PT Progress Note, it is

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F 323	Continued From page 12 unclear as to the exact circumstances of Resident #6's fall. Both documents also fail to indicate if the pad alarm was in place at the time of the fall. * Facility Event Report, dated 07/31/12 at 3:45 p.m.: ". . . Took self to bathroom, slid onto butt when getting off - alarms were on. . . ." * A nurses' note, dated 07/31/12 at 3:45 p.m.: ". . . Found on floor in bathroom - states attempted to sit in W/C [after] vdg [voiding] on toilet 'and it just rolled away.' . . ." * PT Progress note, dated 08/03/12: ". . . Notification of fall slip received. Patient fell on 07/31/12 at 15:45 hours [3:45 p.m.]. Apparently patient took self to the bathroom, alarm was not on correctly. Patient indicated to staff that she was trying to get up and sit in her wheelchair, but it rolled away from her. . . . We do have an order that patient not have the wheelchair in the bathroom with her, but when she takes herself to the bathroom we are unable to carry that out. . . . It should be noted that she's had more and more difficulty over the past few days with standing and turning is almost impossible. Because of that I have initiated the use of EZ stand for all transfers. . . . Also recommend patient continue to use a baby pin with the clip alarm. . . ." Because inconsistencies exist between the Event Report (which stated the alarms were on) and the PT Progress Note (which stated the alarm was not on correctly), it is unclear as to the exact circumstances of Resident #6's fall. Both documents also fail to indicate if the pad alarm was in place at the time of the fall. Observations throughout the survey showed	F 323		

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F 323	Continued From page 13 Resident #6's clip alarm pinned to the back of her shirt and not to her bra as recommended by PT. Observation on 08/27/12 at 4:38 p.m. showed a CNA (#9) assisted Resident #6 to the bathroom using an EZ stand lift. The CNA stated the resident "recently had a fall so she has a sore leg," and the staff now use an EZ stand lift. Observation on 08/28/12 at 9:19 a.m. showed Resident #6 inside a bathroom near the nurses' station. Observation showed the resident remained unattended in the bathroom, and staff failed to check on/assist the resident until 10:01 a.m. At 9:53 a.m., Resident #6 shouted from inside the bathroom, "Can somebody come here and help me?" At 9:55 a.m., the resident again shouted, "Help me! Please!" At 10:01 a.m., a CNA (#8) entered the bathroom to assist Resident #6 with personal cares. The resident was incontinent of stool, and observation showed stool on the toilet, the resident's legs, and the resident's clothing. The resident was attempting to clean herself using toilet paper. Another CNA (#10) entered the bathroom to assist Resident #6. A CNA (#10) applied a gait belt to Resident #6's waist and assisted her to stand by standing in front of the resident and using both hands to grasp the gait belt while the other CNA (#8) performed perineal cares. Resident #6 stated, "I can't stand on this leg no more. Gotta sit down. It hurts!" The CNA (#10) then assisted Resident #6 to sit on the toilet. The CNAs assisted Resident #6 to stand again, and the CNA (#8) resumed perineal cares. The resident stated, "I can't stand here very long! It hurts my legs!" The CNAs assisted Resident #6	F 323		

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F 323	Continued From page 14 to sit on the toilet and allowed the resident to rest. Then the CNAs assisted Resident #6 to stand for a third time. While one CNA (#10) grasped the gait belt with both hands, the other CNA (#8) finished perineal care. Resident #6 stated, "I can't take this anymore! It hurts!" The CNA (#8) stated, "Almost done." The CNA (#8) then placed a new brief on Resident #6, and the CNAs assisted her to sit in her wheelchair. During an interview on 08/28/12 at 10:23 a.m., a CNA (#8) stated she was unsure who took Resident #6 to the bathroom and that another nursing staff member (#7) told the CNA the resident took herself. The CNA also stated, "I didn't even know she was in there until [staff #7] told me just now." During an interview on 08/28/12 at 1:05 p.m., a nursing staff member (#7) stated Resident #6 took herself into the bathroom, and she (staff member #7) placed the resident's clip alarm and moved her wheelchair into the hallway. She then told the CNAs Resident #6 was in the bathroom. During an interview on the morning of 08/30/12, two supervisory nursing staff members (#1 and #2) agreed it was unsafe to leave Resident #6 in the bathroom unattended. The staff member (#2) confirmed staff were expected to transfer Resident #6 with an EZ stand lift. The staff failed to transfer Resident #6 appropriately, which caused her pain and jeopardized her safety. Staff also failed to thoroughly investigate/document the circumstances of Resident #6's falls, ensure the consistent implementation of all fall prevention	F 323		

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F 323	Continued From page 15	F 323		

measures (pinning the clip alarm to her bra, verifying the pad alarm was in place, removing the wheelchair from the bathroom), and provide adequate supervision to help prevent future falls.

- Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Parkinson's disease, osteoporosis, limb pain, and pyogenic arthritis involving the shoulder. The current MDS, dated 08/23/12, identified the resident is understood and understands others, intact cognition, and extensive assistance from two or more people for transfers and toilet use.

The current care plan stated, ". . . 07/18/12 Initiate use of clip alarm in bed/chair at all times . . ."

Observation during initial tour, on 08/27/12 at 10:40 a.m., showed Resident #1 asleep in bed with a clip alarm pinned to the back of her shirt between her shoulder blades.

Physician's orders identified the following:
*07/18/12: "Initiate use of clip alarm in bed/chair at all times. Initiate assist [with] all transfers to and from bed, chair, or toilet . . ."
*07/30/12: "Reminder for use of clip alarm at all times bed or chair . . ."
*08/27/12: "Pt. [patient] should have clip or pad alarm on in bed or chair at all times. . . ."

Facility Event Reports identified the following falls:
*07/12/12 at 9:20 a.m.: ". . . Resident put call light on, discovered sitting on buttocks [with] back resting against dresser, states she was dressing

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F 323	Continued From page 16 @ time of fall . . ." *07/17/12 at 10:00 a.m.: ". . . Resident toileted self [and] had taken bathrobe off [and] was attempting to reach attends that were on the shelf . . . Clip alarm added by PT . . ." *07/27/12 at 10:20 p.m.: ". . . Resident lying on floor on right side, semi fetal position. Stated she bent over to pick something up, became dizzy and slid off bed. Denies injury. Clip alarm was not on. . . ." The report failed to identify a reason the clip alarm was not in place. *07/29/12 at 7:30 p.m.: ". . . Bathroom alarm sounding [and] resident found sitting upright on floor in front of toilet. States stood [without] assist [assistance] from toilet [and] attempted to retrieve item from shelf . . ." *08/12/12 at 7:15 p.m.: ". . . Staff heard resident crying, discovered res. face down [and] lying on [left] side, resident states she 'was reaching for something on floor [and] lost balance,' had taken self to BR, undressed self . . . also took off personal alarm. . . ." *08/14/12 at 6:15 p.m.: ". . . Took alarm off per self [and] attempted to transfer from W/C to toilet [without] staff assist. Fell to floor in bathroom . . ." *08/20/12 at 3:30 a.m.: ". . . Resident found kneeling at side of bed, stated she rolled out of the bed . . ." The report does not identify if the bed alarm was in place at the time of the fall. During an interview on 08/27/12 at 4:48 p.m., Resident #1 stated she had to wear the clip alarm because "I was a bad girl. I forgot to call for help a couple times." The resident also stated she does not remove the clip alarm, and she is unable to unhook the alarm herself. Observations throughout the afternoon on	F 323		

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F 323	Continued From page 17 08/28/12 showed Resident #1 resting in bed without her clip alarm in place. The alarm remained attached to the back of her wheelchair, and staff failed to apply it as per physician order. During an interview on the morning of 08/30/12, two supervisory nursing staff members (#1 and #2) verified Resident #1 is supposed to have a clip alarm on when she is in bed. - Written information submitted by the complainant identified staff left Resident #5 unattended in the bathroom during the night of 08/07/12 and Resident #5 fell to the floor. Review of Resident #5's medical record occurred on August 27-30, 2012. A nursing note, dated 08/07/12 at 5:00 a.m., identified the following: "Resident toileted, appears to have attempted to stand per self slid to floor, found sitting beside toilet, holding on to grab bar, denies pain, no apparent injury." A physician's order, dated 08/08/12, stated "use E-Z stand for toileting - may use pivot technique chair to bed transfers only." Written information submitted by the complainant also identified, on 08/10/12, facility staff utilizing a stand lift left Resident #5 in the bathroom for three hours and Resident #5 was discovered when her roommate returned from an outing. Resident #5's nursing notes failed to include any documentation on 08/10/12 regarding staff leaving the resident in the bathroom unattended for an extended period of time.	F 323		

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F 323	Continued From page 18 During an interview on 08/28/12 at 1:10 p.m., a nursing staff member (#6) stated she reported the incident to her supervisor and to administrative nursing staff. This staff member (#6) assessed Resident #5, identified no injuries, and stated she failed to document the incident in Resident #5's medical record or complete an incident report. The nursing staff member (#6) received information later that evening that a CNA (#12) utilized the stand lift to transfer Resident #5 to the bathroom at approximately 1:00 p.m. on 08/10/12 and "forgot her." Resident #5's medical record identified diagnoses of orthostatic hypotension, dizziness, osteoarthritis, osteoporosis, chronic low back pain, spinal stenosis, and paranoia with hallucinations. The current quarterly MDS, dated 06/29/12, identified short and long term memory problems, and extensive assistance of one staff for transfers and toilet use. The current care plan, last reviewed 06/12/12, stated the problem/concern, "I am concerned that I might take a fall . . . Goals - I don't want to fall, help me make safe transfers . . . Approaches . . . Assist me with my . . . transfers . . . Use the stand for my transfers . . ." The care plan failed to address the need to not leave Resident #5 unsupervised in the bathroom after the incidents on 08/07/12 and 08/10/12.	F 323	F- tag 356 It is the intent of Garrison Memorial LTC Facility to comply with F-tag 356 to post nurse staffing information. #1 & 2) This deficient practice may affect residents and families that	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date.	F 356		

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F 356	Continued From page 19 o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to post, at the beginning of each shift, the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care on 3 of the 3 days of survey (August 28 - 30, 2012) the posting of staff was viewed. Findings include:	F 356	want this information on a daily basis, the nursing staff will complete this form as part of their report at the beginning of the shift #3) The procedure for completing the staffing form will be reviewed at the all staff meeting on Sept. 24th, 2012. #4) The date of correction will be October 4, 2012. #5) A 3 month weekly and randomly for 3 more months QA study will be conducted on all shifts for timely completion of this form. *(Exhibit 15)* completed by DON & ADON via telephone call CT by DON 10/2/12 @ 10:54 AM CT	

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F 356	Continued From page 20 A tour of the environment on 08/28/12 at 8:50 a.m. identified a standard form, posted across from the nurses' station, used to post staffing data for all three shifts on a daily basis. The form included five columns titled: Shift (nights, days, and evenings), Category of Staff, Actual Hours Worked, Staffing Total, and Total Hours; and three rows titled: Nights 11 p.m. - 7 a.m., Days 7 a.m. - 3 p.m., and Evenings 3 p.m. - 11 p.m. The form is designed so facility staff can fill in the blanks with the following required information: the current date, the total number and the actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift, and the resident census. Observation of the nurse staffing data posted across from the nurses' station on August 28 - 30, 2012 identified the following: * On 08/28/12 at 8:50 a.m., 11:15 a.m., 1:42 p.m. and 4:05 p.m. - no posting for the day shift. * On 08/29/12 at 5:00 p.m. - no posting for the evening shift. * On 08/30/12 at 7:45 a.m. - no posting for the day shift.	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	F tag 441 It is the intent of Garrison Memorial LTC facility to comply with F-tag 441 to prevent the transmission of disease and infection. #1) Cleaning of multi use devices (glucometers) will be done	

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F 441	Continued From page 21 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/29/2011 Based on observation, review of facility policy and procedure, review of Material Safety Data Sheet (MSDS), record review, and staff interview, the facility failed to follow standard infection control practices for 1 of 2 sampled residents (Resident #8) observed during blood glucose monitoring	F 441	appropriately according to policy, Wearing and changing of gloves will be done appropriately according to policy #2) All diabetic residents that have Accu √ have the potential to be affected by this practice. All residents that need assistance with toileting have the potential to be affected by this practice. #3) All nursing staff will be educated on Sept 24th at an all staff meeting of the revised policy "Glucose Monitors - Cleaning" ***(exhibit 16)*** approved disinfectants. Glove usage will also be reviewed from information from the World Health Organization ***(exhibit 17 a&b)*** #4) The Date of correction will be October 4, 2012. #5) A 3 month QA study ***(exhibit 18 a&b)*** will be conducted doing weekly, then randomly for 3 months observations on all shifts of glove usage and cleaning of glucometers.	completed by DON and noon via telephone call c both DON 10/2/12@10:50AM CT

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F 441	Continued From page 22 and 1 of 6 sampled residents (Resident #1) observed during toileting. Failure to properly sanitize blood glucose meters (devices used to measure blood sugar levels) after each use may result in the transmission of blood-borne pathogens between residents. Failure to follow infection control practices related to glove usage and hand hygiene has the potential to cause or spread infection to residents, staff and visitors. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined standards of practice for disinfecting glucometers and stated glucose monitoring devices may transmit pathogens if devices contaminated with blood or body fluids are shared without cleaning and disinfecting between uses for different residents. Review of the facility policy titled "Glucose Monitors - Cleaning (Multi-use device)" occurred on 08/30/12. This policy, dated 01/09/12, stated ". . . To prevent the spread of infection from patient to patient or resident to resident the following cleaning guidelines will be followed for patient multi-use devices. Procedure: . . . 2. Gently wipe the meter's surface with a soft cloth slightly dampened with one of these cleaning solutions; super sani-cloth [germicidal wipe used to kill organisms and blood borne pathogens], 70% rubbing alcohol, mild household bleach solution . . ." The facility policy does not meet current infection control guidelines regarding the use of alcohol as an effective sanitizer.	F 441	QA studies will be submitted to the hospital QA committee for further recommendations.	

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F 441	Continued From page 23 Review of education titled "Health-care facility recommendations for standard precautions" (written by the World Health Organization and provided to facility nursing staff on 08/16/12) occurred on 08/30/12. This information stated, ". . . 2. Gloves . . . Wear when touching blood, body fluids, secretions, excretions, mucous membranes, nonintact skin. . . . Change between tasks and procedures on the same patient after contact with potentially infectious material. . . . Remove after use, before touching non-contaminated items and surfaces, and before going to another patient. Perform hand hygiene immediately after removal. . . ." - Observation of medication pass occurred on 08/27/12 ay 4:35 p.m. with a nursing staff member (#6). The nurse used a blood glucose meter to test Resident #8's blood glucose. After completing the task, the nurse used an alcohol prep pad to cleanse the blood glucose meter. During an interview on 08/29/12 at 1:45 p.m., an administrative nursing staff member (#1) stated she expected staff to use of a bleach - clorox wipe to sanitize the blood glucose meter. During an interview with this nursing staff member at 4:00 p.m., she confirmed she found no information regarding the use of an alcohol prep pad being an effective sanitizer for the blood glucose meter. - Observation on 08/28/12 at 9:28 a.m. showed a licensed nurse (#6) assisted Resident #1 in the bathroom. The resident was incontinent of stool, and observation showed stool on her pants, the floor, and the toilet. When the resident finished toileting, the nurse donned gloves and assisted	F 441		

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F 441	Continued From page 24 the resident to stand. The nurse performed perineal cares, wiped stool from the toilet seat and bowl, and then used perineal cleansing wipes to wipe her gloved hands. Wearing the same gloves, the nurse pulled up the resident's clean brief and pants, assisted the resident to sit in the wheelchair, removed the gait belt and hung it on the wall, unlocked the wheelchair brakes, and pushed the resident's wheelchair to the sink. The nurse then removed her gloves and washed her hands. The staff member failed to remove her soiled gloves after completing perineal cares and prior to completing other tasks. During an interview on the morning of 08/30/12, a supervisory nursing staff member (#1) agreed the nurse should have removed her gloves right after performing perineal care.	F 441		
F 454 SS=E	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to comply with NFPA 101, Life Safety Code, to protect the health and safety of residents, personnel, and the public when doors to the entrance of 4 of 12 resident rooms (Rooms 306, 307, 309 and 310) located in the East/West wing failed to open readily from the egress side. This failure puts residents, staff, and/or visitors at risk of not being able to exit a resident room during an emergency situation.	F 454	F tag 454 #1) Room doors 306, 307, 309 and 310 were inspected to determine the cause of the malfunction during the August 30th survey. #2) All doors with this type of handicap door hardware were inspected in our facility during the survey. #3) We found that the smoke barrier on some of the doors was putting too much pressure on the door strike. We removed the smoke barrier on the doors where it was causing problems. This material is	

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F 454	Continued From page 25 Findings include: Life Safety Code requirements state the following: "7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. . . ." "7.2.1.5.4 A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions . . . Doors shall be operable with not more than one releasing operation." "7.2.1.4.5 The forces required to fully open any door manually in a means of egress shall not exceed 15 lbf [foot-pound] (67 N [newton]) to release the latch, 30 lbf (133 N) to set the door in motion, and 15 lbf (67 N) to open the door to the minimum required width. Opening forces for interior side-hinged or pivoted-swinging doors without closers shall not exceed 5 lbf (22 N). These forces shall be applied at the latch stile." Observation of cares occurred in resident room number 307 on 08/29/12 at 8:15 a.m. When the surveyor attempted to exit the room, the door to the room would not open. A staff member present in the room demonstrated how to open the door by pushing on the middle of the door with one hand while, at the same time, pulling on the door handle with the other hand. Observation of all the doors to the entrance of resident rooms and other resident areas occurred on 08/29/12 at 9:25 a.m. After entering each resident room / resident area and closing the door behind, the surveyor attempted to exit the rooms by pulling on the door handle. The doors to the	F 454	no longer required when the gap of the door is less than the thickness of the door stop. done by maintenance Supervisor per Beth DON - phone call 10/2/12 @ 1056 AM CT #4) A monitor will be put in place to check the doors quarterly and the staff will be informed to report any malfunction to the Maintenance dept. staff who will report to Quality Assurance Committee quarterly. #5) The corrective action was completed August 31, 2012.	

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F 454	Continued From page 26 following rooms would not open: * Room 306 (occupied by two residents) * Room 307 (occupied by one resident) * Room 309 (occupied by two residents) * Room 310 (occupied by two residents) On 08/29/12 at 9:50 a.m., interview with an administrative nursing staff member (#2) identified the seven residents occupying these four rooms always wanted their room doors open and/or were unable to close these doors per self. On 08/29/12 at 10:35 a.m., observation of the above-stated resident room doors occurred with an administrative staff member (#4) present; and on 08/29/12 at 10:50 a.m. with a maintenance management staff member (#13) present. During both observations, after entering the resident room and closing the door behind, these staff members could not always exit the rooms by just pulling on the door handle. The surveyor showed the staff members (#4 and #13) how the doors could be opened by pushing on the middle of the door with one hand while, at the same time, pulling on the door handle with the other hand. During these observations, both staff members (#4 and #13) agreed the doors failing to readily open when attempting to exit the rooms was a significant safety issue.	F 454		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	F Tag 514 It is the intent of Garrison Memorial LTC Facility to comply with F-Tag 514, to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete accurately documented, readily accessible and systematically organized.	

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F 514	Continued From page 27 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on information submitted by the complainant, record review, review of professional reference, and staff interview, the facility failed to maintain clinical records in accordance with accepted professional standards and practices for 1 of 9 sampled residents (Resident #5). Failure to ensure the medical record is complete and accurately documented limited the facility's ability to ensure the provision of appropriate resident care and services. Findings include: Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice 9th Edition by Berman and Snyder, copyright 2012 Pearson Education, Inc. stated the following regarding documenting and reporting on page 263, and 266; "Because the client's record is a legal document and may be used to provide evidence in court, many factors are considered in recording. Health care personnel . . . meet legal standards in the process of recording. . . . Notations on records must be accurate and correct. . . ." Review of the facility policy titled "General Rules	F 514	#1) Addendum to nurses note done 9/21/2012, by nurse working at time of incident, ***(exhibit 19)*** a neglect investigation was completed at time of survey and submitted to Health Department, #2) All residents can potentially be affected. #3) The policy "General Rules for charting" was reviewed at all staff meeting on Sept 24th, 2012, along with policies noted in F-tag 224 and 225. #4) Date of correction will be October 4, 2012. – done by Beth DON and ADON per phone call c Beth 10/2/12 10:50AM CT #5) A 6 month QA study will be completed ***(exhibit 5)*** as defined in F-Tag 225. This information will be submitted to the hospital QA committee for further recommendations.	

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F 514	Continued From page 28	F 514		

for Charting" occurred on 08/30/12. This policy, dated January 2004, stated "1. All charting must be in black ink and legible. The date, time and signature . . . is written with each entry. . . 7. . . . 4) Omitted Information - Chart information when you remember it and if it's the same shift write 'Late Entry for time' and information to be charted. If it's the following day or later write 'present date, addendum entry for date you are charting for', followed by information to be charted. . . ."

Review of written information submitted by the complainant identified certified nurse assistants (CNAs) placed residents on the toilet and left them alone, instructing the residents to pull the call light when done. The complainant stated these residents usually do not remember instructions.

The complainant stated on 08/10/12, Resident #5 remained in the bathroom on the toilet for at least three hours and Resident #5's roommate found the resident in the bathroom upon returning from an outing.

Review of Residents #5's medical record occurred August 27-30, 2012. Nursing Notes identified entries on 08/07/12 and 08/12/12. The Nursing Notes included no entries for the dates August 08 -11, 2012 and the medical record failed to include documentation of the incident on 08/10/12.

During an interview on 08/28/12 at 1:10 p.m., the nursing staff member (#6), working a twelve hour day shift on 08/10/12, confirmed she failed to include documentation in Resident #5's nursing

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F 514	Continued From page 29 notes regarding the incident on 08/10/12. Refer to F224.	F 514		