STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING _____ B. WING _____	C 12/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH AVE S GRAND FORKS, ND 58201

(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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey and complaint survey started on 12/19/11 and completed on 12/22/11, the sample included five residents for complete review, 22 residents for focused review, and three closed records for review. The sample included three additional residents to verify specific concerns during the survey.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, resident interview, and staff interview, the facility failed to ensure prompt efforts to resolve grievances for 1 of 1 sampled resident (Resident #4) and 2 supplemental residents (Resident #32 and #33) who voiced concerns regarding cold temperatures and drafts from resident room windows. Failure of facility staff to report the residents' concerns to appropriate staff delayed action to resolve the residents' grievances. Findings include: Review of the facility's Grievance Procedure occurred on 12/22/11. This procedure, revised 09/12/11, stated "Each resident . . . have a right to present complaints . . . to the facility's staff . . .	F 166	**F 166** **It is the policy of VMH that every resident has the right to prompt efforts by the facility to resolve grievances the resident may have including those with respect to the behavior of other residents.** **The windows in Resident #4, #32 and #33 have all been re-caulked and assessed for drafts. All the residents expressed satisfaction. Today, 01/26/12, maintenance supervisor visited with all three gentlemen and checked their rooms and they all were fine today, in fact Resident #33 stated his room was too warm today. In the Spring, the facility will do an Infiltration Draft Test of 20 windows.** **All staff will be educated regarding the importance of listening and addressing resident's concerns and contacting the appropriate staff members to resolve the issue. We have a facility concern form along with a new policy of how and when to complete this form and also the procedure for follow-up to resolve the grievance.**	02-03-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Greg Hanson — TITLE: PRESIDENT/CEO — (X6) DATE: 02/01/12

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 166	Continued From page 1 2. . . . The grievance may also be submitted . . . verbally . . . 3. The Administrator or designate will . . . respond . . . within seven (7) working days. . . ." During the initial tour of the facility, conducted on the afternoon of 12/19/11, Resident #32 informed the surveyor his room is "always cold." The resident stated he informed the facility staff about his concern with his room temperature. Observation showed Resident #32 seated in his recliner with a blanket covering his legs and chest. Also, during the initial tour of the facility, Resident #33 informed the surveyor of a concern regarding a cool draft of air coming from the window in his room. Observation showed the curtains to Resident #33's window drawn shut and a folded flannel blanket placed against the window pane. The surveyor felt a cool draft coming from the window. - Observation on 12/20/11 at 12:47 p.m. showed two CNAs (#15 and #39) completing Resident #4's catheter cares while he laid in bed. The CNA (#39) asked the resident, "Isn't your bed usually away from the window?" Resident #4 replied, "Yes, there is a draft that is just enough to make my legs really get going [leg spasms]." The resident further stated he had previously informed other staff members about his concern with the draft from his window. The two CNAs (#15 and #39) adjusted the resident's bed by pulling the foot of the bed approximately one and a half feet from the window, and then covered his legs with a sheet.	F 166	Continued from page 1 Mike Lien, environmental supervisor will audit any grievances and resolutions for environmental grievances. Kathy Dubuque, ADON will audit nursing department grievances. This will occur monthly times 6 (six) months, then annually if no problems.	02-03-12

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F 166	Continued From page 2 During interview on 12/22/11 at 7:55 a.m., Resident #33 stated he experienced concerns with the cool draft from the window from late November 2011 to the present. Resident #33 stated a facility maintenance staff member applied caulking to the window previously, but the draft persists. Resident #33 stated facility nursing staff members moved his bed approximately two-three feet away from the window on at least three separate occasions due to the cool draft coming from the window. In the afternoon on 12/21/11, maintenance management staff member (#5) reported the facility staff caulked the windows in Resident #4's and #32's rooms and the residents no longer felt the cold drafts. This staff member reported Resident #33's complaint required further investigation. Failure to notify the facility's maintenance staff of the residents' complaints of cold drafts delayed resolution of the problem and may have resulted in Resident #4 experiencing leg spasms.	F 166		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care in a manner that maintained or enhanced dignity for 5	F 241	**F 241** **It is the policy of VMH that we would promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.** **Resident #9 is no longer in the facility.** **Resident #17 is no longer in the facility.** **Continued on Page 4**	

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F 241	Continued From page 3 of 27 sampled residents (Resident #9, #13, #17, #19, and #23) and during 1 random observation on 12/22/11. Failure to knock on residents' doors prior to entering the room, pull privacy curtains when providing cares, and speak to residents respectfully may negatively impact a resident's self-esteem and sense of self-worth. Findings include: - Observation on 12/20/11 at 3:17 p.m. showed two certified nursing assistants (CNAs) (#1 and #2) transferred Resident #9 onto the bed and placed a bed pan underneath her. An unidentified staff member knocked on the door, and the two CNAs (#1 and #2) stated, "Hold on a minute." The unidentified staff member immediately entered the room and stated, "It's just me." Observation showed Resident #9 fully exposed from the waist down. At 3:42 p.m., two CNAs (#1 and #2) provided perineal cares for Resident #9. Another unidentified staff member entered the room without knocking and stated, "It's just me." The unidentified staff member then stated, "I knocked, but nobody responded." A CNA (#1) stated, "Well, we didn't hear you." Observation showed Resident #9 fully exposed from the waist down. - A random observation on 12/22/11 at 7:45 a.m. showed a staff member entered a resident's room (which was dark) without knocking. The staff member turned on the lights and stated, "Good morning, are you ready to get up?" Observation showed the resident in bed. During an interview on the morning of 12/22/11, a supervisory nursing staff member (#3) agreed	F 241	Continued from Page 3 Residents #13, #17 and #23 have had audits completed to assess dignity and privacy areas noted. All residents have the potential to be affected by this deficient practice, staff will be educated regarding the importance of knocking on residents doors and waiting for an answer before entering the room, providing privacy by pulling the curtains when providing cares and be sure to only call residents by the desired name. Licensed staff involved with Resident #23 was counseled one/one. Staff will also be trained on the use of a facility concern form to address grievances or concerns of any nature brought forward in discussion. We will complete on-going random audits weekly times one (1) month, monthly six (6) times and then as needed based on results. These will be distributed to nursing staff by Corinne Johnson, Staff Development/Infection Control nurse. In-service will be held for Licensed Nursing and C.N.A. staff on February 2, 2012.	02-03-12

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F 241	Continued From page 4 staff failed to maintain the residents' privacy/dignity. - Observations on 12/20/11 at 10:45 a.m. and 10:50 a.m., showed a CNA (#7) entered Resident #17's room on two separate occasions and failed to knock on the resident's door each time prior to entering the resident's room. - Observation on 12/21/11 at 8:20 a.m. showed two CNAs (#15 and #16) provided personal cares and dressed Resident #13. The CNAs failed to close the curtains in the resident's room to allow for privacy during cares. During this observation, a CNA (#16) entered Resident #13's room without knocking or announcing herself first. - During an interview with Resident #19 on 12/21/11 at 4:35 p.m., an unidentified nurse entered the resident's room and stated, "Oh, you turned it off," referring to the nebulizer machine. The nurse failed to knock or announce herself before entering Resident #19's room. - Review of Resident #23's medical record occurred on December 21-22, 2011. An annual Minimum Data Set (MDS), dated 12/13/11, identified Resident #23 had a Brief Interview of Mental Status (BIMS) score of 15; identifying the resident as cognitively intact, and requiring supervision while eating. During interviews on 12/19/11 at 2:45 p.m. and 12/21/11 at 4:30 p.m., Resident #23 revealed a nurse described her as being "a little piggy" as she fed herself. She further stated, "I was embarrassed and couldn't believe someone would say that. It hurt my feelings." During interview on 12/22/11 at 9:15 a.m., a	F 241		

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F 241	Continued From page 5 supervisory nursing staff member (#40) revealed the resident and her family did discuss the incident during her care conference, "but didn't want to get anyone in trouble."	F 241		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #6) demonstrating symptoms of dysphagia received supervision during meals and a bedside swallow/videofloroscopy examination as ordered, and failed to ensure 1 of 4 sampled residents (Resident #10) received nectar thickened liquids as ordered. Failure to adequately assess and provide services based on the assessment has the potential to affect the resident's overall swallow safety, putting him/her at greater risk of aspiration and limiting his/her nutritional intake. Findings include: Resident #6's medical record, reviewed December 19-22, 2011, identified diagnoses including cerebral vascular accident, dementia, diabetes, and reflux. The resident's annual	F 309	F 309 It is the policy of VMH that 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, in accordance with the comprehensive assessment and plan of care. Resident #6 was seen for a clinical swallow evaluation secondary to coughing and gagging on pills and coughing with thin liquids. Resident was agitated during this assessment and process. Consistency of liquids was changed to nectar thick with speech therapy to follow. As of 1/4/2012 the resident is receiving regular liquids per speech and textures and supplements per LRD and doing well. Resident #10 order is for nectar thick liquids, no sips of water, even though resident asks staff for thin. Staff member involved with Resident #10 was made aware of the importance to follow plan of care. All staff will be educated regarding the importance of following the plan of care. Resident has been observed receiving nectar thick liquids which is in the plan of care. Continued on Page 6	

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F 309	Continued From page 6 Minimum Data Set (MDS), dated 11/15/11, identified severely impaired cognition and independent for eating. Resident #6's current plan of care identified, ". . . Problem: I need help with some of my daily cares . . . Approaches: . . . I eat in the big dining room. Bring my food to the table and get it ready for me to eat - then I can eat on my own." The physician's progress note, dated 11/28/11, stated, ". . . I received a call today from [Resident #6's] daughter with a few concerns. . . . She is having more difficulty swallowing pills and she is on diltiazem which cannot be crushed. . . ." The physician's order, dated 11/28/11, stated, "Bedside swallow eval [evaluation] [and] video [videoflouroscopy] if needed." Observations revealed the following: * On 12/20/11 at 11:55 a.m., Resident #6 sat at the dining room table with peers. Staff provided tray set-up. Resident #6 fed herself very slowly, with minimal intake. * On 12/21/11 at 11:55 a.m., Resident #6 sat at the dining room table with peers. Staff provided tray set-up. Resident #6 fed herself very slowly, with minimal intake. Resident cleared her throat once and coughed five times when drinking thin liquids from a cup. * On 12/21/11 at 5:00 p.m., Resident #6 sat alone at a table in the dining room. She drank coffee very slowly, with minimal intake. Resident #6 cleared her throat eight times, began crying and stated, "I feel like I have something in my throat." She presented with a wet, gurgly vocal quality as she answered questions during transport to her	F 309	Continued from Page 6 All residents have the potential to be affected by this deficient practice. All staff will be inserviced/educated on the importance of following the plan of care to ensure the safety of the residents. This will occur on February 2, 2012. Audits will be completed monthly times six (6) months and then quarterly. ADON will complete these audits for compliance with following the plan of care. All staff will be in-serviced and educated on the importance of following the plan of care on February 2, 2012.	02-03-12

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F 309	Continued From page 7 room. During interview on 12/21/11 at 3:45 p.m., when asked if a swallow study had been performed, a supervisory nursing staff member (#40) stated, "We're not sure how this was overlooked. The bedside swallow evaluation will be done tomorrow." When asked if staff had implemented any interventions [thickening liquids or modifiying diet] until the swallow study could be completed, she stated, "We did not make any changes to her diet." The facility failed to 1) identify the resident's signs/symptoms of dysphagia/aspiration (throat clearing and coughing on thin liquids during a meal, resident complaint of something sticking in her throat, and a wet, gurgly vocal quality following a meal) and 2) assess the resident's swallow as ordered by her physician. - Record review for Resident #10 occurred on December 20-21, 2011. Medical diagnoses included a history of stroke, hemiplegia, and dysphagia. A quarterly MDS, dated 10/18/11, identified Resident #10 with moderate cognitive impairment and total assistance with eating. Nutritional assessments, dated 04/18/11 and 09/27/11, identified Resident #10 required nectar thickened liquids. A physician's order, dated 09/20/11, identified nectar thickened liquids. The current comprehensive care plan stated, " . . . I have trouble with dysphagia, . . . I receive blenderized [diet] with nectar thick liquids. . . ." Observation on 12/20/11 at 3:20 p.m. identified Resident #10 sitting in his wheelchair in the dining room. A staff member (#38) offered the resident a	F 309		

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F 309	Continued From page 8 glass of water. Observation showed the staff member gave the resident water from a water dispenser in the dining room. The staff member failed to thicken the water to nectar consistency prior to giving Resident #10 sips of water. When asked, the staff member (#38) stated Resident #10 can have sips of regular water. Additional review of Resident #10's medical record did not identify staff could give the resident fluids without thickener. During an interview on 12/21/11 at 11:30 a.m., a dietician (#37) and an administrative nurse (#3) confirmed the facility placed Resident #10 on nectar thickened liquids in 2008 due to swallowing problems/coughing observed at meals. The dietician (#37) stated Resident #10 has done well on nectar thickened liquids and should not have thin liquids.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed	F 314	F 314 It is the policy of VMH that we must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individuals clinical condition demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Resident #7 is no in the facility. Resident #10 continues to receive care and Continued on Page 10	

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F 314	Continued From page 9 to ensure 2 of 5 sampled residents (Resident #7 and #10) who are dependent on staff to provide pressure relieving interventions received the treatment and services necessary to prevent or promote healing of pressure ulcers. Failure to provide pressure relieving interventions may have contributed to the reoccurrence of a coccyx ulcer and the development of new spinal ulcers for Resident #7, and may result in the development of a new coccyx ulcer for Resident #10. Findings include: Review of the facility policy titled "Skin Prevention Protocol," occurred on December 22, 2011. The policy, revised 09/07, stated, "Purpose: To prevent the breakdown of skin integrity by identifying those residents at risk and incorporating interventions to alleviate/minimize pressure . . . Interventions . . . 3. OT [occupational therapy] or PT [physical therapy] evaluations for . . . pressure relieving devices (mattress, cushions and/or positioning. 4. Limited time up in wheelchair . . . 11. Assist to reposition every 2-3 hours and PRN [as needed]. . . " - Review of Resident #7's medical record occurred on December 20-22, 2011. Diagnoses included a Stage II pressure ulcer to the coccyx, dementia, and a history of cerebrovascular accident. Resident #7's current Minimum Data Set (MDS), dated 11/21/11, identified short term and long term memory problems, severely impaired daily decision making skills, total assistance for bed mobility and dressing, always incontinent of urine and stool, and a Stage II pressure ulcer. The MDS also identified the use of a pressure reducing device for the chair and a	F 314	Continued from Page 9 services that maximize comfort and well being. Resident care plan has been changed to indicate that resident is now being laid down after meals, changed for incontinent cares to aid in promoting healing of any pressure areas and preventing any new areas. The resident prefers to stay up in chair where other people are present, but the staff have visited with resident about the benefits of position changes. Resident prefers to lay on back due to pain when on the right side and recurring pressure areas on the left side. Resident is being lifted by C.N.A's and position changed when in the chair. This is care planned as well. All residents can be affected by this deficient practice, so the staff will be educated regarding the importance of repositioning resident and also providing incontinence cares to promote healing and prevention of pressure areas. See below... ADON will be completing audits to ensure that the plan of care is being followed and that residents are being repositioned. ADON will do this monthly times six (6) months and then quarterly to maintain compliance. All staff will be inserviced/educated on February 2, 2012. 02-03-12 Addendum: Any adaptive equipment such as heel boots will be applied as ordered. Per telephone conversation with Carol DON 2/7/12 @ 11:29 am K. Beechie	

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turning/repositioning program. Resident #7's Care Area Assessments (CAAs), dated 08/26/11, stated, ". . . Res [resident] has pressure reducing mattress and W/C [wheelchair] cushion. . . ."

The current care plan stated, ". . . I am at risk for my skin breaking down. I need assistance with bed mobility. I am incontinent of bowel and bladder. . . . Interventions . . . Give me medications/TX [treatments] per RX [as prescribed] . . . Encourage/assist me to reposition as needed [every] [two hours] . . . Assess my need for pressure reducing devices such as cushions . . ." A handwritten entry stated, "12/16/11 Areas noted to spine."

A nurse's note dated 12/16/11 stated, ". . . CNA [certified nursing assistant] noted open areas on spine. Resident has 4 small areas . . . each on bony prominence . . . Each area yellow [with] scab, [no] drainage. Probably resulting from shearing. . . ."

A "Wound and Skin Progress Report" identified a Stage II pressure ulcer to Resident #7's coccyx on 10/03/11, which resolved on 11/02/11. The report identified a new Stage II pressure ulcer to Resident #7's coccyx on 11/16/11. According to the report, the pressure ulcer was diminishing in size and currently measured 0.1 centimeter (cm) by 0.1 cm.

An Occupational Therapy (OT) Evaluation, dated December 2010, identified Resident #7 used a wheelchair with a pressure relieving seat cushion in place. In March 2011, an OT evaluation identified staff would now position Resident #7 in a Tilt and Recline wheelchair. The evaluation did

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not identify whether staff should continue to use a pressure relieving seat cushion.

Observations throughout the survey identified Resident #7 used a Tilt and Recline wheelchair which lacked any type of pressure relieving seat cushion.

On 12/22/11 at 10:25 a.m., a supervisory nursing staff member (#3) stated the Tilt and Recline wheelchair cushion "is already pressure relieving;" therefore, Resident #7 did not need an additional cushion. Facility staff failed to provide additional information related to the pressure-relieving capabilities of the Tilt and Recline wheelchair. The Tilt and Recline wheelchair owner's manual failed to identify any pressure-relieving capabilities of the seat cushion.

On 12/22/11 at 10:45 a.m., a supervisory nursing staff member (#3) stated OT would implement a thin gel cushion to Resident #7's wheelchair seat due to her "fragile bottom."

Resident #7's current physician's orders, stated, ". . . Heel lift boots on full time except BID [twice a day] for cares . . ."

Observation during the initial tour on the afternoon of 12/19/11 showed Resident #7 asleep in bed with a heel protecting boot to her right foot, and no boot to her left foot.

Observations on 12/20/11 from 9:30 a.m. until 1:11 p.m. showed Resident #7 seated in her wheelchair. During an interview at 1:11 p.m., a CNA (#4) stated, "She's [Resident #7] one of the

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first ones I get up, around 6:15 [a.m.]." The CNA stated she took Resident #7 to breakfast, the activities staff took her to Mass after breakfast, the resident then ate lunch, and she would assist Resident #7 to lie down in a few minutes. During an interview at 3:15 p.m., a CNA (#2) stated Resident #7 had been incontinent of urine after lunch when staff checked her brief. Observations and interviews identified staff failed to check Resident #7 for incontinence or reposition/off-load pressure areas from 6:15 a.m. until after 1:00 p.m. (approximately seven hours), resulting in direct pressure to her coccyx and spinal areas.

Observation on 12/20/11 at 3:05 p.m. showed two CNAs (#1 and #2) checked Resident #7's brief (which was dry) and transferred her from the bed to the wheelchair. Observations until 6:00 p.m. showed staff failed to reposition/off-load Resident #7. A CNA (#1) stated the resident would eat supper at 6:00 p.m. and go to bed shortly after that.

Observations throughout the day on 12/20/11 showed Resident #7 up in her wheelchair or lying in bed without heel boots to either foot.

Observation on 12/21/11 at 7:50 a.m. showed Resident #7 seated in her wheelchair without heel boots. At 9:37 a.m., two CNAs (#8 and #9) transferred Resident #7 from her wheelchair into bed and failed to check her incontinence brief or place heel boots. A CNA (#8) stated, "The nurse thought we should lay her down," and that she had gotten the resident up "about 7:00 [a.m.] [two and a half hours earlier]." At 10:13 a.m., a certified medication assistant (CMA) (#11) entered the room to apply cream to Resident #7's

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F 314	Continued From page 13 coccyx. Observation showed the resident was incontinent of urine and stool, and a small open area surrounded by a reddened area on Resident #7's coccyx. The CMA prompted the CNA (#8) to place a heel boot, which the CNA applied to the resident's left foot. Observation on 12/21/11 at 11:44 a.m. showed Resident #7 seated in her wheelchair without heel boots. At 3:50 p.m., Resident #7 sat in her wheelchair with a heel boot on her left foot. Observation on 12/22/11 at 8:00 a.m. showed Resident #7 in her wheelchair without heel boots. During an interview on the morning of 12/22/11, a supervisory nursing staff member (#3) stated she expected staff to apply the heel boots as ordered and reposition/off-load every two hours. - Record review for Resident #10 occurred on December 20-21, 2011. Medical diagnoses cerebral vascular accident with hemiplegia and a history of skin breakdown (a pressure ulcer on the left thumb). The quarterly MDS, dated 10/18/11, identified moderate cognitive impairment, bowel and bladder incontinence, and total assistance with bed mobility and transfers. Resident #10's CAAs, dated 04/18/11, identified Resident #10 at risk of pressure ulcers due to immobility. The medical record identified the use of a tilt-in-space chair when out of bed. The current comprehensive care plan stated, "Problem: I am at high risk for my skin breaking down. I need assist of two staff to reposition me when I am in bed. . . . I have had a stroke, my skin is densensitized to pain or pressure. Goals:	F 314		

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F 314	Continued From page 14 My skin will remain intact, no redness . . . Interventions: . . . Staff to follow protocol for prevention of pressure ulcers/skin breakdown . . . Encourage me to lie down after meals and as needed. . . . Staff to provide for position of comfort. I need to be repositioned every two hours and as needed. . . . I need total assist with my ADLS [activities of daily living]. . . . I am incontinent of bowel and bladder. Staff need to check and change me 2-3 times a shift and as needed. I need to lie down after meals . . ." Observation on 12/20/11 at 10:00 a.m. showed Resident #10 asleep in bed on his back. At 11:35 a.m. identified two CNAs (#26 and #27) checked and changed Resident #10's brief, soiled with a large amount of stool. Observation showed Resident #10's coccyx reddened. The CNAs transfered Resident #10 to his wheelchair and brought him into the dining room. Observation on 12/20/11 at 11:45 a.m. showed Resident #10 sitting in his wheelchair in the dining room. The resident ate his lunch at 12:00 p.m. and remained in his wheelchair in the dining room until 6:00 p.m. Observation showed Resident #10 reclined in his wheelchair in the same position during this time. Facility staff did not lie Resident #10 down after lunch, did not offer repositioning, and did not check the resident for incontinence. Observation on 12/21/11 at 9:00 a.m. showed two CNAs (#9 and #27) assisted Resident #10 to lie down after breakfast. The CNAs transferred Resident #10 to bed using a Hoyer lift and positioned the resident on his backside after checking his brief. At 9:45 a.m. the CNAs checked and changed Resident #10's brief, soiled	F 314		

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F 314	Continued From page 15 with a large amount of stool. Observation showed Resident #10's coccyx reddened. The resident voiced pain during this observation, but the CNAs did not offer to repositioning, and the resident remained on his back. During an interview immediately after the observation, the CNA (#27) stated there is no set repositioning schedule for Resident #10. All other observations of Resident #10 throughout the survey showed him positioned on his back when in bed. During an interview on 12/22/11 at 10:30 a.m., an administrative staff member (#3) agreed facility staff need to follow the care plan and need to reposition Resident #10 to prevent skin breakdown.	F 314		
F 323 SS=G	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: 1. Based on record review, facility policy and procedure review, and staff interview, the facility failed to ensure 1 of 1 sample resident (Resident #1) who experienced an injury and decline following a fall, 1 of 1 sampled resident (Resident #3) who fell from a Hoyer lift (a type of	F 323	F 323 **It is the policy of VMH that we must ensure that the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents.** **Resident #1 is no longer in the facility.** **Resident #3 continues to reside here. She is improving since the fall and fracture. As of 01-24-2012 the referral from her Ortho physician states: allow WBAT with FWW and one assist. This is a great improvement for her.** **Resident #2 continues to reside here. She has been changed to a full mechanical lift now due to being unable to safely bear weight and assist with any part of the standing lift process.** **Continued on Page 17**	

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F 323	Continued From page 16 mechanical lift that supports the entire weight of the resident), and 2 of 3 sampled residents (Resident #2 and #16) observed during transfers utilizing a stand lift (a type of mechanical lift designed to support only the upper body of the resident and requires the resident have some weight-bearing capability) received adequate supervision and assistance to prevent accidents and injury. Findings include: Review of the facility procedure titled "TRANSFERRING THE RESIDENT TO AND FROM BED TO CHAIR" occurred on 12/22/11. This procedure, revised April 2010, stated, "A. Transfer from Bed to Chair or to Ambulate: 1. Equipment: a. Gait belt is always used in transfers with 1-2 staff members. . . ." Review of the facility procedure titled "Fall Risk Assessment" occurred on 12/22/11. This procedure, revised May 2007, stated, "PURPOSE: To identify and set up a prevention plan for those residents at high risk for falls . . . PROCEDURE: A. Upon admission (within 24 hours), follow up after a fall with Fall Assessment . . . and quarterly thereafter, the resident will be assessed for risk of fall. At the discretion of the Charge Nurse or Care Coordinator, the assessment may be done more frequently if the resident has a change in condition . . . C. If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention care plan should be initiated and documented on the care plan. D. Possible interventions for high risk residents	F 323	Continued from Page 16 Resident #16 continues to reside here. His ability varies and the staff continue to use the standing lift and assist of 2 for transfer with him. The care coordinator will assess his abilities to stand and will determine if the standing lift is safe transfer for him. The sizing chart for the slings we use is posted on every unit in the clean utility room. The size and color of sling is based on the weight of the resident. See below for adderdum... Resident #5 continues to reside in the facility. His care plan indicates that he is non-compliant in many areas of his care. He has refused to have lid placed on his coffee mug. The burn has been resolved and he has not had any further issues with his coffee. The DON spoke with the dietary manager about checking the temperature of the coffee. She stated they check the coffee temperatures in the main/multipurpose dining rooms on a daily basis. I have requested that they check the temperatures in the parlors as well. She stated to me that she checked with other establishments regarding the proper temperatures and they stated the coffee temperature was at 200 degrees. The temperature here is at 170 degrees and this is a good temperature for the liking of the residents. Resident #4 continues to reside in the facility. Continued on Page 18	

Per telephone conversation with Carol DON on 2/7/12 @ 11:30 a.m.
K. Beechie

Adderdum: The size of the sling is also on the lift. If the resident's weight is questionable, CNAs are to contact the clinical coordinator and the therapy department for determination of the sling size. The size of the sling will be added to the resident's care plan.

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F 323	Continued From page 17 might include: 1. Low beds with blue mat 2. Defined perimeter mattress 3. Bed and/or chair checks 4. Schedules for toileting and/or exercise 5. Environmental modifications (e.g., room arrangement) 6. Other anticipation of needs as defined in Care Plan. . . ." Review of the facility procedure titled "Fall Management" occurred on 12/22/11. This procedure, revised May 2007, stated, "POLICY All residents admitted to Skilled Nursing of Valley Memorial Homes will be assessed upon admission for being at risk for falls and reassessed according to change in medical condition and/or quarterly. PURPOSE: 1. To provide a safe environment for resident and enhance resident care by reducing number of falls. 2. Implement appropriate fall prevention strategies. PROCEDURE: 1. Fall Risk Assessment from will be completed upon admission with quarterly assessments, and with changes in condition (if indicated). 2. If resident indicates to be at risk for falls and/or if a resident falls, the following fall prevention strategies will be considered: A. Orient or re-orient resident to call light, bathroom location, and bedrail use. B. Remind resident about careful ambulation, body mechanics, and other precautionary practices. C. Inform resident to call (using call light) for	F 323	Continued from Page 17 We have developed a smoking assessment and one has been completed on Resident #4. We also have a new agreement form that describes the methods by which residents are deemed safe to smoke, weather conditions and how they will acquire assistance when needed. Resident #4 will have the nurses station number programmed into his cell phone and he will use that to contact staff for assistance as needed. All residents have the potential to be affected by these deficient practices. All staff will receive education and in-service training on February 2, 2012. Topics to be covered will be proper transfer techniques, correct sling sizing, appropriate reporting between shifts to be sure important information is passed on, safety with hot liquids and safety with smoking. We have started doing Resident Transfer audits. These audits involve a nurse watching a resident with a transfer in the morning (out of bed), a transfer in the evening and the resident's bed mobility during the night. Each resident will have an audit completed one time per month, using the same schedule each unit uses for resident care plan reviews. The objective of these transfer audits is to determine if the resident's care planned mode of transfer and bed mobility is safe for the resident and the staff. If it is not, the transfer/bed mobility will be changed so that it is safer. Continued on Page 19	Added per Carol DON 2/7/12 gait belts, mechanical lifts, See Addendum below

Addendum: This information is passed onto the CNAs on their reporting sheets.
Per telephone conversation with Carol DON on 2/7/12 @ 11:30am
KellyBeechie

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F 323	Continued From page 18 assistance. D. Place bed in low position when unattended. E. Secure locks on beds and wheelchairs when appropriate for safety. F. Use side rails and/or restraint alternatives . . . G. Place call light, personal items, cane and/or walker within easy reach. H. Place needed items on functional side of resident. I. Review selection and use of proper non-slip footwear. J. Place on regular observation/schedule and toilet resident as he/she requests. K. Assure floor areas are dry and unobstructed. L. Clear room of unnecessary equipment. M. Cognitive status of resident is a consideration for all strategies. 3. Immediate post-fall actions: A. Assess and document status of Resident. B. Treat sustained injuries. C. Inspect environment to determine potential cause of falls. D. Interview resident and witnesses. E. Assess need for restraint alternatives and document findings . . . 4. Additional Treatment A. Attending physician or GNP [Geriatric Nurse Practitioner] notified and resident examined if injury noted. B. Family notified of resident's injury, unless permission is not granted by resident. C. Review Care Plan. D. Referral to PT [physical therapy] and/or OT [occupational therapy] as indicated. E. Follow-up Assessment of Resident by Licensed Nurse utilizing Physical Assessment Monitoring Form. 5. Documentation	F 323	Per Carol DON on 2/1/12 @ 11:30am Continued from Page 18 When an injury is sustained during ~~a transfer using mechanical lifts,~~ type of transfer the staff development nurse will receive a copy of the incident report and she will initiate an investigation follow-up with the staff involved. She will cover safe transfer techniques. She will also evaluate the room and the amount of things in the room to ensure that the transfer can occur safely for the resident. If there are concerns about safety regarding clutter, staff will need to determine what can be done to alleviate the situation and assist with making transfer situations safer. Monthly audits will be done by the ADON, and the Staff Development Nurse with observation of staff using the lifts and following proper techniques. These audits will be completed monthly times six (6) months, then quarterly. Follow-up and on-going education/in-service is offered to the staff quarterly. The next in-service due will be in March, provided by Kassidy Robles, Physical Therapist Assistant.	02-03-12

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F 323	Continued From page 19 A. Complete Physical Assessment Monitoring Form every shift as indicated. (Licensed Nurse) B. Complete Resident/Incident/Accident Report, as indicated in procedure. C. RN Care Coordinator or designee will evaluate fall and document results. (Fall RAP sheet or chart note may be used for documentation of follow up). D. Resident compliance/non-compliance with fall prevention strategies. E. Inability of resident to understand fall precautions (Diagnosis list- dementia). F. Update Care Plan. . . ." Review of information provided by the facility titled "Report" occurred on 12/22/11. This undated information, stated, "Verbal or taped Include all pertinent info: Falls . . . Change in condition . . . ADL changes Family concerns or complaints. . . ." Review of the facility procedure titled "PAL PRO 1 Lift, Procedure for the use of" occurred on 12/22/11. This procedure, dated 10/01/98, stated, "PURPOSE: To provide instruction for safe use of the PAL PRO 1 Lift. The PAL PRO 1 Lift is a total body lift . . . CAUTIONS FOR USE OF PAL: 1. Always have 2 staff persons present when using the Pro 1 . . . 8. Make sure all 4 loops from the sling are on the hooks of the hanger before lifting a resident. 9. Do not use sling that shows excessive wear or is torn. 10. Use only PAL slings designed for use with the PAL PRO 1 model . . .	F 323		

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F 323	Continued From page 20 PROCEDURE: . . . B. SELECTING THE STYLE OF SLING TO BE USED The first step is to select the style of the sling to be used . . . All the styles have a color coded border to easily indicate the size of the sling . . . The loops on the straps are color coded for positioning the sling to the desired location. Changing the orientation of these loops will change the angle of the person being transferred. This comes in handy for charting the colors that would work best for each individual. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included arthropathy, congestive heart failure, acute renal failure, and chronic obstructive pulmonary disease. The current Minimum Data Set (MDS), dated 10/23/11, identified the resident with a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition; showed the resident required extensive assistance of one staff member for toilet use and transfers; no falls since admission or the prior assessment; continent of bowel and bladder; and not on a toileting program. The medical record showed the resident with a history of falls, occurring on 10/31/11, 11/13/11, 11/26/11, two occurrences on 12/08/11, and on 12/20/11. The care plan, dated September 2011, stated, ". . . 09/27/11 . . . After a long hospital stay for pneumonia, I'm quite weak and need help with my cares until I get stronger . . . Interventions, I may need help with bed mobility: assist of 1-2 with bed mobility, I need help with transfers: transfers with assist of 1-2, I need help with ambulation: ambulates with assist of 1 with use of	F 323		

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FWW [front-wheeled walker] , distance as tolerated. (This intervention was crossed out and "I am not walking anymore" handwritten on December 2011) . . . I need help with toileting: requires assist of 1 with toileting. I am usually continent of bladder and of bowel. (A handwritten note, dated December 2011, identified the resident as occasionally incontinent of bowel and with an indwelling catheter) . . . I can feed myself after being set up (A hand written note, dated December 2011, identified the resident currently needs help with his meals) . . . I have been evaled [evaluated] by therapy [and] deemed safe to use my electric scooter (handwritten and dated October 2011). . . ." An additional section of the care plan, dated October 2011, stated, ". . . 10/10/2011 . . . I can be unsteady on my feet at time [sic], especially since I've been sick, so please help me when I request so I don't fall . . . Interventions, Keep my furniture in consistent place to promote familiarity. Keep walkways open and free of clutter, Staff will report changes in LOC [level of consciousness] i.e. increased confusion, sedation, lethargy. Report unsteady gait, transfers, physical strength, etc . . . I transfer with assist of 1. I am able to ambulate with assist of 1 with FWW [front-wheeled walker]. Uses w/c [wheelchair] for primary mobility . . . Please make sure my call light [is] within reach. Encourage to use for assistance with transfers/ambulation. Safety devices: I will use my call light for help, though I do appreciate when staff come in and check on me . . . Staff will [sic] falls risk assessment quarterly. . . ." A handwritten intervention, dated 11/11 (November 2011), stated, "I like to be Independent in my rooms [sic], I don't always like to let staff help me, so I may make unsafe decisions that put me at higher

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risk of falling," and another intervention, dated 12/11 (December 2011), stated, "perimeter mattress, bed [checks], fall mat." The care plan identified inconsistencies regarding the level of assistance Resident #1 required.

During an interview on 12/21/11 at 4:20 p.m., an administrative nurse (#12) stated staff implemented a perimeter mattress, bed alarm, low bed, and fall mat after his fall from his bed on 12/20/11. (The care plan listed above lacked the specific date the facility staff implemented these interventions.)

During the initial tour, family members visiting Resident #1 stated he was alert, cognitively intact, ambulatory, and spoke clearly prior to his second fall on 12/08/11. Observations during the survey showed Resident #1 lethargic; his eyes closed the majority of the time; speech incomprehensible; decreased responsiveness; bedridden; bruising under both eyes, on the right side of his neck, and on the right side of his forehead.

Review of Resident #1's Resident Care Notes identified the following:
*12/08/11 at 10:50 a.m. - "Data: [name of CNA] in rm [room] [with] resid [Resident]. Resid stepped back [with] walker [after] washing his hands @ [at] sink. Resid lost his balance, fell back, landing on buttocks . . . Resid did not hit head. No injuries observed. Resid able to move all 4 extremities [without] difficulty. Resid assisted to stand [with] [3] assists et walker. Resid amb [ambulated] to electric scooter [with] assist. [No] difficulty."
*12/08/11 at 8:30 p.m. - "Data: [name of CNA] in room with resident assisting with HS [hour of

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F 323	Continued From page 23 sleep] cares as he allowed. He was at the sink brushing teeth, she was tidying room. She heard him hit the floor. Found face down, head turn [sic] so [right] cheek resting on floor. Arms at sides. Blood coming from both nares. Large bump to right side of head. [Right] eye swollen. Call placed to [name of physician] as [Resident #1] was unresponsive to verbal and pain stimuli. Assist of 4 to roll to back, maintaining good head alignment. Call placed to [name of son]. Unresponsiveness lasted from 7:50 p.m.- 8:08 p.m. Unable to assess [right] eye refraction. [Left] eye sluggish, 2 mm [millimeter] dilation. Son requested he be sent to the ER [emergency room] and stated he would come. Call placed to [Name of facility] for ambulance. C-collar applied by ambulance staff. Assisted by staff to move to gurney." *12/08/11 at 10:30 p.m. - "Data: Call from hospital. [Resident #1] will be returning. X-rays, scan negative. Will be sending clamp if nose bleeds clamp until stops if unable to stop, send back to ER. . . ." *12/08/11 at 11:45 p.m. - "Data: Back on unit at 11:30 p.m. Transported on gurney from [Name of ER] per our facility gurney et staff. 4 assist to transfer to bed . . . Responds with eye flutter, mumbling to voice." *12/09/11 at 3:30 a.m. - "Data" Sleepy oriented X [times] 3. Does not remember fall. Denies pain. Dried blood to nares. Nurse explained we wanted to wait until moring [sic] to clean nose well outside of nare cleansed. No headache. Slightly reddened area to lateral [upper] [left] arm. Bilateral black eyes, hematoma-like area to [right] eye and right side of head." *12/09/11 at 6:15 a.m. - "Data: Noc [night] nurse states resident has bloody nose she is unable to	F 323		

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stop - even [with] nose clamp et ice pack et pinching via fingers. Call placed to ER et informed resident would be sent over."
*12/09/11 at 6:45 a.m. - "Data: Resident transported to ER @ this time. Went via gurney et accompanied by noc nurse et CNA. . . ."
*12/09/11 at 10:00 a.m. - "Data: Resident admitted to [name of hospital] . . . Dx [diagnosis] of nose bleed."

During an interview on 12/20/11 at 4:00 p.m., a CNA (#32) identified she was with the resident in his room during the second fall on the evening of 12/08/11. She stated when she assisted Resident #1 with HS cares, he wanted to wash his face at the sink independently. She stated while he washed his face, she walked over to adjust his bed, and then she looked and saw Resident #1 fall back and hit the right side of his head on the floor, resulting in blood loss and emergency treatment. She further stated she was unaware of Resident #1's fall that occurred that same morning on 12/08/11.

Review of Resident #1's Resident Care Notes upon return from his hospital admission identified the following:
*12/16/11 late entry for 11:40 a.m. - "Data: Resid returned from [name of hospital] via gurney, accompanied by . . . transport aid . . . hosp diagnosis [sic] - fall, coagulopathy, closed head injury, subdural [hematoma], subarachnoid bleed, epistaxis . . . anemia - acute blood loss, acute encephalopathy, hypernatremia, peripheral edema . . . cardiomyopathy, et coccyx skin breakdown. . . ."
*12/16/11 at 4:00 p.m. - "Data: Skin assessment done. Lge [large] bruises under both eyes - purple

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red in color. Bruises to lateral jaw-line down to neck - faded purple. Knuckles to both hands are red. Purple bruise to [left] forearm et [left] elbow. Red bruise to crook of [right] arm. . . ."

Review of the Physician Discharge Summary for Resident #1's hospital stay December 09-16, 2011, stated, ". . . Discharge (or Final) Diagnoses:
Fall; ground level . . .
Closed head injuries: subdural hematoma; subarachnoid bleed (small); parenchymal bleed - secondary to above
Epistaxis; severe
Anemia of acuate [sic] blood loss - epistaxis; requiring transfusions X 3 units . . .

Hospital Course: . . .
3. Acute encephalopathy. . . ."

Review of the Resident Care Notes showed the following entries after Resident #1's return from the hospital:
*12/17/11 at 2:45 p.m. - "Data: . . . Lethargic but arousable - barely opens eyes. Speech mumbled at times . . . Ate fair for lunch [with] staff feeding him . . . Bedrest - turned et repos [repositioned] timed [every] 2 hr [hours] et prn [as needed]. Total assist [with] ADLs [activities of daily living]. . . ."
*12/19/11 at 2:30 a.m. - "Data . . . Speech still cont [continues] to be non-coherent . . . Res [resident] bedrest. . . ."
*12/19/11 at 10:00 a.m. - "Data . . . Resident awake this am [morning] speaking another language besides English. Remains . . . on bedrest . . . Received total assist [with] ADLs. . . ."
*Resident Care Note not timed or dated. Per staff

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member, entry completed 12/20/11 at 12:30 a.m. - ". . . Res found sitting on floor by bed, back up against bed . . . Res on antibiotics for C-diff [clostridium difficile] [no] injuries noted res is non verbal, talks garbled so you can't understand what he is saying. . . ."
*12/20/11 at 9:45 a.m. - "Data: . . . Resid offers no verbalization this am . . . Has remained on bedrest. . . ."
*12/20/11, untimed - "Data: Bed check et fall mat had been placed this am after fall et perimeter mattress placed on bed this am. Res remains confused et requires extensive to total assist [with] ADLs. Will cont to monitor."

During an interview on 12/20/11 at 4:00 p.m., two CNAs (#32 and #33) stated they were unaware of Resident #1's fall from bed earlier that morning, at 12:30 a.m. Both CNAs stated the fall was not on their written report sheet and was not communicated to them.

Review of the CNA report sheet on the afternoon of 12/20/11 showed the facility failed to identify/communicate Resident #1's fall, which occurred that same morning at 12:30 a.m., to the oncoming shift caring for the resident.

During an interview on 12/21/11 at 11:15 a.m., when asked about the inconsistencies in the medical record regarding the level of assistance Resident #1 required, an administrative nurse (#12) stated Resident #1 required assistance of one staff member for transfers and toileting since his admission, and stated she expected staff to use a gait belt when assisting him. She stated she was unaware staff failed to use a gait belt when assisting Resident #1 during both incidents

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F 323	Continued From page 27 on 12/08/11. She stated the use of gait belts are not always identified on a resident's care plan, as it is the facility's expectation to use a gait belt when a resident requires assistance. This nurse (#12) stated she expected the CNA (#32) working the evening shift on 12/08/11 to have known about Resident #1's fall earlier that morning, and to have been extra cautious when caring for the resident. The nurse (#12) stated communication occurs between shifts by the following methods: the nurse working each shift fills out a shift report sheet which the CNAs read when they start their shift, or the nurses tape a verbal report for the nurse starting the next shift. At 11:55 a.m., this nurse (#12) stated the CNA report sheet correctly identified both falls occurring on 12/08/11, and confirmed staff failed to identify Resident #1's fall occurring at 12:30 a.m. on 12/20/11. Based on evidence reviewed, the facility staff failed to take a proactive approach and implement fall interventions upon Resident #1's return from the hospital on 12/16/11 to prevent further falls; failed to ensure effective communication of Resident #1's falls to oncoming shifts; and failed to provide the assistance necessary to ensure Resident #1's safety on the evening of 12/08/11. These failures resulted in an avoidable fall on the evening of 12/08/11, which required extensive acute medical interventions to treat life-threatening injuries. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included rheumatoid arthritis, chronic pain, lupus, peripheral neuropathy, muscle weakness, and a right acetabular and pelvic fracture (admitted with in April 2011). The quarterly Minimum Data Set	F 323		

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F 323	Continued From page 28 (MDS), dated 11/21/11, indicated intact cognition; showed the resident required extensive assistance of two or more staff members for transfers; and had no falls since the prior assessment. The care plan, dated September 2011, stated, ". . . I fell and broke my right hip and lower leg, so I need lots of help with my ADLs . . . Bed Mobility: I need assist of 1 or 2 with bed mobility . . . Transfers: I need transfers with assist of 2 and total lift (care plan revised to assist of 1 for transfers without a total lift, dated November 2011) . . . I will have safe transfer to and from bed, w/c, and toilet . . ." Review of Resident #3's Resident Care Notes identified the following: *08/30/11 at 6:00 a.m. - "Data: Resident's BR [bathroom] call light on, resident found laying on the BR floor on Rt) [right] side, resident denied hitting head et [and] saying she was ok, able to move extremities [with] [no] c/o [complaints of] . . . resident hoyered off of the floor [with] assist of 4, bruise noted to Rt) knee - pink in color - measuring 3 cm X [by] 3.8 cm, sm [small] red, purple bruise to Rt) [upper] cheek, resident still denied hitting head but writer pointed out bruise to Rt) cheek et resident said "well I don't know I guess I must have hit my head," CNA [certified nurse aide] assisting resident to change gown et resident unable to bear wt [weight] on Rt) leg et c/o her pain being a 9, writer asked resident if she wanted to go to the ER [Emergency Room] et get checked out resident said "yeah I suppose I should," resident given a prn [as needed] percocet before going over to the ER." *08/30/11 at 11:00 a.m. - "Data: [Resident]	F 323		

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returned from . . . ER . . ." (Orders upon Resident #3's return from the ER, stated, "Res [resident] to be NWB [non-weight bearing] until is seen by [name of physician].")

Review of the Emergency Department Note, dated 09/01/11, for the incident on 08/30/11, stated, ". . . PHYSICAL EXAMINATION: . . . EXTREMITIES: She is able to fully flex and extend the knee, but she has some pain with that . . . I did get x-ray of the tib-fib [tibia-fibula] [outer lower leg bone]. I did review this and I do not see any obvious fractures. Radiology report pending.

ASSESSMENT:
1. Right leg contusion [bruise].
2. Status post fall.

PLAN: I discussed the case with the patient and care coordinator. She was discharged back to the nursing home. She does have plenty of help there in moving about. I talked to her about following up with her primary or with orthopedics, particularly if she is not on a course of progressive improvement and I did talk to the patient and the caregiver about occult [hidden] fractures.

ADDENDUM: The finalized report on this tib-fib did reveal a nondisplaced distal fibular fracture. The patient will be contacted and we will see if a postoperative boot or CAM [controlled ankle movement] walker will be tolerated by the patient for treatment of this injury."

Review of Resident Care Notes following Resident #3's return from the ER identified the following:
*08/31/11 at 6:50 a.m. - "Data: Bath aide and

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CNA in room Res refused shower. Bed bath given while in bed. Hoyer sling (blue) was used to get her out of bed. Blue sling was around her et she started sliding et she let go et slid through sling landing on her back/bottom lying on her w/c [wheelchair] footrests [with] head on her w/c seat. denies hitting head several abrasions to back from footrests. leg [sic] were stretched out in front of her next to her recliner. Staff tried to get w/c underneath her but unable . . . Res is alert. Has pain from previous incident on 8/30 [08/30/11]. Res lifted from floor using mesh bath sling et hoyer [with] [three] assist. [Name of son] was called et informed . . . Did also inform him about crack to distal fibula et the orders we received . . ."

*08/31/11 - "Data: appt [appointment] made [with] [name of physician] . . ."

*08/31/11 at 11:00 p.m. - "Data . . . resident denied pain at time of assessment, says it hurts when she moves Rt) leg but if she is just laying still she feels ok, has been getting prn percocet for pain, will continue to monitor."

*09/01/11 at 8:45 a.m. - "Data: To appt [with] [name of physician] . . ."

*09/01/11 at 10:00 a.m. - "Data: Returned from appt. To wear boot @ [at] all times . . . NWB on (R) [right] L/E [lower extremity]."

*09/07/11 at 12:40 p.m. - "Data: [Name of physician] here et Rsd [resident] c/o [increased] pain to R) hip . . . received x-ray orders to R) hip . . . ordered to [increase] percocet PRN order d/t [due to] [increased] pain . . . Action: Rsd to [name of facility] for R) hip x-ray."

(Review of the x-ray results, dated 09/07/11, stated, ". . . Bony structures appear demineralized . . . There is a fracture involving the right femoral neck. That is mildly displaced

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F 323	Continued From page 31 and somewhat angulated . . . There is a degenerative change of both hips . . .") *09/07/11 at 3:00 p.m. - "D [data]: Phone call from [Name of physician]. A [action]: Continue to use hoyer for transfers from bed-w/c-bed . . . He will talk over with collegues [sic] about plan for surgery . . ." *09/07/11 at 3:15 p.m. - "D: Notified son of [name of physician] plan. and of [right] hip fx [fracture]." Review of a Physician Progress Note, dated 09/10/11, stated, ". . . being evaluated for hip surgery. Subjective: She fell a little over a week ago and sustained an injury to her right leg. Initially it appeared that she had fractured her fibula and nothing else. However, because of continued pain in her right hip area, another x-ray was taken, which showed a displaced fracture of the right femoral neck. She has been evaluated by orthopedic and it is felt that surgical intervention should be done . . ." Review of an additional Resident Care Note stated the following: *09/14/11 at 12:00 p.m. - "Data: Resid [resident] returned to VEC [Valley Eldercare] . . . Resid hosp [hospital] diagnosis - s/p [status post] [right] bipolar hip arthroplasty which was done 09/11/11 . . ." During an interview on 12/21/11 at 4:45 p.m., a CNA (#33) stated the facility has different types of Hoyer slings available to transfer residents, including full body slings and toileting slings. The CNA (#33) stated therapy determines the appropriate sling size to be used for each resident and stated each resident should have	F 323		

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F 323	Continued From page 32 their own sling in their room. During an interview on 12/22/11 at 7:40 a.m., two CNAs (#22 and #23) stated the CNAs look at a weight chart in the clean utility room to determine the correct sling size for residents. On 12/22/11 at 7:45 a.m., a nurse (#43) stated therapy usually evaluates residents to determine the proper sling size when they are changed to a mechanical lift transfer. An interview with a physical therapy staff member (#24) and with an occupation therapy staff member (#25) occurred on 12/22/11 at 8:15 a.m. The staff members stated therapy does not always evaluate a resident for transfers when a clear reason exists for needing a different transfer method, such as changing to a non-weight bearing status. The therapy staff members (#24 and #25) stated the CNAs and nurses decide what size of mechanical lift sling to use based on the resident's weight. Discrepancies existed between different staff members when asked about the process to determine the appropriate size sling for residents who transfer with a mechanical lift. On the morning of 12/22/11, an administrative nurse (#12) stated she and another administrative staff nurse (#36) both investigated Resident #3's fall from the Hoyer lift, occurring on 08/31/11. She stated she was unaware what exact sling was used in the transfer, or what exactly happened to cause the fall, but more than likely staff used the wrong size sling. She stated the CNAs look at a weight guide to determine which sling to use	F 323		

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F 323	Continued From page 33 when transferring residents. Each resident has their own sling located in their room. On 12/22/11 at 8:20 a.m., an administrative nurse (#36) involved in the fall investigation, stated she also didn't know what happened to cause Resident #3's fall from the Hoyer lift sling on 08/31/11. She stated she was unaware what exact sling they used, but stated the staff probably should have used a different sling, and "couldn't imagine her slipping out." The staff members failed to determine the specific type of sling used during the fall from the Hoyer lift on 08/31/11 (full body sling or toileting sling versus "blue" sling), why the resident slid out of the sling, and what interventions to implement to prevent a reoccurrence. Failure to determine the specific type of sling used during the fall from the Hoyer lift on 08/31/11 (full body sling or toileting sling, etc., versus "blue" sling) and why the resident slid out of the sling; and failure to have a consistent process in place across all facility disciplines to determine the safe and appropriate sling size may have resulted in an avoidable fall and harm to Resident #3. Failure to ensure safe transfers with a Hoyer lift may cause falls and injuries in the future to all residents who transfer with a Hoyer lift. - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included end-stage dementia, rheumatoid arthritis, osteoarthrosis, and history of a cerebrovascular infarction. The significant change Minimum Data Set (MDS), dated 09/28/11,	F 323		

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identified the resident required extensive assistance of two or more staff members for transfers. The resident's current care plan identified the resident transferred with a mechanical stand lift and assistance of two staff members and showed the resident experienced occasional pain related to her arthritis.

Observations of staff transferring Resident #2 showed the following:
* 12/20/11 at 11:00 a.m. - Two certified nurse aides (CNAs) (#18 and #19) used a mechanical stand lift to transfer Resident #2 from her wheelchair to the commode and back to her wheelchair. During the transfer, the resident grimaced and said, "Oooh," indicating discomfort. Observation showed the resident slouched in the lift with her knees bent (i.e. unable to fully bear weight), shoulders shrugged upward, and her elbows bowed out. Resident #2 let go of the handle bar with her right hand and the CNA (#19) then placed her hand over the resident's hand to grasp on to the handle bar for the remainder of the transfer.
* 12/20/11 at 5:45 p.m. - Two CNAs (#20 and #21) used a mechanical stand lift to transfer the resident from her wheelchair to the toilet and back to her wheelchair. During the transfer, observation showed Resident #2 slouched in the lift with her knees bent (i.e. unable to fully bear weight), the sling sliding up and resting under her axilla, her shoulders shrugged upward, and her elbows bowed out.
* 12/22/11 at 7:45 a.m. - Two CNAs (#22 and #23) used a mechanical stand lift to transfer Resident #2 from the bath chair to her wheelchair. During the transfer, observation showed the resident with her eyes closed,

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slouched in the lift with her knees bent, the sling sliding up under her axilla, her shoulders shrugged upward, and her elbows bowed out.

An interview with a physical and occupational therapist (#24 and #25) occurred on 12/22/11 at 8:15 a.m. After hearing about the observations of the mechanical stand lift transfers with Resident #2, the staff members stated staff should no longer transfer the resident with that type of lift. The staff members expect the CNAs to notify the nurse on duty if a resident experienced difficulty with transfers and the nurse then contacts therapy for an evaluation. They stated staff failed to notify/consult therapy regarding Resident #2's increased difficulty using the mechanical stand lift to transfer.

- Review of Resident #16's medical record occurred on December 20-22, 2011. Diagnoses included cerebral vascular accident, and arthritis.

Resident #16's quarterly MDS, dated 11/17/11, showed the resident displayed moderate impairment in daily decision making, extensive two person physical assistance with transfers, extensive one person physical assistance with locomotion on the unit and with toileting, and bilateral functional limitation in range of motion to his lower extremities.

Resident #16's current care plan, included the following intervention, dated 12/20/11, regarding transfers as "variable [with] transfers - [one] [with] PAL [type of standing mechanical lift] or [two] [person] stand/pivot."

Observation on 12/21/11 at 7:50 a.m. showed a

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F 323	Continued From page 36 CNA (#10) transferred Resident #16 off of the toilet using a standing mechanical lift. Observation showed Resident #16's elbows suspended higher than his shoulders as the resident gripped the handle bars of the lift and his legs bent at the knees throughout the transfer. The CNA (#10) completed perineal cares for the resident and transferred the resident out of the bathroom and lowered him into his wheelchair. Throughout the entire transfer, the CNA (#10) failed to raise the mechanical lift to a higher position to allow the resident to bear full weight on his legs to alleviate the strain to his shoulders. Failure to use a mechanical stand lift appropriately has the potential to cause falls, injuries, or pain to Resident #2 and Resident #16, and all other residents who transfer with a mechanical stand lift. 2. Based on record review and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #5) received the care and services necessary to attain the highest degree of safety possible while drinking coffee in his room/parlor. Failure to provide coffee at a safe temperature and/or in a safe container caused Resident #5 to experience unnecessary discomfort and treatment related to a burn to his groin. This also places other residents drinking coffee at risk for injury. Findings: Review of Resident #5's medical record occurred on December 19-22, 2011. The resident's annual Minimum Data Set (MDS), dated 10/26/11, identified moderately impaired cognition and	F 323		

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supervision while eating. Resident #5's current care plan stated, ". . . Problem: I need help with some of my daily cares . . . Approaches: . . . I eat in the parlor. Bring my food to the table and get it ready for me to eat. . . ." The current care plan did not address the resident spilling coffee on his lap and burning his groin area.

The physician's progress note, dated 09/20/11, stated, ". . . they noted a red burn to his right groin. It is presumed that he spilled some hot coffee on himself. . . . The area measures approximately 2 x [times] 3 cm [centimeter] with some white slough in the middle. There is no blistering, and he denies any complaints of pain. . . . I will order some Silvadene cream for the nurses to try to apply. We will monitor for infection."

The resident care notes, dated 09/20/11-10/13/11, identified the following:
* 09/20/11 at 6:40 p.m., ". . . CNA [Certified Nurse Aide] reports area to [right] inner thigh/groin. Area appears to be a burn from coffee. Unaware of how or when occurred. Area measures 2.9 cm W [width] x 2 cm L [length]. Area is superficial and red/white in color. Denies pain to area. TAO [triple antibiotic ointment] [and] Telfa [dressing] applied. Writer attempted to encourage to come out of room to drink coffee at the table. Became upset with suggestion . . . order rec's [received] for Silvadene cream on R [right] groin tid [three times daily] x one week. Call if [increased] redness or drainage. . . ."
* 09/22/11 at 6:30 a.m., ". . . R groin burn measures approx [approximately] 10 cm W x 2 cm L. Would not let writer measure. Silvadene applied. Does refuse cream frequently. 50%

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F 323	Continued From page 38 green. 50% red. . . ." * 09/29/11, ". . . R groin burn has a black/green scab with red peri-wound, area measures 5.3 cm W x 1 cm L, became upset with measuring of skin issues. . . ." * 10/13/11 at 6:30 a.m., ". . . burn to R groin is resolved x week 2 [actually 24 days] . . ." During interviews on 12/21/11 at 11:20 a.m. and 3:45 p.m., when asked where the coffee had been prepared, a supervisory nursing staff member (#40) stated, "On the unit." When asked if staff checked the temperature of the coffee after the incident, she stated, "No, I don't think we even have the equipment for something like that." When asked what interventions had been attempted other than the initial suggestion that he drink his coffee in the parlor, she stated, "We usually try to put interventions in place. He's pretty resistive. He becomes upset and agitated. I thought they tried to cover it [the burn]. I almost think we talked about it [attempting different cups/lids]. There is no documentation though." She also confirmed the care plan did not address the resident's burn. 3. Based on observation, record review, staff interview, and facility policy, the facility failed to assess 1 of 1 resident (Resident #4) as being safe to smoke in the designated area without supervision. Failure of the facility to assess smoking safety places residents at risk for possible accidents and/or injury. Findings: Review of the facility's policy titled "Tobacco	F 323		

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Policy - Residents/Tenants/Visitors" occurred on 12/22/11. This policy, dated 03/24/08, stated, ". . . A. Tobacco use by residents . . . is prohibited in any Valley Memorial Homes facility. . . . D. Under no circumstances or conditions will staff of Valley Memorial Homes supervise or facilitate tobacco use by residents . . ."

Review of Resident #4's medical record occurred on December 19-22, 2011. The resident's admit Minimum Data Set (MDS), dated 12/09/11, identified intact cognition, extensive assistance of more than two staff for transfers, and independent of locomotion on/off unit. Resident #4's current care plan stated, ". . . Problem: Self care deficits . . . Approaches: . . . Does not ambulate. Will have primary mobility per w/c [wheelchair] with staff assist prn [as needed] to meet destinations on and off the unit. Has electric w/c. . . ." The current care plan did not address Resident #4's smoking habits.

Observations revealed the following:
* On 12/20/11 at 10:40 a.m.,12:28 p.m., and 3:10 p.m., Resident #4 sat in his electric wheelchair, smoking alone, next to the ashtray located on the sidewalk in front of and to the left of the facility. Prior to the first observation, an unidentified staff member stated, "If you can't find [Resident #4] check outside, he's probably smoking again. He goes out there whenever he wants."

During interview on 12/21/11 at 10:20 am., when asked if a smoking assessment had been performed, a supervisory nursing staff member (#40) stated, "We don't have a smoking assessment. We talked about it, so it's in process. . . . We do it informally." When asked if

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F 323	Continued From page 40 the resident is required to check in/out prior to leaving the building to smoke, she stated, "We don't make them check in/out. He's alert enough to get back in or ask for help." She also confirmed Resident #4's care plan did not address the resident's smoking habits. The facility failed to ensure Resident #4 received the care and services necessary to attain the highest degree of safety possible while smoking outside the facility. They failed to 1) revise their policy describing the methods by which residents are deemed safe to smoke without supervision, 2) assess Resident #4's capabilities and deficits to determine whether or not supervision is required, 3) ensure the safety of designated smoking areas which includes protection of residents from weather conditions, and 4) identify how Resident #4 would acquire assistance from staff when they are often unaware he has left the facility.	F 323		
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, professional reference, and staff interview, the facility failed to provide fluids for 4 of 6 sampled residents (Resident #7, #10, #12, and #14) dependent on staff for fluid needs and 2 of 2 residents (Resident #11 and #19) with a diagnosis of dehydration. Failure to encourage	F 327	F 327 It is the policy of VMH that we provide each resident with sufficient fluid intake to maintain proper hydration and health. Resident #7 is no longer in the facility. Resident #10 continues to reside on the 400 Unit, he receives nectar thicked water which he does not like. Offer and encourage additional fluids every shift is added to the C.N.A. assignment sheet for residents who are deemed at high risk by the dietician. Resident #10 has this on his care sheet. Continued on Page 42	

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F 327	Continued From page 41 and/or offer fluids placed these residents at risk of dehydration. Findings include: Review of the facility policy titled "Hydration/Dehydration" occurred on 12/22/11. This policy, dated 2003, stated, "PURPOSE: The facility will offer each resident sufficient fluid intake to maintain adequate hydration. . . . PROCEDURE: A. Assessment of Dehydration Risk: . . . 2. The RN [registered nurse] Care Coordinator and Dietitian will work together in formulating a plan of care to meet the needs of residents that have been identified as being at risk for dehydration. 3. The Dietitian will recommend to the RN Care Coordinator dehydration prevention interventions to be carried out by direct care staff. . . . B. Maintaining Adequate Hydration: 1. The Charge Nurse will be responsible to check intake monitoring at the end of each shift and to ensure it is recorded on the MAR [medication administration record]. . . . C. Other: 1. Fluid needs are dependent on many variables including medical diagnosis . . . 3. The resident Care Plan is the guide for staff to follow. 4. If the resident is unable or unwilling to take oral fluids, the physician is notified. . . ." Lippincott, Williams, and Wilkins "Nursing 2011 Drug Handbook," page 424, stated, "Bumex [a diuretic] . . . Adverse Reactions: . . . volume depletion and dehydration . . ."	F 327	Continued from Page 41 Staff were conference by the Unit Care Coordinator regarding the need to offer fluids in between meals and with each resident contact. Resident # 12 is no longer in the facility. Resident #14 is totally dependent on staff for food and drink. DON has visited with staff on all units and reminded all the staff of the importance to offer food and drink. It has been added to his care sheet to encourage and offer additional fluids every shift. It has been noted by the DONS during her a.m. and p.m. rounds that residents are being offered fluids by the staff. Whether it be water, juice and coffee are offered in the parlor. Resident #11 is being offered fluid when she is awake and likes to sit at the parlor table and have juice. Resident #19 is alert and oriented and doing well, she drinks and eats when she wants and staff are alerted to respond when noted any change in her ability to ask. All residents can be affected by this deficient practice therefore staff have been reminded about the importance to provide fluids for those who cannot drink on their own. It has been observed by the DON and other Nurse Management that fluids are being offered. All fluids are to be charted. If CNAs note any decline or decrease of intake, they are to report to the Nurse immediately. Per telephone conversation with Carol DON on 2/7/12 @ 11:30 am Kelly Beechie Continued on Page 43	

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F 327	Continued From page 42 Kozier and Erbs "Fundamentals of Nursing: Concepts, Process, and Practice," Ninth Edition, page 1459, states, "Fluid and Electrolyte Imbalance. . . . Older adults are at high risk for fluid and electrolyte imbalance because of decreases in: * Thirst sensation * Ability of the kidneys to concentrate urine . . . Other factors that may influence fluid and electrolyte balance in older adults are: * Use of diuretics for hypertension and heart disease * Decreased intake of food and water, especially in older adults with dementia or who are dependent on others to feed them and offer them fluids. . . . these conditions increase older adults' risk for fluid and electrolyte imbalance . . . The change can happen quickly and become serious in a short time. . . ." - Review of Resident #19's medical record occurred on December 21-22, 2011. Diagnoses included dehydration and chronic kidney disease. Medications included Bumex (a diuretic) twice a day. The record identified a hospitalization from 12/15/11 to 12/22/11 with a diagnoses of dehydration, anemia, and renal insufficiency. Review of the resident's care plan stated, "Problems . . . I need a lot of help . . . especially since I hurt my knee . . . Interventions . . . Encourage adequate food & fluid intake . . ." Review of the nutritional assessment, dated 12/06/11, identified Resident #19 consumed between 1180 and 1540 milliliters (ml) every day. The assessment failed to identify the resident's	F 327	Continued from Page 42 Audits will be completed to observe staff giving fluids. These will be provided by the Staff Development Nurse and completed by the Licensed Nursing staff on each unit. These will be done weekly times one month and monthly times six (6) months, then quarterly. All C.N.A.'s are monitored during their 3 month evaluation and annual appraisals using the Valley Memorial Homes QA Resident Services assessment tool. This tool includes assessment of staff in relation to food services to include fluids being offered between meals and proper documentation. All staff will be in-serviced and educated on February 2, 2012. Additional in-service and education can be provided as needed by the dietician to reinforce the importance of proper hydration.	02-03-12

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F 327	Continued From page 43 daily fluids requirements or the history of dehydration. Review of Resident #19's daily fluid intake record from December 1-15, 2011 identified the following: * 12/01/11 - 1180 ml * 12/02/11 - 1350 ml * 12/03/11 - 1540 ml * 12/04/11 - 1235 ml * 12/05/11 - 1920 ml * 12/06/11 - 1410 ml * 12/07/11 - 1200 ml * 12/08/11 - 950 ml * 12/09/11 - 740 ml * 12/10/11 - 560 ml * 12/11/11 - 620 ml * 12/12/11 - 1030 ml * 12/13/11 - 1220 ml * 12/14/11 - 320 ml * 12/15/11 - 780 ml Resident #19's medical record failed to show facility staff's awareness or concerns regarding the resident's decrease in fluid intake on approximately 12/08/11 and again on 12/14/11. Review of Resident #19's nurses notes identified the following: * 12/14/11 at 1:05 p.m. - ". . . periods of forgetfulness . . ." * 12/15/11 at 9:30 a.m. - "Data: Has reported resid [resident] has had [increased] confusion . . ." * 12/15/11 at 12:30 p.m. - ". . . occas. [occasional] forgetfulness." * 12/15/11 at 5:00 p.m. - "Data: Dr. [primary care physician] here . . . Informed of resid's [increased] confusion . . ." * 12/15/11 at 9:30 p.m. - ". . . Daughter [name] here at this time stating resident is getting worse	F 327		

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F 327	Continued From page 44 et [and] is so confused that she isn't even able to swallow . . ." Resident #19's medical record identified an admission to the hospital on 12/15/11 at 9:57 p.m. for acute renal failure and dehydration. - Review of Resident #14's medical record occurred on December 20-21, 2011. Diagnoses included Parkinson's disease, dysphagia, and anxiety. The resident's quarterly Minimum Data Set (MDS), dated 12/04/11, identified long and short term memory difficulties and total dependence on staff for eating. Observation on 12/20/11 at 12:15 p.m. showed Resident #14 in bed. The certified nursing assistant (CNA) (#13) stated the resident had not been out of bed yet and had not had breakfast. The CNA (#14) stated, "he likes to sleep in." The CNAs checked and changed Resident #14's brief and exited the room. The CNAs failed to offer the resident fluids. Resident #14 remained in bed during the lunch meal and did not receive food or fluids. Observation on 12/21/11 at 10:30 a.m. showed two CNAs (#13 and #14) provided personal cares for Resident #14. After completion, the CNAs transferred the resident via wheelchair to the parlor. The CNAs failed to offer Resident #14 fluids. - Record review for Resident #10 occurred on December 20-21, 2011. Medical diagnoses included dysphagia, hyponatremia (low sodium), constipation, congestive heart failure, and hemiplegia. The quarterly MDS, dated 10/18/11, identified moderate cognitive impairment and total	F 327		

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assistance with eating. The medical record showed Resident #10 on nectar thickened liquids.

The current comprehensive care plan stated, "Problem: I am at nutritional risk because I have trouble with dysphagia . . . I need total assist at meals. . . . Interventions: . . . Offer/Encourage additional fluids every shift. . . ."

Observation on 12/20/11 at 11:35 a.m. showed two CNAs (#26 and #27) provided cares to Resident #10. Observation showed a glass of nectar thickened water at the resident's bedside. The CNAs did not offer the water to the resident.

Observation on 12/20/11 at 3:20 p.m. showed Resident #10 reclined in his wheelchair in the dining room. A staff member (#38) offered him sips of water that was not at nectar consistency. (Refer to F 309). Observations showed no other fluids offered after lunch or prior to supper.

Observation on 12/21/11 showed two CNAs (#9 and #27) provided cares to Resident #10 at 9:00 a.m. and again at 9:45 a.m. Observation showed a glass of nectar thickened water at the resident's bedside, but the CNAs failed to offer the resident fluids.

- Record review for Resident #11 occurred on December 20-21, 2011. Medical diagnoses included acute renal failure, hypotension, and dehydration. The most recent MDS, dated 11/07/11, identified moderate cognitive impairment, ability to make self understood and understand others, and supervision/set up assistance with eating.

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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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The current comprehensive care plan stated, ". . . I eat in the MDR [main dining room] with set up assist. . . . Give me nutrition per orders and Dietician. Encourage me to consume adequate food and fluid [sic]. . . ."

Review of Resident #11's fluid intake records identified the following daily fluid intake recommendations broken down by shift: Day shift fluid intake goal: 800 ml-900 ml; PM [evening] shift fluid intake goal: 400 ml-500 ml; NOC [night] shift fluid intake goal: 150 ml-200 ml; for a daily total fluid intake goal of 1350 ml-1600 ml.

Review of the fluid intake records for the month of December showed the following 24-hour totals:
Dec. 1- 120 ml
Dec. 2- 780 ml
Dec. 3- 880 ml
Dec. 4- not recorded
Dec. 5- not recorded
Dec. 6- 180 ml
Dec. 7- 60 ml
Dec. 8- 600 ml
Dec. 9- 180 ml
Dec. 10- 300 ml
Dec. 11- 940 ml
Dec. 12- 580 ml
Dec. 13- 400 ml
Dec. 14- 520 ml
Dec. 15- 1050 ml
Dec. 16- 1040 ml
Dec. 17- 560 ml
Dec. 18- 280 ml
Dec. 19- 675 ml
Dec. 20- 760 ml
Dec. 21- 1220 ml

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F 327	Continued From page 47 Observation on 12/20/11 at 3:50 p.m. showed two CNAs (#1 and #2) assisted Resident #11 with cares. Observation showed a glass of water nearby on the bedside stand. The CNAs did not offer fluids to the resident or remind her to drink. Observation on 12/20/11 from 5:00 p.m. until 6:00 p.m. showed Resident #11 seated at the dining room table. The resident repeatedly stated, "I'm hungry," "I'm thirsty," and "Can I get something to eat?" At 5:25 p.m., the resident requested ice cream to which a CNA responded, "Just wait, [Resident name]. It's almost time for supper." Observation showed staff failed to offer Resident #11 anything to eat or drink until 5:50 p.m. when a CNA offered Resident #11 apple juice, which the resident accepted. - Record review for Resident #12 occurred on December 20-21, 2011. Medical diagnoses included dementia, kidney disease, congestive heart failure, constipation, and a history of urinary tract infections. The current MDS, dated 11/06/11, identified severe cognitive impairment and independent, set up assistance with eating. The physician's orders identified Lasix [a diuretic] 40 mg twice a day. The current comprehensive care plan stated, ". . . Encourage me to take adequate food and fluid intake. . . ." Observation on 12/20/11 at 11:45 a.m. showed a CNA (#26) provided cares to Resident #12. Observation showed a glass of water on the bedside table. The CNA did not encourage Resident #12 to drink fluids.	F 327		

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F 327	Continued From page 48 Observation on 12/20/11 at 12:50 p.m. showed a CNA (#26) provided cares to Resident #12. Observation showed a glass of water present in the room, but the CNA did not encourage Resident #12 to drink fluids. During an interview on the morning of 12/22/11, an administrative nursing staff member (#3) stated the expectation is for staff to offer fluids with cares or anytime staff have contact with residents. - Review of Resident #7's medical record occurred on December 20-22, 2011. Diagnoses included constipation, a Stage II pressure ulcer to the coccyx, dementia, and a history of cerebrovascular accident. Resident #7's current MDS, dated 11/21/11, identified short-term and long-term memory problems, severely impaired daily decision-making skills, and total assistance from one staff person required for eating. The current care plan stated, ". . . I am at risk for my skin breaking down . . . Interventions . . . Encourage me to take in adequate food & fluid. . . ." Observations throughout the morning on 12/20/11 showed Resident #7 attended activities after breakfast and then sat in the dining room area. Staff failed to offer Resident #7 fluids after breakfast (approximately 8:30 a.m.) until 12:16 p.m. when a staff member assisted her to eat lunch. Observation on 12/20/11 at 3:05 p.m. showed two CNAs (#1 and #2) transferred Resident #7 from her bed to her wheelchair. The CNAs failed to offer Resident #7 fluids. Observations until 6:00	F 327		

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F 327	Continued From page 49 p.m. showed staff failed to offer Resident #7 fluids. Observation on 12/21/11 at 9:37 a.m. showed two CNAs (#8 and #9) transferred Resident #7 into bed and failed to offer the resident fluids. Observations throughout the afternoon from approximately 3:00 p.m. until 6:00 p.m. showed Resident #7 seated in her wheelchair in her room or in the dining room. Staff failed to offer the resident fluids during this time. During an interview on the morning of 12/22/11, a supervisory nursing staff member (#3) stated she expected staff to offer residents fluids with cares.	F 327		
F 441 SS=F	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 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	F 441	F 441 It is the policy of VMH to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and prevent the development and transmission of disease and infection. Resident #1 is no longer in the facility. Resident #9 is no longer in the facility. Resident #17 is no longer in the facility. Resident #14 continues to reside in the facility and his care needs are being met. Resident #13 continues to reside in the facility and his care needs are being met. Resident #24 continues to reside in the facility and her care needs are being met. Continued on Page 51...	

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F 441	Continued From page 50 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: Based on observation, review of facility policy and procedure, record review, and resident and staff interview, the facility failed to follow standard infection control practices on 4 of 4 days of survey (December 19-22, 2011). Failure to post and follow isolation precautions; effectively clean resident care equipment, resident rooms, and bathrooms; and failure to perform hand hygiene when appropriate may result in the spread of infection to other residents, visitors, and staff. Findings include: Review of the facility policy titled "Clostridium Difficile" occurred on 12/22/11. This policy, revised in 2010, stated ". . . Purpose . . . 2. To prevent transmission of Clostridium Difficile to others. . . . Procedure Guidelines, 1. Prevention . . . b. Employees should wash their hands: 1. After	F 441	Continued from Page 50 Resident #4 continues to reside in the facility and his care needs are being met. The care-giver's providing cares for Resident's #14, #13, #24 and #4 have been observed for proper technique regarding hand-washing, sanitation needs, isolation. They have been noted to be wearing gowns and gloves as needed. We have changed our sanitation wipes which is being used by both nursing staff and housekeeping staff. The product name is Cavi wipes. It is tuberculocidal, bactericidal, virucidal and fungicidal. It is effective on MRSA, VRE, C-Diff. We have new signage on the doors of residents with isolation precautions. The signs are magnetic and say: STOP—See Nurse for Instructions. All resident's can potentially be affected by this deficient practice. All staff will be re-educated at an in-service on February 2, 2012. The infection control nurse will discuss infection control policies regarding: contact isolation practices for residents with MRSA, VRE, C-Diff, hand-washing, personal protective equipment (gowns, gloves), proper sanitation in resident's rooms and bathrooms. The staff will be informed as to the importance of following policies for the protection of the resident and also protecting themselves against disease.	02-02-12

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incontinence care; 2. After helping toilet a resident; 3. After handling potentially contaminated items; . . . 8. After removal of personal protective clothing . . . d. Disinfect any visible fecal contamination with germicidal wipes or 1:10 bleach solution. e. Disinfect shared items which may be fecally contaminated (i.e., commode chair) between resident use and especially on arms of chair using germicidal wipes or 1:10 bleach solution . . . h. Contain all fecal soiling . . . placing soiled briefs from incontinent residents into red bags. . . ."

Review of the facility policy titled "Handwashing" occurred on 12/22/11. This policy, revised in 2010, stated, "Policy Statement: Handwashing shall be regarded by this organization as the single most important means of preventing the spread of infections. . . . handwashing must be performed under the following conditions: . . . f. After handling . . . contaminated equipment, etc; g. Before and after assisting a resident with toileting (cleansing/wiping perineal area or providing incontinent cares); h. After contact with a resident with infectious diarrhea, including, but not limited to, . . . C. difficile; i. After contact with . . . body fluids, excretions . . . j. After handling items potentially contaminated with blood, body fluids, excretions . . ."

Review of the facility policy titled "Hand Hygiene" occurred on 12/22/11. This policy, revised in 2010, stated, "Objectives: To prevent the spread of infectious diseases. . . . Appropriate hand hygiene must be performed under the following conditions: . . . 11. Upon and after coming in contact with a resident's intact skin, (e.g. . . . lifting a resident); . . . 13. Before and after

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F 441	Continued From page 52 assisting a resident with toileting; . . . 16. After contact with a resident's . . . body fluids or excretions; . . . 17. After handling soiled or used linens . . . 20. After removing gloves . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Clostridium difficile infection(C. diff). Resident #1's care plan identified the problem of "Infection, Actual R/T [related to] C - diff - loose stools - occ. [occasional] emesis." The CNA [certified nursing assistant] care plan included a laminated information card which stated the following: "Contact Guard Precautions . . . Clostridium Difficile in his stool . . . He will stay on these precautions until testing negative. Healthcare workers should take some extra steps to protect themselves when caring for him: 1.) ALWAYS use good hand washing with soap and water after any tasks where you might be in contact with stool. **ALCOHOL RUB IS NOT EFFECTIVE FOR C-DIFF. MUST USE SOAP & [and] WATER & FRICTION!!! ALWAYS FLUSH TOILET TWICE!!! 2.) Use caution when emptying commode, changing linens & briefs and avoid splashing when rinsing clothing or linens. 3.) Wear a gown when you anticipate potential contact with stool. 4.) Bag linen and clothes that may have stool on them in YELLOW BAGS. 5.) Use RED BAGS for trash that contains stool. . . ." Observation on all days of survey showed an isolation cart located outside Resident #1's room. An orange laminated sign located on the top of	F 441		

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the cart identified "Contact Precautions," but the sign was not visible to staff and visitors.

Observation on 12/20/11 at 10:30 a.m. showed a CNA (#28) emptied Resident #1's Foley catheter and failed to wash her hands after removing her gloves and donning a new pair of gloves. The CNA (#28) proceeded to assist two other CNAs (#29 and #30) transfer Resident #1 with a Hoyer lift (a full body mechanical lift) and replace the resident's standard mattress on his bed with a perimeter mattress. All three CNAs wore gloves, but failed to wear gowns when changing the linen and replacing the mattress on the bed. The CNA (#28) held the linen to her body before bagging it. After repositioning the resident in bed, all three CNAs (#28, #29, and #30) removed their gloves and exited the resident's room without performing hand washing. A nurse (#31) assisting with the transfer and mattress change, cleansed her hands with Epi-Clenz alcohol based foam hand sanitizer (ineffective against C. diff) prior to exiting the resident's room. The Epi-Clenz alcohol based foam hand sanitizer was mounted on the wall in the resident's room.

On 12/20/11 at 11:25 a.m. a CNA (#28) donned gloves and fed Resident #1 his noon meal. After feeding the resident, the CNA (#28) removed her gloves, exited the resident's room, and went to the dining room to see if any residents needed assistance getting back to their rooms. The CNA (#28) failed to perform hand washing prior to leaving Resident #1's room.

During an observation on 12/20/11 at 3:50 p.m., two CNAs (#32 and #33), wearing gloves and gowns, entered Resident #1's room to check and

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F 441	Continued From page 54 change his brief while the resident remained in bed. The brief was soiled with a moderate amount of loose stool. After performing perineal cares, the CNA (#33) removed her gown and gloves and exited the resident's room to retrieve a clean blanket. The CNA (#33) failed to wash her hands prior to exiting the isolation room. Upon returning with a clean blanket, the CNA (#33) donned a gown and gloves and assisted the other CNA (#32) to reposition Resident #1 and covered him with a blanket. After removing their gowns and gloves, the CNA (#32) appropriately washed her hands and the other CNA (#33) inappropriately sanitized her hands with the foam sanitizer in the resident's room prior to exiting the isolation room. Observation on 12/21/11 at 8:00 a.m. showed two CNAs (#34 and #35), wearing gowns and gloves, sponge bathing Resident #1 as he remained in bed. While checking the resident's brief, observation showed a small amount of loose stool on the resident's buttocks and in his brief. Both CNAs (#34 and #35) assisted with perineal cares and removed their gloves. After both CNAs donned a clean pair of gloves, a CNA (#34) applied cream to the resident's buttocks, and using the same gloves and without washing her hands, continued to apply lotion to the resident's upper torso and lower extremities. The CNA (#35) applied lotion to the resident's face, assisted the other CNA (#34) to reposition the resident, removed her gloves, sanitized her hands with foam sanitizer instead of performing hand washing, and donned a new pair of gloves. The CNA (#35) then removed Resident #1's dentures, brushed them, and then put his dentures back into his mouth.	F 441		

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An observation on 12/21/11 at 10:00 a.m. showed a nurse (#31) donned a pair of gloves upon entering Resident #1's room, removed his bilateral lymphedema wraps, applied lotion to his legs, removed her gloves, and used hand sanitizer instead of hand washing prior to exiting the isolation room.

During an interview on 12/22/11 at 8:20 a.m., an administrative nurse (#36) stated she expected staff to wear a gown when handling the linen of a resident who has C. diff. She also stated staff should never use hand sanitizer when caring for a resident with C. diff and should wash their hands prior to exiting an isolation room, no matter what cares they provided to the resident. She stated she expected staff to wash their hands immediately after performing perineal care and before completing other tasks and touching other items in the resident's room.

- Review of Resident #9's medical record occurred on December 20-22, 2011. Diagnoses included C. diff infection and colonized methicillin-resistant staphylococcus aureus (MRSA) in her urine.

Resident #9's CNA care plan included notices which stated the following: ". . . [Resident name] . . . has MRSA in her urine. Use CONTACT PRECAUTIONS when providing direct care for her. . . . ALWAYS USE GLOVES & GOWN! HANDWASHING is the most important thing. . . ." and "CONTACT GUARD PRECAUTIONS . . . [Resident name] . . . has Clostridium difficile in her stool. . . . ALWAYS use good hand washing with soap and water after any tasks where you

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F 441	Continued From page 56 might be in contact with stool. . . . Wear a gown when you anticipate potential contact with stool. . . . Use RED BAGS for trash that contains stool. . . ." Observation during the initial tour on the afternoon of 12/19/11 showed an isolation cart outside Resident #9's room. A laminated sign located on the top of the cart identified "contact precautions;" however, the sign was not visible to staff and visitors. Observation on 12/20/11 at 3:42 p.m. showed two CNAs (#1 and #2), wearing gowns and gloves, assisted Resident #9 to use a bed pan. After the resident voided, a CNA (#1) performed perineal cares, emptied the bed pan into the toilet, and removed her gloves. Without performing hand hygiene, the CNA (#1) then assisted the other CNA (#2) to place a new brief and pull up the resident's pants. The CNA (#1) transferred the resident to her wheelchair using a Hoyer lift (a full body mechanical lift) and placed the lift in the hallway outside the resident's room. The CNA (#1) failed to sanitize the lift upon leaving the isolation room. The other CNA (#2) (who assisted with perineal cares, bed pan placement, and the brief change) removed her gloves and gown and, without performing hand hygiene, left the room to obtain a garbage bag. The CNA (#2) then re-entered the room, bagged the garbage and soiled linen, and took the items to a soiled utility room, failing to perform hand hygiene prior to leaving the room. Observation on 12/21/11 at 10:40 a.m. showed two CNAs (#8 and #26) entered Resident #9's room to check and change her brief. The CNAs	F 441		

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wore gloves, but failed to wear gowns. The CNAs transferred Resident #9 onto her bed using a Hoyer lift and checked her incontinence brief. The brief was wet with urine and soiled with a moderate amount of loose stool. The CNA (#26) performed perineal care, removed her gloves, and transferred Resident #9 to the wheelchair using a Hoyer lift. The CNA (#26) moved the lift into the hallway and failed to sanitize it upon leaving the isolation room. The CNA (#26) also combed Resident #9's hair and handed her the phone before washing her hands. The other CNA (#8) took the garbage (which contained an incontinence brief that was soiled with urine and stool) to the soiled utility room. The CNA (#8) failed to bag the garbage in a red bag and also failed to wash her hands prior to exiting the isolation room. At 11:00 a.m., the surveyor informed a CNA (#27) of the unsanitized lift, who then used a Sani-Cloth germicidal wipe to sanitize the Hoyer lift.

During an interview on 12/22/11 at 8:53 a.m., a supervisory nurse (#3) stated she expected staff to wash their hands after performing perineal care and before touching the lift and other items in the resident's room. She also stated staff should wash their hands and sanitize lifts prior to exiting an isolation room, and place garbage from an isolation room in a red bag.

- Observation on all days of survey (December 19-22, 2011) identified yellow "isolation carts" placed outside some resident rooms. The tops of the carts held boxes of gloves and laminated cards approximately eight inches by five inches which stated "DROPLET PRECAUTIONS . . . VISITORS: Report to nurse before entering. . . ."

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F 441	Continued From page 58 or "CONTACT PRECAUTIONS . . . Visitors - Report to Nurses' Station Before Entering Room . . ." Observation showed the laminated cards were not visible to staff and visitors. Review of the facility's current Precautions/Isolation Log, provided by the facility staff on 12/19/11, identified 11 residents with Contact Precautions and one resident with Droplet Precautions. Observation during the initial tour, on 12/19/11 at 3:20 p.m. and 3:45 p.m., respectively, showed isolation carts outside two rooms without cards identifying the types of isolation precautions. Residents in these rooms were identified on the facility's Precautions/Isolation Log. - Review of Resident #17's medical record showed the resident tested positive for Clostridium difficile. Observation on December 20-22, 2011 showed a yellow cart (which contained isolation equipment) located right outside the entrance to Resident #17's room. Observation showed two boxes of gloves located on the top of the cart and a sign affixed to the top of the cart which stated, "Contact Isolation;" however, the sign was not visible to staff and visitors. - Review of the facility's current Precautions/Isolation Log, provided by the facility staff on 12/19/11, identified three residents with C. diff infection control precautions. During interview, on 12/22/11 at 7:50 a.m., a housekeeping management staff member (#6)	F 441		

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	355067	A. BUILDING _____ B. WING _____	C 12/22/2011

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reported the facility staff observe "contact precautions" for those residents with C. diff. This staff member reported the rooms and are cleaned with the facility's cleaning products and the toilets facilities are wiped with a separate product. Review of the container of the product used to clean the toilets showed the label stated "Bleach Free" and the list of infectious organisms affected failed to include C. diff. The staff member (#6) reported she would provide additional information.

On 12/22/11 at 9:25 a.m., staff member (#6) confirmed the "Bleach Free" product was not effective against C. diff; the facility ordered a product that would be effective on C. diff; and, the new product would arrive the next week. This staff member reported the facility had used the "Bleach Free" product for several months and prior to the wipes the facility had used a bleach solution.

- Observation on 12/20/11 at 12:15 p.m. showed Resident #14 positioned on his bed and two CNAs (#13 and #14) changed his soiled brief. The CNA (#13) removed the soiled slip-pad underneath the resident and placed it on the bedside table. The other CNA (#14) placed the slip-pad into a bag, but failed to sanitize the bedside stand. After the two CNAs completed cares for Resident #14, one CNA (#14) sanitized her hands but the other CNA (#13) failed to sanitize or wash her hands before exiting the room.

- Observation on 12/20/11 at 12:30 p.m. showed Resident #13 seated in his wheelchair and exiting the bathroom with his pants and underwear

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down. As the resident stood by his recliner and pulled his pants and underwear up, observation showed feces on the white cushion of his wheelchair. A CNA (#13) entered the room as the resident stood and assisted him with his pants. The CNA then went into the bathroom and flushed the toilet. Observation showed toilet tissue smeared with feces on the floor next to the toilet and phlegm on the toilet seat. The CNA (#13) failed to dispose of the toilet tissue or clean the toilet seat and failed to clean or replace the soiled wheelchair cushion. Resident #13's bathroom is also used by the resident in the adjoining next door. Observation showed the bathroom remained unclean until approximately 3:00 p.m.

- Observation on 12/21/11 at 8:20 a.m. showed two CNAs (#15 and #16) in Resident #13's room. The CNA (#16) stated, "BM [bowel movement] everywhere this morning, floor, wheelchair, cushion, shoes, clothes." After the CNAs cleaned the room and assisted Resident #13 with cares, they removed their gloves. The CNA (#16) gathered the bagged soiled linen, clothing, and garbage and exited the room. The CNA (#16) failed to perform any hand hygiene during the entire observation and prior to exiting the resident's room.

- Observation on 12/22/11 at 9:35 a.m. showed a CNA (#17) donned gloves, utilized a sit to stand lift, and assisted Resident #24 to the toilet. After the CNA provided perineal cares, she removed her gloves and transferred the resident to her wheelchair. The CNA (#17) removed the lift from the room and placed it in a storage area down the hallway. The CNA re-entered the room, gathered

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F 441	Continued From page 61 and bagged the garbage, and exited the room. The CNA (#17) failed to sanitize her hands after she removed her gloves and before she exited the room. - Review of Resident #4's medical record occurred on December 19-22, 2011. The resident's diagnoses included traumatic brain injury, quadriplegia, traumatic fracture, open wound to the ankle, knee and leg, heel ulcer, and MRSA. The latest culture, dated 11/29/11, stated, ". . . MRSA Source: Right Leg Wound . . ." Resident #4's current care plan did not address the infection in his right leg wound. During the initial tour on 12/19/11 at 2:00 p.m., a supervisory nursing staff member (#40) stated Resident #4 had a diagnosis of "MRSA in his urine." No visible signage indicating isolation could be seen on either the door to the resident's room or on the cart sitting directly outside his room. Observation on 12/20/11 at 12:47 p.m. showed two CNAs (#15 and #39) completing Resident #4's catheter cares. The CNA (#15) stated, "He has MRSA in his leg [wound], so we just need to wear gloves." Failure of facility staff to correctly identify the source of the MRSA, care plan for the infection, and/or provide instruction for staff/visitors to use the appropriate precautions, may result in the spread of the infection to other residents, visitors, and staff.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465	F 465 It is the policy of VMH that we provide a safe, Continued on Page 63	

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F 465	Continued From page 62 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a safe and functional environment on 5 of 5 resident care units (200, 300, 400, 500, and Transitional Care Unit) during all days of survey (December 19-22, 2011), regarding the continuous placement of clean linen carts and mechanical transfer lifts in resident corridors. Placement of clean linen carts and mechanical resident transfer lifts in hallways throughout the day obstructed residents' mobility and limited access to the handrails. Findings include: Observation on December 19-22, 2011, on all resident care units (200, 300, 400, 500, and Transitional Care Unit) identified clean linen carts and mechanical transfer lifts placed in the hallways of the resident care units throughout the day. These carts and lifts were placed on both sides of the hallways and obstructed access to the handrails. Observation on 12/20/11 at 10:45 a.m. on the 500 unit, showed Resident #16 propelled his wheelchair (w/c) out of his room and attempted to propel the w/c down the hallway, when the w/c came into contact with a mechanical lift left in the hallway. Observation showed Resident #16 used his right hand to move the mechanical lift out of	F 465	Continued from Page 62 Functional, sanitary and comfortable environment for residents, staff and the public. The mechanical lifts and linen carts are in the hallways only during the times of high care needs, after the busy time of the morning and afternoon cares, these carts and lifts are removed from the hallways. Resident #16 is able to propel his w/c down the hallway. If at times he has difficulty a staff member should assist him. Audits have been completed randomly on a daily basis and will be on-going. We will extend to weekly for one month, monthly times six (6) months and then quarterly. These audits will be completed by the DON, ADON, and the Staff Development Nurse. All staff will be in-serviced on February 2, 2012 on the importance of keeping the hallways free and clear so the residents can have the ability to use the hand rails to propel down the halls.	02-02-12

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F 465	Continued From page 63 the way so his w/c wheels would not become entangled in the lift. Observation showed staff member (#7) present in the corridor and this staff member failed to provide assistance to Resident #16. This mechanical lift restricted Resident #16's ability to propel his w/c in the hallway. During interview, on 12/21/11 at 10:30 a.m., a maintenance management staff member (#5) and a housekeeping management staff member (#6) reported the facility staff keep the linen carts and the lifts in the halls throughout each day. Placement of the clean linen carts and the lifts in the hallways throughout the day when they are not in use by facility staff limited the residents' access to the handrails and created a hazard for Resident #16 during his independent mobility activities.	F 465		