ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING _____ B. WING _____	R 12/31/2013

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

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F 000}	INITIAL COMMENTS An on-site revisit was conducted December 30-31, 2013 to determine compliance with the deficiencies identified during the September 23-26, 2013 survey. The revisit sample included 11 residents for focused review of the areas of non-compliance. The tag numbers enclosed in { } denotes citations that remained not met as derterminied by the on-site revisit.	{F 000}	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared	
{F 309} SS=G	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: 1. Based on record review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide care and services necessary to prevent hypoglycemia for 1 of 3 sampled residents (Resident #10) who received insulin injections. Failure to ensure Resident #10 consumed adequate nutrition to stabilize blood sugar levels after administration of a fast-acting insulin (on 12/07/13 and 12/30/13) resulted in hypoglycemic episodes which required emergency intervention (i.e. glucose gel and IM Glucagon). Findings include:	{F 309}	and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation F 309 Part 1 Insulin See F 333 1. Resident #10 is receiving adequate nutrition to avoid a hypoglycemic reaction. She was seen by the physician on 1-2-2014 and adjustment was made to the insulin dosage. The blood	

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

J. [signature] | Administrator | 1/27/2014

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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{F 309}	Continued From page 1 The facility policy titled "Hypoglycemic Incidents," revised August 2013, stated the following: ". . . 2. For blood glucose levels 70 [mg/dL] [milligrams per deciliter] and below, or physician's guidelines, as long as resident is able to swallow . . . Give a rapidly absorbed carbohydrate* such as: 1) 4 oz [ounces] of orange, apple, or grape juice OR 2) 6 oz regular soda . . . b. Repeat blood glucose test after 15 minutes. c. Repeat administration of carbohydrate if necessary . . . 3. For blood glucose levels 45 or below as long as resident is able to swallow: a. Give glucopaste/glucogel/tube per physician's order. . . . b. Repeat blood glucose test after 15 minutes. c. If continues 45 or below, repeat glucopaste or glucogel after 15 minutes from when first given or if resident remains alert to swallow. d. Notify physician immediately. . . . 4. If resident is unable to swallow and has an order for glucagon intramuscular or subcutaneous, it should be administered, or the resident should be transported to local emergency room via ambulance. a. Glucagon should be given per physician's order and physician notified per policy. b. Monitor blood glucose levels every 15 to 30 minutes until blood glucose is above 70. . . . 6. Transport to emergency room if glucagon is ineffective or blood sugar remains below 45 after 30 minutes from the beginning of the hypoglycemic event. . . ." The Nursing 2013 Drug Handbook, page 737, identified the onset of action for subcutaneous NovoLog (a rapid-acting insulin) as 15 minutes, with the peak action in 1-3 hours. Page 741 identified the onset of action for subcutaneous Lantus (a long-acting insulin) as 1 hour. Page 664 identified intramuscular Glucagon's (an anti-hypoglycemic) onset of action as 4-10	{F 309}	glucose monitoring has been changed to daily and prn. The sliding scale insulin coverage was discontinued 1-02-2014 when she was seen by the doctor. Care plan review and updated as needed. 2. All residents that receive short acting insulin are at risk to be affected in this area. A list of residents will be generated and each resident that receives insulin and have physician orders to check and monitor blood glucose levels will be reviewed. 3. Nurses received education on 1-30-2014 on the procedure titled "Hypoglycemic Incidents" with a focus on the blood glucose parameters and the onset times for the different types of insulin, that the residents receiving insulin needs adequate nutrition within 5-15 min. of receiving the rapid acting insulin, and on the	

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{F 309}	Continued From page 2 minutes, peak action as 13 minutes, and duration of action as 12-32 minutes. Review of the manufacturer's instructions for NovoLog insulin occurred on 12/31/13. The instructions stated, ". . . You should eat a meal within 5 to 10 minutes after using NovoLog to avoid low blood sugar. NovoLog is a fast-acting insulin. The effects of NovoLog start working 10 to 20 minutes after injection. . . Do not inject NovoLog if you do not plan to eat right after your injection. . . ." During an interview on the morning of 12/31/13, a nursing staff member (#5) identified meal times as "open breakfast" from 7:30 a.m. until 9:00 p.m., lunch at 12:00 p.m., and dinner at 6:00 p.m. Review of Resident #10's medical record occurred on December 30-31, 2013. Diagnoses included diabetes. Current medications included *Lantus (a long-acting insulin): 22 units subcutaneously (SQ) at 6:00 a.m. *NovoLog (a rapid-acting insulin): 3 units at 8:00 a.m., 12:00 p.m., and 6:00 p.m. *NovoLog: per sliding scale at 6:00 a.m., 11:00 a.m., and 5:00 p.m. *Blood glucose monitoring at 6:00 a.m., 11:00 a.m., and 5:00 p.m. Current physician's orders included: *"Call MD [medical doctor] if blood glucose level 30 or below. . . . Call MD if blood glucose level is 45 [mg/dL] or below and the resident is not responding . . ." *"For a blood glucose level below 60 and the resident is able to swallow, give: 4 oz orange, apple, or grape juice or 6 oz regular soda. . . ." *"Glutose 15 Gel 40%. Give 15 ml [milliliters] by	{F 309}	importance of accurate documentation. An all staff meeting was held on 1-29-14 in order to educate staff on the new changes. 4. An audit tool will be developed to monitor the times of insulin administration. The DNS or designee will be responsible for the completion of the audit. The audit will be completed 3 times per week for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 5. February 14, 2014 F 309 Part 2 constipation management 1. For residents #2, #4, # 7, and #10 are receiving care and services to manage constipation for each resident. Each resident	

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{F 309}	Continued From page 3 mouth as needed for low blood sugar . . . For a blood glucose level at 45 and below and the resident is able to swallow, give glutose . . ." *"Glucagon Kit 1 mg [milligram]. Inject 1 mg intramuscularly [IM] as needed . . . for a blood glucose level below 60 and the resident is unable to swallow give glucagon: Monitor blood glucose levels every 15-30 min. [minutes] until glucose level is at 60 or above: Transport to Emergency Room if ineffective . . ." Resident #10's medication administration record (MAR), blood sugar monitoring record, "location of administration report" (used to identify the time staff administers insulin), and nurses' notes dated 12/07/13 identified the following: *5:14 a.m.: Blood glucose 150 mg/dL *5:34 a.m.: 22 units of Lantus given *7:28 a.m.: 3 units of scheduled NovoLog given *8:30 a.m.: ". . . Blood sugar 35. 6 oz OJ [orange juice] given. Resident was diaphoretic. . . ." *8:37 a.m.: ". . . Rechecked BS [blood sugar] 38. Gave 3 oz whole milk . . ." *8:43 a.m.: ". . . Rechecked blood sugar after milk was 42 . . ." *9:05 a.m.: ". . . Eating breakfast blood sugar now 74 . . ." Facility staff failed to ensure Resident #10 consumed adequate food/fluids to prevent hypoglycemia after receiving fast-acting insulin, and failed to administer glutose gel as per physician order/facility policy when Resident #10's blood sugar was less than 45 mg/dL. Resident #10's MAR, blood sugar monitoring record, "location of administration report," and nurses' notes dated 12/30/13 identified the following:	{F 309}	will have their individual bowel history and medications reviewed. Nurses will follow the Bowel protocol of oral medication for constipation on the second day of no BM, suppository for day 3 of no BM, and a rectal check, bowel sounds assessed, and offer a fleets enema after 4 days of NO BM. 2. All resident that routinely do not have a BM every two days has the potential to be affected in this area. All residents identified will have their drug regimen and bowel history reviewed with the physician. Orders and care plans will be updated as needed. 3. System Change: Charge nurse will use the NO BM Report daily to identify all residents that have had NO BM in 2-4 days. 3. On January 30, 2014, the nurses were re-educated on the bowel regimen protocol, the	

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{F 309}	Continued From page 4 *5:27 a.m.: 22 units of Lantus given *5:41 a.m.: Blood glucose 154 mg/dL. The record identified staff administered Lantus insulin prior to checking a blood sugar level. *5:41 a.m.: 2 units of sliding scale NovoLog given *7:23 a.m.: 3 units of scheduled NovoLog given *8:00 a.m.: Called MD [medical doctor] on call at SAHC [St. Andrew's Health Center] not there. Faxed info to [provider name] since not in til 1pm . . ." *8:15 a.m.: Blood glucose 27 mg/dL *8:15 a.m.: (per nurse's note) ". . . 1 more tube glutose given . . ." A nurse's note, timed at 8:00 a.m., identified staff administered glutose; however, the note was later identified as a "documentation error." *8:15 a.m.: The MAR identified the nurse gave the resident juice or soda *8:30 a.m.: (per nurse's note) ". . . Glucagon IM [intramuscular] given Per order for BS [blood sugar] 23 . . ." The MAR identified the Glucagon as "effective." *8:43 a.m.: Blood glucose 28 mg/dL *8:43 a.m.: (per nurse's note) ". . . 1 tube glutose administered . . ." *8:45 a.m.: (per nurse's note) ". . . Blood sugar now 49 after glucagon will monitor . . ." *8:49 a.m.: The MAR identified the nurse administered 15 ml Glutose gel and documented the response as "ineffective." *9:00 a.m.: Blood glucose 49 mg/dL *9:15 a.m.: Blood glucose 69 mg/dL *9:22 a.m.: (per nurse's note) ". . . [provider name] was faxed regarding low blood sugar since he was unavailable til 1pm today. . . ." *10:12 a.m.: (per nurse's note) ". . . Phone call received [sic] from [provider name] regarding low blood sugar and to notify him of upcoming appt [appointment] on Thursday . . ."	{F 309}	importance of running the NO BM report daily and following up on residents that have not had a bowel movement in 2 days. Nurses will follow the Bowel protocol of oral medication for constipation on the second day of no BM, suppository for day 3 of no BM, and a rectal check, bowel sounds assessed, and offer a fleets enema after 4 days of NO BM. An all staff was held on 1-29-14 in order to educate staff on the new changes. 4. An audit tool will be developed to monitor the no BM reports. The report will indicate which residents have not had a BM on day 2, 3, or 4. If the bowel protocol for no BM's on days 2, 3, 4 was implemented, if dietary provided the 4 oz of high fiber juice with breakfast, if the appropriate medication was provided on the correct day without a BM and if the care plan addresses the constipation. The DNS or designee is	

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{F 309}	Continued From page 5 A fax to the physician, dated 12/30/13 at 9:20 a.m., stated, ". . . Resident had [low] BS this a.m. Gave [2] glutose still low. Called on call MD not available. Gave Glucagon 1 mg IM BS [increased] 49. 15 [minutes] later [increased] 69. . . ." When requested, the facility failed to provide evidence of the fax sent to the physician on 12/30/13 at 8:00 a.m. as per the nurse's note. It is unknown why the nurse called the on-call physician. The above fax to the physician identified the nurse administered two tubes of glutose gel; however, the MAR identified only one tube as given at 8:49 a.m. with a response of "ineffective." Resident #10's blood glucose monitoring report identified staff obtained a reading of 49 mg/dL at 9:00 a.m., not 8:43 a.m. as per the nurse's notes. It is unknown why staff administered glutose gel (at 8:49 a.m.) if they obtained a blood glucose reading of 49 mg/dL at 8:43 a.m. Another discrepancy exists between the blood glucose monitoring record, which showed a blood glucose reading of 28 mg/dL at 8:43 a.m., and the nurse's notes, which identified a blood glucose reading of 49 mg/dL at 8:45 a.m. (two minutes later). Staff failed to ensure Resident #10 consumed adequate nutrition after receiving rapid-acting insulin in order to prevent a hypoglycemic reaction. Staff also failed to follow physician's orders, as well as the facility's protocol, in response to the hypoglycemic reaction. These failures resulted in Resident #10 experiencing low blood sugars for an extended period of time which required emergency intervention (IM	{F 309}	responsible for the completion of the audit. The audit will be completed 3-5 times per week for two weeks, then weekly for four weeks, and then monthly for two months, the audit results will be reported to the QA committee for further recommendations. 5. February 14, 2014	

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glucagon and glutose gel).

2. Based on record review and review of the facility's Plan of Correction (POC), the facility failed to provide the necessary care and services to manage constipation for 4 of 11 sampled residents (Resident #2, #4, #7, and #10) with constipation. Failure to implement appropriate and timely interventions may have resulted in Resident #2, #4, and #7 receiving unnecessary suppositories/enemas. Failure to provide interventions for Resident #10 resulted in no bowel movement (BM) for four days on two separate occasions.

Findings include:

The facility's POC stated, ". . . The nurses were educated on the Bowel protocol of: No BM in 2 days offer MOM [milk of magnesia] 30 cc [cubic centimeters], No BM in 3 days offer a dulc [Dulcolax] suppository, if no BM in 4 days do a rectal check for BM and offer a fleets enema. . . ."

- Review of Resident #4's medical record occurred on December 30-31, 2013. Diagnoses included unspecified constipation. Current medications included Senna S (a laxative/stool softener) one tablet twice per day (BID), MOM 30 cc as needed (prn), Dulcolax suppository prn, and Fleets enema prn.

Resident #4's bowel records and prn Medication Administration Records (MARs) showed the following:
*A BM on 11/26/13. No interventions provided until 11/29/13 at 6:26 a.m. (Day 3), when staff attempted to give Resident #4 a suppository (the resident refused). At 12:53 p.m., staff attempted

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to give Resident #4 MOM (the resident refused). Records identified staff failed to attempt interventions on Day 2 without a BM and failed to attempt MOM prior to a suppository as identified in the facility's bowel protocol.
*A BM on 11/29/13. No interventions provided until 12/02/13 at 5:58 a.m. (Day 3), when staff administered a suppository. At 1:58 p.m., staff administered MOM, and at 7:48 p.m., staff administered a fleets enema. Bowel records showed a small BM on the evening of 12/02/13. The MAR identified staff also administered MOM on 12/03/13 at 4:01 a.m. Staff failed to attempt interventions on Day 2 without a BM and failed to attempt MOM prior to a suppository. It is unknown why staff administered MOM on 12/03/12 when records identified Resident #4 had a BM on 12/02/13.

- Review of Resident #10's medical record occurred on 12/31/13. Diagnoses included unspecified constipation. Current medications included Senna Plus two tablets BID and MOM 30 cc prn.

A nurse's note, dated 12/16/13 at 7:50 a.m., stated, "Prune juice given for 4 day without BM." The medical record showed Resident #10 had a BM on 12/12/13. Staff failed to provide interventions for constipation prior to prune juice on the morning of 12/16/13. The record also showed Resident #10 had a BM on 12/22/13 and 12/27/13 (5 days later). Staff failed to provide any interventions to help manage Resident #10's constipation.

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- Review of Resident #2's medical record occurred on December 30-31, 2013. Diagnoses included constipation. Medications included Senna-S twice daily, Colace once daily, and MOM, biscolax suppository and Fleets enema PRN for constipation.

Review of the BM report and MAR for December 2013 identified Resident #2 had three BM's on the 15th. The facility administered a suppository on December 18th before attempting a less invasive medication.

- Review of Resident #7's medical record occurred on December 30-31, 2013. Diagnoses included constipation. Medications included Senna S twice daily, and MOM, lactulose, Dulcolax suppository, and a Fleets enema PRN for constipation.

Review of Resident #7's BM reports and MARs for December 2013 identified the facility administered a suppository on December 4th (before attempting a less invasive medication) even though the resident had a large BM on 12/02/13.

The facility failed to provide effective treatment to manage constipation according to the protocol and failed to ensure implementation of the Plan of Correction.

{F 314} SS=D 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES {F 314}

Based on the comprehensive assessment of a resident, the facility must ensure that a resident

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who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, review of facility policy, and staff interview, the facility failed to identify and assess and the presence of a pressure ulcer for 2 of 2 sampled residents (Resident #6 and #9) identified by the survey team with facility acquired pressure sores. Failure to identify, assess, and monitor pressure sores limited the facilities ability to implement measures to promote the healing of Resident #6 and #9's Stage II pressure ulcers and further deterioration and/or prevent development of additional pressure areas.

Findings include:

Review of the facility policy and procedure titled "Pressure Ulcers: Skin Assessment and Prevention" occurred on 12/31/13. This policy, revised 01/12, stated:
" PURPOSE: To systematically assess residents with regard to risk of skin breakdown. To accurately document observations and assessments of residents to appropriately use prevention techniques and pressure redistribution surfaces on those residents at risk for pressure ulcers. . . . 5. A systematic skin inspection will be made daily by the nursing assistant assigned to those residents at risk for skin breakdown . . .

1. Resident # 6's individual needs will be met by adding a low air loss air mattress on 12-31-2013 to his bed and moved to a large private room on the North Unit to allow for a recliner to off load for frequent position changes. Administrative nurse #6 was counseled on the need to contact the physician for an order for a dressing to the skin on 1-21-2014.

Resident #9 pressure area is resolved as of 1-17-2014.

2. All residents with current pressure ulcers have the potential to be affected in this area. All listed residents will have daily documentation with at least a weekly measurement on the wound care flow sheet.

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{F 314}	Continued From page 10 Developing an individualized repositioning schedule is recommended based on observation of the resident's skin over a period of time. Individual pressure points are observed for redness or discomfort . . . 7. If a pressure ulcer is identified, cleanse the area prior to observations being made to allow the wound bed and depth to be more accurately observed. The registered nurse should record the type of wound and the degree of tissue damage . . . The licensed nurse records the location of the area, the measurements and the ulcer/wound characteristics. Document the information on the Wound Flow Sheet . . . 8. Notify the physician/practitioner of the ulcer and resident's condition to obtain orders for a treatment. . . . 10. Notify dietary . . . 11. The interdisciplinary teams should determine any modifications that are necessary to the resident's plan of care. . . . 12. When a pressure ulcer is present, daily monitoring . . . should include . . . presence of possible complications . . . Whether pain . . . is adequately controlled 14. The pressure ulcer should be assessed/evaluated at least weekly and documented on the Wound Flow Sheet . . . with every treatment change. Observation of the ulcer's characteristics may be documented by a licensed nurse and should include at least the following: *Measurements - length, width, depth *Characteristics of the ulcer . . . *Presence of pain *Current treatments . . ." - Review of Resident #6's record occurred on December 30-31, 2013. Diagnoses included	{F 314}	3. All nursing staff were re-educated on 1-30-2014 on the procedure titled: "Pressure Ulcers" with a focus of the education to licensed staff on the need to document daily on all open pressure ulcers and suspected deep tissue injuries. The wound care flowsheet will be used for daily documentation and weekly measurements. An all staff meeting was held on 1-29-14 in order to educate staff on the new changes. 4. An audit will be developed to monitor daily documentation of open wounds and weekly measurements. The audit will be complete weekly for 4 weeks, then monthly for two months. The DNS or designee is responsible to ensure the audits are completed and analysis. The audit results will be reported by to the QA committee for further recommendations. 5. February 14, 2014	

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	355093	A. BUILDING _____ B. WING _____	R 12/31/2013

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vascular dementia, cerebrovascular disease with hemiplegia (weakness of one side of the body), and insulin dependent diabetes mellitus.

Review of progress notes identified:
* 11/27/13, "Talked with resident and he agreed to sit in a recliner in afternoon. This is to releave [sic] pressure to coccyx. Also possibility for air mattress to bed. . . ."
* 12/12/13 at 9:11 a.m., "Weekly skin evaluation resident has pimple on right outer buttock intact no redness to bottom no other new skin issues at present. Will continue to monitor weekly."
* 12/23/13 at 4:19 p.m., "Care plan adjusted to show residents receipt and us [use] of 2 inch memory foam cushion, with goal to resume use of ROHO [pressure reducing cushion for a chair] for skin break down."
* 12/30/13 at 9:14 p.m., "Resident has open area on right buttock just to the right of buttock crease. Area measured is 1.8 cm [centimeters] [by] 1.4 cm. Duoderm dressing removed had sanguineous drainage. The open area is not deep and appears as if skin has been scraped off. New duoderm applied."

Resident #6's progress notes and treatment records failed to identify weekly skin assessments on 12/05/13, 12/19/13, and 12/26/13.

A "Report for Quality Committee," dated 11/19/13, for the deficiency at F 314, cited during the standard survey on 09/26/13, identified, ". . . goal . . . to have staff checking pressure points during cares & reporting any unusual areas to the nurses. Summarize your current work . . . they are checking & a few areas were reported to the nurses . . . How have you measured . . . improvement? . . . to continue monitoring skin.

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What changes or improvements have occurred? Better inspection of the skin. . . . [No] . . . new issue/area for improvement been identified."

A "Report for Quality Committee," dated 11/24/13, identified, ". . . [Resident #6] has 2 reports of red coccyx. Will investigate to see when he is repositioned . . . What is the issue/concern? to prevent press [pressure] sores. . . . List possible systems, processes and departments that may be involved in improvement plan. Communication sheet for Bath aides, Educate, Educate, Educate! Do a QA [quality assurance] to check on positions."

Review of Resident #6's care plan failed to identify the problem and interventions for the "pimple" identified on 12/12/13 on the "Treatment Administration Record" to the right outer buttocks. The record lacked evidence of weekly skin assessments for the following three weeks.

During observation on 12/30/13 at 4:25 p.m., two certified nursing assistants (CNAs) (#2 and #6) provided toileting and performed incontinence cares for Resident #6. Before providing the cares, a CNA (#2) stated Resident #6 had a duoderm dressing on his buttock due to the presence of a sore. A nurse (#8) also reported Resident #6 had an open area. Following cares, observation showed a duoderm dressing on Resident #6's right buttock. The inner edges of the duoderm adjacent to the crevice of the buttock showed evidence of drainage under the duoderm and possible loosening on the edge of the duoderm close to the crevice of the buttock.

During interview on 12/30/13 at 4:45 p.m., an administrative nurse (#1) stated Resident #6

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"had" an open area, but duoderm is now being used to protect the area.

During interview on 12/30/13 between 4:45 p.m. and 5:30 p.m., an administrative nurse (#1) and staff nurse (#7) identified a communication book/Kardex which addressed Resident #6's skin cares. The Kardex included two written communications: dated 11/30/13, "Good pericares and often [sic] as possible when inc [incontinent], Put calmo [calmoseptine] on bottom" and on "12-28 Duoderm type drsg [dressing] applied to Rt [right] coccyx." The staff nurse (#7) identified nursing staff completed a weekly "skin check." The staff nurse (#7) stated she observed the resident's buttock on December 12 and December 19 and identified a pimple on the right buttock. The staff nurse (#7) identified the completion of the "evaluation" occurs on the "Treatment Administration Record" and the nurse documents the appearance in the progress notes. The record showed the weekly skin check scheduled for Thursdays in December: December 5, December 12, December 19, and December 26. The administration record lacked evidence an evaluation/assessment occurred on December 5 and December 26. The record lacked documentation of the appearance of the skin on December 19. The staff nurse (#7) stated the "Wound Flow Sheet" is kept by the administrative nurse (#1).

On the evening of 12/30/13 at 9:05 p.m., a staff nurse (#3) removed the duoderm dressing and reapplied a new duoderm. The nurse identified a 1.8 centimeter (cm) by 1.4 cm open area with sanguineous (bloody) drainage on Resident #6's right inner buttocks region near the crevice.

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On 12/31/13 at 8:30 a.m., an administrative nurse (#1) reported talking to the staff nurse (#4) who placed the duoderm on Resident #6's buttock on 12/28/13. The administrative nurse (#1) reported the staff nurse (#4) placed the duoderm on the buttock on 12/28/13 as the area was "just barely" open, and plans were to call the physician for an order on 12/30/13.

During interview on 12/31/13 at 8:40 a.m., a staff nurse (#4) reported she did not do an assessment on 12/26/13 as scheduled on the "Treatment Administration Record" and stated on Saturday, 12/28/13, she noted a small open area at the "top" of Resident #6's right buttock. She stated the resident experienced pain so she applied a duoderm and left a note for the administrative nurse (#1) for the following Monday (12/30/13). The staff nurse (#4) provided a copy of the note, dated 12/28/13, which stated, "I put a Duoderm CGF [control gel formula] border 4 x [by] 4 [inch] on [Resident #6's] sore it was draining a little - If its ok or you want something else plz. [please] have [another staff nurse] get an order. Thanks."

During interview on 12/31/13, at 9:40 a.m., an administrative nurse (#1) stated no "Wound Flow Sheet" had been initiated regarding the open area on Resident #6's buttock.

The "Treatment Administration Record" and progress notes lacked evidence staff completed the scheduled weekly skin assessments. The record lacked an assessment of the area on 12/28/13 prior to the application of a duoderm dressing and lacked evidence of an assessment of the pressure area until 12/30/13. Information request dring the entrance conference on the

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F 314}	Continued From page 15 morning of 12/30/13 failed to identify Resident #6's pressure ulcer. - Review of Resident #9's medical record occurred on 12/31/13. Diagnoses included dementia. The current care plan stated, "The resident has potential impairment to skin integrity R/T misture [sic] /heat in skin folds, frequent incontinence, impaired physical functions E/B [evidence by] H/O [history of] reoccuring coccyx redness . . ." Review of Resident #9's progress notes identified the following: *12/21/13 - "Small 0.75 cm open area on her coccyx, area was cleansed and dried well and calmoseptine applied" * 12/29/13 - "Resolving open area to coccyx area will continue to monitor purple area to lt upper buttock area blanches and no c/o [complaints of] discomfort." The facility failed to assess Resident #9's pressure ulcer and document the findings on a wound flow sheet; failed to notify the resident's physician and obtain a treatment order; and failed to notify the dietary department.	{F 314}		
{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: THIS DEFICIENCY WAS NOT CORRECTED AT THE TIME OF THE ON-SITE REVISIT, FOR	{F 333}		

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F 333}	Continued From page 16 THE STANDARD SURVEY COMPLETED ON 09/26/2013. Based on record review, review of manufacturer's recommendations, review of professional reference, and staff interview, the facility failed to ensure administration of insulin occurred within the ordered/recommended times and failed to administer scheduled and sliding scale NovoLog insulin in one injection for 2 of 3 sampled residents (Resident #6 and #10) with Type II insulin dependent diabetes. Failure to administer NovoLog (a rapid-acting insulin) at the correct time may result in hypoglycemia, and failure to administer scheduled and sliding scale insulin resulted in unnecessary pain for Resident #10. These practices may negatively impact all diabetic residents residing at the facility. Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 5th ed., Addison Wesley Longman, Inc., California, page 1321, states, " . . . Mixing Medications in One Syringe . . . Frequently, clients need more than one drug injected at the same time. To spare the client the experience of being injected twice, two drugs (if compatible) are often mixed together in one syringe and given as one injection. . . ." Review of the manufacturer's instructions for NovoLog insulin occurred on 12/31/13. The instructions stated, ". . . You should eat a meal within 5 to 10 minutes after using NovoLog to avoid low blood sugar. NovoLog is a fast-acting insulin. The effects of NovoLog start working 10 to 20 minutes after injection. . . Do not inject NovoLog if you do not plan to eat right after your	{F 333}	F 333 See also F 309 for resident #10's individual plan. 1. Resident # 6's individual needs have been met on 1-15-2014 his primary care physician discontinue his sliding scale coverage, reduced the frequency of blood glucose monitoring checks to QID to TID. The resident will receive adequate nutrition within 5-15 minutes of the rapid acting insulin. 2. A list of residents that are receiving short acting insulin has been generated. These residents will be offered adequate nutrition within 5-15 minutes of the rapid action insulin administration.	

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F 333}	Continued From page 17 injection. . . ." During an interview on the morning of 12/31/13, a nursing staff member (#5) identified meal times as "open breakfast" from 7:30 a.m. until 9:00 p.m., lunch at 12:00 p.m., and dinner at 6:00 p.m. - Review of Resident #6's medical record occurred on December 30-31, 2013. Diagnoses included Type II insulin dependent diabetes mellitus. Medications included: Levemir (a long-acting insulin) 50 units subcutaneously (SQ) two times a day, scheduled NovoLog 8 units SQ three times per day, and sliding scale NovoLog three times per day. The Medication Administration Record (MAR) identified staff administered Levemir at 6:00 a.m. and 8:00 p.m.; scheduled NovoLog at 7:30 a.m., 11:30 a.m., and 5:30 p.m.; and sliding scale NovoLog at 6:00 a.m., 11:00 a.m., and 5:00 p.m. Record review for the month of December 2013 identified staff administered Resident #6's sliding scale and scheduled NovoLog between 5:08 a.m. and 6:25 a.m. on 21 different occasions (over an hour before breakfast begins). The record failed to identify any snack given prior to breakfast. Staff also administered Resident #6's sliding scale and scheduled NovoLog between 4:10 p.m. and 4:52 p.m. on 10 different occasions (over an hour before supper begins). The nurse's notes identified a snack of crackers or juice given with the insulin administrations; however, staff do not serve the supper meal until 6:00 p.m. Record review for the month of December 2013 further identified staff administered scheduled and sliding scale NovoLog in two separate	{F 333}	3. A nursing inservice will be held on 1-30-2014 to educate the nurses on the Drug Reference Handbook on novolog insulin administration reaction times and the need for the resident to receive adequate nutrition within 5-15 minutes after rapid acting insulin administration. An all staff meeting was held on 1-29-14 in order to educate staff on the new changes. System change: Insulin administration times have been change in the PCC to 0800, 1200, 1800 so you can not give insulin hour early. Insulin is administered and resident needs to eat within 5-15 minutes.	

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ENTERS FOR MEDICARE & MEDICAID SERVICES

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F 333}	Continued From page 18 injections on 22 occasions prior to the breakfast meal and 8 occasions prior to the supper meal, in addition to Resident #6's twice per day Levemir and lunch time NovoLog injections. This resulted in Resident #6 receiving up to seven needle sticks per day (on 12/18/13, 12/21/13, 12/22/13, 12/23/13, and 12/24/13). Resident #6's progress notes stated the following: *11/30/13 at 5:25 a.m., stated, ". . . Resident received insulin to the stomach and stated '[expletive]! You [expletive] poke yourself in the stomach!' While nurse was recording Resident's blood sugar outside room nurse heard Resident state '[expletive]! I hate those [expletive] [expletive] needles. Do it to yourself and see how much you like it. . . ." *12/31/13 at 5:42 a.m.: ". . . Resident also was angry this AM when taking his accucheck [blood sugar monitoring] and giving insulin. Resident screamed 'Ow.' . . ." - Review of Resident #10's medical record occurred on 12/31/13. Diagnoses included type II diabetes. Current medications included Lantus (a long-acting insulin) 22 units SQ once per day, NovoLog 3 units SQ three times per day (TID), and sliding scale NovoLog TID. The MAR identified staff administered Lantus at 6:00 a.m.; scheduled NovoLog at 8:00 a.m., 12:00 p.m., and 6:00 p.m.; and sliding scale NovoLog at 6:00 a.m., 11:00 a.m., and 5:00 p.m. Record review for the month of December 2013 identified staff administered Resident #10's sliding scale and scheduled NovoLog between 5:28 a.m. and 6:18 a.m. on 13 different occasions (over an hour before breakfast begins). The	{F 333}	4. An audit tool was developed to monitor the time of administration of the rapid acting insulin and the time the resident received adequate nutrition. The audit will be completed by the DNS or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the QA committee for further recommendations. 5. February 14, 2014	

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{F 333}	Continued From page 19 record failed to identify a snack given prior to breakfast. Staff also administered Resident #10's sliding scale and scheduled NovoLog between 4:15 p.m. and 4:42 p.m. on 10 different occasions (over an hour before supper begins). The nurse's notes identified a snack of crackers (and occasionally cheese) given with the insulin administrations; however, staff do not serve the supper meal until 6:00 p.m. Record review for the month of December 2013 further identified staff administered scheduled and sliding scale NovoLog in two separate injections on 8 occasions prior to the breakfast meal, 2 occasions prior to the noon meal, and 10 occasions prior to the supper meal, in addition to Resident #10's Lantus injection. This resulted in Resident #10 receiving up to seven needle sticks per day (on 12/08/13 and 12/30/13). During interview on the morning of 12/31/13, an administrative staff nurse (#5) stated nursing staff provide residents a snack with insulin administration to avoid low blood sugars. Facility staff administered fast-acting insulin over an hour prior to meals and provided residents with snacks rather than meals at those times, which resulted in unstable blood sugar levels for Resident #10 and may result in unstable blood sugar levels for other insulin dependent residents in the facility. Facility staff administered sliding scale NovoLog separately from scheduled NovoLog, which resulted in unnecessary needlesticks and/or pain. Refer to F309.	{F 333}		