STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING _____ B. WING _____	R 10/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	407 3RD AVE SE GARRISON, ND 58540

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{F 000}	INITIAL COMMENTS An onsite revisit was conducted 10/11/12 to determine compliance with the deficiencies identified during the 08/20/12 survey. The revisit sample included nine residents for focused review of the areas of non-compliance.	{F 000}	F- TAG 323 The intent of Garrison Memorial LTC Facility is to ensure a safe environment for residents and to provide adequate supervision and assistance to prevent accidents.	
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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, medical record review, review of facility policy, and staff interview, the facility failed to provide assistive devices necessary to prevent accidents for 3 of 4 sampled residents (Resident #1, #3, and #5) observed during a gait belt transfer and failed to consistently implement fall prevention measures for 1 of 5 sampled residents (Resident #3) identified with a chair alarm. Failure to implement the chair alarm and use gait belts appropriately placed the residents at risk for falls and injuries. Findings include: Review of the facility policy titled "Use of Gait Belt" occurred on 10/11/12. This policy, revised June 2008, stated, ". . . 3. Always use a GAIT BELT. This will allow the caregiver to properly	{F 323}	1)Resident #~~6~~ 11 KG will have a gait belt in the bag of her wheelchair for staff to use, as she often goes into the bathroom per self and does not have a gait belt on. Care Plans for #~~6~~ 1, KG #~~3~~ 3 KG and #5 were updated to address use of gait belts with transfers. The facility policy on gait belt usage addresses the need to use gait belts on residents/patients needing assistance. Part of the care planning process is to care plan all transfers and ambulation needs. (Exhibit 1,2,3) 2) All residents that need assistance with transfers, or have a history of falls will have the potential to be affected. 3) A meeting was held on Oct. 15th for the LTC staff and a	Phone Call with DON 10/29/12. KG

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Eileen Mattern — TITLE: Administrator — (X6) DATE: 10/25/12

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.

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

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FORM APPROVE
OMB NO. 0938-039

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{F 323}	Continued From page 1 support the patient if required. GAIT BELTS must be used with all patients needing assistance. . . ." - Review of Resident #1's medical record occurred on 10/11/12. Diagnoses included Alzheimer's dementia, osteoporosis, degenerative joint disease, and a history of falls. Resident #1's current care plan stated, ". . . I don't want to fall, as I have fallen before. . . . Approaches . . . Use moderate assist of 1 [with] pivot transfer to B.R. [bathroom] using grap [sic] bars. . . ." The care plan failed to address the use of a gait belt as per facility policy. Observation on 10/11/12 at 9:45 a.m. showed a certified nurse aide (CNA) (#1) transferred Resident #1 from the toilet to her wheelchair without using a gait belt. The CNA instead grasped the back of Resident #1's pants to lift and guide the resident to her wheelchair. - Review of Resident #3's medical record occurred on 10/11/12. Diagnoses included orthostatic hypotension, Parkinson's disease, osteoarthritis, osteoporosis, and dementia. Resident #3's current care plan stated, ". . . I am concerned that I might take a fall as I am 102 years old [and] sometimes I get up by myself when I know I shouldn't and I also take many medications. . . . Approaches . . . Assist me with my bed mobility and transfers . . . Use pivot technique for Bed to Chair transfers . . . I have problems [with] my memory [and] [with] reasoning . . . Bed [and] chair alarms used . . ." The care plan failed to address the use of a gait belt as per facility policy. Observation on 10/11/12 at 9:55 a.m. showed	{F 323}	demonstration of proper positioning and tightness of gait belts was done by K. Olson PT. (Exhibit 4) CNA's working on day of survey revisit, have been educated by D.O.N. On 10-19 and 10-22 on proper usage of the gait belt, gait belt policy revised (exhibit 5) and given to staff at meeting, 4)Date of correction is Oct. 26th 5)A continuation of the existing QA study for this F-tag 323 from the initial survey will be done, we increased education of gait belt usage and training for all staff to 2 times per year, we added weekly monitoring of appropriate gait belt usage, and monitoring of appropriate fall alarm usage. (Exhibit 6) The QA plan is being conducted weekly for 3 months, with a minimum of 5 observations (with real time re-education being done) then on a random basis for an additional 3 months Individual training of CNA staff on gait belt usage was done by the DON. (Exhibit 7)	

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{F 323}	Continued From page 2 Resident #3 in the lounge area, asleep in a recliner without a chair alarm in place. A CNA (#2) assisted the resident to sit up in the recliner and applied a gait belt around the resident's waist. The CNA positioned the wheelchair on the resident's left side, assisted her to stand, and pivoted her to the right. Observation showed Resident #3's feet became crossed at the ankles, and she did not fully bear weight. During the transfer, the gait belt slipped upward under the resident's axilla. Upon transferring Resident #3 to her wheelchair, the CNA then assisted the resident to the bathroom, once again using a pivot transfer from the wheelchair to the toilet and from the toilet to the wheelchair. The gait belt remained loose, rested across Resident #3's chest, and slid upward into her axilla during the transfers. The CNA failed to readjust and tighten the gait belt at any time. Observations throughout the morning of 10/11/12 showed Resident #3 seated in her wheelchair or in a recliner without a chair alarm in place. The chair alarm was attached to the resident's bed in her room. - Review of Resident #5's medical record occurred on 10/11/12. Diagnoses included osteoarthritis and osteoporosis. Resident #5's current care plan stated, ". . . may transfer standing turning technique with grab bars or walker as tolerated with moderate assist of one . . ." The care plan failed to address the use of a gait belt as per facility policy. On 10/11/12 at 10:30 a.m., a CNA (#1) assisted Resident #5 to transfer from her wheelchair to the toilet, and from the toilet to her wheelchair. During	{F 323}	Due to our orientation and training programs not having successful outcomes, we are committed to making changes to our processes in our LTC Unit. 1. The Clinical Coordinator position has been eliminated, and a RN has been hired to be the Unit Manager who will evaluate our programs and make necessary changes to facilitate positive outcomes. The CNA coordinator position has been eliminated. Her duties will be assigned under the LTC Manager for the purpose of accountability. 2. 10-29-2012 all staff meetings will be held to announce the changes that are taking place.	10/26/1

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{F 323}	Continued From page 3 both transfers, observation showed the gait belt was loose and slid up across the resident's shoulder blades. The CNA failed to readjust and tighten the loose gait belt. During an interview on 10/11/12 at 4:20 p.m., a nursing staff member (#3) stated she expected staff to readjust and tighten gait belts if they become loose during resident transfers, and staff should ensure Resident #3's chair alarm is in place when she is in her wheelchair or the recliner.	{F 323}		