STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345558	A. BUILDING _____ B. WING _____	C 10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NC STATE VETERANS HOME-BLACK MOUNTAIN	62 LAKE EDEN ROAD BLACK MOUNTAIN, NC 28711

(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 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview and staff interviews, the facility failed to provide incontinence care (Resident #7) and bathing (Resident #8) for 2 of 5 reviewed residents for provision of activities of daily living (ADL). Findings included: 1. Resident #7 was admitted to the facility on 05/07/13 and readmitted 01/24/14 with diagnoses including a history of cerebrovascular disease, difficulty walking, lack of coordination, muscle weakness, hemiplegia on his dominant side, dementia without behaviors and anxiety. His most recent Minimum Data Set (MDS) dated 07/28/14 revealed the resident was understood, could understand other, was severely cognitively impaired and had no moods and no behaviors. Resident #7 required extensive 2 person assistance with toileting and had a range of motion impairment on one side of his body affecting an upper and a lower extremity. He was coded as always incontinent of bowel and bladder. The resident took antidepressant and diuretic medication for all 7 days of the MDS assessment period. His care plan reviewed on 07/28/14 included the intervention of an elevated	F 312	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws. 1. a. Veteran # 7 will be provided incontinent care, toileting and assisted per his care plan. b. Veteran #8 will be offered and receive his preferred whirlpool Specialty Bathing per his request. 2. a. Veterans with the risk to be affected by delayed toileting assistance will be audited by the Interdisciplinary team to establish if this occurrence had the potential to affect them. Any Veterans identified will be provided incontinent care, toileting and assistance per his/her care plan. b. Veterans with risk for bathing scheduling variances will be audited by	10/31/14

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

Electronically Signed | 10/23/2014

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F 312	Continued From page 1 toilet seat to increase independence with toileting and noted Resident #7 had incontinent episodes which required prompt pericare. Another care plan update on 07/31/14 documented his having a urinary tract infection (UTI) with all appropriate interventions. An interview with Nurse Aide (NA) #2 on 10/01/14 at 6:30 PM revealed there were at that time 2 NAs on Resident #7's unit and it got very busy. She stated staffing around dinner time was particularly bad as residents needed toileting before meal service, transporting to the dining room, assistance with meals, transporting back to rooms, toileting and incontinence care and then assistance to bed. She stated sometimes some residents could not have their call lights answered fast enough when there was not enough staff. She stated staff tried to get to residents known for heavy wetting first but sometimes they were not successful. She stated Resident #7 rang his call bell that evening and staff did not get to him fast enough as they were busy with another resident and when they finally got there around 5:15 PM before dinner, he was completely wet. NA #2 stated when staff got to him quickly he could be toileted with no accidents, but if it took a long time to get to him he would have an accident. NA #2 stated Resident #7 was last toileted around 1:45 PM and stated NAs were expected to provide assistance with toileting every 2 hours. She stated she got busy with other residents and did not have a chance to get back into Resident #7's room. An observation of Resident #7 on 10/01/14 at 6:45 PM revealed him to be awake, communicative and understood. His clothing was dry and there were no odors present. Observed	F 312	the Interdisciplinary team. Any Veteran identified will be offered and receive his/her preferred bathing per request/schedule. 3. a. Veterans identified with potential to be affected in toileting assistance methods will include but not limited to: i. Nursing staff will be educated on Activities of Daily Living, timely incontinence care and toileting needs of our Veterans by the Clinical Competency Coordinator ii. New nursing employee□s will be educated during orientation to veteran care including Activities of Daily Living, timely incontinence care and toileting needs of our Veterans by the Clinical Competency Coordinator iii. Staff who are found non-compliant with providing Activities of Daily Living, timely incontinence care and toileting needs to the Veterans will be counseled by the Nursing Administration per the centers policy and receive additional education when indicated by the Clinical Competency Coordinator/designee. b. Veterans with Specialty Bathing preferences identified with concerns on bathing scheduling will have : i. Bathing schedules and preferences will be reviewed by the Nursing Management. ii. Establishment of alternate acceptable schedule if routine schedule does not present as optional iii. Education by the Interdisciplinary team to all nursing staff the bathing	

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F 312	Continued From page 2 in the corner of the shower enclosure of his bathroom were a tan colored pair of pants and a used incontinence brief. The pants were completely wet and the incontinence brief was completely saturated with a urine odor. An observation on 10/01/14 at 7:05 PM revealed NA #2 and the Director of Health Services (DHS) enter Resident #7's bathroom. NA #2 stated the tan pants and used incontinence brief in the shower enclosure were removed from Resident #7 before dinner. The DHS was observed putting on gloves and unrolling the pants and brief and stated the brief was very saturated. The DHS asked NA #2 when she last did rounds and NA #2 replied around 1:30 PM. The DHS stated the brief smelled of urine and had a yellow color. The DHS stated that the tan pants were completely saturated. NA #2 was observed bagging up the used incontinence brief and wet pants and removed them from the room. An interview with the DHS on 10/01/14 at 7:05 PM revealed she expected staff to offer toileting assistance or incontinence care every 2 hours and there should have been staff available to answer Resident #7's call light in a timely manner to prevent this incontinent episode. 2. Resident #8 was admitted to the facility on 06/18/14 with diagnoses including bacterial pneumonia, neuropathy and anxiety state. Review of the Minimum Data Set (MDS) dated 09/15/14 indicated Resident #8 was coded as cognitively intact and was able to understand and make himself understood. Resident #8 required extensive assistance with assist of 2 persons for dressing, toilet use, personal hygiene and total dependence for bathing.	F 312	schedule and preferences of Specialty Bathing iv. Education to nursing staff by the Interdisciplinary team in approach and communication in the event regular schedule cannot be followed with the need to recruit cooperation from Veteran for alternate plan established. v. New nursing staff employees will be educated during orientation to veteran care including providing Veterans bathing preferences/schedules by the Clinical Competency Coordinator. vi. Veterans will be monitored by the Interdisciplinary Team on an ongoing basis for changes in their bathing preferences and provide this information to the nursing staff. vii. New Admissions/re-admissions/changes in conditions will be reviewed by the Interdisciplinary Team for bathing preferences and this information will be provided to the nursing staff. 4. Veterans will be monitored for provided incontinent care, toileting and assistance per his/her care plan. 4 times per week for 4 weeks 3 times per week for 4 weeks 2 times per week for 4 weeks 1 time per week for 4 weeks Monthly for 4 Months 5. Veterans will be monitored for being offered and receive his/her preferred bathing per request/schedule. 4 times per week for 4 weeks 3 times per week for 4 week	

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F 312	Continued From page 3 Review of the Care Area Assessment Summary (CAA) dated 06/25/14 revealed Resident #8 had been hospitalized with pneumonia and before the hospitalization he was more independent with activities of daily living (ADL). He was admitted to the facility for therapy because of increased weakness and poor endurance and wanted to reach his prior level of functioning. He was care planned for ADL due to the noted risk factors. Review of the care plan dated 06/25/14 and reviewed 09/15/14 revealed Resident #8 had a need for nurse aide care interventions. One of the approaches included "PLEASE OFFER WHIRLPOOL BATH ON SHOWER DAYS PER RESIDENTS REQUEST." Review of the shower schedule for Resident #8 revealed he was to receive whirlpool baths on Sundays, Wednesdays and Fridays. An interview on 10/01/14 at 11:34 AM with Nurse Aide (NA) #2, NA #10 and NA #15 who had worked on the unit Resident #8 resided revealed the change of shift began at 2 PM and instead of 3 NA on the evening shift only 2 NA would be available to provide assigned showers, incontinence care, personal hygiene, feeding assistance and answering call lights. The NA stated it would be difficult without another NA to get care done but they would divide up the residents and assist one another as needed. On 10/02/14 at 4:00 PM an interview was conducted with Resident #8. He stated he had whirlpool baths scheduled three times a week, Sundays, Wednesdays and Friday evenings on second shift. Resident #8 revealed when staff	F 312	2 times per week for 4 weeks 1 time per week for 4 weeks Monthly for 4 Months 6. Reports will be submitted monthly to Quality Assurance Performance Improvement Committee for review, modification, and validation until substantial compliance has been deemed met by Quality Assurance Performance Improvement Committee	

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have arrived on second shift they are given a list of residents who need showers. He stated he had not received his whirlpool bath on the previous night (10/01/14) because he had been told there was not enough staff available to give him his whirlpool bath. He revealed he called the nurse to report he was told he could not get his whirlpool bath and the nurse had not followed up with him. He stated he had missed whirlpool baths on Sundays and Wednesdays approximately four times because he had been told there was not enough staff to provide it. He reported he had wanted his whirlpool bath at 9:00 PM. He stated he had stayed up and received it as late as 11 PM when the nurse on the hall became aware he had missed his whirlpool bath and had the NA give it to him. He stated he had looked forward to his whirlpool bath because it was relaxing and soothed his muscles and joints.

On 10/02/14 at 2:06 PM an interview was conducted with NA#15. She stated she worked on the unit Resident #8 resided on from 6:00 AM to 2:00 PM. She revealed at shift change Resident #8 had not received his whirlpool bath the previous night (10/1/14) because there was not enough staff to give showers. NA #15 stated Resident #8 had whirlpool baths scheduled Sundays, Wednesdays and Fridays and staff know he looks forward to getting his whirlpool baths. She reported when she came on shift there were three NA scheduled on the unit and she had two showers scheduled and the other NA had two scheduled showers. She said the third nurse aide had responsibility for other care including mouth care, personal hygiene such as washing hands and faces, and getting residents ready to go down to the dining room to eat. NA #15 revealed she did not have time to give

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F 312	Continued From page 5 Resident #8 a whirlpool bath and because of staff being short he had missed whirlpool baths on other scheduled days. On 10/04/14 at 10:10 AM an interview was conducted with Nurse #5, who had been the night supervisor on 10/01/14. She stated she had been responsible for supervision of all four units that night and she had been made aware that Resident #8 had not received his whirlpool bath. She reported that because the staffing was short she had not talked with the resident or followed up with him about his missed whirlpool bath to make sure it would get done. She stated she had been busy on the other units attending to staff and resident needs and was unable to make sure Resident #8 had received his whirlpool bath.	F 312		
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: Based on record review and staff interviews, the facility failed to provide timely response to a fall alarm resulting in a fall with serious injury for 1 of 3 residents (Resident #3) identified with a history of repeated falls. Findings included:	F 323	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the	10/31/14

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F 323	Continued From page 6 Review of a hospital discharge summary dated 08/27/14 revealed Resident #3 to have left 9th and 10th rib fractures, the resident falling easily, a history of a fall, hurting his left hip and being brought to an emergency room Resident #3 was admitted to the facility on 08/27/14 and transferred to a hospital on 09/14/14 with diagnoses including paralysis agitans, previous history of multiple rib fractures resulting from a fall, muscle weakness, lack of coordination, gait abnormality and depression. A review of the admission Minimum Data Set (MDS) dated 09/03/14 revealed the resident as cognitively intact with adequate vision, no behaviors and no wandering. Resident #3 was coded as requiring extensive 2 person assistance with most activities of daily living (ADL) which included transfers and toileting. Balance during transitions, which included moving from a seated to standing position and surface to surface transfers (between a bed and chair or wheelchair [WC]), were coded for Resident #3 as not steady and as only able to stabilize with staff assistance. The MDS noted the resident with range of motion (ROM) impairment of both his lower extremities. No fall history on or since admission to the facility was noted. Resident #3 was coded as receiving antianxiety and antidepressant medication for all 7 days of the MDS assessment period. A review of Resident #3's Care Area Assessment summary revealed a history of falls prior to, but none since, his facility admission. Review of a progress note dated 08/28/14 revealed Resident #3's family requested bed and chair alarm which were put in place. This note documented the resident as able to use the call	F 323	requirements by State and Federal Laws. 1. Resident got out of bed, fell sustaining fractured ribs, immediate transfer to ER for treatment. Veteran subsequently transferred to a Hospice House close to his wife, then re-admitted to a NCSVH-Facility closer to his wife□s home. 2. Audit performed by Case Mix Directors to identify the potential of any veterans at risk on 10/3/14 to ensure each resident had adequate supervision and assistance devices to prevent accidents. a. Veterans who were identified with Risk for falls by the Case Mix Directors had the falls risk assessment completed to establish appropriate interventions in place b. Interventions changed as indicated to current individualized needs c. Assessments were reviewed to validate reflection of risk and the individualized care plan was updated as indicated to provide proper supervision to prevent accidents 3. Systemic Changes on Communication and Reporting a. Communication to nursing staff of indicated change consists of: b. Shift to shift report communication c. Care plan changes will reflect on the Kiosk Screen for communication to direct line care givers d. Education provided by director of Health Care Services, Senior Care Partner, and Nursing Supervisors to all	

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F 323	Continued From page 7 bell but he may not have had recall to know how or why to use it. This note documented the family as providing much of the information for the admission process. Review of a progress note and fall incident report dated 08/30/14 revealed Resident #3 was found by an nurse aide (NA) face down on the floor of his bedroom, in front of his WC which was overturned, the WC alarm sounding and presenting with a small cut above his right eyebrow and a small hematoma right forehead. The assessment revealed him to have full ROM and neurological checks as within normal limits. Notifications were documented as made to the physician, responsible person (RP) and the Director of Health Services (DHS). Review of Resident #3's physician orders for September 2014 revealed him to have prescribed the antidepressant Paxil 40 milligrams (mg) by mouth daily at hour of sleep and the antianxiety medication Ativan 0.5 mg by mouth daily. A review of an interim care plan form documented a fall on 08/30/14 with injury and with the resident educated to use the call bell for assistance with toileting. Review of his care plan dated 09/04/14 revealed nurse aide (NA) interventions which included placement of bed and WC alarms at his family's request due to a history of falls and use of a WC or rolling walker with assistance. The problem of falls was noted based on his history with interventions including bed and chair alarms. Additional handwritten care plan updates for the problem of falls included entries on 09/10/14 (unwitnessed fall in bathroom with no injuries), 09/11/14 (fall with no injuries), 09/13/14 (unwitnessed fall in room with no injuries) and	F 323	licensed and certified nursing staff AND all other ancillary support staff on Fall/Occurrence reporting and investigation process. e. All Staff currently on schedule on 10/3/14 have completed this education f. All Additional staff not present on this day has had education completed upon return to work g. New employees will be educated on job specific orientation 1. Initiation and Completion of Reporting Tool for Incident/Accident a. Employee who found resident statement b. Licensed care giver statement c. Certified care giver statement d. Any employee who witnessed the occurrence will have a statement attached to the investigation 2. Interdisciplinary Team review of all falls a. to evaluate effectiveness of actions and immediate interventions b. change and/or update as indicated interventions to meet resident needs c. information is communicated via shift to shift report d. data is placed directly in to the Kiosk Screen for the electronic communication record for direct care staff notification e. Supervisors will direct the immediate safe accommodation of veteran needs and care based on their professional assessment of veteran acuity, staff present for duty, weighing the emergent situations as indicated Direct	

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F 323	Continued From page 8 09/14/14 (fall with injury). Additional handwritten interventions for the problem of falls were noted on 09/10/14 (place resident in bed after meals), 09/11/14 (resident to be toileted after dinner before being put to bed), 09/13/14 (increased visual of resident) and 09/14/14 (sent to emergency room [ER] for evaluation). Review of a progress note dated 09/01/14 revealed that at 3:07 AM on this date, Resident #3 verbalized understanding that he was to ring for staff assistance with all attempts at transferring but he transferred himself at 6:30 Pm from his WC to his bed without assist, which was discovered by a nurse when his alarm went off. Another note dated 09/02/14 revealed the resident verbalized understanding to use the call bell before attempting a transfer. Review of a physician's history and physical (H & P) report dated 09/08/14 revealed the resident presenting with history of a fall , evaluation of left hip and flank discomfort, history of Parkinson's, gait instability, slowness and stiffness of movement and progressive behavioral problems. Review of a progress note and fall incident report dated 09/10/14 revealed that at 7:08 PM that day Resident #3 was found on his bathroom floor, his head propped against shower and as reporting he hit his head and had a headache. The assessment revealed him to have full ROM and neurological checks as within normal limits. Notifications were documented as made to the physician, RP and DHS. Staff were to be notified to place the resident in bed after dinner to avoid any further falls and that it appeared he was becoming more confused at night. Review of a nurse staffing schedule for 09/10/14 revealed 3	F 323	communication with Director of Health Services AND Administrator is expected with any event the RN Supervisor assesses a higher risk level for Veteran Safe Care and Services 4. Monitoring of the identified individuals who have the potential to be affected will be performed 4 times per week for 4 weeks 3 times per week for 4 weeks 2 times per week for 4 weeks 1 time per week for 4 weeks Monthly for 4 Months Reports will be submitted monthly to Quality Assurance Performance Improvement Committee for review, modification, and validation until substantial compliance has been deemed met by Quality Assurance Performance Improvement Committee	

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NAs scheduled from 6:00 PM to 10:00 PM on Resident #3's unit with one of these names crossed out and noted as "termed." Review of a unit assignment sheet dated 09/10/14 for the resident's unit revealed for the 2:00 PM to 10:00 PM shift 4 NAs, with one name crossed out and another name noted as working only to 6:00 PM. Review of time clock reports dated 09/10/14 and corroborated with the unit assignment sheet for 09/10/14 revealed 2 NAs clocked in to work on Resident #3's unit from 6:00 PM to 10:00 PM.

Review of a progress note dated 09/11/14 revealed that at 3:50 AM Resident #3 was observed disarming his chair and bed alarms, that he was spoken to and that he verbalized understanding but shortly after the conversation the resident was found attempting to turn off the alarm again.

Review of a progress note and fall incident report dated 09/12/14 revealed that on 09/11/14 at approximately 6:45 PM a nurse heard an alarm go off and found Resident #3 in his room, on his stomach and next to his bed. The note documented the resident denying that he hit his head and that he needed to go to the bathroom. This note documented the resident as wearing non-skid shoes, eyeglasses, floor was dry and having a functioning chair alarm functioning. Staff were educated on the importance of Resident #3 being assisted to the bathroom after dinner then placed in bed. The assessment revealed him to have full ROM and neurological checks as within normal limits. Notifications were documented as made to the physician, RP and DHS. Review of a nurse staffing schedule for 09/11/14 revealed 3 NAs scheduled from 6:00 PM to 10:00 PM on Resident #3's unit with one of

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these names partially crossed out. Review of a unit assignment sheet dated 09/11/14 for the resident's unit revealed for the 2:00 PM to 10:00 PM shift 4 NAs, with one name crossed out with the words "no call no show" and another name noted as working only to 6:00 PM. Review of time clock reports dated 09/11/14 and corroborated with the unit assignment sheet for 09/11/14 revealed 2 NAs clocked in to work on Resident #3's unit from 6:00 PM to 10:00 PM.

Review of a progress note dated 09/12/14 at 9:50 AM revealed Resident #3 receiving assistance with ADL and transferring. The resident was reminded to use a call light for assistance with all transfers as he was unsafe with transfers, the resident nodded his head to indicate "yes" and that he was forgetful with requesting assistance with toileting, upon arising and in between meals.

Review of a progress note and fall incident report dated 09/13/14 revealed that at 12:15 PM an NA found the resident on his back on the floor beside his bed, the fall was unwitnessed and he was wearing non-skid shoes. The assessment revealed him to have full ROM and neurological checks as within normal limits. Notifications were documented as made to the physician, RP and DHS. Review of a nurse staffing schedule for 09/13/14 revealed 4 NAs scheduled from 6:00 AM to 2:00 PM on Resident #3's unit with one of these names crossed out and an additional NA on orientation ("o"). Review of a unit assignment sheet dated 09/13/14 for the resident's unit revealed for the 6:00 AM to 2:00 PM shift 4 NAs, with one name crossed out and an additional name as on "o." Review of time clock reports dated 09/13/14 and corroborated with the unit assignment sheet for 09/13/14 revealed 4 NAs

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clocked in to work on Resident #3's unit from 6:00 PM to 2:00 PM with an additional orienting NA.

Review of a nurse staffing schedule for 09/13/14 revealed 2 NAs scheduled to work 10:00 PM on Resident #3's unit with one of these names circled with the words "not on schedule" and the name of NA #1 added in the margin. Review of a unit assignment sheet dated 09/13/14 for the resident's unit revealed for the 10:00 PM to 6:00 AM shift 2 NAs (one of these being NA #1). Review of time clock reports dated 09/13/14 and corroborated with the unit assignment sheet for 09/13/14 revealed 1 NA (NA #1) clocked in to work on Resident #3's unit from 10:00 PM to 6:00 AM.

Review of a nurse's note, dated 09/14/14 at 2:15 AM and signed by Nurse #1, revealed Resident #3 was found lying on his left side on his bedroom floor, his head against a wall and the bed alarm going off. This note documented that when the resident was touched on his right side and staff attempted to move him off his side he yelled in pain and lung sounds suggested fluid in his lungs. Review of a progress note, dated 09/14/14 at 3:04 AM and signed by Nurse #2 (night shift nursing supervisor) revealed she was called to the unit to evaluate Resident #3 due to a fall, lying on his left side, right arm favoring right side and the resident refusing to allow staff to turn or move him. This nurse documented a dark purple bruise on right side measuring 6 centimeters by 5 centimeters, the resident stating it hurt when he breathed and his right side hurt when he moved. This nurse documented on-call physician was notified and ordered Resident #3 be sent to the ER and the RP was also notified. This nurse documented that at 2:45 AM

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emergency medical technicians (EMTs) arrived and lifted the resident onto a stretcher for transport to a local hospital. This note documented that neurological checks were started and within normal limits but not finished due to transfer of the resident.

Review hospital ER notes dated 09/14/14 revealed Resident #3 fell in his room at the nursing home striking his right ribs on a dresser and complaining of severe pain with movement and deep breathing. Interpretation of x-rays by the ER physician revealed multiple bilateral rib fractures with subcutaneous emphysema and a small pneumothorax on the right side of his chest. Computerized tomography (CT) of his chest revealed nine right sided rib fractures with a small pneumothorax with potential for a tension pneumothorax. Consultation with general surgery revealed their recommendation to transfer him to the trauma service of another hospital.

Review of hospital discharge summary records dated 09/19/14 revealed Resident #3 was transferred there from an outside hospital after losing his balance at the nursing home and striking his right ribs on a dresser. Further radiographic imaging revealed a flail chest from the right 6th through 10th ribs, a small right pneumothorax and small right hemopneumothorax which required a chest tube. Due to the significant rib fractures and comorbidities, Resident #3 underwent epidural catheter placement for pain control. The resident was admitted to a neurotrauma intensive care unit. Due to rather slow progression and minimal improvement during hospitalization, the resident's family decided to transfer him to hospice and have the epidural catheter and chest tube

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removed.

An observation on 10/02/14 at 10:15 AM revealed that the room where Resident #3 fell was located 37 paces from door frame to nursing station room and required walking around columns and furniture in a common area and walking around a corner in the hallway.

An interview with NA #1 on 10/02/14 at 6:02 AM revealed she had been assigned to Resident #3 on 09/13/14 during the 10:00 PM to 6:00 AM night shift. She stated normal practice was to have 2 NAs scheduled on night shifts with one NA at one end of the hall and the other NA at the other end. She stated she was on the resident's unit by herself on the morning of 09/14/14 and Resident #3 fell at the opposite end of the hall. She stated she heard the bed alarm go off as she was leaving another resident's room at the opposite end of the hall. She stated Resident #3 was a known fall risk, was known to scoot in bed and when the alarm would go off staff had a window of opportunity to rush over and get to him. She stated she felt that if there were an NA on that end of the hall that night they would have heard the alarm and attended to him and that this is how it would play out when you had 2 people on the unit. NA #1 stated someone had called out that night and that was the reason why she was by herself. She stated by the time she got to Resident #3 he was already on the floor. She stated Nurse #1 was in the charting room but could not hear the alarm, but NA #1 stated she got the nurse after finding the resident and returned to his room. NA #1 stated she did a sprint from one end of the hall to the other in about 10 to 15 seconds at full force and that if someone was at that end of the hall where the

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resident's room was located, it would have taken them 3 or 4 seconds at the most. She stated there was some time involved with the resident doing that scooting and, assuming staff were not doing rounds or involved with showers, she felt the fall could have been prevented. She stated at night Resident #3's bed was lowered all the way to the ground so he took more time to stand up.

A phone interview with Nurse #1 on 10/02/14 at 7:34 AM revealed she was assigned to Resident #3 from 10:00 PM to 6:00 AM on 09/13/14 through 09/14/14. She stated that at 6:00 PM they would normally have started with 2 NAs and would keep 2 NAs through to 6:00 AM. She stated she recalled a shift a few weeks prior where there was only 1 NA and the night nurse supervisor tried to plug the hole but they were not successful. She stated she assisted NA #1 with answering call bells and they were answered. She stated she remembered the fall occurring with Resident #3 and NA #1 was the only NA working the night the fall occurred. Nurse #1 stated she was in the medication room (located inside the nurse's charting room) and NA #1 got her really fast and they went right back to the resident's room. Nurse #1 stated she called the night nurse supervisor (Nurse #2). She stated her assessment of Resident #3 revealed that upon touching his ribs he yelled and it sounded like there was a pneumothorax where she could hear air leaking into the chest cavity. She stated the fall occurred in the early morning hours, between midnight and 1:00 AM or so. She stated when she arrived Resident #3 was on the floor lying on his left side with his head against the wall. She stated when touching his right side he said it hurt, he could talk to you, everything was hurting and he would not let staff move him. She

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stated the EMTs had a hard time getting him up because when they moved him he screamed and hollered. Nurse #1 stated she called the physician and family, followed the protocol, the night nurse supervisor did the assessment entry in the computer, everything flowed according to normal procedure and there were no delays. Nurse #1 stated Resident #3 was a known fall risk and that any unit needed more than 1 NA as that was not enough staff. She stated NAs worked together and at times one would go to one end of the unit and the other would go to the other end. She stated the fall could have happened even if there was 2 NAs but that 1 NA was not good and having 2 NAs would have increased the chances of one hearing the alarm and responding. She stated that particular shift was the only time she ever worked with just 1 NA. Nurse #1 stated she hardly knew Resident #3 as he was new to her and she was not aware that he would scoot in the bed before he would fall. She stated NA #1's explanation of the resident's pattern of getting up unassisted seemed plausible to her based on past experience with similar residents. She stated that being in the medication room, she could hear nothing and in the nurse charting room she could hear some and that night the door to the medication room was open and the door to the charting room was partially open. Nurse #1 stated that if there were another staff member and the resident was scooting the way NA #1 described, then it was probable someone could have prevented him from falling, not a 100% chance but if that was his pattern then more staff would have allowed him to be helped more. She stated she thought it would have been better off it there were 2 NAs with one doing vital signs and the other listening to call bells, one at one end of the unit and the other at the other end. Nurse #1

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stated it was not a good night with just her and NA #1, it was a busy night, she felt like they were short staffed and it was part of the reason why he fell.

An interview with Nurse #2 (night nursing supervisor) on 10/02/14 at 12:38 PM revealed that on the morning of 09/14/14 Nurse #1 had just given medications and completed neurological checks for another resident who fell earlier in the day on 09/13/14, after which Nurse #1 went back into the charting room while NA #1 did vital signs on that resident. She stated NA #1 left that resident's room for another resident to do neurological checks and vital signs when she heard the fall alarm to Resident #3's room and it happened so fast. She stated a pressure alarm was in place. She stated Resident #3's most vulnerable time was his transition to standing and that is where staff assistance was required. She stated he was cognitive enough to understand to use the call bell but he had intermittent confusion, was stubborn or forgetful to tell staff when he would stand up. Nurse #2 stated NA #1 was so good that sometimes she was left alone and it was a lot of work for the NA to be by herself with the nurse. She stated she felt staffing could have been a contributing factor and due to short staffing the facility had more injuries.

An interview with the DHS on 10/03/14 at 4:44 PM revealed a review of the staffing sheet for 09/13/14 showed Nurse #2 assumed an NA role but the DHS stated she was calculated as part of the registered nurse formula for staffing. She stated interventions to prevent resident falls might eventually lead to one on one monitoring, beds lowered to the floor or placement of mats. She stated one had to look at the circumstances and

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F 323	Continued From page 17 these things might not fix it but staff would kept trying. She stated bed alarms were for notification and would not necessarily prevent a fall. The DHS stated that staffing was not ideal the night Resident #3 fell and that there should have been 2 NAs on that shift. She stated the expectation was the nurse supervisor should have placed a call to me to fill the gap if all options were exhausted. A follow-up interview with Nurse #2 on 10/03/14 at 7:30 PM revealed nursing supervisors made sure staff showed up during change of shift and that staff from the previous shift stayed on for those who did not show up. She stated they received staff call-ins and if the call-in was not an extra scheduled staff person, they would hit the phones to find a replacement. She stated if they knew they were going to be short staffed they would call the administrator or DHS who would make decisions. She stated the nursing supervisor might step down to take a medication cart so that the scheduled nurse could become an NA and if the scheduled nurse could not physically take the cart due to physical limitations then she as the nursing supervisor would step down to be the NA. Nurse #2 stated she and the weekend supervisor worked on getting staff in on Saturday, 09/13/14. She stated it was not realistic for her to be the second NA on the unit. She stated she had to clock out for lunch which is what she did just before Resident #3 fell. She stated Resident #3 needed someone to sit with him that night.	F 323		
F 353 SS=G	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to	F 353		10/31/14

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F 353	Continued From page 18 provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview and staff interviews, the facility failed to provide sufficient nursing staffing resulting in a resident having a fall with injury (Resident #3), incontinence (Resident #7) and a missed bath (Resident #8) for 3 of 8 reviewed residents. Findings included: 1. Cross refer to tag F323. Based on record review and staff interviews, the facility failed to provide timely response to a fall alarm resulting in a fall with serious injury for 1 of 3 residents (Resident #3) identified with a history of repeated falls.	F 353	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by State and Federal Laws. 1. F-353 is subsequent to the findings in: F-312 F-323 2. Alpha, Bravo, Charlie and Delta	

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F 353	Continued From page 19 2. Cross refer to tag F312. Based on observation, record review, resident interview and staff interviews, the facility failed to provide incontinence care (Resident #7) and bathing (Resident #8) for 2 of 5 reviewed residents for provision of activities of daily living (ADL). An interview with NA # 3 on 10/01/14 at 12:50 PM revealed the facility was working on transitioning NAs from a 12 hour shift to an 8 hour shift. She stated there seemed to be call outs mainly on weekends and it seemed to be particular NAs that called out more than others. She stated Resident #3's unit was more difficult because they had more residents that required assistance. An interview with NA #4 on 10/01/14 at 6:15 PM revealed staffing had been "rough" and they were often short handed. He stated that he often did not get resident showers done, especially on Resident #3's unit because they had heavy care needs and some residents required extensive assistance requiring 2 NAs for their care. He stated he felt there was not enough help for the evening shift from 6:00 PM to 10:00 PM. An interview with NA #5 on 10/01/14 at 7:35 PM revealed Resident #3's unit required 3 NAs from 2:00 PM through 10:00 PM due to the heavy workload associated with toileting and showers. She stated on some days no more NAs would come in at 6:00 PM and the nurses sometimes had to help with resident care. She stated there had been residents who experienced incontinence because the NAs could not get to them on time. She stated she could tell the difference between an incontinent accident and need for incontinence care after a prolonged	F 353	Wings of our facility would have the potential to be affected. a. Audit performed by Case Mix Directors to identify the potential of any veterans at risk on 10/3/14 to ensure each resident had adequate supervision and assistance devices to prevent accidents. b. Veterans who were identified with Risk for falls by the Case Mix Directors had the falls risk assessment completed to establish appropriate interventions in place 3. Distribution of staff will be according to RN Supervisor□s assessment of current acuity, staffing present and special needs. a. Director of Health Services will complete all staffing schedules on 10/3/2014 for CNA□s and Licensed Nurses until decided otherwise by Administrator b. Nursing Supervisor will be responsible to correct Posted Nursing hours to reflect changes as indicated in staffing numbers as these changes occur c. Daily staffing changes to meet acuity and special needs will be performed daily by the Director of Health Services or Designee and as needed by Registered Nurse Supervisor when indicated d. Roll Call at time clock will be conducted by the Nursing Supervisor at the beginning of each shift to confirm/validate attendance of scheduled staff and ensure accuracy for regulatory requirement of Daily Nursing Hours Posting. e. Nursing Supervisor is responsible to	

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period of time.

An interview with NA #6 on 10/02/14 at 5:11 AM revealed she always worked nights, either from 10:00 PM through 6:00 AM or from 6:00 PM through 6:00 AM. She stated sometimes they had 3 NAs on her unit until 10:00 PM and then at 10:00 PM went down to 2 NAs. She stated there were times nurses were called in to do the work of NAs because they were short staffed due to callouts. She stated having very little help resulted in a lot of falls and with one more staff person every resident could be properly cared for.

A phone interview with Nurse #2 (night nursing supervisor) on 10/02/14 at 12:38 PM revealed that ideal NA staffing for 8 hour shifts was 4 NAs/per unit on day shifts (6:00 AM through 2:00 PM), 3 NAs/per unit on evening shifts (2:00 PM through 10:00 PM) and 2 NAs/per unit on night shifts (10:00 PM through 6:00 AM) but it was not always that way. She stated at least once a week she was short from 6:00 PM through 10:00 PM on staffing which was the time residents were finishing dinner, wanting night time ADL done and to go to bed. She stated she would have 1 or 2 NAs and she would help them to do their work. She stated lots of NAs and nurses applied to work at the facility for 12 hour shifts, because they work other jobs, but they were suddenly told they would transition to 8 hour shifts and it was not a smooth transition. She stated historically the evening shift was always the hardest to staff, there were the most call outs and staff were least willing to work. Nurse #2 stated when they were short staffed it was sometimes all about keeping residents dry, clean and turned with no time for the extras. She stated she arrived to the facility a half an hour early and would get on the phone or

correct and/or change hours as indicated with staffing changes to reflect actual present and working nursing staff numbers.

f. Call in□s will be taken by Nursing Supervisor. Nursing supervisor will then call non-scheduled staff to make every effort to fill indicated open caregiver area.

g Nursing Supervisor will notify Director of Health Services and Administrator if ongoing effort to fill call in needs.

h. Supervisor will direct present staff to stay until adequate relief is obtained and provided continued care on assigned wing until appropriate assistance arrives. Nursing Supervisor must maintain communication with the Director of Health Services and Administrator until crisis is resolved

i. Director of Health Services and Administrator will participate, delegate and assist in obtaining, providing gathering appropriate staffing coverage along with other licensed and certified caregivers, to ensure the adequate level of care is provided based on acuity and special needs.

j. Director of Health Services and Senior Care Partner on 10/3/2014 Nursing Supervisor and licensed nurse□s education to call every staff member not currently scheduled, supervision of current coverage until relief arrives based on staffing parameter guidelines, communication with subordinates, peers and other Supervisors.

k. CNA education includes, attendance policy, progressive discipline regarding attendance, communication with peers

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F 353	Continued From page 21 text and ask staff to come in and help. She stated she would call nurses to work as NAs and overtime was not approved. Nurse #2 stated one night she was assigned as an NA on two units and was required to schedule rounds on different times, with one NA remaining on each of these units. She stated when nurses were done with medication pass around 11:00 PM they could take over and she could get her shift supervisor work done. She stated if an emergency popped up on another unit while filling in for NA care on another unit, she had to leave the other NA alone and that made it difficult. She stated that considering the size of the building and that all rooms were private there was really a need for 3 NAs on each unit just to hear what was going on, as one NA on the one end could not hear what was going on the other end and vice versa, like call bells and fall alarms. She stated that after medication pass was done the nurse would pick up the middle of the hallway or where the need was greatest. She stated if nurses were in the medication room they would prop the door open and always keep the door open to the charting room. An interview with the Director of Health Services (DHS) with the Administrator present on 10/02/14 at 3:45 PM revealed that normal NA staffing for the facility (for all units) was 8 NAs and 2 restorative aides on day shift, 8 NAs on evening shifts and 8 NAs on night shifts. She stated some of the day shift NA overlap the evening shift to assist residents with evening meals. A phone interview with the Clinical Care Coordinator (CCC) on 10/03/14 at 11:00 AM revealed she was the person responsible for scheduling NAs during the previous 6 weeks. She	F 353	and supervisors with options for coverage if calling in. I. All clinical nursing staff will have education completed by Nursing Supervisor prior to reporting for Resident care on assigned unit. Compliance with education will be evident on 10/3/2014. 4. Monitoring of appropriate, Scheduling and Staffing requirements will be performed by the Director of Health Services/Designee Ongoing compliance will be validated by the Director of Health Services with Administrator oversight 5 times per week for 4 weeks 4 times per week for 4 weeks 3 times per week for 4 weeks 2 time per week for 4 weeks Weekly for 4 weeks Monthly for 4 Months Reports will be submitted monthly to Quality Assurance Performance Improvement Committee for review, modification, and validation until substantial compliance has been deemed met by Quality Assurance Performance Improvement Committee	

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	345558	A. BUILDING _____ B. WING _____	C 10/03/2014

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F 353	Continued From page 22 stated she created an NA schedule by taking the list of NAs per their assigned shifts and in accordance with their corporate formula of patients per day (PPD). She stated this created problems as a corporate decision was made to change NAs from a 12 hour shift to an 8 hour shift and that overtime was not permitted. She stated she would attempt to get staff to come in and cover a shift, sometimes asking those already scheduled to come in 4 hours early or asking those who already worked to stay 4 hours, particularly on the 2:00 PM to 10:00 PM shift. The CCC stated managers knew about the schedule every day as they received a copy along with staffing sheets and were ultimately responsible. She stated she was told she could hire NAs to fill schedule holes for the 2:00 PM through 10:00 PM shift and had hired some through networking. She stated she was having to pull nurses to come in and provide coverage for NA schedule slots. She stated she did not know when people called out and it was only during the day shifts when she assisted in helping to find coverage. She stated the corporate PPD formula did not look at resident acuity. She stated she received an e-mail from the administrator that reminded her of the expectation of scheduling 3 NAs/unit from 6:00 AM through 2:00 PM, 3 NAs/unit from 2:00 PM through 10:00 PM and 2 NAs/unit from 10:00 PM through 6:00 AM. She stated this was the expectation regardless of acuity or unit. She stated that as far as she knew the DHS was to be notified by supervisors on weekends if there were call outs and those expected NA staffing numbers could not be met.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		10/31/14

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F 356	Continued From page 23 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and staff interviews, the facility failed to post staffing hours for the licensed and unlicensed staff directly responsible for resident care in the facility.	F 356	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of	

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F 356	Continued From page 24 Findings included: Review of the facility document titled "Staffing Hour Posting regulations for Healthcare Centers" revealed positing and record keeping requirements for skilled nursing facilities as defined by the Center for Medicare Services (CMS). The rule requires that a on a daily basis for each shift, the center must post nursing data for licensed and unlicensed staff responsible for direct resident care. The required data elements of the rule are as follows: the facility name, current date, resident census per shift, facility specific shifts for the 24 hr period, categories of nursing staff employed per shift (ex: RN's. LPN's, CNA's.), actual time worked including split shifts, the number of nursing staff worked per shift and name and title of a clinical supervisor available for each shift. The rule further required nurse staffing data must be retained for 18 months. On 10/01/14 at 11:15 AM the Administrator advised the survey team that the facility census was 94 residents. The Daily Nursing Hours Posting Form (DNHP) indicated census of 94 and the staffing hours were completed for 6 AM to 2 PM and 2 PM to 10 PM. There were no hours posted for 10 PM to 6 AM. Additional observation on 10/01/14 at 1:15 PM revealed the actual hours for 10 pm to 6 AM were omitted from the posted daily staffing information and the census number was changed to 95. The DNHP form copy dated 10/01/14 was provided on 10/03/14 and was completed with the 3rd shift staffing data and a census change of 96. Copies of the DNHP forms from 09/01/14 through 10/03/14 were provided to the survey team by the administrator on 10/03/14. A review of the staffing	F 356	Correction is submitted to meet the requirements by State and Federal Laws. 1. Daily Hours Nursing Posted Form was immediately corrected and put in place 2. Daily Posting has the potential to be affected 3. Instructions and education on completion and posting of this Form Federal Regulation for it to be posted daily Data must include Name of Facility Current date Resident census per shift Registered Nurses Licensed Practical Nurses Certified Nursing Assistance Any specific data split shifts additional call in to replace Subtraction of hours of individuals who call out or leave Name and Title of Nursing Supervisor available for each shift Completion of entire form each shift is required It is the Nursing Supervisor□s responsibility to perform this duty Staffing Data must be retained for 18 months Education to Nursing supervisors New employee□s will be education on job specific orientation 4. Monitoring of Daily Hours Nursing Posting requirements:	

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F 356	Continued From page 25 posting documentation revealed the following: · There were no completed DNHP forms for the dates of 09/01/14, 09/04/14, 09/09/14, 09/16/14, 09/25/14, 09/28/14, and 09/29/14. · The DNHP form dated 09/06/14 was not fully completed and was missing staffing posting hours for 6 PM to 6 AM and no census count for that shift. · The DNHP form dated 09/07/14 was not fully completed and was missing the designated shift times for the hours after 6 PM and the census count for that shift. · The DNHP form dated 09/11/14 was not fully completed and was missing staffing posting hours for 6 AM to 6 PM and no census count for that shift. · The DNHP form dated 09/13/14 was not fully completed and was missing staffing posting hours for 6 PM to 6 AM. The census was completed as 99. · The DNHP form dated 09/19/14 was not fully completed and was missing the census for 6 PM to 6 AM shift. · The DNHP form dated 09/21/14 was not fully completed and was missing the census for the 6 AM to 6 PM shift and missing the staffing posting hours for 6 PM to 6 AM and no census count for that shift. · The DNHP form dated 09/23/14 was not fully completed and was missing the census number for the 10 PM to 6 AM shift and had hours posted for 3 shifts.	F 356	Will be performed by the Director of Health Services/Designee Ongoing compliance will be validated by the Director of Health Services with Administrator oversight 5 times per week for 4 weeks 4 times per week for 4 weeks 3 times per week for 4 weeks 2 time per week for 4 weeks Weekly for 4 weeks Monthly for 4 Months Reports will be submitted monthly to Quality Assurance Performance Improvement Committee for review, modification, and validation until substantial compliance has been deemed met by Quality Assurance Performance Improvement Committee	

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F 356	Continued From page 26	F 356		

· The DNHP form dated 09/24/14 was not fully completed and was missing staffing posting hours for 6 AM to 6 PM shift.

· The DNHP form dated 10/03/14 was not fully completed and was missing staffing posting hours for 6 PM to 6 AM and no census count for that shift.

· The names and titles of the clinical shift supervisors were missing on 09/06/14, 09/07/14, 09/11/14, 09/12/14, 09/13/14, 09/14/14, 09/15/14, 09/19/14, 09/20/14, 09/21/14, 09/24/14, 09/27/14, and 10/03/14.

During an interview on 10/02/14 at 3:45 PM the Director of Health Services (DHS) stated she was not aware the daily staffing forms were not completed as required. The DHS further stated it was the responsibility of the nursing supervisor each day for each shift that completed the staffing posting. The DHS explained that the staffing posting is put up in the front bulletin board case at the facility entry. The DHS stated that the nursing supervisors completed the information for each shift and corrected it on the posting sheet that they posted afterwards. She stated the daily staffing information was expected to be complete -and posted as required.