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 07/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS For the complaint investigation conducted July 16-17, 2013, the sample included five (5) closed records for review.	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 information alleged by the complainant, review of facility complaint/abuse investigations, review of facility's grievance policy/procedure, and staff interview, the facility failed to investigate all alleged concerns identified by the complainant and failed to provide a written response to the complainant following the facility's review/investigation for 1 of 1 complaint/grievance involving Resident #3. Failure of the facility to investigate all identified concerns and respond to the complainant does not provide an opportunity for resolution of complaints between the resident/family members and the facility. Findings include: The facility's "Grievance Procedure," last revised 09/12/11, stated; " Each resident, the resident's immediate family, any existing legal guardian of the resident, friends, facility staff, and the other persons have a right to present complaints on the behalf of the resident . . . The procedure for the	F 166	F 166 The goal of VEC is to always resolve grievances as they arise. The Grievance Policy has been revised to show the response to a grievance may be oral as well as written. Staff education will occur during Facility Management meeting of 8/13/13, Nursing Management Meeting on 8/26/13 and in the Quality Assurance meeting on 9/18/13. The process of responding to grievances will be reviewed at those meetings. Audits of facility response to formal grievances will be completed by the Director of Social Services on a monthly basis for 3 months and then quarterly thereafter for one (1) year. The Director of Social Services will report on the audits at the facility QA meetings.	8/21/13

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

Brad Hanson — August 21, 2013

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	F 166		

registration and disposition of complaints is as follows: . . . 3. The Administrator or designate will review the written complaint and will respond in writing within seven (7) working days. A conference will be held between the parties as needed. . . . The comfort, safety, health, and happiness of each resident is our concern, and we hope you will give us the opportunity to assist you in any way should a problem arise. However, if none of the above steps resolve your problem, you may take your grievance to an outside representative of your choice. . . ." The names, addresses, and telephone numbers are listed for the State survey/certification and ombudsman agencies.

Information received from the complainant by the Division of Health Facilities on 06/04/2013 included concerns alleged by the complainant regarding a resident (#3) sustaining a fall, development of a pressure ulcer, experiencing incontinence due to staff not providing toileting assistance, and not receiving the prescribed diet. The complainant indicated these concerns had been brought to the attention of facility management staff, and staff had indicated an investigation would be conducted and he would receive a call back at the conclusion. The complainant indicated the facility did not respond. During an interview on the morning of 07/17/13, a facility management staff member (#2) validated the complainant had called the facility on 05/17/13, and the facility returned the complainant's call on 05/18/13. The staff member validated the above referenced concerns had been identified by the complainant on 05/17/13.

Review of the facility's investigation of the

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F 166	Continued From page 2 complainant's concerns occurred on 07/16/13 and showed the facility investigated the fall experienced by Resident #3, but did not investigate the other concerns identified by the complainant. The facility completed the investigation regarding the fall on 05/22/13. The investigation did not show the facility provided the complainant with written notification, or telephone notification within seven (7) working days following receipt and conclusion of the investigation. The administrative staff member (#2) indicated the facility did not have any additional communication with the complainant after the 05/18/13 telephone call, and did not investigate all alleged problems/concerns identified by the complainant.	F 166		8/21/13
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of the facility's abuse investigation policy/procedure, review of an abuse/neglect investigation completed by the facility, and staff interview, the facility failed to implement additional investigation/monitoring of quality issues identified during the investigation process, and failed to notify the State survey/certification agency of 1 of 1	F 226	226 Valley Eldercare Center (VEC) does have a policy that: Gait belts are provided to assist staff to safely transfer or ambulate residents who require assist of 1 or 2 staff members; any variance from that policy should result in an Incident Report and an Abuse/Neglect Investigation. There are no noted variances in the last year. VEC has an ongoing training in gait belt usage. In the last nine(9) months 156 staff have attended in-services and have been skilled validated Continued on Page 4	

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F 226	Continued From page 3 abuse/neglect investigation (Resident #3) completed. Failure to implement the quality assurance and improvement phase of the investigation did not ensure staff utilized gait belts during transfer/ambulation per facility policy/procedure to prevent resident care related negligence resulting in avoidable falls and/or injuries. Findings include: Review of the facility policy titled, "Investigation of Alleged Resident/Tenant Abuse, Neglect or Misappropriation of Property," occurred on 07/17/13. The policy stated, "I. Policy. Valley Memorial Homes shall investigate and document all alleged violations related to mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident/tenant property through established procedures. . . . B. 3. All reported alleged acts of abuse, neglect, suspicious injuries of unknown origin, or misappropriation of property will be immediately and thoroughly investigated. . . . d. Additional staff training or changes to facility practices may be necessary as part of the quality assurance and improvement phase of the investigation. ... C. 2. The Final Written Investigation Report must be submitted within 5 days via one of the following methods [Mail, Fax, and E-Mail addresses/telephone numbers for the State survey and certification agency identified]." - Review occurred on July 16-17, 2013, of an investigation completed by the facility on May 22, 2013 of a fall experienced by Resident #3 while being assisted with transfer/ambulation by staff, without the aid of a gait belt. The investigation	F 226	Continued from Page 3 In the Alleged Resident/Tenant Abuse, Neglect Investigation two nursing staff (RN and CNA) who did comment on gait belts did speculate that gait belts are not always used but did not indicate that they had witnessed non-usage of gait belts. One LPN indicated that she does not usually stay in the room when CNA's are in there unless they need help; but did not indicate in any way that she had witnessed non-usage of gait belts. One CNA did indicate that one resident would not allow the use of gait belts on him but did not indicate that gait belts were not being used. VEC will establish additional Gait Belt Usage audits, these audits will include spontaneous in-room audits (see attached Audit Form). There will be 42 (forty two) monthly in-room gait belt audits. There are currently 76 (seventy six) residents requiring gait belt transfers at this time. If any variances occur they will result in an appropriate Abuse/ Neglect Investigation. If no variances occur in four (4) months the audits will be reduced to four (4) months annually. If no variances occur in two (2) years the audits will be reduced to two (2) months per year. The Gait Belt Audits will be reported to the QA Committee.	8/21/13

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F 226	Continued From page 4 concluded the lack of a gait belt could not have prevented the fall with any high degree of certainty, however, interviews by the facility during the investigation of three nursing staff members identified the following in response to the facility's question regarding the use of gait belts by staff: * Facility's interview with a registered nurse on 05/21/13 - "I don't think they always use them." * Facility's interview on 05/20/13 with a certified nurse assistant (CNA) - "I think everyone has one on, but they are not using one." During an interview with an administrative nursing staff member (#1) on the morning of 07/17/13, the staff member indicated staff (CNAs) wear the gait belt around their waist so it is accessible for use on a resident when needed. * Facility's interview with a licensed practical nurse on 05/20/13 "I think they have them on them. I don't usually stay in the room when CNAs are in there unless they need help." During an interview with administrative staff members (#1, #2, and #3) on the morning of 07/17/13, the staff members indicated the facility had not implemented a monitoring plan to track the use of gait belts in response to the above information provided during the referenced abuse/neglect investigation. The staff members indicated other residents had also experienced falls resulting from gait belts not being used. - Review of the above referenced alleged abuse/neglect investigation concerning Resident #3 showed the facility failed to notify the State survey and certification agency of the investigation findings until 07/16/13, the date the surveyor requested the facility provide all abuse	F 226		

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F 226	Continued From page 5 investigations completed by the facility in the months of May and June 2013.	F 226		8/21/13
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on information received from the complainant, record review and staff interview, the facility failed to provide the necessary toileting assistance to allow 1 of 1 resident (Resident #3) to maintain bowel and bladder continence. Failure to provide necessary assistance resulted in avoidable bowel and bladder incontinence and unnecessary emotional trauma to Resident #3. Findings include: Information received from the complainant indicated Resident #3 experienced incontinence on the night shift after activating her call light and receiving no response/assistance from staff to the bathroom. The complainant indicated the resident called a family member at 2 a.m. during the night shift "very upset" because she "had to go to the bathroom and staff would not respond to her call light."	F 310	Bladder and Bowel (B&B) assessments will be completed on all residents noted to be incontinent at the time of admission or whenever there is a change in cognition, physical ability or urinary tract or bowel function. The CNA's will record resident bladder and bowel patterns for at least 72 hours using the Bladder and Bowel Diary. The licensed nurse will review and initial this assessment at the end of each shift. After 3 days (72 hours), or longer if indicated, of assessment, the RN Care Coordinator will evaluate and determine appropriate program for that resident based on data collected. Data collected from Bowel and Bladder Diary will be incorporated into the Bladder and Bowel Assessment Form completed by the RN Care Coordinator within 7-14 days from admission. The Diary can be used prn if there is a change in continence noted to see if the current toileting program is stiff effective for the resident or if changes are needed. Residents on toileting or retraining program will be reviewed at least quarterly and with a significant change incontinence status. Residents found to be continent will be reviewed quarterly during care conferences to monitor risk factors. Continued on page 7	

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F 310	Continued From page 6 Review of Resident #3's record occurred July 16-17, 2013, and showed the facility admitted the resident on 05/13/13. The admission nursing assessment and care plan developed on 05/13/13 identified Resident #3 as "Continent of bowel and bladder, and requiring one person assistance with toileting. "The nursing assessment determined Resident #3 as able to make her needs known and able to make her own decisions. The facility call light activation records, reviewed 07/17/13, showed Resident #3 activated her call light at 1:39 a.m. on 05/14/13, and at 1:18 a.m. on 05/15/13. Both dates showed deactivation of the call light within a short period of time following activation. However, on 05/14/13 the "CNA [certified nursing assistant] Flowsheet" identified Resident #3 as incontinent of bowel and bladder on the night shift, and incontinent of bladder on the night shift on 05/15/13. The resident remained continent on the night shift during the remainder of her stay until discharged to the hospital on 05/19/13. During an interview with an administrative nursing staff member (#1) on the morning of 07/17/13, the staff member indicated the call light can be deactivated in the room without care or assistance being provided. The staff member also indicated the facility could not provide an explanation for the incontinence on 05/14/13 and 05/15/13, and had not investigated why the incontinence had occurred. The lack of providing toileting assistance may result in an inaccurate determination of resident	F 310	Continued from Page 6 A Bladder and Bowel Assessment will be completed annually or if a significant change in continent status is identified. See attached policies. Call light response times and the staff presence duration will be reviewed monthly on an ongoing basis and the results reported to the Facility Quality Assurance (QA) monthly meetings.	8/21/13

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F 310	Continued From page 7 incontinence during the initial comprehensive assessment period for any resident unless instances of unexpected incontinence are investigated and appropriate corrective actions are implemented.	F 310		8/21/13