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

PRINTED: 12/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355059	A. BUILDING _____ B. WING _____	11/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSOURI SLOPE LUTH CARE CTR	2425 HILLVIEW AVE BISMARCK, ND 58501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid survey started on 11/21/11 and completed on 11/23/11, the sample included five (5) residents for complete review, twenty-two (22) residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy and procedure, review of professional reference, and staff interview, the facility failed to ensure 4 of 8 sampled residents with insulin dependent diabetes (Resident #4, #12, #16, and #24) received the necessary care and services regarding low blood glucose levels. Failure to follow the licensed health care practitioner's orders to contact the providers regarding low blood glucose levels placed the residents at risk of illness, weight loss, other effects of low blood glucose levels, and limited the providers' ability to ensure the quality of resident care.	F 309	F309 **How corrective action will be accomplished for those residents affected by the deficient practice:** For Residents 4, 12, 16, and 24 physicians or nurse practitioners were notified of blood sugars that occurred outside of the set parameters. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents in the facility who have a diagnosis of Diabetes have the potential to be affected. **What measures we have put in place or systemic changes we have made to ensure that the deficient practice does not recur:** Nurses were in-serviced during the week of December 5-9, 2011. **Monitoring we have put in place to ensure deficient practices will not recur;** A CQI will be completed by the Unit Directors monthly for 3 months then quarterly. CQI will be monitored by the Director of Resident Services.	12-28-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert S Thompson	President/CEO-MSLCC	12-22-11

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 309	Continued From page 1 Findings include: The American Diabetes Association internet site, diabetes.org, states ". . . Once you've checked your blood glucose and treated your hypoglycemia, wait 15 or 20 minutes and check your blood again. . . ." Review of the facility policy and procedure "Diabetes Management" occurred on 11/23/11. This undated document stated "POLICY: Care for residents with Diabetes Mellitus will be individualized according to their physician's orders. . . ." - Review of Resident #12's medical record occurred on November 21-23, 2011. The facility admitted the resident to the special care unit in February 2011. Current diagnoses included diabetes mellitus. Resident #12's physician orders included the following: *NovoLog insulin, sliding scale four times each day, before meals and at bed time, from 141 milligrams per deciliter (mg/dl) to 425 mg/dl; and, ". . . if < [less than] 70 [mg/dl] or > [greater than] 425 [mg/dl] call MD [physician] or FNP [family nurse practitioner]." Initiated on 02/04/11 and discontinued on 11/03/11. * Accuchecks (blood glucose levels), daily, at varying times, before meals and bedtime, initiated on 11/03/11. * Glipizide 2.5 mg, two times each day (BID), initiated on 02/04/11. (oral antidiabetic) Resident #12's Medication Administration Record (MAR) for August, September, and October 2011	F 309		

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F 309	Continued From page 2 showed blood glucose levels below 70 mg/dl or not recorded as follows: * August 04, 12:00 noon - 67 mg/dl August 09, 12:00 noon - not recorded August 17, 12:00 noon - 68 mg/dl August 31, 12:00 noon - 61 mg/dl * September 05, 12:00 noon - 61 mg/dl September 14, 12:00 noon - 64 mg/dl September 16, 12:00 noon - not recorded September 26, 12:00 noon - 61 mg/dl September 30, 12:00 noon - 64 mg/dl * October 01, 5:00 p.m. - 64 mg/dl October 02, 12:00 noon - 68 mg/dl October 07, 12:00 noon - 56 mg/dl October 09, 12:00 noon - 65 mg/dl October 10, 12:00 noon - 64 mg/dl October 11, 12:00 noon - 66 mg/dl October 12, 12:00 noon - 63 mg/dl October 15, 12:00 noon - 65 mg/dl October 25, 12:00 noon - 60 mg/dl October 28, 8:00 p.m. - not recorded Resident #12's MAR and Nurse's Notes showed the facility staff rechecked the resident's blood glucose on one occasion, 09/30/11, after the above low levels were identified. The medical record lacked evidence the facility staff notified the physician or family nurse practitioner of the low blood glucose levels, as ordered. The providers' progress notes for this period failed to show the facility staff notified the providers of the low blood glucose levels. The provider's progress notes, dated 11/03/11, identified the blood glucose levels being "stable" and the provider discontinued the sliding scale insulin and scheduled blood glucose checks.	F 309		

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F 309	Continued From page 3 During interview, on 11/23/11 at 10:30 a.m., a supervisory nursing staff member (#7) agreed facility staff should have notified Resident #12's provider of the low blood glucose levels and should have re-checked the blood glucose levels. Additional information was requested from facility staff and no additional information was provided. Failure to re-check Resident #12's blood glucose levels and failure to notify Resident #12's physician or nurse practitioner of the resident's low blood glucose levels may have resulted in the premature discontinuation of scheduled blood glucose monitoring; limited the providers' ability to ensure the quality of care; and, placed the resident at risk of illness related to hypoglycemia. - Review of Resident #4's medical record occurred on November 21-23, 2011. The facility admitted the resident in June 2011. Current diagnoses included diabetes mellitus and anxiety. Resident #4's physician orders included scheduled and sliding scale insulin, blood glucose checks before meals and at bedtime, and to call the physician if blood glucose levels were greater than 400 mg/dl or less than 60 mg/dl. Resident #4's Nurse's Notes and MARs showed blood glucose levels below 60 on 08/31/11 and 09/06/11. The Nurse's Notes stated the following: * 08/31/11, 6:15 p.m. - "Resident's blood sugar was 47 [mg/dl] at 4:45 p.m. Snack of Rice Krispie bar given. Rechecked @ [at] 5:00 p.m. - 58 [mg/dl]. 4 oz. [ounces] skim milk given & [and] resident brought down to dining room for evening meal. 5:00 p.m. insulin was held. Will monitor for s/s [signs/symptoms] of [low] blood sugar."	F 309		

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F 309	Continued From page 4 * 09/06/11, 5:20 p.m. - "Resident's blood sugar at 4:45 p.m. was 45 [mg/dl]. Cookie given. 5:15 [p.m.] blood sugar 66 [mg/dl], sent down for dinner meal." 9:00 p.m. - "Blood sugar 92 [mg/dl]. . . ." The medical record lacked evidence of follow-up blood glucose monitoring on 08/31/11; and, lacked evidence the facility staff contacted the physician regarding holding the insulin on 08/31/11 or the low blood glucose levels on 08/31 and 09/06/11. During interview, on 11/23/11 at 7:40 a.m., a supervisory nursing staff member (#9) agreed the facility staff should have contacted Resident #4's physician regarding the blood glucose levels below 60 mg/dl. Additional information was requested from the facility staff and no additional information was provided. - Resident #24's physician orders included blood glucose checks four times a day and to call the physician if blood glucose levels were less than 60 mg/dl. Review of the Medication Administration Records for Resident #24's identified the following regarding blood glucose monitoring: * 08/30/11, 9:00 p.m., 54 mg/dl * 08/31/11, 5:00 p.m., 52 mg/dl * 09/08/11, 5:00 p.m., 51 mg/dl * 09/09/11, 5:00 p.m., 51 mg/dl * 10/25/11, 5:00 p.m., 45 mg/dl * Staff failed to perform blood glucose checks at 9:00 p.m. on three occasions in both September and November 2011.	F 309		

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F 309	Continued From page 5 The medical record lacked evidence nursing staff contacted the physician regarding blood glucose levels below 60 mg/dl. During an interview on 11/23/11 at 4:40 p.m., an administrative nursing staff member (#7) stated nursing staff failed to contact Resident #24's physician for the above low blood glucose levels. - Review of Resident #16's medical record occurred on November 21-23, 2011. The facility admitted the resident in July 2011. Current diagnoses included diabetes mellitus. Resident #16's physician orders, dated 07/27/2011, stated to call the physician for blood sugars below 60 mg/dl or above 400 mg/dl. Review of the Blood Glucose Monitoring Flow Sheet for Resident #16 identified the following: * 09/04/2011 in the a.m. (before noon) - 52 mg/dl * 09/05/2011 in the a.m. - 43 mg/dl The medical record lacked evidence the facility staff contacted the physician regarding the blood glucose levels below 60 mg/dl. During an interview on 11/23/11 at 12:50 p.m., a supervisory nursing staff member (#9) verified facility staff failed to contact Resident #16's physician regarding the above blood glucose levels below 60 mg/dl.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323	F323	

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F 323	Continued From page 6 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy and procedure, the facility failed to ensure the environment remained as free of accident hazards as possible for 1 of 3 sampled closed records of a resident (Resident #28) who experienced a fall. Failure to ensure adequate supervision and assistance for the resident resulted in the resident's fall and placed the resident at risk of injury related to the fall. Failure to provide assistance with her oxygen tank placed the residents, staff, and visitors at risk of injury related to the ignition hazard of oxygen in the area of an open flame. Findings include: Review of the facility policy and procedure "Resident Smoking Policy" occurred on 11/23/11. This document, revised 09/11, stated "POLICY: . . . Residents wishing to smoke will be permitted to smoke outside the building at a designated location. . . . PROCEDURES: . . . 3. Residents will be permitted to smoke in the designated area outside on the South Central Patio. 4. Residents must be able to get themselves to and from the designated smoking area. 5. Residents must be able to smoke safely unsupervised. This will be evaluated by the care team as needed. . . ."	F 323	**How corrective action will be accomplished for those residents affected by the deficient practice:** This resident was a closed record review and has expired. **How will the facility identify other residents having the potential to be affected by the same deficient practice:** All residents who are ambulatory or are deteriorating physically or cognitively are at increased risks for falls and should receive more assistance as needed. **What measures we have put into place or systemic changes we made to ensure that the deficient practice will not recur:** Nurses were in-serviced December 5-9, 2011. Resident Incidents/Safety Policy was changed to read: #8. Ambulatory residents will be evaluated for safety as needed when condition declines or a significant change has occurred. Assistance will be provided by staff as needed. **Monitoring we have put into place to ensure practice does not recur:** A CQI will be completed monthly x 3 months then quarterly. This CQI will be completed by Unit Directors. CQIs will be monitored by the Director of Resident Services.	12-28-11

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F 323	Continued From page 7 Observation throughout the survey identified the facility's smoke hut as a glass enclosed area adjacent to a hallway connecting two resident care units. Resident #28's room was located approximately 200 feet from the smoking hut. Access to the smoking hut is through a single door without an automatic opener and a small incline on both sides of the door threshold for wheelchair access. Random observations throughout the survey showed residents alone and unsupervised in the smoke hut. Review of Resident #28's closed medical record occurred on November 21-23, 2011. The facility admitted the resident in June 2011 and the resident expired in November 2011. The facility admitted the resident with Hospice care and admission diagnoses included chronic obstructive pulmonary disease (COPD), nicotine addiction, anxiety, cataracts, and tremors. The quarterly Minimum Data Set (MDS), dated 09/10/11, identified the resident was cognitively intact, required extensive assistance of one person for transfers and locomotion on the unit, and required total assistance for locomotion off the unit. Resident #28's Care Area Assessment (CAA) summary, dated 06/23/11, stated ". . . She does require limited to total assistance with her ADLs [activities of daily living]. She is ambulatory. Risks and complications for ADLs include pain, unsteady gait, chronic back pain, impaired balance, and some limitation of her lower extremity range of motion. . . . These limitations directly affect her ability to be independent with her ADLs. . . ."	F 323		

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F 323	Continued From page 8 The Falls CAA, dated 06/23/11, stated ". . . Risks and complications include end-stage COPD . . . impaired balance . . . receives pain medications, receives oxygen (the tubing could be a risk factor), routine antianxiety and antidepressant medication usage, impaired vision, easily fatigued, and goes often to the smoke room. . . ." Resident #28's care plan, dated 06/10/11, stated "Problem, Nicotine addiction & [and] smokes . . . Approaches . . . Res. [Resident] educated she cannot have O2 [oxygen] on while smoking. . . ." Resident #28's facility and Hospice Nurse's Notes stated the following: * Facility, 10/30/11, 3:00 p.m. - ". . . Res. [Resident] states she has not had any cigarettes today, instead she has stayed in bed and rested. . . ." * Facility, 10/31/11, 9:10 p.m. - "Resident very lethargic this evening. . . ." * Hospice, 11/01/11, 12:45 p.m. - ". . . Mental Status - Forgetful, Disoriented/Confused, Lethargic, Increased lethargy today and past 2 days. Staying in bed and does not even go to smoke hut . . . ADL . . . Fall Risk . . . ASSESSMENT . . . Very lethargic . . . Staff reports that pt. [patient] has been this way the past 2 days - does not get out of bed and does not go to smoke hut at all. . . . assisted pt. to wheelchair then to bathroom and she was able to transfer with help of one. . . ." * Facility, 11/01/11, 4:30 p.m. - "Resident insisted on going out to smoke hut against advice of nurse and staff, as res. has been so lethargic and weak. Res. insisted - was told she would have to take herself [without] staff assistance. Res. got to door of smoke hut, got up from wc	F 323		

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F 323	Continued From page 9 [wheelchair] and got tangled in O2 tubing (to shut it off) and sat on the floor [with] back to the wall. Denies injury or pain. . . ." Resident #28's Accident Report, dated 11/01/11 at 4:30 p.m., stated the same information provided in the facility Nurse's Note, dated 11/01/11 at 4:30 p.m. This report also stated the accident occurred while transferring by the smoke hut; there had been a change in the resident's mental status in the last week before the fall; the resident was ambulatory with weakness; and, "Attempts to Prevent Recurrence: Advised resident to stay in room and not go to smoke until she's stronger and feeling better. . . ." The Nurse's Note and the Accident Report failed to identify if facility staff observed Resident #28 fall, how long she may have been on the floor, or if she turned off the oxygen. The facility identified Resident #28 as a fall risk and showed a decline in mental and physical status in the days before the fall on 11/01/11. The Hospice Nurse's Notes, approximately three and one half hours before the fall, identified the resident required assistance of one person to transfer and was confused and disoriented. Failure to identify the resident's change in mental status and physical abilities since her admission and failure to assist the resident to the smoke hut, placed Resident #28, facility residents, staff, and visitors at risk of injury.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	F332	

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F 332	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's specifications, and staff interview, the facility failed to ensure a medication error rate of less than five percent during observation of medication administration for 3 of 6 residents (Resident #3, #31, and #32) who received insulin. Failure to prime insulin pens as indicated in manufacturer's specifications and failure to administer insulin immediately after drawing in the syringe may result in inaccurate doses of insulin. Five errors occurred during staff administration of 41 medications, which resulted in a 12 percent error rate. Findings include: Review of the facility policy/procedure titled "Medication Administration" occurred on 11/23/11. This policy, revised January 2007, stated, ". . . Medications should be dispensed and given at designated time. If resident refuses, discard medication and dispense when trying again to reduce risk of error . . ." Review of the manufacturer's medication package insert for NovoLog FlexPen occurred on 11/23/11. This insert, dated 07/14/09, stated, ". . . NovoLog in use: Vials . . . Do not draw up NovoLog into a syringe and store for later use . . . Giving the airshot before each injection, Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units . . . Hold your	F 332	**What corrective action will be accomplished for those residents affected by the deficient practice;** The identified residents were not affected by the deficient practice, but however receiving the wrong dose of insulin could result in elevated blood sugar and priming with 5 units is wasteful and is a cost factor to the resident. Insulin drawn up and not given immediately could result in a medication error of wrong medication to wrong resident. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents receiving insulin could be affected by this deficient practice. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:** The insulin pen procedure was reviewed at an in-service Dec. 5-9, 2011 and all nurses demonstrated back to management staff the correct procedure of priming insulin pens. Also reviewed policy of medication pass; not setting up medications until ready to be given to the resident.	

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F 332	Continued From page 11 NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge . . . Keep the needle pointing upwards, press the push-button all the way in . . . The dose selector returns to 0 [zero]. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the NovoLog FlexPen . . . A small air bubble may remain at the needle tip, but it will not be injected . . ." Observation of medication pass on 11/21/11 showed a nurse (#15) administered insulin to Resident #3 at 5:00 p.m. and to Resident #31 at 5:10 p.m. During both observations, the nurse (#15) dialed the dose selector on each resident's NovoLog FlexPen to the number of units prescribed by the provider. The nurse entered each resident's room separately and administered the insulin injection to the residents. Prior to administering the ordered dose of insulin to each resident, the nurse failed to "prime" or expel the air from the attached needle with two units of insulin, as identified in the manufacturer's specifications. Observation of medication pass on 11/22/11 at 4:55 p.m. showed a nurse (#16) dialed the dose selector on Resident #3's NovoLog FlexPen to five units and then expelled the five units to prime the needle. The nurse stated the needle on the insulin pen "popped" and needed to be replaced. After attaching a new needle, the nurse again dialed the dose selector to five units and then expelled the five units to prime the new needle. The nurse then dialed the dose selector to the	F 332	Monitoring we have put into place to ensure practice does not recur; A CQI will be completed monthly x 3 then quarterly. CQI will be monitored by the Director of Resident Services.	12/28/11

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	355059	A. BUILDING _____ B. WING _____	11/23/2011

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F 332	Continued From page 12 number of units prescribed by the provider and administered the insulin. The nurse incorrectly primed the needle on the insulin pen with five units, instead of priming the needle with two units of insulin, as identified in the manufacturer's specifications. Priming the needle on the insulin pen with more units than specified by the manufacturer resulted in the nurse (#16) wasting 10 units of Resident #3's insulin rather than four units if done correctly in the above observation. - Observation of medication pass on 11/22/11 at 4:43 p.m. showed the staff nurse (#3) prepared 15 units of Novolog insulin in a syringe and 76 units of Lantus insulin in another syringe and placed both syringes in the top drawer of the medication cart. The nurse (#3) stated she should put Resident #32's name on them and proceeded to label both syringes with a single sticky note identifying the resident's name. The nurse (#3) stated she prepared the insulins now and would administer the insulins closer to mealtime. The nurse (#3) administered both insulins to Resident #32 at 4:58 p.m., 15 minutes later. During an interview on 11/23/11 at 2:20 p.m., an administrative nursing staff member (#8) stated nurses should not prepare insulins ahead of time.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional	F 333	F333 What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents 24 and 25 received no negative outcome by this deficient practice. Involved nursing staff received job coaching and re-instruction to make sure they had an	

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F 333	Continued From page 13 literature, and staff interview, the facility failed to follow professional standards for medication administration for 2 of 8 sampled residents (Resident #24 and #25) whose Medication Administration Records (MARs) showed errors related to insulin administration. Failure to administer the correct dose of insulin has the potential for the resident to experience adverse consequences related to hypoglycemia (low blood sugar). Findings include: Taylor, Lillis, and LeMone, Fundamentals of Nursing, The Art & Science of Nursing Care, 4th ed., Lippincott, Philadelphia-New York-Baltimore, 2001, pg 581, stated, "The five rights help to ensure accuracy when administering medications. The nurse gives the . . . (3) right dosage . . . at the (5) right time." - Resident #24's medical record, reviewed 11/23/11, identified diagnoses including type 2 diabetes mellitus. The medical record contained the following physician's orders, dated 09/14/11 concerning diabetic medications: * Humalog (a rapid-acting insulin) 4 units every morning at 7:00 a.m. if blood sugars are greater than 90 mg/dl plus appropriate sliding scale. * Humalog 13 units at noon if blood sugar is greater than 90 mg/dl plus appropriate sliding scale. * Humalog 5 units at 5:00 p.m. (if blood glucose is greater than 90 mg/dl) plus sliding scale. * Lantus (a long acting insulin) decreased to 27 units subcutaneous daily on 10/20/11. * Humalog per sliding scale, for blood glucose	F 333	understanding of the insulin order as well as the sliding scale order. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents who are diabetic and receive insulin could have the potential to be affected by the same deficient practice. **What measures will be put into place or systemic changes made to ensure the deficient practice will not recur;** Nurses were in-serviced the week of Dec. 5-9, 2011. **Monitoring we have put in place to ensure practice does not recur;** A CQI will be completed monthly x 3 then quarterly by the Unit Directors. CQIs will be monitored by the Director of Resident Services.	12/28/11

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F 333	Continued From page 14 levels of 70-150 milligrams per deciliter (mg/dl) no insulin is given; 151-200 mg/dl 2 units are to be administered; and 201-250 mg/dl 4 units are to be administered. Review of Resident #24's Medication Administration Records (MARs) identified the following times the resident received scheduled Humalog insulin with blood glucose levels below 90 mg/dl: * 08/02/11 at 7:00 a.m. blood glucose 84 mg/dl * 08/14/11 at 7:00 a.m. blood glucose 83 mg/dl * 10/01/11 at 7:00 a.m. blood glucose 81 mg/dl * 10/06/11 at 5:00 p.m. blood glucose 86 mg/dl Review of Resident #24's MARs identified the following times nursing staff administered an incorrect dose of insulin or failed to administer insulin: * 09/05/11 at 5:00 p.m. Humalog insulin eight units sliding scale for a blood sugar of 231 mg/dl. The orders identified staff are to administer four units for a blood sugar of 231 mg/dl. * 09/12/11 at 7:00 a.m. Lantus insulin not administered * 10/26/11 at 11 a.m. scheduled Humalog and sliding scale insulin for a blood sugar of 197 mg/dl not administered. The physician order identified staff are to administer 13 units of Humalog insulin and two units of Humalog per sliding scale. * 11/01/11 at 11:00 a.m. Humalog insulin not administered - Resident #25's medical record, reviewed 11/23/11, identified diagnoses including diabetes mellitus. The medical record contained the following physician's orders, dated 11/17/11	F 333		

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F 333	Continued From page 15 concerning diabetic medications: * Novolog (a rapid-acting insulin) 4 units at noon plus appropriate sliding scale. * Novolog insulin 8 units at 5:00 p.m. daily plus appropriate sliding scale. * Novolog Flexpen 1-5 units per sliding scale. Sliding Scale for blood glucose levels of 200-249 mg/dl 2 units are to be administered. Review of Resident #25's MARs identified the following times nursing staff administered insulin when the resident's blood glucose level was less than 80 mg/dl: * 10/13/11 at 5:00 a.m. blood sugar 78 mg/dl * 11/03/11 at 11:00 a.m. blood sugar 75 mg/dl Review of Resident #25's MARs identified the following times nursing staff administered an incorrect dose of insulin: * 10/23 at 5:00 p.m. Novolog 2 units sliding scale for a blood sugar of 87 mg/dl. * 11/23 at 11:00 a.m. Novolog 2 units sliding scale for a blood sugar of 87 mg/dl. During an interview on 11/23/11 at 1:00 p.m., an administrative nursing staff member (#7) stated nursing staff should not have given insulin to Resident #24 when the blood glucose monitoring is less than 90 mg/dl and for Resident #25 when blood glucose monitoring is less than 80 mg/dl. This same nurse (#7) identified nursing staff are to follow a resident's sliding scale insulin orders.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441	F441 What corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F 441	Continued From page 16 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of facility	F 441	No specific residents were harmed by this practice. Involved nurse who completed dressing change on resident # 7 was given verbal coaching and re-instruction when doing a dressing change. **How will the facility identify other residents having the potential to be affected by the same deficient practice;** All residents who have altered skin integrity and receive dressing changes could be affected by this deficient practice. All residents in the facility have the potential to be affected by deficient infection control practices. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;** All nurses were in-serviced on correct procedure when completing a clean dressing change during the week of Dec. 5-9, 2011. Nurses were given keys to access the janitors closet to get refills for the soap dispensers and in-serviced on changing them out. CNAs were in-serviced on correct procedures for rinsing commodes and reporting to the charge nurse or supplies when soap dispensers become empty. **Monitoring we have put in place to ensure practice does not recur;**	

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F 441	Continued From page 17 policies/procedures, the facility failed to follow infection control practices for 3 of 25 residents (Resident #7, #9, and #14) during care observations. Failure to follow infection control practices has the potential to spread infection within the facility placing residents, staff, and visitors at risk of infection. Findings include: Review of the facility policy/procedure titled "Dressings- Clean" occurred on 11/23/11. This policy, revised date July 2006, stated, "Policy: MSLCC [Missouri Slope Lutheran Care Center] nursing staff will do aseptic dressing changes as indicated in an attempt to protect open wounds from contamination and to absorb drainage. Procedure: . . . 6. Put on clean gloves. 7. Remove soiled dressings and discard in plastic bag. 8. Cleanse wound as indicated using aseptic technique. 9. Remove and discard gloves. Apply clean gloves. 10. Apply dressings. . . ." - Review of the medical record for Resident #7 occurred November 21-23, 2011. Resident #7 experienced three second-degree burns from an accident. A quarterly Minimum Data Set (MDS), dated 10/02/11, identified Resident #7 to be cognitively intact, and required extensive assistance of one staff member for personal hygiene. Observation of dressing changes for Resident #7 occurred on 11/22/11 at 3:45 p.m. The facility placed Resident #7 in contact isolation for a multidrug resistant microorganism. Staff and the surveyor entering the room applied personal protective equipment (PPE) including gown and	F 441	A CQI was completed on Dec. 13 by Environmental Services and will be completed quarterly. This CQI will be monitored by the Director of Environmental Services. A CQI will be completed monthly x 3, then quarterly for infection control issues; proper cleaning and rinsing of commodes and proper procedure for changing clean dressings. This CQI will be completed by the Unit Directors and monitored by the Director of Resident Services.	12-28-11

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F 441	Continued From page 18 gloves. The nurse (#1) began dressing changes to the three second degree burns on Resident #7's thighs and inside of the left knee, as the resident lay in bed. The resident's left thigh burns were covered with gauze dressings held in place by an elastic web-type wrap and the right thigh dressing was held in place by a padded protector. As the nurse (#1) moved the elastic webbing from the burn on the left thigh, the dressing fell off. The nurse (#1) then cleansed the burn with gauze she had moistened with saline. After the nurse (#1) cleansed the burn, she applied silvadene cream, wearing the same gloves. With the same gloves, the nurse (#1) opened a nonstick dressing, placed it over the burn, and held the dressing in place while positioning the elastic webbing. The nurse (#1) then changed the dressing on the inside of the left knee, repeating the same procedure without changing gloves. Continuing with the same gloves, the nurse (#1) removed the padded protector securing the dressing to the burn on the right thigh. Part of the old dressing fell off and the CNA (#2) moved it out of the nurses' way. The nurse (#1) peeled off a dressing sticking to the burn, cleansed the burn with a moistened gauze pad, applied silvadene cream, and placed a clean dressing. The nurse (#1) wore the same pair of gloves to remove the soiled dressings, clean and redress all three burns. During an interview on 11/23/11 at 4:30 p.m., an administrative nursing staff member (#7) stated she would have expected the nurse to don clean gloves to apply the silvadene cream to the burns. This nursing staff member (#7) expected the nurse to follow facility policy and apply clean gloves prior to applying the clean dressing for each wound/burn treated.	F 441		

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F 441	Continued From page 19 - Review of the medical record for Resident #9 occurred November 21-23, 2011. A quarterly MDS, dated 10/31/11, identified Resident #9 as dependent on two staff members for transfers; requiring extensive assistance of two staff members for toilet use; and requiring extensive assistance of one staff member for personal hygiene. Observation of cares for Resident #9 occurred on 11/22/11 at 1:45 p.m. Two CNAs (#4 and #5) transferred Resident #9 to a commode in her room using a full body mechanical lift. After Resident #9 was done, the CNAs (#4 and #5) provided the resident peri care and assisted the resident to bed. A CNA (#4) removed the commode pail from the commode and carried it to the bathroom to empty. The commode pail contained urine and stool. The CNA (#4) emptied the commode pail into the toilet, carried it to the resident's sink, and obtained water from the faucet to rinse the commode pail. The CNA (#4) emptied the rinse water into the toilet, and repeated the process. Observation showed the toilet had a bed pan rinsing device. The CNA (#4) then returned the commode pail to the commode. The CNA (#4) failed to sanitize the sink after using the faucet to obtain water for the rinsing of the commode pail. A nurse (#1) then came into the room to provide care and/or treatments. The nurse accessed the sink/faucet to add water to gauze pad to cleanse the resident's eyes, and to wash her hands prior to leaving Resident #9's room. During an interview on 11/23/11 at 2:55 p.m., an administrative nursing staff member (#7) stated	F 441		

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F 441	Continued From page 20 staff are educated to use the bed pan rinsing device located in the bathroom to clean commode pans. - Review of a orientation guide titled, "Environmental services housekeeper orientation checklist," occurred on 11/23/11. This checklist revised February 2011 stated, ". . . Specific job duties & responsibilities . . . 6) Keep all dispensers adequately supplied . . . must be filled for weekends (paper towel, soap, toilet paper, disinfectant spay [sic], deodorizers) . . ." Observation on 11/21/11 at 4:13 p.m. revealed, two CNAs (#10 and #11) assisted Resident #14 to the bathroom. After the resident voided, the CNA (#10) provided personal cares, removed gloves before flushing the toilet, and assisted the resident back to a wheelchair. The CNA (#10) moved Resident #14 closer to the bed, rolled a bedside table next to the wheelchair, and returned to bathroom. The CNA (#10) pushed the soap dispenser and when no soap came out, stated, "No soap." The CNA placed her hands under the running water, dried her hands, and exited the room. Observation on 11/22/11 at 7:30 a.m. revealed, two CNAs (#12 and #13) assisted Resident #14 to the bathroom. The CNA (#12) provided pericares and removed gloves. After transporting the resident into a wheelchair, the CNA (#12) pushed the empty soap dispenser, turned on the water, placed her hands under the water, dried her hands and left the room. Observation on 11/22/11 at 8:50 a.m. revealed two CNAs (#12 and #13) assisted Resident #14	F 441		

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F 441	Continued From page 21 into the bathroom. The CNA (#12) removed the soiled brief, took off her gloves, pushed the empty soap dispenser, placed her hands under water, and dried her hands. When the resident finished voiding, the CNA (#12) flushed the toilet, provided personal cares, removed her gloves, pushed the empty soap dispenser, placed her hands under the running water, and dried her hands. During an interview on the afternoon of 11/23/11, an administrative staff member (#14) indicated laundry and housekeeping staff are responsible for making sure soap dispensers are full.	F 441		