

**Iowa Department of Inspections and Appeals**  
**Health Facilities Division**  
**Citation**

<b>Citation Number:</b> <b>6604</b>		<b>Date:</b> <b>August 14, 2017</b>		
<b>Facility Name:</b> <b>Oakland Manor</b>		<b>Fine amount reduced by 35% to \$1,300.00 on September 6, 2017 pursuant to Iowa Code Section 135C.43A</b>		
<b>Facility Address/City/State/Zip</b> <b>737 North Highway Oakland, IA. 51560</b>		<b>Survey Dates:</b> <b>July 5, 2017 to July 26, 2017</b>		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
<b>58.28(3)e</b>	<p><b>481-58.28(3) Resident safety.</b>  <b>e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III)</b></p> <p><b>DESCRIPTION:</b></p> <p>Based on observation, record review, and staff interviews, the facility failed to provide adequate supervision to one out of three residents (Resident #6); and failed to ensure safe transfers for 2 of 3 residents (Resident #5 and Resident #4). Record review revealed Resident #6 had a history of falls and on 7/9/16 the resident fell 3 times. The resident demonstrated signs of an unsteady gait and fell at 2:50 p.m., and 3:15 p.m., and again at 4:45 p.m., requiring sutures for a head laceration. The facility failed to use an appropriate sized gait belt for safe transfers for (Resident #5); and failed to pull up a disposable brief from around Resident #4's knees while assisting the resident with walking from their bedside to the bathroom. The facility reported a census of 46 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated 6/5/17 documented Resident #6 had diagnoses of dementia, anxiety, depression, schizophrenia, atrial fibrillation, unsteadiness on feet, history of falling, difficulty walking and lack of coordination. The MDS also noted Resident #6 had long and short term</p>	<b>I</b>	<b>\$2000.00</b>	<b>Upon Receipt</b>

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	<p>memory problems and a severely impaired cognitive status with inattention and disorganized thinking. According to the MDS, Resident #6 had delusions and wandered on a daily basis. The MDS documented Resident #6 received antipsychotic, antianxiety, antidepressant, anticoagulation and diuretic medications and had two or more falls with injuries since being admitted to the facility.</p> <p>The care plan noted Resident #6 exhibited signs of confusion, depression and being confused to person, place and time of day, which contributed to anxiety. According to the Care Plan, staff should allow Resident #6 to ambulate around the facility, check on him/her frequently and intervene as needed for safety. According to the revision dated 1/13/14, Resident #6 has a history of urinary tract infections (UTI). The Care Plan indicated that changes in usual routines and diminished functional abilities should be observed and reported. Resident #6 ambulates independently throughout the facility. The 1/30/17 revision instructed staff to intervene and attempt to lower Resident #6 to the floor if they observed a fall in progress. According to the 2/26/17 revision, when Resident #6 appeared to be tired, staff should sit with the resident in his/her room in hopes h/she falls asleep. On 7/9/17 staff received education about not following Resident #6 too closely while they are supervising him/her. According to the 3/18/17 Care Plan, Resident #6 receives diuretic medication, which may cause dizziness, fatigue and an increased risk for falls.</p> <p>Record review revealed eleven falls were documented</p>			

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	<p>on the resident's Care Plan between 2/26/17 and 7/23/17.</p> <p>A document titled #482 Fall and dated 4/14/17 at 12:32 a.m. noted the nurse saw Resident #6 walk/running down the hall. According to the documentation, as the nurse prepared to tell him/her to slow down, she saw Resident #6 trip and fall to the floor.</p> <p>A document titled #491 Fall and dated 5/14/17 at 11:00 a.m. noted that Resident #6 had a "ground level" fall and sustained a 2.5 centimeter (cm) laceration to the back of the head.</p> <p>A document titled #517 Fall and dated 6/27/17 at 11:57 a.m. noted that as a CNA assisted Resident #6 with cares, h/she made movements ("stutter stepping") that indicated h/she might fall. According to the document, the CNA prevented the fall by guiding the resident to the floor.</p> <p>A Nurses Note dated 6/28/17 at 11:00 a.m. noted Resident had increased wandering.</p> <p>A document titled #525 Fall and dated 7/9/17 at 3:03 p.m. noted that Resident #6 had been walking in the hall when staff witnessed him/her stop for a brief moment and then went to his/her knees.</p> <p>A document titled #526 Fall and dated 7/9/17 at 3:16 p.m. noted that staff witnessed Resident #6 fall again at 3:10 p.m.</p>			

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	<p>A document titled #527 Fall and dated 7/9/17 at 4:50 p.m. noted that Resident #6 had been found on the floor by the Service Aid.</p> <p>According to the document, Resident #6 sustained a 3 cm x 0.5 cm laceration to the back of the head.</p> <p>A Nurses Note dated 7/9/17 at 6:33 p.m. revealed staff contacted the physician due to Resident #6's falls and laceration to back of head, the physician gave orders for possible stiches and head CT (computed tomography). At 7:05 p.m. noted Resident #6 had been transported to the ER by a family member. At 7/9/17 at 10:22 p.m. Resident #6 returned to the facility.</p> <p>A Nurses Note dated 7/10/17 at 3:24 a.m. noted Resident #6 had 3 staples in the back of his/her head to approximate (close) the skin.</p> <p>A Nurses Note dated 7/11/17 at 3:49 a.m. noted Resident #6 had been up ambulating independently earlier in the shift.</p> <p>A Nurses Note dated 7/12/17 at 2:01 a.m. noted Resident #6 had gotten out of bed and started walking around.</p> <p>A document titled #535 Fall and dated 7/19/17 at 2:47 a.m. noted that the nurse heard a loud thump in the living area. According to the document, the Aide said "come into the living area". The nurse documented she found Resident #6 on the floor in a fetal position</p>			

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	<p>crying. According to the author, once vital signs had been obtained, Resident #6 immediately started to walk off.</p> <p>A Nurses Note dated 7/21/17 at 12:49 a.m. noted Resident #6 had been up walking in facility by him/herself.</p> <p>A Nurses Note dated 7/22/17 at 1:19 a.m. noted Resident #6 continued on 15 minute checks and had been walking up and down the halls.</p> <p>A Nurses Note dated 7/23/17 at 2:17 a.m. noted Resident #6 had been up walking most of the shift and continued to be on 15 minute checks to prevent falls.</p> <p>A document titled #538 Fall and dated 7/23/17 at 5:36 p.m. noted that Resident #6 had been on 15 minute checks. According to the document, a CNA heard a loud thump and the resident crying. The nurse documented the CNA found the resident on the floor bleeding from his/her nose, forehead and possibly mouth. Resident #6 cried immediately after the fall and staff called 911.</p> <p>The nurse was unable to obtain a good pupil reaction due to the resident kept his/her eyes closed.</p> <p>The emergency department report dated 7/23/17 documented Resident #6 sustained a laceration on his/her forehead, closed fracture of nasal bone and head injury.</p> <p>A Nurses Note dated 7/24/17 at 3:34 p.m. noted that</p>			

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	<p>Resident #6 walked throughout the facility and continued on 15 minute checks.</p> <p>Documents titled "Resident #6 15 Minute Check" and dated 7/21/17 through 7/26/17 had been submitted to verify checks had been done.</p> <p>When asked for a policy on safe transfers, the DON provided the agenda she used to evaluate staff's clinical skills on 1/27/17. Transfer with gait belts had been included on the agenda.</p> <p>An observation on 7/19/17 at 1:25 p.m. revealed the following. As this surveyor worked in room #206, the door handle turned and Resident #6 entered the room unsupervised. The resident appeared very confused. After about 30 seconds, a CNA walked past the room. The CNA seemed to be preoccupied and did not notice Resident #6 standing in the doorway of another room (206). Without disturbing Resident #6, this surveyor alerted the CNA and intervened at this surveyor's prompt. Resident #6 had been redirected out of room #206.</p> <p>An interview on 7/18/17 at 1:00 p.m. with Staff G, CNA, revealed her description of a movement Resident #6 typically made that sometimes preceded a fall and indicated the resident should be monitored for unsteadiness. Staff G said she worked 7/9/17 when Resident #6 fell three times. The CNA said h/she did this "jerking thing" that caused him/her to become unsteady. The CNA said it reminded her of someone seizing up and thought it might be possible to prevent</p>			

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	at least some of his/her falls if someone had been monitoring the resident closely enough. According to the CNA, Resident #6 had been exhibiting those signs more than usual that day. Staff G said Resident #6 had days h/she did not do it at all and other days when h/she does it once in a while. The CNA said Resident #6 had been doing it about every 5 minutes all day long while h/she was awake on 7/9/17. According to the CNA, Resident #6's first two falls on 7/9/17 happened as a result of his/her "jerking". Staff G said "I know because I was standing right there." The CNA said that although her back had been turned, the housekeeper witnessed one of them and said the "jerking thing" caused the fall. According to Staff G, the housekeeper could not intervene, so the fall could not be prevented. Staff G said they do not have enough staff to assign someone to walk with Resident #6 all the time. Staff G said they were able to prevent other falls that day because they were able to steady Resident #6 six or seven other times h/she exhibited the same signs between the first fall and the third fall. According to Staff G, there were only 3 CNAs and 2 nurses in the facility that day. Staff G said Staff A told them "I hate to do it to you guys, but I have to pull one of you to watch Resident #6." The CNA said Staff A asked another CNA to stay with Resident #6 in his/her room until h/she fell asleep after the 2nd fall. According to Staff G, once the resident fell asleep the other CNA left the resident's room. Staff G said after the other CNA left Resident #6's room, the Service Aid reported to the nurse at about 4:45 p.m. that he found Resident #6 on the floor of his/her room bleeding from his/her head. The CNA said once Staff A assessed			

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	<p>Resident #6 and got him/her cleaned up, they laid the resident back down. Staff G said another CNA stayed with the resident until after 6:00 p.m. at which time the Service Aid provided one to one supervision.</p> <p>According to Staff G, she believed the falls might have been prevented if someone had been with Resident #6 the whole time. The CNA said they are not staffed well enough to do that. Staff G said that included the bath aid and RA, which only left three CNAs on the floor about 90% of the time. According to Staff G, there were only two CNAs on the floor from 2:00 p.m. to 6:00 pm about 35% of the time because of high school kids and people calling in. Staff G said there are also times when only two people are scheduled from 2:00 p.m. to 6:00 p.m. because they cannot get anyone to work.</p> <p>The CNA spoke of Mulberry Hall having six people that needed to be transferred by Hoyer lifts. According to the CNA, if someone supervised Resident #6 all the time, there would only be two CNAs left on the floor.</p> <p>The CNA continued by saying if someone that required a Hoyer needed help, nobody except the nurses and CMAs would be left, and some of them are not as good about helping as others. Staff G said she thought the facility would retaliate against her for saying so, but she would rather protect Resident #6 than herself.</p> <p>An interview on 7/18/17 at 3:30 p.m. with Staff A revealed his observations of Resident #6 after h/she awakened on 7/9/17. According to the RN, he could immediately tell the resident would probably have a bad day because h/she demonstrated "jerky motions" h/she sometimes makes that causes him/her to be unsteady. Staff A said "it wasn't a matter of if h/she</p>			

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	would fall, but a matter of when h/she would fall." The RN said because he anticipated it happening he told the CNA's he needed to get his charting and treatments done in preparation for when Resident #6 fell. According to Staff A, shortly after saying that, the housekeeper informed him that she attempted to lower Resident #6 to the floor as h/she fell. Staff A said he and the CNA's went to check his/her vital signs. The RN said Resident #6 seemed as cognizant as h/she normally would be and his/her vital signs were within normal limits (WNL). Staff A said they got the resident back up on his/her feet and put him/her into a wheelchair. The RN stated that did not last long because Resident #6 got up and tried pushing the wheelchair. He said he intervened by taking the wheelchair away to prevent another fall. Staff A said from that point on Resident #6 strolled around the facility like h/she normally did. According to the RN, while he processed the paperwork and notified the doctor. and family at the nurses' station, he heard another "holler" from a CNA in the lounge requesting a nurse's help because Resident #6 had fallen again. Staff A said he went to where the resident had fallen the second time and everything checked out alright. The RN said they stood the resident back on his/her feet and h/she started wandering around the facility again like usual. According to the RN, he proceeded to process the paperwork and make the appropriate notifications for the 2nd fall when the Service Aid informed him he found Resident #6 bleeding while lying on the floor of his/her room. Staff A said he went to the resident's room to complete an assessment. According to the RN, a CNA applied pressure to the			

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	<p>laceration on the back of his/her head using some wash cloths. Staff A said neurological checks and vital signs were initiated and checked out fine. Staff A said at that point he told a CNA "I know we don't have enough staff, but you're going to have to sit with Resident #6." The RN said he checked the resident's wound. He said the wound measured about 3 cm long. He also said it remained approximated which made it hard to tell where h/she was actually bleeding from. The RN said Resident #6 had been trying to get up, so he realized h/she had full range of motion (ROM). According to the RN, he left Resident #6 with the CNA's while he went to do paperwork for the third incident. Staff A said he left a message for the DON and the Assistant Director of Nursing (ADON). According to the RN, he called and spoke to Resident #6's physician right after the third fall. He said he obtained telephone orders to send Resident #6 to the ER by ambulance for a CT or X-ray of the head and sutures as needed. The RN said he suspected Resident #6 was going to fall from the minute he/she got up based on his observations of his/her disposition and unsteadiness. The RN said the resident has what he described as "ticks"; movements that cause the resident's knees to give out. He said some days his/her ticks are worse than other days, and based on the number of ticks h/she had that day, he considered it a bad day. According to Staff A, he would have assigned someone for one to one supervision of Resident #6 that day, but they were not staffed well enough to do that. According to Staff A, he did not think they are adequately staffed, however the problem is compounded by people calling in frequently. He</p>			

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	<p>said that once those issues are factored into the equation, they were almost always short staffed. The RN said he thought someone called in almost daily, or about 90% of the time. Staff A expressed his frustration over nothing being done about it and the problem just continued to happen. According to the RN, having someone walking side by side or trailing Resident #6 caused him/her to become anxious or nervous. Staff A spoke of the importance of being close enough to make observations of potential falls, but not so close to contribute to them. Staff A said Resident #6 seemed more receptive to some people than others. He also described it as a balance between safety and causing the resident to be agitated.</p> <p>According to the RN, Administration would have to make more staff available to them in order to monitor the resident well enough to prevent the "preventable falls." Staff A said he believed some of his/her falls could be attributed to being short staffed.</p> <p>An interview on 7/19/17 at 9:20 a.m. with Staff F, LPN revealed she reported for her shift at about 6:00 p.m. on 7/9/17. According to Staff F, Staff A reported Resident #6 had fallen three times and gashed his/her head on the third fall. Staff F said the off-going nurse told her he had assigned someone to Resident #6 for one on one supervision. Staff F thought Resident #6 had been in her room at the time she reported for work, but h/she got up soon after which caused the wound to slightly bleed again. Another nurse on duty addressed the bleeding. According to the LPN, Staff A told her he had notified the doctor of all 3 falls via fax. The LPN said since the bleeding started again, she</p>			

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	<p>told Staff A to call the doctor for orders. Staff F said Staff A called the doctor immediately and obtained an order to have Resident #6 sent to ER for CT and evaluation for treatment. Staff F said Resident #6 returned to the facility with three staples in the back of his/her head. According to Staff F, they are supposed to get ahold of the doctor anytime a resident gets injured, no matter how minor. The LPN said she got upset when she walked into work and realized Staff A had only faxed the doctor and not called him. Staff F said a fax would only be appropriate if a fall did not result in an injury.</p> <p>An interview on 7/19/17 at 12:45 p.m. with the Director of Nursing (DON) revealed that although she had mixed feelings about assigning staff one to one with Resident #6, she agreed that it would be necessary in order to determine if any of the resident's falls were preventable. The DON concurred that if nobody was present to witness the falls, they would not know if they could have been prevented.</p> <p>An interview on 7/19/17 at 3:30 p.m. with Staff D, Service Aid, revealed his account of the fall that caused a head laceration to Resident #6 on 7/9/17 at about 4:15 p.m. According to Staff D, Resident #6 either spent his/her time walking around the facility or taking naps. He said h/she "did a kind of lurching/stumbling" thing as if his/her foot caught the floor. He said it resembled falling forward. The Aid said they told him he should shadow Resident #6 when he came to work at 4:00 p.m. because of Resident #6's tendency of wandering</p>			

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	<p>into other residents' room, not because of being at risk for falling. The Service Aid said he could not actually help the resident walk, but if h/she stumbled he could intervene and help steady him/her. According to the Aid, he usually walked a little bit behind and to the side of the resident. Staff D said the resident randomly talked to him and smiled, but never became agitated or anxious as he shadowed him/her. The Aid said Resident #6 almost seemed amused with him sometimes. Staff D said he could not locate the resident for a little while. He described his primary responsibility as passing ice water and snacks, but had been instructed to walk with Resident #6 too. The Aid said he usually passed ice water and/or snacks to a couple of rooms and then checked on Resident #6 to keep a close eye on him/her. Staff D said he checked in Resident #6's room about 4:15 p.m. and found him/her alone lying on the floor [on 7/9/17]. The Service Aid said he noted a little bit of blood on the floor, and on his/her hand and face. The Aid said he went to get Staff A. According to Staff D, nobody told him Resident #6 had fallen two other times that day.</p> <p>A subsequent interview on 7/24/17 at 9:50 a.m. with Staff A revealed his account of Resident #6's most recent fall on 7/23/17. According to the RN, Resident #6 had been strolling around all day. He said h/she seemed pretty steady and stable, but his/her pace seemed faster than he would have liked to see him/her walk. Staff A said Resident #6 had been assigned to another nurse that day. The RN said he and the resident's nurse anticipated that Resident #6</p>			

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	<p>may fall based on the pace he/she had been walking. Staff A said he did not think anyone witnessed the fall. He said an aide told him Resident #6 had fallen down by the Sunshine room at 4:30 p.m. According to Staff A, a couple CNA's were there assisting Resident #6 when he arrived. The RN said there were already bloody rags there when he got there, but he did not know who applied the pressure. He said the other nurse approached the site to do vital signs and an assessment right after he got there. Staff A said once the other nurse completed the assessment, they left Resident #6 with the CNA's while they went to the nurses' station where the other nurse called 911. According to Staff A, Resident #6 had blood on his/her forehead and in his/her mouth. Staff A said nobody had been walking with the resident, but there had been "a lot of eyes on him/her." Staff A said they had been keeping a closer eye on the resident because it bothered him that h/she had been walking so fast. The RN mentioned that a helmet might be an appropriate intervention in light of the fact that Resident #6 sustained head injuries on multiple occasions.</p> <p>A subsequent interview on 7/24/17 at 12:40 p.m. with the DON revealed they had been doing hourly checks on Resident#6. According to the DON, she did not consider that as adequate so fifteen minute checks were implemented last Friday morning. According to the DON, they also had to record what Resident #6's activities were at the time of the check. She said Corporate recently agreed to provide one on one supervision for Resident #6 24 hours a day, seven days a week. The DON said Resident #6's daughter</p>			

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	<p>threw a fit about one to one supervision. According to the DON, whether or not Resident #6 got agitated by being so closely supervised depended on the person following him/her. When asked about staff to resident ratio, the DON said bath aids and restorative aids are counted amongst the numbers scheduled as direct care givers. According to the DON, RAs do not provide restorative therapy during meals so they were able to help feed and answer call lights. The DON said otherwise she scheduled one CNA to each of the three halls and one nurse or one certified medication assistant (CMA) to each hall. The DON agreed, some nurses and CMAs help CNAs more than others. The DON said there were ten to twelve residents that required the assistance of two staff members to transfer them with a Hoyer (mechanical lift) and one staff member to transfer 3 residents with EZ stands (mechanical lift). The DON said the CNAs have scheduled lunch breaks, and they are also supposed to take 15 minute breaks. The DON said nurses and CMAs cover their breaks and she insisted that they take them.</p> <p>A subsequent interview on 7/24/17 at 3:15 p.m. with Staff G said she worked on 7/23/17 when Resident #6 fell again and cut his/her head. According to Staff G, nobody witnessed the fall. She said the resident had been walking at a very fast pace and they kept encouraging him/her to slow down. Staff G said she was nearby and heard the "thump" and crying after Resident #6 fell. Staff G said they had been "on top" of the resident's fifteen minute checks, but it still happened. According to Staff G, it would absolutely</p>			

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	<p>take someone being with Resident #6 at all times to prevent any falls that might be preventable.</p> <p>An interview on 7/25/17 at 11:55 a.m. with Staff E, LPN, revealed what she knew of Resident #6's most recent fall on 7/23/17. According to Staff E, Resident #6 walked the halls quite a bit and had been down by the activity room when h/she fell. The LPN said a CNA reported the fall to her. Staff E said when she arrived, a CNA sat next to Resident #6 as h/she laid on the floor. According to Staff E, they had already placed a rag on the resident's forehead to stop the bleeding. Staff E said Resident #6's forehead appeared to have an indentation at the site of the laceration and his/her nose bled with swelling on the bridge of his/her nose. Staff E said Resident #6 had been crying. The LPN said she called 911 and then called the doctor who told her to call 911. The LPN relayed the information to a family member; telling them the injury seemed bad and the doctor also ordered a CT. According to Staff E, the fall occurred at about 4:30p.m. When asked about the resident's disposition prior to the fall, Staff E said h/she had been quiet, walking the halls and carrying his/her baby like usual. The LPN said she thought Resident #6 needed a dementia unit to address his/her needs.</p> <p>An interview on 7/26/17 at 9:50 a.m. with Staff H, Housekeeper revealed she worked 7/9/17 from 1:00 a.m. to 5:00 p.m. in activities. According to Staff H, she happened to be near Resident #6 as h/she stumbled and fell. The Housekeeper said she managed to soften the fall and prevented Resident #6 from hitting his/her head. Staff H said she did not notice any injuries, but</p>			

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	<p>immediately called for other staff to assist. According to Staff H, Resident #6 had been stumbling a lot that day, which caused him/her to be unsteady on his/her feet. The Housekeeper also said that Resident #6 "goes when h/she wants to go, whether h/she is stumbling or not. There's no stopping him/her". Staff H said the resident needs placement in a dementia unit because h/she "isn't safe here."</p> <p>2. The MDS assessment dated 6/16/17 noted dementia, respiratory failure, atrial fibrillation (irregular heart rhythm), muscle weakness and unsteadiness on feet as diagnoses of Resident #4. The MDS also noted Resident #4 had been unsteady, could only stabilize with staff assistance and required limited assistance of one staff to transfer and toilet. The MDS documented Resident #4 had two or more falls since being admitted to the facility.</p> <p>The Care Plan noted on 2/3/17 Resident #4 began receiving diuretic (medication to induce urination) therapy, which may cause dizziness, fatigue and an increased risk of falling. The Care Plan also documented that Resident #4 required one staff to assist with toileting, transfers and ambulation, and had nine falls between 3/8/17 and 7/19/17 related to deconditioning.</p> <p>An observation on 7/6/17 at 8:00 a.m. revealed Staff B, Certified Nurses' Assistant (CNA) and Staff C, CNA as they assisted Resident #4 to stand from the bed and walk to the bathroom. As the resident sat on the side</p>			

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	<p>of the bed, Staff B put a new disposable brief on the resident and pulled it up to his/her knees, although Resident #4 was already wearing a brief. Staff B applied a gait belt and assisted Resident #4 to stand. Without pulling the new brief up any farther, Staff B assisted the resident to walk with a walker from the bed to the toilet (approximately 6 to 8 feet). After a few steps, Staff B realized the brief hindered Resident #4's ability to walk, so she pulled one side up just above the knee. As the resident shuffled towards the bathroom, the brief fell back down around his/her knee. It remained there until h/she completed the walk to the bathroom, at which time the resident's other brief was removed so he/she could sit down on the toilet.</p> <p>3. The MDS assessment dated 6/21/17 noted anemia (deficiency of red blood cells or hemoglobin), schizophrenia, anxiety, depression, atrial fibrillation, weakness, lack of coordination, and the need for assistance with personal care as diagnoses of Resident #5. The MDS also noted Resident #5 had been unsteady, could only stabilize with staff assistance and required limited assistance of one staff to transfer and extensive assistance of one staff to toilet.</p> <p>The 7/22/14 Care Plan noted that Resident #5 had anemia and should be monitored for fatigue, dizziness and weakness. The Care Plan also noted that Resident #5 required assistance of one staff, a gait belt and walker to transfer.</p>			

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	<p>An observation on 7/6/17 at 8:15 a.m. of Staff A, RN assisting Resident #5 revealed the following. The RN borrowed a gait belt from a CNA in the room. As Resident #5 sat on the side of the bed, Staff A attempted to apply the gait belt to the resident. Staff A said to the CNA, "your gait belt doesn't fit" the resident. The gait belt would not buckle because of being too short to fit around the resident. Staff A grabbed Resident #5's shirt with the same hand that he held the two ends of the gait belt together with and used his other hand under Resident #5's arm to help the resident stand from the bed and transfer to the wheelchair.</p> <p>During the transfer, Resident #5 seemed very weak and struggled to stand even with assistance. When asked, the RN said he did not take the time to get a gait belt that fit.</p> <p>An interview on 7/26/17 at 11:10 a.m. with the DON revealed that though their corporation agreed to provide one to one supervision for Resident #6, they need to hire more staff in order to accomplish that. This surveyor observed Resident #6 walking around the facility alone on 7/26/17 at 9:45 a.m., which prompted the surveyor to ask the DON about her previous statement that one to one supervision would be provided.</p> <p>The DON said she would have to "steal" people from the floor to provide that kind of supervision, and they just do not have the manpower yet. When asked, the DON said she would have expected Staff A to use an appropriately sized gait belt to ensure Resident #5's safety when transferring him/her. The DON also said</p>			

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	<p>she would have expected Staff A to call the doctor immediately after a fall with injury per protocol instead of just faxing the SBAR. The DON said she would have expected Staff B to pull Resident #4's brief all the way up so as not to jeopardize his/her safety.</p> <p>On 7/26/17 at 11:45 a.m., the Corporate Nurse had been overheard saying "the skills checklist provides guidance to staff, but a formal document titled Transfer Safety Policy does not exist" in response to this surveyor asking the DON for a policy.</p> <p><b>FACILITY RESPONSE:</b></p>			

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