

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

August 19, 2014

Mr. John Danforth, Administrator
Redstone Villa
7 Forest Hill Drive
St Albans, VT 05478-1615

Dear Mr. Danforth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 22, 2014**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN
Licensing Chief

PC:jl



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

RECEIVED
Division of

PRINTED: 08/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	AUG 14 14 Licensing and Protection	(X3) DATE SURVEY COMPLETED C 07/22/2014
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NAME OF PROVIDER OR SUPPLIER REDSTONE VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 7 FOREST HILL DRIVE ST ALBANS, VT 05478
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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation regarding care and services and an investigation of a facility self report were completed by the Division of Licensing and Protection on 7/21/14 & 7/22/14. Regulatory violations were cited as follows:	F 000	Redstone Villa, (the "Provider") submits this plan of correction, (POC), in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a comprehensive care plan to meet the needs of 1 of 3 residents in the survey sample (Resident #2). Findings include:	F 279	The Provider submits this POC with the intention that it be inadmissible by any third party any civil or criminal action against the Provider or any employee, agent, officer, director or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings, that are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether any such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the State of Vermont or any other entity. Any changes to Provider Policy or Procedure should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceedings on that basis. F279 Develop Comprehensive Care Plans 1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? Resident #2 Care Plans for Falls was initiated on 7/23/14. Resident #2 was not harmed. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents with the potential for falls are at risk by this alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John Penfold</i>	TITLE <i>Executive Director</i>	(X6) DATE
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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 279 Continued From page 1
Per record review on 7/22/14, there was no plan of care to address Resident #2's needs related to fall risk. Resident #2 was admitted to the facility on 5/19/14 with diagnoses that included a recent traumatic fracture of the hip, difficulty walking, muscle weakness, edema, hypertension, dementia with behavioral disturbances and other chronic medical conditions. On his/her 5/19/14 nursing admission evaluation, a fall risk assessment identified him/her as at high risk for falls with a fall risk score of 11. Per record review, the resident had falls on 6/4/14, 6/9/14 and 6/28/14; subsequent fall risk assessments on 6/4/14 and on 6/9/14 identified the resident's fall risk score as 20. Per 7/21/14 review, the facility policy "Falls Management Assessment," states in section 1. c. "A Falls Risk Evaluation score of 10 or above represents a high risk for falls and will require the development of a care plan implementing interventions designed to prevent falls." Under section 2. b. "Care Planning," the policy states that residents who sustain a fall will have a care plan developed or the existing plan updated... The care plan interventions will address those elements determined by investigation as probable causal factors that contributed to the fall..."

On 7/21/14 at 1:57 PM, the DNS (Director of Nursing) confirmed the above information and that no care plan was developed for Resident # 2. S/he stated that typically the MDS (Minimum Data Set) identifies fall risk and that should have triggered a care plan to be developed.

F 282
SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in

F 279

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

Re-education for Care Plan Coordinator on initiating fall care plans per protocol was done on 7/23/14.

4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?

DNS or designee will audit care plans 3 times per week for 3 months for fall risk. Results to QA committee

5. Include dates when a corrective action will be completed.

DNS will be responsible for compliance of POC and regulatory requirements by 8/22/14.

F279 POC accepted 8/18/14 SDennis APRN/PMC

F 282

F282 Services by Qualified Persons/Per Care Plan

7. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?

Extra staff was initiated on 7/21/14 for nite shift for 1:1. Residents were not harmed by this alleged deficient practice.

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F 282	<p>Continued From page 2 accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record and staffing schedule review and interview, the facility failed to implement the plan of care for 1 of 3 residents related to providing 24 hour supervision for inappropriate behaviors (Resident #1). Findings include: Per 7/21/14 review, Resident #1 was admitted to the facility on 4/3/14 with diagnoses that included dementia with physical behaviors, depressed mood, cognitive disorder, and other chronic diseases. On 7/9/14 Resident #1 was identified as the perpetrator of a staff witnessed incident where s/he was observed by LNA (Licensed Nursing Assistant) staff to have placed his/her hand down another resident's pants and was touching his/her breast. After the incident, Resident #1's care plan was revised for inappropriate touching; the revised plan stated "1:1 at all times." On 7/21/14 at approximately 8 AM, the DNS (Director of Nursing) stated that staff began providing 1:1 "100 % supervision" for Resident #1 after the incident on 7/9/14. The DNS reported that supervision is provided to Resident #1 even at night as the resident can get him/herself up. Per 7/21/14 review, the facility census identified that there were 26 residents residing in the facility from 7/11-7/14/14 and 27 residents from 7/15-7/20/14. Per 7/21/14 review of the facility staffing schedule provided by the DNS (Director of Nursing), on 7/11, 7/12, 7/15, 7/16 and 7/20/14 there was one LPN and one LNA who worked the night shift (during the time that Resident #1 was</p>	F 282	<p><u>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> All residents are at risk by this alleged deficient practice.</p> <p><u>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> Licensed Nurses were re-educated on coverage for call outs and providing 1:1 on nite shift by 8/22/14.</p> <p><u>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> Scheduling audits will be done 3 times per week for nite shift while 1:1 coverage is needed for 3 months. Results will be reviewed at quarterly QA meeting.</p> <p><u>5. Include dates when a corrective action will be completed.</u> DNS will be responsible for monitoring to assure compliance with POC and regulatory requirements by 8/22/14.</p> <p><i>F282 POC accepted 8/18/14 S. Dennis RN/PMC</i></p>	
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F 282	<p>Continued From page 3</p> <p>care planned to have 24 hr./day 1:1 supervision). Per 7/21/14 interview with LNA #1, s/he reported Resident #1 "is quick" ...and "aggressive" when told [s/he] can't do what [s/he] is doing. S/he reported that "sometimes may run one or two LNAs at night;" "it's not enough staff when only one LNA is on at night to provide 1:1 and care for other residents." Per interview with LNA #3, s/he reported that Resident #1 "watches staff and [staff] cannot take eyes off [him/her] or [s/he] may approach another resident." Per review of the 7/20/14 1:1 staffing log for Resident #1, there is a note stating that "[Resident #1] shuts off [his/her] alarm before [s/he] stands up now-Be aware." On 7/21/14 at 4:45 PM, staff nurse #2 reported that some nights only 1 LNA is scheduled with the nurse and s/he reports being unsure how staff can supervise Resident #1 and do the care that they need to do, stating if both staff members need to attend to someone who falls or needs help, not sure how Resident #1 would be supervised.</p> <p>Per 7/21/14 interview at approximately 5:30 PM, LNA #5 reported working the night shift alone with one nurse (on 7/16/14 per facility schedule) and sharing 1:1 coverage [for Resident #1] while providing care for the other [26] residents in the facility. S/he reported that s/he worked in the hall while Resident #1 was sleeping and responded to his/her bed alarm to check him/her. S/he confirmed that it would be difficult to care for an emergency and provide 1:1 supervision at the same time.</p> <p>Per 7/21/14 at 5:11 PM interview with nurse #3 who works the night shift, s/he reported that Resident #1 generally sleeps in his/her room and has a bed alarm on; s/he reported we hear the alarm and go right up- we don't sit in [his/her] room.</p>	F 282		
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F 309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to assure that each resident is provided the necessary care and service to attain or maintain the highest practicable emotional, physical, and psychosocial well-being. This has the potential to effect all residents residing in the facility (27 Residents). Findings include: On 7/21/14 at approximately 8 AM, the DNS (Director of Nursing) stated that staff began providing 1:1 "100 % supervision" for Resident #1 who was the perpetrator of a resident to resident incident on 7/9/14. The DNS reported that supervision is provided to this resident even at night as the resident can get him/herself up. On 7/21/14 at 10:50 AM during a care observation, the relative of a resident stated that s/he is at the facility at least 5 days of week and has the opportunity to observe care. S/he stated that residents in the facility are being punished because of the one resident requiring 1:1 supervision and reported that 1 LNA (licensed nursing assistant) is pulled off the floor to supervise him/her and the other 2 LNAs cannot do all the care that is required. She reported that his/her relative's roommate stayed in bed until noon on the weekend; s/he wanted to get up,</p>	F 309	<p>F309 Provide care and services for Highest Well Being</p> <p><u>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</u> Scheduling was initiated on 7/21/14 to provide 1:1 coverage for Resident #1 for day and evening shifts on 7/22/14. Residents were not harmed by this alleged deficient practice..</p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</u> All Residents have the potential to be at risk by this alleged deficient practice.</p> <p><u>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</u> Re education of all Licensed Nurses staffing for 1:1 coverage and staffing requirements on Day and evening shifts by 8/22/14..</p> <p><u>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</u> DNS/Designee will audit staffing daily for 1:1 coverage and to meet the Nursing Staffing guidelines for all other Residents. Also random audits of observation of care and random Resident surveys of care for 3 months. Results to QA meeting quarterly.</p> <p><u>5. Include dates when a corrective action will be completed.</u> DNS will be responsible for monitoring to assure compliance with POC and regulatory requirements by 8/22/14</p>	
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F309 POC accepted 8/18/14 SDennisArru/PML

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F 309	Continued From page 5 knocked on the wall and was crying. The family visitor reported asking staff for help and they helped the roommate up at lunch time. She stated this resident could not give a history and said "I feel sorry for the residents who have no one to speak for them." S/he added that it's not the [LNAs] fault, they need more staff. S/he reported that over the weekend, s/he did not observe the staff checking rooms like usual. On Saturday night, she reported one gal was helping my [relative] and another LNA was helping his/her roommate and call bells were going off that they could not answer. On 7/21/14 at 3:16 PM the DNS confirmed that there was no increase in LNA staffing since 1:1 supervision was implemented for Resident #1 on 7/9/14 though other non-LNA staff have helped to provide 1:1. Per 7/21/14 review of facility staffing provided by the DNS, from 7/9/14- 7/21/14 (during the period when 1:1 resident supervision started) 3 LNAs were scheduled on the day shift (except 2.5 on 7/13/14); 2 LNAs were scheduled for 5 days and 3 LNAs for 8 of the 13 days on the evening shift; and 2 LNAs were scheduled for 7 days and 1 LNA for 6 of the 13 days on the night shift. Per review, the facility census is currently 27 residents. Per observation, the residents reside on 2 floors in the facility. Per 7/21/14 interviews with LNA staff, LNA #1 stated that LNAs do most of the 1:1 supervision for the above resident. S/he reported that it makes it hard to give the other residents the care they need ..."they deserve more." S/he reported there are 3 LNAs scheduled on the day shift and there has been no increase in LNA coverage since staff started providing 1:1 care for the Resident #1 and expressed concerns for other resident's safety when pulled away to do 1:1. Typically, LNAs on the first floor provide care to	F 309		

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F 309	Continued From page 6 10 residents; on his/her assignment, 7 of the 10 residents required extensive or total assistance. S/he reported it's hard to answer call lights and if a second floor LNA is providing 1:1 there is no LNA for the second floor. LNA #2 also reported that LNAs are doing most of the 1:1 supervision for Resident #1. S/he reported it takes away from the care of the other residents when we have to watch him/her and sometimes, LNA staff have not been able to respond to a bed alarm as have to watch him/her. Try to have someone else respond but there is not always someone available. LNA #3 also reported that on most days, LNAs provide 1:1 for Resident #1. S/he reported there are 8 of 10 residents on his/her assignment that require extensive assistance and 3 require Hoyer lifts [A Hoyer lift is a mechanical device used to transfer residents from bed to chair or toilet and require 2 staff members to operate]. Often residents need to wait for help as one LNA is always providing 1:1 supervision and this takes time away from the care of the other residents. LNA #4 reported that staff lose patient care hours when they are assigned to provide 1:1 supervision. It happens all the time that patients have to wait as staff need to find someone who is available to help with a Hoyer lift. S/he reported that getting residents out of bed, positioning, assisting with bedpan use can all be delayed while waiting for a second person to help. Sometimes have to get an LNA from the second floor or a nurse to help, but it means residents have to wait for care. Per interview with LNA #5, s/he reported working the night shift with one nurse (on 7/16/14 per facility schedule), sharing 1:1 coverage [for Resident #1] while providing care to 26 other residents in the facility. S/he reported that s/he works in the hall while Resident #1 is sleeping and responds to his/her bed alarm	F 309		
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F 309	Continued From page 7 to check him. S/he states that sometimes s/he is unable to get his/her whole assignment done due to providing 1:1 supervision and that the next shift pitches in when they arrive. S/he confirmed that it would be difficult to care for an emergency and provide 1:1 supervision at the same time. Per 7/21/14 interview with nursing staff, Nurse #1 reported that there are 27 residents in the facility, of those residents approximately 24 have some cognitive impairments or dementia and communication deficits. S/he reported concerns about care delays and staff 's ability to provide timely care as the LNAs are moved into 1:1 supervision and it takes time away from the care of other residents. Per review of 1:1 staffing logs, the following lists the amount of LNA time that is scheduled for 1:1 supervision on the following dates and thus not available for the other resident's care (approximately 9-21 hours of reduced time spent with all residents per 24 hr period): on 7/9/14 LNAs provided 1:1 supervision from 2 PM until 11:55 PM (9 hrs 55 min); on 7/10/14 LNAs provided 1:1 from 12:20 AM-9:45 AM, from 1:45 PM-7 PM, and from 11:20- 12 midnight (approximately 14 hrs.); on 7/11/14 LNAs provided 1:1 from 12:05 AM-7:25 AM and from 8 PM- 11 PM (approximately 10 hrs.); On 7/12/14 LNAs provided 1:1 from 7 AM-9 AM, 9:14 AM-7:45 PM and 11:15 PM- midnight (approximately 13 hrs.); on 7/13/14 LNAs provided 1:1 from 12:00 midnight-12 noon and 4:30-12 midnight (19 ½ hrs.); on 7/14/14 LNAs provided 1:1 from 12:40 AM-7:15 AM and 9-midnight (approximately 9 hours); on 7/15/14 LNAs provided 1:1 from 12 midnight-11:50 AM and 3-midnight (approximately 21 hrs.); on 7/16/14 LNAs provided 1:1 from 12 midnight-11:35 AM, 4:40 PM- midnight	F 309		

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F 309	Continued From page 8 (approximately 20 hrs.); on 7/17/14 LNAs provided 1:1 from 12 midnight-6:45 AM, 6:45 PM-12 midnight (approximately 11 hrs.); on 7/18/14 LNAs provided 1:1 from 12 midnight-10 AM, 11:30-2:40 PM and 7:15 PM- midnight (approximately 18 hrs); on 7/19/14 LNAs provided 1:1 from 12 midnight -10 AM, 12:30 -7 PM and 11-12 midnight (approximately 17 hrs.); on 7/20/14 LNAs provided 1:1 from 12 midnight-5:45 PM and from 7-12 midnight (approximately 20 hrs.); on 7/21/14 LNAs provided 1:1 from 12 midnight-8 AM and 1:30-3:30 PM (10 hrs.).	F 309		
F 353 SS=E	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to 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.</p> <p>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:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>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.</p>	F 353	<p>F353 Sufficient 24-HR Nursing Staff Per Care Plans</p> <p>1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Scheduling was initiated to provide 1:1 coverage and adequate Nursing Staffing Per Regulatory requirements on 7/22/14. Residents were not harmed by this alleged deficient practice.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All Residents are at risk by this alleged deficient practice.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Re-education for Licensed Nurses on staffing for 1:1 and staffing for Regulatory requirements by 8/22/14.</p>	

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER REDSTONE VILLA		STREET ADDRESS, CITY, STATE, ZIP CODE 7 FOREST HILL DRIVE ST ALBANS, VT 05478		
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F 353	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to assure sufficient nursing staff to provide nursing and related services to attain or maintain the highest emotional, physical, and psychosocial well-being of residents. This has the potential to effect all residents residing in the facility (27 Residents). Findings include: On 7/21/14 at approximately 8 AM, the DNS (Director of Nursing) stated that staff began providing 1:1 "100 % supervision" for Resident #1 who was the perpetrator of a resident to resident incident on 7/9/14. The DNS reported that supervision is provided to this resident even at night as the resident can get him/herself up. On 7/21/14 at 10:50 AM during a care observation, the relative of a resident stated that s/he is at the facility at least 5 days of week and has the opportunity to observe care. S/he stated that residents in the facility are being punished because of the one resident requiring 1:1 supervision and reported that 1 LNA (licensed nursing assistant) is pulled off the floor to supervise him/her and the other 2 LNAs cannot do all the care that is required. She reported that his/her relative's roommate stayed in bed until noon on the weekend; s/he wanted to get up, knocked on the wall and was crying. The family visitor reported asking staff for help and they helped the roommate up at lunch time. She stated this resident could not give a history and said "I feel sorry for the residents who have no one to speak for them." S/he added that it's not the [LNAs] fault, they need more staff. S/he reported that over the weekend, s/he did not observe the staff checking rooms like usual. On Saturday night, she reported one gal was helping my [relative] and another LNA was helping his/her	F 353	<div style="border: 1px solid black; padding: 2px;"> <p>4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur?</p> <p>DNS/Designee will audit daily on staffing for 1:1 and regulatory requirement for 3 months.. Results will be reviewed at quarterly QA meeting.</p> </div> <div style="border: 1px solid black; padding: 2px;"> <p>5. Include dates when a corrective action will be completed.</p> <p>DNS will be responsible for monitoring to assure compliance with POC and regulatory requirements by 8/22/14.</p> </div> <p><i>F353 POC accepted 8/18/14 S Dennis APRN/PMC</i></p>	

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F 353	Continued From page 10 roommate and call bells were going off that they could not answer. On 7/21/14 at 3:16 PM the DNS confirmed that there was no increase in LNA staffing since 1:1 supervision started for Resident #1 on 7/9/14, though other non-LNA staff have helped to provide 1:1. Per 7/21/14 review of facility staffing provided by the DNS, from 7/9/14- 7/21/14 (during the period when 1:1 supervision started for Resident #1) 3 LNAs were scheduled on the day shift (except 2.5 on 7/13/14); 2 LNAs were scheduled for 5 days and 3 LNAs for 8 of the 13 days on the evening shift; and 2 LNAs were scheduled for 7 days and 1 LNA for 6 of the 13 days on the night shift. Per review, the facility census is currently 27 residents. Per observation, the residents reside on 2 floors in the facility. Per 7/21/14 interviews with LNA staff, LNA #1 stated that LNAs do most of the 1:1 supervision for Resident #1. S/he reported that it makes it hard to give the other residents the care they need..."they deserve more." S/he reported there are 3 LNAs scheduled on the day shift and there has been no increase in LNA coverage since staff started providing 1:1 care for Resident #1 and expressed concerns for other resident's safety when pulled away to do 1:1. Typically, LNAs on the first floor provide care to 10 residents; on his/her assignment, 7 of the 10 residents required extensive or total assistance. S/he reported it's hard to answer call lights and if a second floor LNA is providing 1:1 there is no LNA for the second floor. LNA #2 also reported that LNAs are doing most of the 1:1 supervision for Resident #1. S/he reported it takes away from the care of the other residents when we have to watch him/her and sometimes, LNA staff have not been able to respond to a bed alarm as have to watch him/her. Try to have someone else respond but there is	F 353		

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F 353	Continued From page 11 not always someone available. LNA #3 also reported that on most days, LNAs provide 1:1 for Resident #1. S/he reported there are 8 of 10 residents on his/her assignment that require extensive assistance and 3 require Hoyer lifts [A Hoyer lift is a mechanical device used to transfer residents from bed to chair or toilet and requires 2 staff members to operate]. Often residents need to wait for help as one LNA is always providing 1:1 supervision and this takes time away from the care of the other residents. LNA #4 reported that staff lose patient care hours when they are assigned to provide 1:1 supervision. It happens all the time that patients have to wait as staff need to find someone who is available to help with a Hoyer lift. S/he reported that getting residents out of bed, positioning, assisting with bedpan use can all be delayed while waiting for a second person to help. Sometimes have to get an LNA from the second floor or a nurse to help, but it means residents have to wait for care. Per interview with LNA #5, s/he reported working the night shift with one nurse (on 7/16/14 per facility schedule), sharing 1:1 coverage [for Resident #1 while providing the care to [26] other residents in the facility. S/he reported that s/he works in the hall while Resident #1 is sleeping and responds to his/her bed alarm to check him/her. S/he stated that sometimes s/he is unable to get his/her whole assignment done due to providing 1:1 supervision and that the next shift pitches in when they arrive. S/he confirmed that it would be difficult to care for an emergency and provide 1:1 supervision at the same time. Per 7/21/14 interview with nursing staff, Nurse #1 reported that there are 27 residents in the facility, of those residents approximately 24 have some cognitive impairments or dementia and communication deficits. S/he reported concerns	F 353			

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F 353	Continued From page 12 about care delays and staff's ability to provide timely care as the LNAs are moved into 1:1 supervision and it takes time away from the care of other residents. Per review of 1:1 staffing logs, the following lists the amount of LNA time that is scheduled for 1:1 supervision on the following dates and thus not available for the other resident's care (approximately 9-21 hours of reduced time spent with all residents per 24 hr period): on 7/9/14 LNAs provided 1:1 supervision from 2 PM until 11:55 PM (9 hrs 55 min); on 7/10/14 LNAs provided 1:1 from 12:20 AM-9:45 AM, from 1:45 PM-7 PM, and from 11:20- 12 midnight (approximately 14 hrs.); on 7/11/14 LNAs provided 1:1 from 12:05 AM-7:25 AM and from 8 PM- 11 PM (approximately 10 hrs.); On 7/12/14 LNAs provided 1:1 from 7 AM-9 AM, 9:14 AM-7:45 PM and 11:15 PM- midnight (approximately 13 hrs.); on 7/13/14 LNAs provided 1:1 from 12:00 midnight-12 noon and 4:30-12 midnight (19 ½ hrs.); on 7/14/14 LNAs provided 1:1 from 12:40 AM-7:15 AM and 9-midnight (approximately 9 hours); on 7/15/14 LNAs provided 1:1 from 12 midnight-11:50 AM and 3-midnight (approximately 21 hrs.); on 7/16/14 LNAs provided 1:1 from 12 midnight-11:35 AM, 4:40 PM- midnight (approximately 20 hrs.); on 7/17/14 LNAs provided 1:1 from 12 midnight-6:45 AM, 6:45 PM-12 midnight (approximately 11 hrs.); on 7/18/14 LNAs provided 1:1 from 12 midnight-10 AM, 11:30-2:40 PM and 7:15 PM- midnight (approximately 18 hrs); on 7/19/14 LNAs provided 1:1 from 12 midnight -10 AM, 12:30 -7 PM and 11-12 midnight (approximately 17 hrs.); on 7/20/14 LNAs provided 1:1 from 12 midnight-5:45 PM and from 7-12 midnight (approximately 20 hrs.); on 7/21/14 LNAs provided 1:1 from 12	F 353		

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F 353	Continued From page 13 midnight-8 AM and 1:30-3:30 PM (10 hrs.).	F 353		