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Fortunately, things have changed for the better over the last 10 years as more long-term care facilities encourage the use of mechanical lifting devices to prevent staff and resident injuries.

**EQUIPMENT CHOICES**

There are many tools to choose from: sit-to-stand lifts, full body or total lifts, repositioning sheets, gait belts and slide boards are common. Some facilities also use transfer seats for whirlpools and baths.

“The devices significantly reduce physical exertion of both residents and caregivers, resulting in fewer injuries to both,” says Jeff Mullins, senior director, risk management for Genesis HealthCare.

Not only have there been great safety advancements in the equipment, but the costs have come down over the past five years, allowing facilities to purchase more tools.

“I think administrators really need to look at the costs of the lifts versus the cost of injured staff,” says Michael Holz, administrator at The Health Center at Bloomingdale, N. J. “I think it’s far more effective to bite the bullet and buy the equipment.”

He also recommends that all equipment be inspected yearly to make sure it is in proper working order at all times.

**FORMAL POLICIES**

Genesis initiated its safe handling program in 2004, with the help of a consultant group.

“Each of our nursing centers was treated to a full day of introduction and education, with several follow up/troubleshooting visits occurring in ensuing weeks,” says Mullins.

“The consultant then visited each center at 10-, 20- and 40-week intervals to assess performance and consistency, and provide feedback to the regional support team, so they could help the centers make adjustments where necessary.”

Upon orientation, Genesis educates new staff about the safe handling program and policies, addresses care-plan-based assessment.
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and offers hands-on education about how to use lifting equipment and assistive devices. This education is then included in annual training, and is refreshed as necessary.

At Vicar’s Landing in Ponte Vedra Beach, Fla., education is broad based. “Our training includes any video or written training from the manufacturer of the equipment; inservice materials regarding lifting and safe working; in-person training from the therapy department on safe transfer and lifting; and hands-on lift training, including the opportunity to be lifted to understand the resident’s perspective,” says Bruce Jones, MBA, CNHA, director of health services.

“We also review all injuries to staff and residents and, if we determine that our standard of practice was not followed, we address it at that point with the employee, holding them accountable.”

**ASSESSMENT**

A no-lift policy begins the moment a resident enters the facility at The Health Center at Bloomingdale. An RN assesses every new resident upon arrival to ensure the he or she is transferred in a way that’s safest for the resident and staff. Each resident is treated as an individual with his or her own needs and corresponding lift plan.

The Health Center also stresses the importance of taking your time. “We don’t want employees getting hurt and we certainly don’t want the residents getting hurt,” says Holz. “We take a lot of time with our staff discussing the importance of taking your time, getting lifts where they are needed and choosing proper equipment for repositioning.”

Staff are injured in bad transfers more than residents, he adds. Staff members who don’t follow the rules are jeopardizing their bodies and jobs. “We review any occurrences regarding resident handling, and also review it at a quality assurance meeting every month.”

No-lift programs don’t reduce the human touch in the care delivery process, they just reduce stress and injuries.

Keith Loria is a freelance writer.

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My friend, Joe, owned a 20-year-old, blind iguana who had lived in the same apartment for its entire life. Day in and day out, the iguana sat perched near the window, barely moving.

One day, Joe moved about a mile away. He placed the iguana near the new window and went to work. When he returned home, the iguana was gone. Joe searched frantically and called the police, the fire department and every pet store he could find. But he didn’t think to look in the one place the reptile most loved. The iguana had managed to leave his new home and make his way back to the old apartment, where he resumed his post exactly in his old spot. Blind, aged and unable to communicate, he was able to sense his way back home.

It’s often not such a happy ending for elderly humans with Alzheimer’s disease or dementia. AD affects about 5.4 million people and will only grow more prevalent over the next 20 years. And around 60 percent of those affected with Alzheimer’s disease and living in a group or communal setting will wander away at least one time. If we’re lucky, they’ll find their way back home. But we are not always so lucky, so we must work diligently and constantly to make sure our wards remain safely in our care.

**Wandering Behavior**

Myra A. Aud, PhD, RN, defines wandering as “a purposeful behavior that attempts to fulfill a particular need from the context of the wanderer.” She describes four characteristic patterns of wandering:

- direct travel, or moving from one place to another without diverting attention
- random travel, or moving without seeming purpose and to multiple locations
- pacing, or walking back and forth in a discrete area
- lapping, or circling an area larger than one would lap.

People with Alzheimer’s disease can’t control these behaviors, and any one person affected with the disease may do one or all of them. Aud notes that “wandering becomes dangerous when wandering around becomes wandering away.”

**Identifying the Challenge**

Considering the numbers of those who either already have been diagnosed or will be diagnosed with Alzheimer’s disease, we are talking about a colossal task in trying to limit this dangerous behavior. In fact, wandering and elopement, and the difficulty in caring for these behaviors, is a main reason why people are placed in long-term care facilities.

Our task as caregivers is to assess elopement.
Alzheimer’s Disease Statistics

- An estimated 5.4 million people, including one in eight older Americans, have Alzheimer’s disease.
- In less than 20 years, the number of Americans with Alzheimer’s disease is projected to reach 7.7 million people.
- People 65 years and older who have AD will live approximately four to eight years, but they can live as long as 20 years with the disease.
- They will spend 40 percent of the time during which they are affected with the disease in a nursing home.
- Two-thirds of people who are dying from dementia will do so in a nursing home, as opposed to 20 percent of people dying from cancer.
- Seventy percent of those with Alzheimer’s and/or dementia live at home with the help of family, friends and caregivers.
- As of June 2010, more than 47 percent of all nursing home residents had Alzheimer’s or another form of dementia.

risks and prevent them before they happen. According to the Global Deterioration Scale, Alzheimer’s disease and dementia progress in seven stages.

1. no cognitive decline
2. very mild cognitive decline (age-associated memory impairment)
3. mild cognitive decline (mild cognitive impairment)
4. moderate cognitive decline (mild dementia)
5. moderately severe cognitive decline (moderate dementia)
6. severe cognitive decline (moderately severe dementia)
7. very severe cognitive decline (severe dementia).

George A. Voyzey asserts that a person with dementia is most likely to elope at stage 5, between the point of mild cognition disruption (stage 2) and the end of the disease (stage 7).4 Stages 3, 4 and are also high risk. By stage 5, the individual’s anger has abated and he or she is really no longer aware they are cognitively impaired and deteriorating, Voyzey says.

INEFFECTIVE MANAGEMENT
Meanwhile, Aud identified three main patterns of ineffective management that contribute to dangerous wandering:
• poor or ineffective safety measures
• staff failure to know where residents are at all times
• poor use of alarms.

I once encountered a situation in which a psychiatrist was discussing a young male patient, explaining how the patient was definitely not suicidal or an elopement risk. While the doctor was pontificating on his theories, the patient exited the floor from a locked ward elevator (after the door opened for someone else), walked across the street and jumped off the top of a building.

The patient lived, suffered hundreds of broken bones and sued this psychiatrist. They both learned a very valuable lesson.

PLAN OF ATTACK
Any suggestion that a resident wants to leave must be taken to heart. If your resident talks constantly about missing home, consider that a risk. What might seem like casual conversation could be a tip worth investigating.

The buck ultimately stops with us. As guardians, it is always our responsibility to keep on our toes, make sure staff are on top of their game and ensure that alarms are in working order. Preventing elopement starts on admission, by insisting that staff ask questions about any habits of wandering and elopements, successful or otherwise.

Next, we need to create a specific, indi-
individually plan for each resident that includes constant monitoring and an awareness of when and how elopement might occur. Moore, Algase, Powell-Cope, Appelgarth and Beattie detailed some of the behaviors we may see:

- shadowing delivery people, staff, visitors and others
- packing bags, lunches or suitcases
- calling taxi cabs or others to pick them up
- lingering near exit doors
- going into unsupervised areas
- arising in the middle of the night or early in the morning to go somewhere, even if they don’t know where.

All of these scenarios demand our rapt attention. Resident safety depends upon it. Staff must develop routines, checklists and double checks that take into account the unique features of your facility (halls, exits, elevators, and so forth).

Temporary staff should not be solely accountable for the whereabouts of your residents. We need to double check. Elopement drills should be as common as fire drills.

SMART ALARM USE

Alarms are only as good as the person who manages them. Alarms without constant human monitoring are worthless. We should never assume an alarm went off for no reason. A particular staff member should be assigned to listen for alarms and investigate when they sound. Alarms should be tested, maintained and re-tested. They should be placed in any spot where a patient could exit and should be on at all times.

Advances in technology likely will make our jobs easier, but as the numbers of patients climb, so will our responsibilities. Caring for the person with dementia is not an easy task, but it is surely one of the most noble.

References


Jeff A. Beaty is chief research officer for Signature HealthCARE, Louisville, Ky.
Nancy Kinder was admitted to a Missouri nursing home on Dec. 20, 2004, and was immediately classified as an elopement risk. The very next day she walked out the front door without anyone noticing. A passing motorist called the facility and Nancy was found two blocks away.

That was just the beginning: During the time she was at the facility, Nancy eloped a total of 61 times. Frequently, she walked toward nearby railroad tracks—and that is where her story came to an end on March 18, 2010. She eloped from the facility, sat down on the railroad tracks, and was hit by a train.1

When a facility has a patient with multiple elopements, but does not have the funds to secure anti-elopement hardware, or the ability to implement effective anti-elopement procedures, it must discharge the resident to a facility that can. Any time a jury hears that a facility let a patient elope 61 times, the facility is going to experience an adverse judgment.

NEGLIGENCE AND NEGLIGENCE PER SE
Every nursing home is charged with a duty of protective oversight by both federal and state statute. In most cases, common law negligence applies when a facility fails to supervise and provide protective oversight to a resident.

The law itself can be very inflexible. If a statute or a federal regulation provides for 24 hour a day protective oversight and a resident elopes from the facility, it would appear to be a violation of the statute. In some states, the violation of a statute of this nature is negligence per se, which is an instruction from the judge that the jury may consider the violation of the statute to be proof of negligence.

It’s up to the nursing facility to rebut that presumption by showing it was not negligent. Even where state law doesn’t permit the presumption, showing the statute and its violation may always be considered as evidence of negligence.

MANAGEMENT SOLUTION
Elopement prevention is a multi-faceted discipline. It requires a facility to identify patients at risk of elopement, classify and place those residents close to the nursing station, and actively monitor those patients during every shift, and especially closely in hot and cold weather.

Identify risk. Residents who stand at doorways, check doors or try frequently to open them, and those who watch staff enter keypad codes should be identified as residents likely to wander.

Consider location. Residents who wander and demonstrate a propensity toward elopement should be placed in a room that is close to the nursing station so staff can assess their status frequently. They should not be placed close to doorways or exits.

Use technology wisely. When possible, residents should be outfitted with bracelets and other technology that would alert staff to wandering. But reliance should be on monitoring by nurses, not on technology.

WHEN THE WORST HAPPENS
The most important part of any elopement prevention program is to have a plan for when a resident cannot be located inside the facility. Staff should drill (just as they
do for fire drills) searching the facility for a missing resident. Being trapped indoors, such as being confined after a fall, can be just as dangerous as leaving the facility. Ideally, staff should be able to thoroughly search the facility within five minutes. Some facilities use a mannequin and reward the person who “finds” the missing resident inside the facility with a consumer gift card. Drilling on finding missing residents helps demonstrate that the facility was aware of the problem and had taken steps to prevent elopement and deal with it properly if it occurred.

If a resident cannot be located within five minutes of an alert, the facility must immediately alert authorities, even though it is sure to bring state inspectors in to follow up. One of the most common citations issued by state regulators in elopement cases is for the failure to notify authorities in a timely manner. Further, delay screams negligence to a jury, and noncompliance to state authorities. Immediate action can help rebut a presumption of negligence.

Nursing staff should work with all staff on duty to determine when the resident was last seen. This information, along with the resident’s picture, habits and prior history should be made available to authorities when police and fire department personnel arrive.

ALARM CONSIDERATIONS

Another common problem is that alarms are frequently either bypassed or non-functioning at the time of an elopement. Alarms can lead to the “Crying Wolf” effect. When staff make frequent trips outside (for example, for smoking breaks), the tendency is either to ignore or deactivate alarms.

In Kernersville, N.C., a legally blind resident with dementia left the facility through a door where the alarm had been turned off. The resident drowned in a puddle outside. In Connecticut, even 15-minute bed checks and a sounding alarm could not keep a resident from escaping, falling down an embankment, and suffering a fatal head injury.

For these reasons, reliance on electronic alarms cannot replace active intervention by staff in identifying and intervening where a resident is intent on elopement.

The key to managing the risk of elopement is in having a sound policy that identifies residents, classifies and places them according to their risk of elopement, and in having a quick response policy when a resident is reported missing.

References


Anthony L. DeWitt is a partner with the law firm of Bartimus, Frickleton, Robertson and Gorny, Jefferson City, Mo. This column is not a substitute for the advice of qualified legal counsel.
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Dining is a key element in a culture change transformation. BY GRACE HOYER

Culture change continues to inspire today’s leaders to transform the way older adults live in long-term care communities. Homestead Village, a non-profit retirement community in the heart of Lancaster, Pa., is in its fourth year of the culture change journey.

Homestead’s goal was to create a person-centered care experience where skilled care residents receive personal care while living in a space that is more reminiscent of home.

Using the existing footprint of the nursing facility, Homestead constructed three smaller households to replace a traditional 60-bed nursing home. These households accommodate 17 to 22 residents per household.

Skilled care residents who live in the Fickes House, Young House and Radcliffe House, which are named after the major donors who supported Homestead’s capital campaign, enjoy private rooms and baths where household staff members work together as a team (or family unit) to meet the needs of the residents.

DINING RETHOUGHT

One of the major changes to Homestead’s household experience is how residents dine. Prior to culture change, residents ate in a large, institutional-style dining room where food was prepared in the main kitchen and delivered on trays via carts to the dining room or the residents’ rooms.

The institutional dining was replaced in 2007 with a made-to-order dining program developed by a team of nursing and dining staff that allowed each resident to receive a made to order meal when they were ready to eat.

Doug Motter, Homestead Village’s CEO, and members of the Cura Hospitality dining team worked with Cornerstone Design Architects to create three state-of-the-art country kitchens with custom cherry cabinetry, modern appliances and granite counters. Residents can eat at breakfast bars or dine at more intimate table settings.

Farm-fresh foods are made to order, improving temperature and quality, as well as giving residents more meal choices. Two of the country kitchens are located on either side of a small commercial kitchen. “We have created the best of both worlds, allowing cooked to-order items in the small commercial kitchen, while baking and meal preparation for other areas of the community are all done in our main kitchen,” says John Lush, general manager of dining services.

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OFFERING CHOICE
With this new style of dining, residents have multiple choices at every meal. At breakfast, for example, residents may dine any time between 7:30 a.m. and 9:30 a.m. They can order items such as pancakes, waffles, eggs, ham, bacon, and hot and cold cereals. Two or three entrées are prepared for lunch and dinner, while an always-available menu features a variety of sandwiches, soups and salads. The new country kitchens also serve as lounge and activity centers for residents, family and friends. Residents may sit in front of the fireplace, watch TV or participate in a dining activity. Recently, Fickes House residents and their families made a lasagna dinner, says Lush. Other activities include musical groups, crafts, cards, chess and even folding laundry. “It’s been our model and culture that if a skilled care resident wants something, we will make it happen for them,” said Motter. Homestead Village has certainly accomplished its goal and residents have embraced the culture changes with positive feedback.

MEADOWS NURSING AND REHAB
At the Meadows Nursing and Rehabilitation Center in Dallas, Pa., breakfast was decentralized for the residents in early August. Since lunch and dinner was decentralized about a year ago, staff was on board with the change.

There is no set menu. Residents can order any breakfast item they desire, which is then cooked to-order in the dining room. Residents may select from pancakes, waffles, French toast, eggs to-order, variety of toast, bacon, sausage, hot and cold cereals, as well as beverages. Breakfast is served from 7:30 a.m. to 8:45 a.m.

There is also a table featuring continental breakfast items available from 7:30 a.m. to 9:30 a.m., where residents may select from fresh fruit, assorted cold cereals, oatmeal, breads and beverages.

The biggest challenge was getting residents to come to breakfast, since the majority of them ate in their rooms. “This was a big culture change for staff and residents since adjustments had to be made to the dining room process,” said Rebecca Sims, RD/LDN, Cura Hospitality regional dietitian. Breakfast is also the most challenging meal to keep temperature standards.

Since the start of decentralized dining for breakfast, there has been only positive feedback from the residents regarding food temperature and variety. “Since offering this style of breakfast service, resident participation has increased by 24 percent,” says Arnie Black, Cura director of dining services.

Grace Hoyer is public relations manager, Cura Hospitality, Orefield, Pa.

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How would you describe your company? MDI Achieve is the largest provider of software to the eldercare industry. Combining the top software innovators in the industry, MDI Achieve is built on a solid foundation of core values that will benefit the providers who choose us as their partner: a commitment to providing our clients with effective and easy-to-use software solutions, and a dedication to personalized, responsive and top-quality support.

What is your company’s mission and vision? Our mission is to help providers achieve the best quality of care in an ever-changing business climate. We do this by providing technology solutions that help improve efficiency and productivity, to help maximize reimbursements and profitability, and by engaging with our clients to provide efficient service and support.

How does your product/service help facilities improve care? MDI Achieve’s software, led by our flagship product Matrix, helps our clients improve the care they provide to their residents in several ways. First, eldercare communities can streamline their business processes by using our software solutions, saving valuable staff time that can be better spent caring for residents.

In addition, our clinical and point of care software provides the tools to more effectively track each resident’s progress immediately after the care is provided, not just at the end of the shift. This helps frontline caregivers identify potential problems more quickly and proactively. Our electronic medication administration tools can also help reduce medication errors.

As an active member of various industry organizations, such as NASL, MDI Achieve is also involved in defining the standards that will guide the eldercare industry to a true electronic health record. This will allow us to be on the cutting edge of standardized EHR technology, to provide products designed to facilitate improved quality of care.

How do you provide customer service to your clients? MDI Achieve maintains a sharp focus on the role our customer service team plays in our client’s success. We have dedicated support analysts who are specialized in specific applications such as, accounts receivable and billing, census, MDS/care plans, POC, eMAR, as well as technical support.

MDI Achieve’s philosophy has always been to create long-term partnerships with each client. We understand that our success depends on the success of our clients and we work hard to help them use the tools we provide to make their jobs easier and their businesses more profitable.

What sets you apart from your competitors? MDI Achieve is committed to the success of our clients and that is reflected in our high rate of client satisfaction and client retention. Client support is unlimited and consistent. Training is on-going and flexible to meet each client’s needs. Our software is stable and continuously enhanced to provide new features and benefits.

In addition, MDI Achieve is staffed with knowledgeable professionals, many of whom have years of direct experience in the eldercare industry. Our customer service professionals understand the daily challenges our clients face and they use that knowledge to help each client get the most from our software. Our unparalleled industry experience is the backbone of our business that allows us to invest in platforms and technological capabilities that will meet the future needs of the marketplace.

We consistently monitor regulatory changes to ensure they are appropriately addressed in MDI Achieve products in a timely manner, while ensuring that these product changes do not negatively affect our clients’ business processes.

How can customers make better use of your product/service? MDI Achieve clients can make better use of our software by taking advantage of the various opportunities provided to increase their knowledge in order to realize the benefits of its more advanced features and functions. Attending Directions sessions, webinars and user groups are just a few of the ways existing users can continue the learning process.

How are you diversifying your business? MDI Achieve is poised to grow and evolve with the eldercare industry. In addition to our clinical and financial solutions, we offer a broad suite of software, including corporate reporting and lead management. As eldercare communities are diversifying the services they offer, MDI Achieve is enhancing our product offering to help manage those services more efficiently.

How can your company help clients manage the current economy? It is more important than ever for providers to be as efficient and productive as possible, in order to stay afloat. MDI Achieve software provides the tools to streamline the day-to-day operations of the facility while still providing the highest quality care. Our clinical software ensures that the proper documentation is completed to capture all of the services that are performed. This information flows automatically to the billing software to ensure that the facility receives all of the reimbursement to which they are entitled for the care provided. Without this type of tight integration, facilities risk leaving money on the table – something few can afford to do.

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How are you helping LTC facilities benefit from technology?
HUR Health and Fitness computerized SmartCard line provides your facility with sophisticated software to automatically track each resident’s attendance and training, to offer outcome based programs, and measurable outcomes. Our software can also provide reports to your resident’s physician, insurance and family members. Easy to read reports let your residents see their improvement, motivating them to set new goals to increase and improve their strength, balance and mobility. The open platform software can easily be integrated with your other databases for a more complete overview of your facility and its residents.

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How can facility owners and administrators make smart purchasing decisions?
Active aging programs should be fun, social and effective. HUR Health and Fitness Equipment is designed to implement and then measure mobility, fall prevention, continence and physical therapy programs. The investment in equipment to implement active aging programs provides ROI through residents’ improved mobility and longer stay. The cost of a well designed fitness/rehab center equals two to three lost sales.

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How would you describe your company? Nurse Rosie Products is passionate about the long-term care industry—it is our only business. We’ve provided time savings and accuracy with the Rosie family of advanced clinical monitoring and measurement devices to the long-term care industry for more than two decades.

Our unique business model offers the advantage of state-of-the-art technology with creative financing options. We minimize impact on capital budgets—and in many cases drive savings dollars to monthly operations budgets with options that include leasing and supply savings through Nurse Rosie Product’s line of high-quality, low-cost diabetic supplies.

How do your products and services help facilities improve care? Nurse Rosie Vital Signs Carts and SmartScales provide solutions by driving time savings and accuracy with the Rosie family of advanced clinical monitoring and measurement devices to the bottom line. Rosie Vitals Carts save three minutes per vitals set over manual readings. In a 100-bed facility, that results in a savings of five caregiver hours per day. The Rosie Vitals Cart provides the same accurate BP, SpO2, pulse and temperature information for staff at any experience level. Rosie SmartScales portable chair and wheelchair scales improve accuracy up to 1,000 lbs with easy-to-use controls that calculate wheelchair weight and BMI.

What sets you apart from your competitors? The Nurse Rosie team is passionate about support and service. Rosie equipment is backed by a warranty and technical support safety net designed for nursing homes that struggle with understaffing, lack of bio-med resources and equipment wear and tear.

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How are you helping LTC facilities benefit from technology? We’re excited to announce the Spring 2012 launch of RosieConnect, our web-based gateway software that translates information from clinical measurement devices, marries those measurements to the resident and caregiver IDs, then wirelessly transmits the information to a receiving electronic medical records system, providing immediate, error-proof clinical data, enhanced decision making, improved quality of care and exceptional caregiver time savings. RosieConnect handles everything at the bedside, automatically, seamlessly and in real time. Caregiver-friendly and easy to use, RosieConnect is a touchscreen tablet mounted on the Rosie 3 Vital Signs Monitoring Cart. The unit also functions as a computer-on-wheels for additional software such as ADL documentation.

At launch, RosieConnect will offer the basic clinical data applications package which includes transmission of vital signs from Rosie 3 (BP, SpO2, pulse, temp), transmission of blood glucose from the Oracle glucometer and transmission of weight and BMI from Rosie SmartScales.

Many more devices are scheduled to be included in future RosieConnect Clinical Data Apps packages.

How can facility owners and administrators make smart purchasing decisions? RosieConnect helps owners and administrators balance budget constraints with quality care and regulatory requirements. RosieConnect is one interface covering multiple devices, so there is no need for a staff-challenged facility to maintain numerous interfaces for an infinite number of devices. RosieConnect is the single translation mechanism interfacing with both the device and the EMR.

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What sets you apart from your competitors?
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We at Penner also take to heart the quality of our products. The biggest gauge of how your product performs is repeat business. Penner customers will purchase not just one Penner spa, but two or three. No one has more color and style option choices when it comes to selecting a spa. A five year parts warranty, live 24/7 phone support and overnight availability of parts truly make Penner a smart choice.

How does your product contribute to culture change?
It’s all about pleasing the eye and making the spa environment more attractive and inviting to residents and staff. Who wouldn’t want to enjoy a soothing bath while watching a favorite show or listening to that special music that takes one back? A spa isn’t the old, antiquated, white institutional tub. Penner makes it look more like fine furniture. Stylish cabinetry, a television, and any color imaginable truly make Penner the leader in changing the culture of bathing.

How can facility owners and administrators make smart purchasing decisions?
The adage “you get what you pay for” often holds true when purchasing bathing systems. What is perceived to be a good idea often isn’t. One consideration should be how to get your residents into the bath. If a back or other injury is incurred during a transfer, that spa has just cost your facility.

There is no Swiss army knife when it comes to spas. Too often, facilities make a purchasing decision for one or two difficult residents, not putting enough emphasis on how it will impact the other 58 residents. Facilities will react to an immediate problem and not look at the overall picture. That is why Penner has 25 models to choose from so a facility can make an intelligent decision that will benefit all residents. There is also no better way to help make a decision than asking for and speaking with facilities that already use Penner spas.

How does your company help LTC providers save or make money?
Penner develops its spas using three repeated criteria: dependability, ease of operation and low cost of ownership. Down time and the need for specialized service technicians can be costly. Years of design experience, and unequaled quality have eliminated the need for specialized service technicians. Penner spas are simple. In addition, the spa area can also be a marketing advantage to those looking for a facility. An area with color and the looks of fine furniture versus the old, institutional white tub would certainly influence their choice.

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RN, BSN, WCC, DWC

**PARTIAL COURSE SCHEDULE FOR 2012**

**MARCH 2012**

| 1-4 | Monroe, LA |
| 5-9 | Des Plaines, IL |
| 8-11 | San Antonio, TX |
| 12-16 | Hartford, CT |
| 15-18 | Denver, CO |
| 19-23 | Indianapolis, IN |
| 26-30 | Middletown, Heights, OH |

**APRIL 2012**

| 2-4 | Santa Barbara, CA |
| 9-13 | Grand Rapids, MI |
| 16-20 | Brentwood, TN |
| 23-27 | Atlanta, GA |
| 30-4 | Rexburg, ID |
| 8-11 | San Antonio, TX |
| 12-16 | Hartford, CT |
| 15-18 | Denver, CO |
| 19-23 | Indianapolis, IN |
| 26-30 | Middletown, Heights, OH |

**MAY 2012**

| 7-11 | Kenner, LA |
| 14-18 | Columbus, OH |
| 15-18 | Denver, CO |
| 23-27 | Atlanta, GA |
| 30-4 | Rexburg, ID |
| 8-11 | San Antonio, TX |
| 12-16 | Hartford, CT |
| 15-18 | Denver, CO |
| 19-23 | Indianapolis, IN |
| 26-30 | Middletown, Heights, OH |

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