

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/03/2016
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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00199460.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00199460 - Substantiated. Federal/State deficiency related to the allegation is cited at F353.</p> <p>Survey dates: February 24, 25, 26 and 29, 2016 and March 1, 2 and 3, 2016</p> <p>Facility number: 000283 Provider number: 155586 AIM number: 100275020</p> <p>Census bed type: SNF: 2 SNF/NF: 118 Total: 120</p> <p>Census payor type: Medicare: 13 Medicaid: 90 Other: 17 Total: 120</p> <p>Sample: N/A</p>	F 0000	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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 0353 SS=E Bldg. 00	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on March 7, 2016 by 17934.</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 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> <p>Based on observation, interview and record review, the facility failed to ensure</p>	F 0353	Please accept this as our credible allegation of compliance to our	04/01/2016

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	<p>sufficient nursing staff provided the necessary care and services to meet the needs of the 120 residents who resided in the building. Including: (Residents B, C, D, E, F, G, H, J, K)</p> <p>Findings include:</p> <p>An observation in the 100 hall (A hall) on 2-26-2016 at 9:26 a.m., indicated a resident was sitting at the nurse's station and the resident indicated she needed to go to the bathroom "right now." There was not a way for the resident to alert staff that she needed assistance and there was not a staff member in sight in the hall or at the nurse's station. A CNA (Certified Nursing Assistant) was found in a room down the hall, as she was assisting another CNA with a resident who required 2 staff assists. At the same time, a call light was observed on at a room at the other end of the hall. At 9:29 a.m., LPN #17 came from that room with the call light still on and indicated the resident needed 2 staff assists to go to the bathroom. At 9:30 a.m., another call light was observed to go off in another room. The activities staff was observed to answer the light but could not assist the resident as the resident needed the assistance from the nursing staff to go to the bathroom. At that time, there were no staff available to assist the resident. At</p>		<p>recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation. We respectfully request the opportunity to have POC reviewed /accepted /approved with paper compliance if possible. Thank you,</p> <p>Corrective Actions to be accomplished for those residents affected: Lutheran Life Villages (LLV) works to assure that sufficient nursing staff are available to provide nursing services to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident, as determined by the resident assessments and individual care plans. LLV works to schedule an appropriate number of nursing staff to meet the resident needs, provide excellent nursing care according to the care plan that has been developed by the Interdisciplinary team as well as work to serve the residents (and their families) with excellent customer service. This occurs through great teamwork of</p>				

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	<p>9:32 a.m., LPN #17 left the resident in the room who needed 2 assists to go help the resident get to the bathroom in the other room.</p> <p>An observation in the 100 hall (A hall) on 2-29-2016 at 9:31 a.m., indicated there was LPN #18 and CNA #19 as the only 2 staff working in the 100 hall with 20 residents. Further observation, indicated while LPN #18 was trying to pass medications, she had to stop several times, put away her medications and answer the call lights and assist CNA #19. The activities staff was observed on the unit trying to get residents who wanted to go to the activity. The residents had to wait until the medications were passed before the activities staff could take them.</p> <p>An observation in the 200 hall (B hall) on 3-1-2016 at 6:12 a.m., indicated LPN #20 was on the unit as the only staff member for 17 residents.</p> <p>A confidential interview with a family member indicated the facility needed more staff as the "staff here work too hard."</p> <p>A confidential interview with a family member indicated their loved one had fallen once each of the last two weeks.</p>		<p>the charge nurse & their nursing assistants. On 2-29-16, it was brought to the administrators attention, that a nurse was working alone with a CNA on A Wing. A nursing assistant had called off for the day, who was scheduled for A Wing. Another nursing assistant, who was working a different unit, should have been reassigned that morning. This nursing assistant was working with another nursing assistant and a charge nurse on a different unit with 9 residents. The Nurse Scheduler did have another CNA coming in that morning @ 9:30am to work on A wing – she was going to replace the CNA that had called in. Additionally, the Charge Nurse from A Wing was providing resident care to a resident, who needed more than their normal care this morning do to the resident circumstances, and the Charge Nurse was fulfilling that care need. Charge nurses are expected to provide care with their CNA's throughout the shift they are assigned to and responsible for. Typically, A wing is scheduled with a Nurse and 2 CNA's. This was an unusual situation; and the staff were working to assure the residents received the care they normally provide. All of the residents did receive their AM care in an appropriate manner and their scheduled meds on time. Additionally, there were no</p>		

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	<p>The family member indicated her loved one had a wet bed last weekend when she came as the sheet had not been changed.</p> <p>A confidential interview with a family member that visited her loved one frequently, indicated the facility needs more staff, especially CNAs. The family member indicated she felt sorry for how hard the staff had to work.</p> <p>A confidential interview with Resident #B indicated there was not enough staff on her hallway. Resident #B indicated the facility was short staffed all the time especially on 2nd shift.</p> <p>A confidential interview with Resident #C indicated the facility was short staffed on nights.</p> <p>A confidential interview with Resident #D indicated it took a long time to answer the call light and had to wait 30 minutes for someone to answer the call light. The resident indicated the waiting happened all the time.</p> <p>A confidential interview with Resident #E indicated she had an incontinent accident because no one answered her call light.</p> <p>A confidential interview with Resident</p>		<p>resident falls during am care on this date on Awing. Administrator spoke with Nurse Scheduler regarding this situation& the specifics surrounding it; and how to address more quickly for future situations. It is also the expectation of all LLV staff, regardless of their role, to answer resident call lights. Regarding the situation on 2-26-2016, on A Wing, where the Activities staff did answer a call light, that is the expectation of any LLV Staff member, to find out what the resident needs/wants and if it is their scope of practice, to assist the resident or to get the appropriate assistance while communicating that to the resident. LLV works to assure the residents needs are addressed and the residents well being, needs are being met. When there are staffing calloffs, typically a Nurse Manager steps in to assist with and work with staff to assure the residents are cared for, while an appropriate replacement is found. This occurs 7 days a week. LLV employs a Nursing House Supervisor for 2nd and 3rd shifts, as well as the weekends, to assure resident needs are being met. Additionally, the nurse management has a weekend on-call rotation. Regarding the resident council minutes from almost 1 year ago, in March 2015, those issues were addressed and resolved by the</p>		

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	<p>#F indicated the facility was understaffed.</p> <p>A confidential interview with Resident #G indicated the facility needed more staff. The resident indicated it was not the fault of the staff working in the facility as they worked very hard. Resident #G indicated the facility needed more staff to assist the staff already working here.</p> <p>A confidential interview with Resident #H indicated she had to wait 2 hours for her call light to be answered. The resident indicated the staff were too busy and there might only be one girl in the hall.</p> <p>A confidential interview with Resident #J indicated the facility was short of staff in the evenings as she has had to wait at least 30 minutes for her call light to be answered while seated on the toilet.</p> <p>A confidential interview with Resident #K indicated sometimes he needed help and he would wait 30 minutes and the staff still did not come.</p> <p>Confidential interview with Staff #B and Staff #C indicated there were not enough staff working to meet the needs of the residents.</p>		<p>DON. Regarding the resident council minutes from the summer of 2015, in July 2015, those issues were resolved as well. LLV had a complaint survey come in the evening of August 6, regarding scheduling needs, etc. After numerous resident and staff interviews, that complaint was not verified. LLV received a letter of substantial compliance on August 10, 2016, stating substantial compliance with no findings. Furthermore, at that time, the facility was hiring staff & had hired numerous staff over the previous month in July of 2015 and has continued to hire qualified staff since then. The facility has an extensive orientation and training program for nursing staff (nurses and nursing assistant); an extensive Mentoring program for new staff and also conducts the basic nurse aide (BNA) training class on a routine basis. There were no staff/scheduling concerns in the resident council minutes since July 2015. On January 7, 2016, LLV had a complaint survey. Again, as is usual, the staff and residents are interviewed, along with the resident council president; walking rounds were made throughout the day with observations, etc. In the exit for that complaint, it was again unsubstantiated however an issue was verified. Administrator reviewed the resident council minutes for</p>		

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	<p>A confidential interview with Staff #D indicated there was not enough staff. Staff #D indicated she was pulled from another unit to cover for a staff member that did not show up to work. Staff #D indicated she was concerned that her residents on the unit she was pulled from would not get their showers. Further interview with Staff #D, indicated every 6 weeks the staff had to pick up a mandatory 16 hours to cover the holes in staffing and if they did not pick up, the hours were assigned. Staff #D was asked if that was how the facility handled the short staffing and Staff #D indicated it didn't work anyway, because staff don't show up or staff would call in.</p> <p>A confidential interview with Staff #E indicated there was not enough staff as she sometimes had to cover 2 halls (37 residents) when a QMA (Qualified Medication Aide) would work the other hall. Staff #E indicated she had to review the blood sugars, would give the insulins and the breathing treatments and would take care of any orders that were not processed. Staff #E indicated it had been this way a long time.</p> <p>A confidential interview with Staff #F and Staff #G indicated there was not enough staff to meet the needs of the</p>		<p>August 2015, September 2015, October 2015, November 2015, December 2015, January 2016, February 2016 and March, with no concerns for staffing noted in any of those months. The interview with the resident council president on 3-2-2016 regarding bed pans and lifts was already investigated & resolved during the complaint survey on January 7, 2016. A CNA had transferred the resident council president with a 1-person, not a 2-person, as was determined by the IDT and was on her CNA assignment sheet. In the follow up with the CNA, she knew this specific resident was a 2-person transfer and made the decision to transfer her on her own, not asking for assistance, although, there was a staff member to help, as she stated further. This was deemed a performance /decision making issue, not a staffing issue. The employee was counseled on the LLV proper transfer policy; with no further incidents from this employee. In further discussions with staff, the Administrator asked staff on this unit, where the resident council president resides, is this an issue – in regards to getting assistance for transfers with other staff members helping; the staff responded no. Typically, this unit, where the resident council president resides is staffed by a nurse and a CNA. Furthermore,</p>		

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	<p>residents.</p> <p>A confidential interview with Staff #H indicated there was not enough staff with the call ins. Staff #H indicated if there was a call in, they would be expected to stay over 4 hours. Further interview with Staff #H, indicated the staff were required to pick up 16 hours every 8 weeks or the hours would be assigned. Staff #H indicated with a family this was too much to do.</p> <p>A confidential interview with Staff #J indicated during the night shift she has had to work her unit (20 residents) by herself or with help during half of the shift. Staff #J indicated meeting the needs of the residents was very tricky.</p> <p>A confidential interview with Staff #K indicated she worked the unit (17 residents) half of her shift alone. Staff #K indicated there was just not enough staff to meet the needs of the residents. Staff #K indicated she normally did not work this unit and was pulled from her normal unit.</p> <p>A confidential interview with Staff #L indicated there was not enough staff to meet the needs of the residents. Staff #L indicated over the weekend she worked with a BNA (Basic Nursing</p>		<p>the Administrator reviewed all family complaints back to November of 2015, there were no staffing complaints by any family members from that date forward through the survey time period. We do get concerns regarding missing clothing, damaged items, food choices, etc. – which LLV follows up immediately to resolve as can be seen by these records. As requested by Statesurveyor, the Administrator did provide the actual worked staffing schedule and clocked in times for the nursing staff on 3-2-2016, for the previous 3 days from 2-27-16 through 2-29-2016. Those staffing hours showed the nursing schedule was fully staffed. Copies were given to the State Surveyor. Other residents having the potential to be affected and the corrective actions: The nursing schedule is reviewed on a daily basis to assure the appropriate number of staff are scheduled to provide the care the residents are requiring per their care plan as established by the IDT team. The Nurse Managers make rounds daily, to assure the scheduled staff are present & to see if there are any issues or unmet needs & that the residents are being cared for appropriately. The House Supervisor on 2nd and 3rd shift, also make rounds, communicating with staff to assure the appropriate scheduled staff are present and if</p>		

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	<p>Assistant-successfully completed the 105 hour class and waiting to take the state test) who was assigned residents and was told to assist the BNA as much as possible. Staff #L indicated she did not know what happened but the BNA walked out.</p> <p>A confidential interview with Staff #M indicated she normally worked 1st shift but came in at 1:00 a.m., due to the unit being short staffed. Staff #M indicated there was not enough staff to meet the needs of the residents.</p> <p>A confidential interview with Staff #N indicated she came in at 2:30 a.m., due to not having enough staff and was the only aide for 31 residents.</p> <p>A confidential interview with Staff #O indicated there was not enough staff to meet the needs of the residents. Staff #O indicated the medication pass gets pushed back because she was answering call lights and trying to prevent falls. Staff #O indicated the facility assigned the BNA their own residents and the BNA worked alone. Staff #O indicated the BNA quit because the BNA was afraid they were going to hurt someone.</p> <p>An confidential interview with Staff #P indicated there was a time when several</p>		<p>there are any problem solving issues with the schedule that need addressed. A staff in service (See attachment A) regarding appropriate staffing levels, the importance of staff fulfilling their schedule, attendance policy, etc. was provided on 3-16-2016 and on 3-20-2016. A review of the nursing schedule has occurred daily, to assure that appropriate staff levels are scheduled to meet resident needs. LLV continually works to recruit, interview, hire, train and retain the very best nursing staff possible. As part of our staff retention, LLV has an orientation for all new staff, which occurs every 2 weeks. All new staff receive company training, the required training for safety, patient care, etc. on day 1 (approx. 8 hours); and on day 2 (approx. 8 hours) all staff go through a departmental training with each Department Head. Nursing staff specifically go through another 2 days of nursing orientation for skills competency, policy training, equipment use, inservicing, appropriate EMR training for both CNA's and Nurses. Afterwards, typically the new staff are put with an approved staff mentor for training. A CNA may take from 5-7 days of training on the nursing unit, to learn the residents and the routine of the shift they will be placed on. A Nurse may take from 1 week to 2 weeks, depending on their comfort level</p>	

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	<p>residents were up during the night in the memory unit and that made it difficult for one aide. Staff #P indicated it just depended on the type of residents there were and how much the residents needed as to whether the scheduled staffing was enough.</p> <p>A confidential interview with Staff #Q indicated she stayed over last night due to staffing issues. Staff #Q indicated there was a staffing problem.</p> <p>A review of the Resident Council Minutes provided by the ADON (Assistant Director of Nursing) on 3-1-2016 at 1:30 p.m., indicated during the February 2016 meeting, "...one resident stated that when there is only one CNA per hall it takes nursing staff to [sic] long to answer the call light...." Further review of the minutes indicated on the January 5, 2016 meeting "...a couple of the residents felt that sometimes bedpans were being left under the resident too long...." The minutes from the July 14, 2015 meeting indicated "...resident council members would like to know if there could be more nursing help on each hallway...." The minutes for March 2015 indicated "...nursing staff are often to [sic] busy to toilet a resident who needs frequent toileting because of a diuretic medication...."</p>		<p>with our EMR system, to learn the residents and the routine of the shift they will be working on. The Mentors (along with the appropriate Nursing Manager) will continue to train and oversee them as a new staff member. New staff members training schedule is communicated to each new employee. Additionally, a change in the scheduling responsibility occurred on March 7th, 2016, to assure appropriate staffing levels were achieved. What Measures were put into place to ensure this does not happen again: A review of the nursing schedule occurs daily, to assure that appropriate staff levels are scheduled to meet resident needs. LLV continually works to recruit, interview, hire, train and retain the very best nursing staff possible. LLV has an orientation (See attachment F353 – B and F353- C) for all new staff, which occurs every 2 weeks. All new staff receive company training, the required training for safety, patient care, etc. on day 1 (approx. 8 hours); and on day 2 (approx. 8 hours) all staff go through a departmental training with each Department Head. Nursing staff specifically go through another 2 days of nursing orientation for skills competency, policy training, equipment use, inservicing, appropriate EMR training for both CNA's and Nurses. Afterwards, typically</p>		

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	<p>An interview with the Resident Council President on 3-2-2016 at 1:30 p.m., indicated staffing had been a concern on weekends and evenings. The President indicated some residents told her they had to wait up to an hour to get off of the the bedpan after turning on their call light. She indicated Tulip Lane had the most complaints. The Resident Council President indicated she told the Administrator that some of the CNAs were using the lift to transfer residents by themselves.</p> <p>An interview with the nursing staff scheduler on 3-1-2016 at 1:17 p.m., indicated the 1st and 2nd shifts had the same number of staff assigned. The A (20 residents) and B (17 residents) halls had a nurse and 2 CNAs assigned to each hall. The C (12 residents-300 hall) and D (10 residents-400 hall) halls had a nurse and a QMA or 2 nurses and 2 CNAs, one CNA for each hall. Tulip Lane was assigned 2 nurses and 3 CNAs for 30 residents. The Rehab hall was assigned a nurse, QMA and a CNA. If the Rehab census was below 11, then the Rehab hall would have a nurse and a CNA. The memory unit, Magnolia, was assigned a nurse and 2 CNAs for 19 residents. For the 3rd shift, the nursing staff scheduler</p>		<p>the new staff are putwith an approvedstaff mentor for training. A CNA may take from 5 – 7 daysof training onthe nursing unit, to learn the residents and the routine of theshift they willbe placed on. A Nurse may take from 1 week to 2 weeks,depending on theircomfort level with our EMR system, to learn the residents andthe routine ofthe shift they will be working on. The Mentors (along withthe appropriateNursing Manager) will continue to train and oversee them as anew staffmember. New staff members training schedule is communicated toeach newemployee. The nursing schedule is reviewed on a daily basis to assuretheappropriate number of staff are scheduled to provide the care the residentsarerequiring per their careplan as established by the IDT team. TheNurseManagers make rounds daily, to assure the scheduled staff are present& tosee if there are any issues or unmet needs & that the residents arebeing caredfor appropriately. The House Supervisor on 2nd and3rdshift, also make rounds, communicating with staff to assure theappropriatescheduled staff are present and if there are any problem solvingissues withthe schedule that need addressed. Additionally, a change inthescheduling responsibility occurred on March 7th, 2016, toassureappropriate</p>	

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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES			STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816		
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	<p>indicated the A and B (100 and 200) hall had 1 nurse and 1 CNA for each hall. The C and D (300 and 400) hall shared a nurse and was assigned a CNA for each hall. The residents on Tulip Lane were assigned a nurse and 2 CNAs. The Rehab and memory unit, Magnolia, were assigned 1 nurse and 1 CNA each.</p> <p>Further interview with the Nursing Staff Scheduler, indicated there were holes in the schedule and the facility would contact staff that were not scheduled and request their help to fill in the open shifts. The Scheduler indicated at the beginning of this year, the facility required all full and part time staff to pick up 16 hours during a 6 week period to help fill in the open shifts. The Scheduler indicated the facility recently had an unusual number of staff quitting and leaving in the middle of their shift. She indicated the night shift had several staff quit in the last month.</p> <p>An interview with the Staff Development Coordinator on 3-1-2016 at 2:00 p.m., indicated the BNA staff were assigned to work on the units after successfully completing their 30 hour classroom and 75 hour clinical work. The BNAs, who were hired by the facility would go through an orientation where they are placed with a CNA mentor for a week.</p>		<p>staffing levels were achieved. A nursing assistant training course (Called the BNA class) is provided at least every quarter to the community, for those people that want to learn how to become a BNA/CNA. The Staff Development Director, who is an approved Director and Instructor is responsible for conducting this 105 hour class. LLV spends 3 full weeks @ 120 hours per BNA. LLV is currently recruiting and hiring for the next BNA class, which is scheduled to start on April 4, 2016. Typically, the BNA class will have 10-12 students in the class. A staff in service (See attachment A) regarding appropriate staffing levels, the importance of staff fulfilling their schedule, attendance policy, etc. was provided on 3-16-2016 and on 3-20-2016. To assure that LLV has appropriate staffing levels Social Services will survey at least 2 residents, per nursing unit, per week through the end of April 2016 to get feedback on staff attentiveness to resident needs, staffing levels, etc.. Starting in May and going through the end of June, 2016, Social Services will survey at least 5 residents, per unit, per month to get resident feedback on staff attentiveness. Social Services will continue asking family members if their loved ones needs are being met during routine care plan</p>		

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	<p>The BNA would then work on the unit under the supervision of the nurse and other CNA until they tested.</p> <p>A review of the current "Resident Census and Conditions of Residents" provided by the ADON (Assistant Director of Nursing) on 2-25-2016 at 1:00 p.m., indicated the following number of residents required an assist of one or two staff for the following ADL (Activities of Daily Living), 112 residents for transferring, 115 residents for toileting and 116 residents for eating and dressing and 50 for bathing. The following number of residents were dependent for the following ADL tasks, for bathing 45 residents, for dressing 4 residents, for transferring 7 residents, toilet use 3 residents and 1 resident for eating.</p> <p>An interview with the ADON on 3-1-2016 at 2:04 p.m., indicated staff were to call in to the scheduling coordinators number when calling off on their shift. The ADON indicated she would try to replace the staff that called in and for the most part staff could be replaced. The ADON indicated if a staff person could not be found to replace the call in, the staff would be re-arranged and pulled from another area. The ADON indicated if a replacement was not found, a nurse or manager would stay.</p>		<p>meetings, occurring according to the care plan schedule. Additionally, Human resources will do a survey (See attachment F353-C) for nursing staff in regards to staffing needs, scheduling needs, workload, suggestions for improving resident care, policy thoughts, etc. This survey will be conducted in April, 2016 – gathering nursing staff feedback between April 4, 2016 and April 22, 2016. Administrator will ask to be invited to the resident council meeting in April and May, to gather feedback from residents on staffing attentiveness, staffing patterns &, staff response times; feedback obtained from the resident council meetings will be evaluated and discussed at the following QA monthly meetings.</p> <p>How the corrective actions will be monitored: To assure that LLV has appropriate staffing levels Social Services will survey at least 2 residents, per nursing unit, per week through the end of April 2016 to get feedback on staff attentiveness to resident needs, staffing levels, etc. This will be incorporated into their monthly QIS surveys they conduct with residents. Starting in May and going through the end of June, 2016, Social Services will survey at least 5 residents, per unit, per month to get resident feedback on staff attentiveness, staffing patterns, etc. Social Services</p>				

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	<p>An interview with the Administrator on 3-1-2016 at 2:36 p.m., indicated there was not a policy for the nurse staffing as the facility would use the schedules for the nursing and CNA staff (Certified Nursing Assistant).</p> <p>A list of residents who required 2 assists was provided by the Administrator on 3-2-2016 at 8:35 a.m., and indicated there were 8 residents in A (100) hall, 5 in B (200) hall, 3 in C (300) hall and 1 in D (400) hall who required 2 staff assists with transfers. Furthermore, there were 9 residents in Tulip Lane, 2 in the Rehab unit and 1 in the Magnolia unit with a total of 29 residents who required 2 staff assists from the nursing staff for transfers.</p> <p>This Federal tag relates to complaint IN00199460.</p> <p>3.1-17(a)</p>		<p>will continue asking family members if their loved ones needs are being met during routine care plan meetings, occurring according to the care plan schedule. Additionally, Human resources will do a survey (See attachment F353-C) for nursing staff in regards to staffing needs, scheduling needs, workload, suggestions for improving resident care, policy thoughts, etc. This survey will be conducted in April, 2016 – gathering nursing staff feedback between April 4, 2016 and April 22, 2016. The results from the Social Services resident surveys, feedback from families during the care plan meetings, Human Resources staffing survey will be reviewed at our monthly QA meetings for compliance. The DON will monitor for compliance. The Administrator will monitor for ongoing compliance. Please find the following attachments: F353 -A Orientation schedule for day 1 and day 2 F353 -B New staff orientation / training schedule for new nursing staff starting on 3-9-16 and 3-23-16 F353 -C Human Resources staffing survey A Staff in service on 3-16-2016 & 3-20-2016</p>		

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

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