STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355063	A. BUILDING _____ B. WING _____	01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on January 13, 2014 and completed on January 16, 2014 the sample included four (4) residents for complete review, ten (10) residents for focused review, and three (3) closed records for review. The sample included seven (7) additional residents to verify specific concerns during the survey.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and resident and staff interview, the facility failed to assess the safety of self-administration of medication (SAM) for 1 of 1 supplemental resident (Resident #19) observed with medications left at the bedside. Failure to determine if SAM is a safe practice has the potential to result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "Self-Administration of Drugs" occurred on 01/16/14. This policy, revised 01/30/12, stated, ". . . Residents in our facility who wish to self-administer their medication may do so, if it is determined that they are capable of doing so . . .	F 176	Resident # 19 was affected by this deficient practice - An assessment for resident to self-administer medication was completed on 1/16/14 by Resident Care Manager and reviewed by IDT (Interdisciplinary Team). Nursing staff were re-educated to Self- Administration of medication Policy on 2/13/14 and 2/17/14. All resident's requesting to self-administer medication have the potential to be affected. Audit of residents and physician orders will be completed on each unit by 2/25/14 to identify other resident's who may have an order for self-administration or who have requested to self-administer medication. Those residents who currently wish to self-administer medication will be assessed by a Licensed Nurse and order will be obtained as appropriate. Residents assessed safe to self-administer medications will be re-assessed quarterly according to MDS schedule. New admissions who express a desire to self administer medications will be assessed on admission by Licensed nurse and practitioner for appropriateness. Those who are appropriate to self-administer medications will be re-assessed quarterly	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Stobel — TITLE: Administrator — (X6) DATE: 3-3-2014

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 176	Continued From page 1 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: a. Ability to read and understand medication labels; b. Comprehension of the purpose and proper dosage and administration time for his or her medications; c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) them; and d. Ability to recognize risks and major adverse consequences of his or her medications. 3. If the staff determine that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications . . . 13. The staff and practitioner will periodically (for example, during quarterly MDS [Minimum Data Set] reviews) reevaluate a resident's ability to continue to self-administer medications." Observation on the morning of 01/13/14 identified a blue pill box containing several medications at Resident #19's bedside. During the observation, Resident #19 reported staff fill her pill box daily with the medication she self-administers 30 minutes before meals. The resident stated she also self-administered artificial tears and kept the bottle in her room. Observation during medication administration on 01/14/14 at 7:38 a.m. identified a nurse (#2) filled Resident #19's pill box with three doses of Carafate and stated the resident self-administered the medication before meals.	F 176	and PRN in accordance to the MDS schedule. Licensed Nurses were re-educated on 2/13/14 and 2/17/13 on facility policy for Self-Administration of Medications. DNS or designee will audit 4 resident's each week for self administration assessment and physician orders for those residents requesting to self-administer their medication X 3 months starting 2/25/14 for compliance. Areas of concern will be address-ed immediately and reviewed in Quality Assurance Meeting monthly X 3 months, then PRN. Date of Completion:	2/25/14

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F 176	Continued From page 2 Review of Resident #19's record occurred on 01/16/14 and diagnoses included esophageal reflux and glaucoma. Current medications included Carafate (used for esophageal reflux) 1 gram four times a day and artificial tears one drop to both eyes as needed. A physician's order, dated 06/28/13, stated, "Has been approve [sic] to self admin. [administer] meds [medications] - rsident [sic] may choice [sic] which meds to self admin." An additional physician's order, dated 03/20/13, stated, "Per family/resident self admin. Carafate only." The resident's medical record lacked an assessment for self-administration of medications. During an interview on the morning of 01/16/14, an administrative nurse (#1) confirmed the facility failed to assess Resident #19's ability to self-administer medications and stated she (#1) assessed the resident that morning (01/16/14) and determined the resident should not self-administer her medications.	F 176		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to promote care for residents in a	F 241	Resident # 20 was affected by this deficient practice. Licensed Nurses were re-educated on 2/13/14 and 2/17/14 on updated policies for: Obtaining Finger Stick Glucose Level and Insulin Administration. All resident's who are diabetic that receive insulin have the potential to be affected. Licensed nurses were re-educated on up-dated policies for: Obtaining Finger Stick Glucose and Administering Insulin.	

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F 241	Continued From page 3 manner and in an environment that maintains or enhances each resident's dignity for 1 of 1 supplemental resident (Resident #20) who received insulin during medication pass. Failure to test blood glucose and administer insulin in a private area did not maintain Resident #20's dignity. Findings include: - Observation on 01/14/14 at 7:58 a.m. showed a nurse (#2) tested Resident #20's blood glucose in the corridor adjacent to the dining room within visual view of other residents. At 8:02 a.m., the nurse (#2) administered insulin in the resident's abdomen in the same corridor adjacent to the dining room within view of other residents. - Observation on 01/14/14 at 12:18 p.m. showed a nurse (#2) tested Resident #20's blood glucose in the corridor adjacent to the dining room within visual view of other residents and a family member. At 12:30 p.m., the nurse (#2) administered insulin in the resident's abdomen in the same corridor adjacent to the dining room within view of other residents and a family member. - On 01/15/14 at 8:50 a.m., observation showed a nurse (#3) administered insulin in Resident #20's abdomen in the corridor adjacent to the dining room within visual view of other residents. During an interview on 01/15/14 at 4:30 p.m., an administrative nurse (#1) stated she expected nursing staff to check residents' blood glucose and administer insulin in a private area.	F 241	DNS or designee will observe finger stick glucose procedure and administration of insulin in private area, performed by 4 nurses per week X 3 months for compliance starting 2/25/14. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly X 3 months, then PRN. Completion Date:	2/25/14
F 242	483.15(b) SELF-DETERMINATION - RIGHT TO	F 242	Resident #3 was affected by	

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F 242 SS=D	Continued From page 4 MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to accommodate the individual choice for 1 of 1 sampled resident (Resident #3) who listened to his church service via telephone. Failure to allow the resident to listen to his church service before assisting him to bed did not recognize the resident's right to make choices significant to him. Findings include: During an interview on the afternoon of 01/13/14, Resident #3 identified religion was very important to him and stated he listened to his church service via telephone every Tuesday evening. The resident stated the church service goes from 7:30-9:00 p.m., but staff put him to bed at 8:30 p.m. Resident #3 expressed disappointment in staff assisting him to bed before the church service finished. The current care plan stated, ". . . Resident listens to church on his phone weekly, and does so independently. Allow him privacy when he is listening to his service. . . ."	F 242	this deficient practice. Staff were re-educated of resident's request to be assisted to bed after his church services are over on Tuesday nights. Residents who express a desire to listen to church services have the potential to be affected. Staff have been re-educated regarding residents rights to make choices involving activities, schedules, and health care. DNS or designee will audit 3 residents church attendance weekly for 3 months starting on 2/25/14. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly X 3 months, then PRN. Completion Date:	2/25/14

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F 242	Continued From page 5 During an interview on the morning of 01/16/14, an administrative nurse (#1) confirmed staff should wait until Resident #3's church service finished on Tuesday evenings before assisting him to bed.	F 242		
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: 1. Based on resident and family interview, group interview, staff interview, and review of the facility's Location Section Activation reports, the facility failed to provide reasonable accommodations of individual needs regarding responding to call lights for 6 of 8 residents (A, B, C, D, and E) interviewed on 4 of 4 nursing units (Prairie, Badlands, Homestead, and Western) and 1 of 2 families (#1) interviewed. Failure to answer call lights in a timely manner may affect the quality of life and quality of care provided to all residents who reside in the facility. Findings include: - During an interview on the afternoon of 01/13/14, Resident E stated it takes staff "more than a half hour" at times to answer his call light. The resident stated he waited on all shifts for staff	F 246	Residents A, B, C, D, and E were affected. Call light activation reports were reviewed for those residents having extended wait times. Resident Care Manager on each unit have their radio's set on the same channel as their unit. Staff were re-educated to Answering call Light Policy on 2/13/14 and 2/17/14. Order was received for Resident #3 for Occupational Therapy for seating eval in wheel chair on 1/17/14. All residents have the potential to be affected. 1). Answering Call light Policy was updated. 2).Call light wait times will be reviewed in Clinical Team meeting daily 5 times per week starting 2/20/14. Those resident's with extended wait times will be identified, and possible contributing factors will be investigated and discussed with direct care staff assigned to unit (during that time) as needed to resolve extended wait time. 3). Resident's who use wheelchairs will be re-assessed for positioning by Resident Care Managers on respective units by 2/25/14 and then quarterly and PRN in accordance to MDS schedule. Residents identified with positioning needs will be referred to therapy services. Nursing staff were re-educated on updated - Answering Call Light Policy and the Repositioning Policy on 2/13/14 and 2/17/14. Resident Care Managers	

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F 246	Continued From page 6 assistance, which resulted in incidents of bladder and bowel incontinence and once he "pooped the bed and floor all the way to the toilet" due to waiting so long (unsure of exact date this occurred). The facility identified this resident as interviewable. Review of the facility's "Location Section Activation" report from 12/28/13 through 01/04/14 occurred on 01/16/14 and identified the following call light response times for Resident E: *50 minutes on 12/30/13 *28 minutes on 12/30/13 *28 minutes on 12/31/13 *25 minutes on 01/01/14 - During the resident group interview on 01/13/14 at 10:45 a.m., Resident A stated she had to wait for help for "45 minutes." Resident B agreed and stated they have to "wait" for staff to come. Both Residents A and B were identified by the facility as interviewable. A review of the facility's "Location Section Activation" report occurred on 01/16/14. This report for the date range of 12/28/13 to 01/04/14, indicated the following response times: Resident A's call light * 24 minutes on 01/01/14 * 40 minutes on 01/04/14 Resident B's call light * 25 minutes on 12/29/13 * 24 minutes on 01/01/14 * 27 minutes on 01/03/14 - During an interview on 01/15/14 at 9:15 a.m., a family member (#1) stated it sometimes takes staff a long time to answer call lights especially on weekends and evenings. An example given by	F 246	were updated on Wheel chair Positioning and seating Assessment. Call light activation reports will be printed 5 times weekly and reviewed by Resident Care Managers, Director of Quality / Staff Development and DNS or designee during Clinical Team meeting 5 times weekly x 3 months starting 2/25/14 for extended wait times. DNS or designee will audit 3 residents weekly x 3 months starting 2/25/14 for wheel chair positioning. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly X 3 months, then PRN. Completion Date:	2/25/14

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F 246	Continued From page 7 the family member identified during an evening visit sometimes within the past two weeks, staff did not answer Residents C's call light for at least 30-40 minutes. The family member stated this has happened frequently during previous visits. - During an interview on 01/15/14 at 4:00 p.m., Resident D stated it took staff a long time to answer the call light earlier today when the resident needed to use the bathroom. Resident D stated extended wait times (greater than 20 minutes) for staff to answer call lights has occurred "occasionally." The facility identified Resident D as interviewable. Review of the facility's "Location Section Activation" report occurred on 01/16/14. This report for the date range of 12/28/13 to 01/04/14, indicated the following response times for Resident D: * 52 minutes on 12/28/13 * 36 minutes on 12/28/13 * 36 minutes on 12/30/13 * 20 minutes on 12/31/13 * 51 minutes on 01/04/14 * 29 minutes on 01/04/14 - During an interview on 01/15/14 at 4:15 p.m., Resident F, reported having to wait for help. She reported being independent with some cares, but does need assistance of one staff person to complete her morning cares and to "get off the toilet." Review of the facility's "Location Section Activation" report occurred on 01/16/14. This report for the date range of 12/28/13 to 01/04/14, indicated the following response times for Resident F:	F 246		

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F 246	Continued From page 8 * 30 minutes on 12/28/13 * 29 minutes on 12/29/13 * 35 minutes on 12/30/13 * 22 minutes on 01/02/14 - A review of the facility's "Location Section Activation" report occurred on 01/16/14. This report for the date range of 12/28/13 to 01/04/14, indicated the following response times on the following units: * Unit 1 Prairie, 21 to 45 minutes - 39 times and 46 to 71 minutes - 7 times * Unit 2 Badlands, 21 to 50 minutes - 7 times * Unit 3 Homestead, 21 to 45 minutes - 33 times and 46 to 60 minutes - 6 times * Unit 4 Western, 22 minutes to 54 minutes - 15 times - During an interview on 01/16/14 at 10:45 a.m., a nurse manager (#8) stated staff should answer call lights within 20 minutes and hopefully less. 2. Based on observation, record review, facility policy review, and resident interview, the facility failed to accommodate the individual positioning needs for 1 of 1 sampled resident (Resident #3) with improper wheelchair positioning. Failure to ensure proper wheelchair positioning may result in residents experiencing reduced range of motion, contractures, and pain. Findings include: Review of the facility policy titled "Rehabilitative Nursing Care" occurred on 01/16/14. This policy, revised April 2013, stated, ". . . 4. Rehabilitative nursing care is performed daily for those residents who require such service. Such program includes, but is not limited to: a.	F 246		

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F 246	Continued From page 9 Maintaining good body alignment and proper positioning. . . ." Review of Resident #3's medical record occurred on all days of survey and diagnoses included spinal stenosis, paraplegia, peripheral neuropathy, osteoarthritis, and generalized pain. The quarterly Minimum Data Set, dated 12/22/13, identified the resident with intact cognition, required extensive assistance for mobility and transfers, impaired range of motion to both lower extremities, and occasional pain rated a "4" on a scale from 0-10 effecting his function during activities. The current "My Daily Living Needs" care card stated, ". . . Prop 2 towels under my right thigh in wheelchair - helps me sit straighter. . . ." All observations on January 13-16, 2014 identified Resident #3 leaned to the right in his wheelchair, with his right arm pressed into the armrest and no towels placed under his right thigh. During an interview on 01/15/14 at 7:35 a.m., Resident #3 identified staff "never" place towels under his right thigh for improved wheelchair positioning and stated "I spose [suppose] it might help." The resident verbalized discomfort when his arm pressed into the armrest of his wheelchair.	F 246		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	Resident # 2 and #14 were affected by this deficient practice. Resident #2's care plan has been updated to address: insomnia, toileting and her rising schedule. Resident #14's Positive Behavior	

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F 280	Continued From page 10 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developped within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the resident's status for 2 of 14 sampled residents (Resident #2 and #14). Failure to review and revise the plan of care limited the facility staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled, "Behavior/Mood Management" occurred on 01/16/14. This policy, dated 12/16/13, stated, ". . . 3. If the behavior is new or increased from the resident's typical behavior, the Charge Nurse will initiate a Psychosocial Monitor Acute Focus Care Plan and notify Nurse Manager and/or Social Services. The	F 280	plan was updated to address the death of her husband and the current household she resides on. Daily Living Needs (DLN) was updated for Resident #14. Care plan was also updated to reflect that resident is not participating in telemed psychiatry visits. All residents residing in the facility have the potential to be affected. 1).Interdisciplinary Team will review and update two resident care plans and two resident Daily Living Needs for accuracy weekly in Clinical Team Meeting. Positive Behavior Plans for those residents currently on them will be reviewed for accuracy by Interdisciplinary Team by 2/25/14. Unit Coordinators will be responsible to update DLN with any changes, Resident Care Managers will update Care Plans quarterly and PRN with changes. Social Services will update Positive Behavior Plans quarterly and PRN with changes. Interdisciplinary Team and Nursing Staff were re-educated on Care Plan Policy, updating Positive Behavior plans and Daily Living Needs on 2/10/14 and 2/17/14. DNS or designee will audit two of each of the following weekly X 3 months: Care Plans, Positive Behavior plans and Daily Living Needs to assure compliance starting 2/25/14. Areas of concern will be addressed	

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F 280	Continued From page 11 Charge Nurse will write the targeted behavior/mood and possible non-medical interventions specific to the resident on the acute focus care plan. Charge Nurse will be responsible for passing on [sic] this on to unit staff so that all staff are aware of interventions that are/have been tried. After 48/72 hours, Nurse Manager and/or Social Services will confer with the Charge Nurse and if effective, have the interventions added to the Resident's Daily Living Needs Plan. If the interventions were ineffective, Social Services will notify the Mental Health Team for further investigation and planning. . . ." Review of the facility policy titled, "Care Plans-Comprehensive" occurred on 01/16/14. This policy, dated April 2012, stated, " . . . Policy Interpretation and Implementation . . . Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included insomnia and urinary retention. The quarterly Minimum Data Set (MDS), dated 11/30/13, identified the resident as having trouble falling or staying asleep 7-11 days. Review of Resident #2's current care plan failed to address the diagnosis of insomnia. Review of Resident #2's "My Daily Living Needs," updated on 11/29/13, identified the following toileting plan, "Take me to the bathroom before and after meals and activities, at bed time and	F 280	immediately and reviewed in Quality Assurance Meeting monthly X 3 months, then PRN. Completion Date:	2/25/14

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	355063	A. BUILDING _____ B. WING _____	01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

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F 280	Continued From page 12 every 2-3 hours at night and as I request." Random observations on 01/13/14 through 01/14/14 identified the resident as having an indwelling catheter. On 01/14/14 orders were received to discontinue catheter. The facility failed to update the careplan to address the use of a catheter and failed to follow a toileting plan once the catheter was removed. Review of Resident #2's "My Daily Living Needs," updated on 11/29/13, stated, "I like to get up at 07:00 [7:00 a.m.] - 08:00 [8:00 a.m.] and I go to bed around 9:00 pm." "I like to nap a lot during the day and I enjoy attending activities." During an interview on 01/14/14 at 7:10 a.m., a nurse (#11) stated Resident #2 likes to get up early. She doesn't sleep well. Around 4:30 a.m. she'll get up and sit in her recliner. Usually she is dressed and ready for the day at 5:30 a.m. "I was surprised she wasn't today." The "My Daily Living Needs" did not reflect the resident's current schedule. The facility failed to develop and implement an individualized careplan to address Resident #2's insomnia, toileting, and rising schedule. - Review of Resident #14's medical record occurred January 15-16, 2014. This record identified the resident's husband died in June of 2013. * Review of Resident #14's current care plan stated, "Problem . . . Resident has a diagnosis of Depressive Disorder as well as memory loss, dementia and Alzheimer's disease. . . . Since her husband's death, she wanders at times looking for him. . . . Approach . . . [Resident #14] is	F 280		

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F 280	Continued From page 13 followed by telemed psychiatry who monitors her mood, behavior, and medications. Please make appointments and follow-up with him as needed and/or ordered. . . . See [Resident #14's] positive behavior plan, and daily living needs plan located in her bathroom and in her chart." * The "Positive Behavior Plan: [Resident #14's name] - . . . " dated 05/08/12, located in Resident #14's bathroom all days of survey, stated, ". . . My husband and I have since moved to the room right next to the TV lounge area. . . . I like to sit on the loveseat with my husband in the great room where the TV is located. But, sometimes, I am looking for things - things to do. Direct me to the cupboard with my name on it in the Prairie North Dining Room. . . ." * The "My Daily Living Needs" for Resident #14 identified the following: ". . . There is a cupboard in dining room for me to fold clothes and do utensil sorting please help me find it when restless. . . ." Neither the "Positive Behavior Plan" or the "My Daily Living Needs" address the death of Resident #14's husband, which occured over six months ago. These documents are the two references posted for Certified Nurse Aides to access for guidance to assist with resident care when she wanders, enters other residents rooms, and/or needs assistance but cannot express what she needs. Review of Resident #14's medical record failed to identify any telemed psychiatry visits as stated in the care plan. The "Positive Behavior Plan" identified Resident #14 lives on Prairie North, her husband is an intervention for her behavior, and there is an activity area for her distraction in the dining room. Observation of Resident #14 showed she does not live on Prairie North, the	F 280		

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F 280	Continued From page 14 current dining room used by the resident does not have a cupboard of activities for Resident #14 and the record showed her husband died over six months ago. During interviews, on the morning of 01/16/14, an administrative social service staff member (#9) identified the facility posted the wrong "Positive Behavior Plan" in Resident #14's bathroom. This staff member also identified Resident #14 has not utilized telemed psychiatric services since 2012.	F 280		
F 309 SS=D	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 staff interview, the facility failed to provide the necessary care and services to manage behavioral and psychological symptoms of dementia (BPSD) for 1 of 4 sampled residents (Resident #2) with a diagnosis of dementia and receiving an antipsychotic medication. The failure to identify BPSD, assess the reason/causative factor(s) for behaviors, implement appropriate individualized interventions (including non-pharmacological interventions) and establish accurate on-going monitoring of the behaviors has the potential for unnecessary use of	F 309	Resident #2 was affected by this deficient practice. Resident was seen via telemed psychiatrist on 2/10//14. to help manage the resident's psychiatric medication and to address some of her ongoing behavior issues and insomnia. Resident's diagnosis for Risperdal was clarified from Dementia to Paranoid Schizophrenia on 2/11/14. According to her medical record this was her diagnosis for Risperdal at the time of her admission to facility. Behavior / Intervention Monthly Flow Record was updated to reflect current diagnosis and Positive Behavior Plan with her individualized non-pharmacological interventions was attached. Resident #2 care plan was updated to reflect diagnosis of Paranoid Schizophrenia. Resident's fall risk was re-evaluated on readmission to facility on 1/22/14. Diagnosis of Osteoporosis was added to Fall Risk Care Plan. Residents on anti-psychotic medications have the potential to be affected. Consultant Pharmacist and Clinical Team reviewed resident's on anti-psychotic medications on 2/11/14 for appropriate diagnosis. Clinical Team will meet with consultant pharmacist monthly to review resident's on psychotropic medications and Behavior /	

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F 309	Continued From page 15 medications, increased falls, and avoidable agitation/anxiety. Findings include: Review of the facility policy titled, "Behavior Assessment and Monitoring" occurred on 01/16/14. This policy, dated April 2007, stated, "Policy Statement, 1. Problematic behavior will be identified and managed appropriately. . . . Policy Interpretation and Implementation, Assessment, 1. As part of the initial assessment, the nursing staff and Attending Physician will identify individuals with history of impaired cognition (e.g., dementia, mental retardation), problematic behavior, or mental illness (e.g., bipolar disorder or schizophrenia). 2. The nursing staff will identify, document, and inform the physician about an individual's mental status, behavior, and cognition, including: a. Onset, duration and frequency of problematic behaviors or changes in behavior, cognition, or mood; b. Any precipitating or relevant factors (e.g., medication changes, infection, recent transfer from hospital). Management, 1. The staff will identify and discuss with the practitioner situations where nonpharmacologic approaches are indicated, and will institute such measures to the extent possible. Monitoring, 1. If the resident is being treated for problematic behavior or mood, the staff and physician will obtain and document ongoing reassessments of changes (positive or negative) in the individual's behavior, mood, and function. 2. The staff will document (either in progress notes, behavior assessment forms, or other comparable approaches) the following information about specific problem behaviors: a. Number and frequency of episodes; b. Preceding or precipitating factors; c. Interventions attempted	F 309	Intervention Monthly Flow Records for: 1) Increased behaviors; 2)Effectiveness of non-pharmacological interventions; 3) Side effects; 4)Developing new individualized interventions (emphasis on non-pharmacological) as needed. Falls will be reviewed at Interdisciplinary Team Meetings daily during the week days for possible causative factors (to include use of psychotropic medications). A Sleep Log will be implemented X 7 days: prior to requesting or when starting a sedative / hypnotic; prior to requesting an increase in dose; and when the dose is decreased or medication is discontinued. Behavior / Intervention Monthly Flow Record will be initiated: at the start of a new behavior; prior to requesting an anti-psychotic medication and when an anti-psychotic medication is initiated. Behavior / Intervention Monthly Flow Record will be continued for 30 days after an anti-psychotic medication is dis-continued. Behavior Assessment and Monitoring Policy and Behavior/Mood Management Policies were updated to reflect current practice. Nursing staff were re-educated on Behavior / Intervention Monthly Flow Record used to assess resident behaviors and develop non-pharmacological inter-ventions for individual resident; updated Behavior / Mood Management Policy; updated Behavior Assessment and Monitoring Policy; Acute Focus Care Plan; and updated Sleep Log form. DNS or designee will audit 3 resident records weekly X 3 months starting 2/25/14 for the following: 1) Appropriateness of their individualized interventions in relation to their behaviors; 2) Utilization of individualized non-pharmacological interventions prior to medicating resident with ordered PRN anti-psychotic medications; and 3) Causative factors for behaviors. Areas of concern will be addressed	

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F 309	Continued From page 16 (if psychoactive drug is used as a intervention, institute appropriate psychoactive drug monitoring); and d. Outcomes associated with interventions. 3. The nursing staff and the physician will monitor for side effects and complications related to psychoactive medications; for example, lethargy, abnormal involuntary movements, anorexia, or recurrent falling. . . ." Review of the facility policy titled, "Behavior/Mood Management" occurred on 01/16/14. This policy, dated 12/16/13, stated, " Policy Statement, All behaviors that are deviant from the resident's usual behavior or social norms will be documented and managed in order to protect the rights and dignity of all residents and staff. St. Luke's Home will maintain a Mental Health Team to monitor and address mood and behaviors within the facility. Positive Behavior Plans will be developed and maintained by the Mental Health Team. Procedure . . . 2. The staff member observing and/or receiving information about the reported changes in the behavior/mood will inform the Charge Nurse immediately. The charge nurse will then document on the appropriate forms and/or progress notes. . . . Positive Behavior Plans, 1. Positive Behavior Plans will be developed on individuals as determined by the Mental Health Team. Positive Behavior Plans will consist of behaviors being exhibited by the resident and interventions that are developed by the team. . . . Review of Residents & Positive Behavior Plan Development, 3. Upon notification of an unresolved behavior issue, the Mental Health Team will review the documentation in the resident's nursing notes, and/or other documentation forms. The team will work to rule out and mitigate acute medical and	F 309	immediately and reviewed in Quality Assurance Meeting monthly X 3 months, then PRN. Completion Date:	2/25/14

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F 309	Continued From page 17 environmental cause for the behavior/mood. If there are no acute medical or environmental issues causing the behavior(s)/mood, a formal Positive Behavior Plan will be developed by the Mental Health Team. The resident/authorized representative will be included in the discussion as appropriate. Notification of Positive Behavior Plan; 4. The unit staff will be made aware that a Positive Behavior Plan has been implemented by the Charge Nurse. The Charge Nurse will chart on the behaviors daily for two weeks after the initiation of the Positive Behavior Plan using the Behavior Acute Focus Care Plan. . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia without behavioral disturbances, mild intellectual disabilities, depression, anxiety, insomnia, and a history of falls (last fall occurred on 01/16/14 at approximately 2:30 a.m. and resulted in a left femur fracture). The quarterly Minimum Data Set (MDS), dated 11/30/13, identified the resident as having moderately impaired cognition, exhibiting other behavioral symptoms not directed toward others four to six days, but less than daily. Resident #2's current medications included: * Ambien (zolpidem) 12.5 mg [milligram] at HS [hour of sleep] for diagnosis of insomnia * Risperdal (risperidone) 1 mg BID [twice a day] for diagnosis of dementia * Zoloft (sertraline) 25 mg daily for diagnosis of depression * Ativan (lorazepam) 1 mg BID PRN [as needed] for diagnosis of anxiety Review of Resident #2's current care plan stated, * ". . . Problem . . . Resident has diagnoses of	F 309		

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F 309	Continued From page 18 dementia and mild mental retardation. She needs some help with decision making. She has had some periods of yelling out . . . Approach . . . Assist [Resident #2] with decisions as needed. She needs cues and supervision. Her appointed Guardian . . . and her case manager . . . are involved in her care and assist with decisions for her health and well being. Please keep them informed . . . At times, she may not understand or may misinterpret what you are telling her. Please keep your explanations simple and short. Allow her time to understand what you are saying and to respond to you . . . Offer reminders as to meal times, activities, etc as needed and assist her to those things . . . [Resident #2] needs reassurance and frequent encouragement. Please offer both as needed. If she is yelling out, please make sure she is safe and offer reassurance. Inform the charge nurse . . . * Problem . . . Resident has diagnoses of paranoid schizophrenia, dementia and depression. In the past, she has had periods of being anxious, fearful and verbally abusive at times . . . Approach . . . If [Resident #2] starts getting anxious or fearful, please make sure she is safe, reassure her that everything is okay. Let her charge nurse and/or the social worker know . . . Please respect [Resident #2's] right to have her space, ask her if she needs anything before you leave her room and keep her belongings she uses often close to her and her room clutter free . . . [Resident #2] enjoys visiting about her life. Offer her reassurance as needed. Stop in when you have time and chat with her. She likes to get hugs. She is very religious and gains much strength with her faith . . . When [Resident #2] has verbal behaviors, offer her reassurance that she is safe and if time, sit an [sic] visit with her. Infmr [sic] the charge nurse . . .	F 309		

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F 309	Continued From page 19 Review of Resident #2's Progress Notes from February 2013 through January 2014 identified the following: * 06/16/13 at 3:45 p.m. - "Resident was sitting on her room floor attempted to transfer herself. No injuries, responsible party was notified via message on answering machine. Primary physician [name of physician] notified via fax. VS [vital signs] BP [blood pressure] 140/70 P [pulse] 72 R [respirations] 20 temp [temperature] 97.2 sats [oxygen saturations] 92% with oxygen on at 2 liters." * 10/17/13 at 6:57 a.m. - "Res [resident] yelled out durning [sic] NOC [night] shift. Started around 9 pm. She was given prn Ativan which did not settle her. Then she was screaming out very loudly that she was having severe pain. She was given 0.5 ml [milliliter] of morphine which did not help either. She was finally gotten up in her w/c [wheelchair] around 0100 [1:00 a.m.] and was content until 4 am where she started yelling out again. She was toileted, repositioned, redirected, given a snack and fluids and no intervention seemed to help." * 10/20/13 at 2:00 a.m. - "Res yelling has not selpt [sic] even after HS meds (given at . . . 2100) Res very restless" * 10/21/13 at 11:08 a.m. - "Sent fax to [name of provider] re: [regarding] resident not sleeping at night. Requesting a different sleeping med. or increase current." *10/23/13 at 12:31 a.m. - "I was walking down the hall at 2415 [12:15 a.m.] to answer res call light and observed her slide herself from her bed to the floor mat next to the bed. She had been yelling out all night and very agitated. She was previously given ativan which did not seem to be effective at this time. Res has no c/o [complaints	F 309		

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F 309	Continued From page 20 of] pain, ROM [range of motion] and neuro [neurological checks] WNL [within normal limits]. Vital signs include BP 133/68, P 95, R 24, T 98.3, O2 [oxygen] 98. Will continue to monitor." * 10/23/13 at 3:30 a.m. - "Res has been calling out all night. Call light log was taken and she used her call light 10 times between 9 pm and 2 am. She has not slept at all and the only intervention that calmed her was getting her dressed and sitting up in her w/c." (Ativan administered and result documented as not effective.) * 10/23/13 at 4:28 p.m. - "Primary [name of guardian] notified that resident was climbing out of bed last night, and has requested to possibly have resident attend more activities during the daytime to help with sleep at night. Primary also said to try having resident play the piano." * 10/24/13 at 4:29 a.m. - "Res did not sleep well this NOC [night] shift. She was yelling out all night and using her call light excessively. When approached resident could not make her needs known. With the new increase in her Ambien I did notice res slept very well until about 2400 [12:00 a.m.]." * 10/25/13 at 7:17 a.m. - "Res was unable to sleep for the most part of the NOC shift. She was on her call light several times." (Ativan administered and result documented as effective.) * 11/12/13 at 3:40 a.m. - "Res yelled out very loudly up until midnight last night. She refused to stop screaming unless we got her in her w/c. Res was offloaded every hour and taken to the bathroom but stayed out of bed all night." (Ativan administered and result documented as not effective.) * 11/21/13 at 2:05 a.m. - "Resident has been calling out for help all shift. Call light in reach, but	F 309		

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F 309	Continued From page 21 has not been using it. Took all scheduled medications. Res has also been tearful at times and not able to explain why. Is able to be redirected but then calls out at times and is not able to voice what she wants. Shall cont [continue] to monitor." (Ativan administered and result documented as semi-effective.) * 11/22/13 at 1:57 a.m. - "Resident was calling out and yelling at times, administered PRN Ativan 1 mg PO [oral] at 2324 [11:24 p.m.] and resident was transferred from bed to recliner and has been sleeping comfortably. Shall cont to monitor." * 11/24/13 at 1:59 a.m. - "Res was calling out wanting h2o [water], was itching, needed turned, hungery [sic], needed to urinate, wanted in her recliner then finaly [sic] was wanting to get up in wheel chair has been fighting sleep has not slelp [sic] yet" * 11/29/13 at 1:45 a.m. - "res [has] been yelling out this night, c/o itching been scrathing [sic] has marks on upper left arm, applied [sic] hydrocort [hydrocortisone] cream seemed to help just some. res has had a pass [sic] of ithcing [sic] and scrathing [sic], sending concern to dr [doctor]." * 01/09/14 at 1:43 a.m. - "Res has hollered out all evening/noc. Restless, unable to redirect, getting in/out of bed, yelling. Admin [administered] PRN Ativan per orders. Will cont to monitor. * 01/13/14 at 11:38 p.m. - "resident appeared to be restless and anxious, noted to be hollering for help and using call light every so often with no apparent reason. Unable to be redirected with all cares rendered. Medicated as per ordered [sic]. Will continue to monitor throughout the shift." (Ativan administered and result documented as effective.) * 01/15/14 at 3:53 p.m. - "NOC CNA reported that res barely slept all night. No adverse effects of Ambien was noted."	F 309		

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F 309	Continued From page 22 * 01/16/14 at 2:33 a.m. - "Resident was not able to sleep whole night, keeps putting light on. Needs were provided by the CNA. Staff responded to call light in resident's room and observed observed [sic] resident sitting facing towards the door in front of recliner. Floor was dry and clean, free of clutter, call light was activated. Res screaming of pain, vital signs and neuro's initiated, ROM to all extremities with c/o pain to Left knee. 2 person assist with hoyer lift to recliner. Resident stated 'I was trying to standup and I fell on the floor, my knee hurts so bad.' Alert to person, confused to time and place. Resident denies hitting her head and fall on her knees. [Name of physician] notified and received telephone order to send resident to ER [emergency room] for further evaluation of Left knee. [name of case worker] notified, CN [charge nurse] called the ER Nurse and sent resident to hospital via ambulance." * 01/16/14 at 7:56 a.m. - "Spoke with ER nurse at [name of hospital]. [Resident #2] has a diagnosis of fractured left femur, and is being transferred to [name of another hospital] at this time, under the direction of [name of provider]. LM [left message] with case worker to return call so update can be made." Refer to F329. The facility failed to develop and revise individualized non-pharmacological interventions prior to resorting to PRN Ativan. The facility's failure to assess (causative factors, time patterns, location, etc.) and implement individualized interventions specific to Resident #2 to address her behavioral and psychological symptoms of dementia, anxiety, and insomnia; and change/revise non-pharmacological interventions/approaches prior to administering medications, resulted in the resident receiving	F 309		

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	355063	A. BUILDING _____ B. WING _____	01/16/2014

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F 309	Continued From page 23 unnecessary medications.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident 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, facility policy review, and resident interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 4 sampled residents (Resident #3) who transferred with a sit-to-stand mechanical lift. Failure to properly use a mechanical lift resulted in Resident #3 experiencing pain to his left shoulder and bilateral axilla (armpits). Findings include: Review of the facility policy titled "Safe Lifting and Movement of Residents" occurred on 01/16/14. This policy, revised September 2013, stated, "Policy Statement, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents . . . Policy Interpretation and Implementation . . . 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an	F 323	Resident # 3 was affected by this deficient practice and was made a hoyer transfer on 1/17/14. All residents who require mechanical lifts for transfers have the potential to be affected. Resident's currently using sit to stand lifts will be reviewed for appropriateness by 2/24/14, then quarterly and PRN per MDS schedule. Nursing staff were re-educated on Safe Lifting and Movement of Residents Policy on 2/13/14 and 2/17/14. DNS or designee will audit 3 resident transfers weekly X 3 months for compliance starting 2/25/14. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly X 3 months, then PRN. Completion Date:	2/25/14

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F 323	Continued From page 24 ongoing basis. Staff will document resident transferring and lifting needs in the care plan or daily living needs. Such assessment shall include: . . . c. Weight-bearing ability. . . ." Review of Resident #3's medical record occurred on all days of survey and diagnoses included spinal stenosis, paraplegia, peripheral neuropathy, osteoarthritis, and generalized pain. The quarterly Minimum Data Set, dated 12/22/13, identified the resident with intact cognition; required extensive assistance for mobility, transfers, and toileting; impaired range of motion to both lower extremities; and occasional pain rated a "4" on a scale from 0-10 effecting his function during activities. The current "My Daily Living Needs" care card stated, ". . . Transfers . . . Sit to stand [mechanical lift] . . . Toileting Plan . . . Do Not take me to the bathroom on the stand lift. I become to [sic] tired. Stand lift to wheelchair, then from wheelchair to toilet. . . ." Observations of staff transferring Resident #3 identified the following: *01/14/14 at 8:40 a.m. - Two certified nursing assistants (CNAs) (#4 and #5) used a mechanical stand lift to transfer the resident from his wheelchair to the toilet and back to his wheelchair. During perineal cares, the resident grimaced and stated he was getting tired standing in the lift and had pain to his left shoulder and bilateral axilla. Observation showed Resident #3 slouched in the lift with his knees bent (unable to fully bear weight), shoulders shrugged upward, and his elbows bowed out. *01/15/14 at 9:40 a.m. - Two CNAs (#6 and #7) used a mechanical stand lift to transfer the	F 323		

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F 323	Continued From page 25 resident from his wheelchair to the toilet and back to his wheelchair. During the transfer, observation showed Resident #3 slouched in the lift with his knees bent (unable to fully bear weight), the sling sliding up and resting under his axilla, his shoulders shrugged upward, and his elbows bowed out. Observation showed Resident #3 grimacing and his face reddened and he stated, "too weak and heavy to support weight." *01/15/14 at 4:00 p.m. - Two CNAs (#4 and #6) used a mechanical stand lift to transfer the resident from his wheelchair to the toilet and back to this wheelchair. During the transfer, observation showed Resident #3 slouched in the lift with his knees bent (unable to fully bear weight), the sling sliding up and resting under both axilla, his shoulders shrugged upward, and his elbows bowed out. The facility staff failed to ensure safe and proper positioning during the transfers which resulted in pain to the resident.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	Resident #2 was affected by this deficient practice. Nursing staff were re-educated on Oxygen Policy on 2/13/14 and 2/17/14. Residents with orders for oxygen have the potential to be affected. An audit of all residents with oxygen orders and Daily Living Needs was done on 2/18/14. Staff were re-educated on Oxygen Policy on 2/13/14 and 2/17/14. Oxygen concentrators and portable Helios tanks will be tagged with resident's current order for oxygen liter flow by 2/24/14. DNS or designee will audit 3 residents weekly X 3 months starting on 2/25/14 for receiving O2 liter flow ordered.	

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F 328	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and facility policy review, the facility failed to ensure 1 of 4 sampled residents (Resident #2) on continuous oxygen received the proper treatment and care. Failure to administer the correct liters of oxygen ordered by the physician may increase the risk of harmful carbon dioxide buildup in the blood. Findings include: Review of the facility policy titled "Oxygen Administration" occurred on 01/16/14. This policy, revised October 2010, stated, "Purpose, The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . . . Steps in the Procedure . . . 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. . . ." Review of Resident #2's medical record occurred on all days of survey and diagnoses included congestive heart failure. The "My Daily Living Needs" care card identified the resident required oxygen at 1-2 liters (L) continuous via nasal cannula (NC). A physician's order, dated 03/08/13, stated, "O2 [oxygen] at 2L/NC to keep sats [saturations] > [greater than] 90% [percent] TID- three times a day; AM, PM, HS [hour of sleep]." Review of Resident #2's January 2014 medication administration record (MAR) identified	F 328	Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly X 3 months, then PRN. Completion Date:	2/25/14

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F 328	Continued From page 27 the resident's oxygen saturations averaged 96%. The MAR showed the resident's oxygen saturations never fell below 90%. Observations identified Resident #2 received the incorrect liters of oxygen at the following times: * 01/13/14 - 3:30 p.m. - Helio (portable liquid oxygen tank) at 3L/NC * 01/14/14 - 9:00 a.m. and 2:35 p.m. - Oxygen concentrator in resident's room at 3L/NC * 01/15/14 - 9:00 a.m. - Oxygen concentrator in resident's room at 3L/NC The facility failed to administer Resident #2's oxygen as ordered by the physician.	F 328		
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329	Resident #2 was affected by this deficient practice. Resident was seen via telemed psychiatrist on 2/10//14. to help manage the resident's psychiatric medication and to address some of her ongoing behavior issues and insomnia. Resident's diagnosis for Risperdal was clarified from Dementia to Paranoid Schizophrenia on 2/11/14. According to her medical record this was her diagnosis for Risperdal at the time of her admission to facility. Behavior / Interventions Monthly Flow Record was updated to reflect current diagnosis. Resident #2 care plan was updated to reflect diagnosis of Paranoid Schizophrenia. Resident's fall risk was re-evaluated on readmission to facility on 1/22/14. Diagnosis of Osteoporosis was added to Fall Risk Care Plan.	

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F 329	Continued From page 28 drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, professional reference review, and staff interview, the facility failed to monitor and assess for adequate indications for use of medications for 1 of 6 sampled residents (Resident #2) who received psychotropic medications to control behavior and had dosages of the drugs increased without evidence of attempts by the facility to minimize the behavior through effective non-pharmacological interventions. Providing psychotropic medications without appropriate monitoring and assessing for adequate indications for their continued use resulted in the resident receiving unnecessary medications and resulted in an avoidable fall and femur fracture on 01/16/14. Findings include: Review of the facility policy titled, "Behavior Assessment and Monitoring" occurred on 01/16/14. This policy, dated April 2007, stated, ". . . Monitoring . . . 4. If psychoactive medications are used to treat behavioral symptoms of dementia, the nursing staff and Attending Physician will periodically reconsider their indication and consider whether they can be tapered or document why tapering cannot or should not be attempted (for example, recurrence of psychotic symptoms after several previous attempts to taper medications). . . ."	F 329	Residents on anti-psychotic medications have the potential to be affected. Consultant Pharmacist and Clinical Team reviewed resident's on anti-psychotic medications on 2/11/14 for appropriate diagnosis. Clinical Team will meet with consultant pharmacist monthly to review resident's on psychotropic medications and Behavior Monthly Flow Record. Falls will be reviewed at Interdisciplinary Team Meetings daily during the week days. Sleep log X 7 days will be implemented prior to requesting or when starting a sedative/hypnotic; prior to requesting an increase in dose; and when the dose is decreased or medication is discontinued. Behavior / Intervention Monthly Flow Record will be initiated at the start of a new behavior - prior to requesting an anti-psychotic medication and when an anti-psychotic is initiated. Behavior / Intervention Monthly Flow Record will be continued for 30 days after an anti-psychotic medication is discontinued. Behavior Assessment and Monitoring Policy and Behavior/Mood Management Policies were updated to reflect current practice. Nursing staff were re-educated on: Behavior / Intervention Monthly Flow Record; updated Behavior / Mood Management Policy; updated Behavior Assessment and Monitoring Policy; Acute Focus Care Plan; and updated Sleep Log. DNS or designee will audit 3 resident records for falls and adequate documentation for use of or increase in anti-psychotic medication weekly X 3 months starting 2/25/14. Areas of concern	

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F 329	Continued From page 29 The "Nursing 2013 Drug Handbook," 33rd edition, Lippincott, Williams & Wilkins, Pennsylvania, page 1421-1422, stated, ". . . Ambien . . . Indications & Dosages, short-term management of insomnia . . . For elderly . . . 5 mg [milligram] P.O. [oral] immediately before bedtime. Or, 6.25 mg of extended-release form. Maximum daily dose is 10 mg immediate-release and 6.25 mg extended-release. . . Action . . . Onset [is] rapid, peak [of] 30-120 min [minutes] . . . Half-life: 2 1/2 hours. . . Nursing considerations . . . Use drug only for short-term management of insomnia, usually 7 to 10 days. . ." Page 843-844, states, ". . . Ativan . . . Indications & Dosages, anxiety . . . Elderly patients: 1 to 2 mg P.O. daily in divided doses. Maximum, 10 mg daily. . . Adverse Reactions . . . Insomnia . . ." Page 1192-1195, states, ". . . Risperdal . . . Indications & Dosages, Schizophrenia . . . Adverse Reactions . . . insomnia . . ." Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia without behavioral disturbances, mild intellectual disabilities, depression, anxiety, insomnia, and a history of falls (last fall occurred on 01/16/14 at approximately 2:30 a.m. and resulted in a left femur fracture). The quarterly Minimum Data Set (MDS), dated 11/30/13, identified the resident as able to make herself understood and usually understands others, moderately impaired cognition, and exhibiting other behavioral symptoms not directed toward others four to six days, but less than daily. This MDS identified Resident #2 as having two or more falls with no injury. A Significant Change MDS, dated 6/19/13, identified Resident #2 as having one fall with no injury.	F 329	will be addressed immediately and reviewed in Quality Assurance Meeting monthly X 3 months, then PRN. Completion Date:	2/25/14

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F 329	Continued From page 30 Resident #2's current care plan stated: * ". . . Problem . . . Resident has diagnoses of dementia and mild mental retardation. She needs some help with decision making. She has had some periods of yelling out . . . Approach . . . Assist [Resident #2] with decisions as needed. She needs cues and supervision. Her appointed Guardian . . . and her case manager . . . are involved in her care and assist with decisions for her health and well being. Please keep them informed . . . At times, she may not understand or may misinterpret what you are telling her. Please keep your explanations simple and short. Allow her time to understand what you are saying and to respond to you . . . Offer reminders as to meal times, activities, etc as needed and assist her to those things . . . [Resident #2] needs reassurance and frequent encouragement. Please offer both as needed. If she is yelling out, please make sure she is safe and offer reassurance. Inform the charge nurse . . . * Problem . . . Resident has diagnoses of paranoid schizophrenia, dementia and depression. In the past, she has had periods of being anxious, fearful and verbally abusive at times . . . Approach . . . If [Resident #2] starts getting anxious or fearful, please make sure she is safe, reassure her that everything is okay. Let her charge nurse and/or the social worker know . . . Please respect [Resident #2's] right to have her space, ask her if she needs anything before you leave her room and keep her belongings she uses often close to her and her room clutter free . . . [Resident #2] enjoys visiting about her life. Offer her reassurance as needed. Stop in when you have time and chat with her. She likes to get hugs. She is very religious and gains much strength with her faith . . . When [Resident #2]	F 329		

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F 329	Continued From page 31 has verbal behaviors, offer her reassurance that she is safe and if time, sit an [sic] visit with her. Infmr [sic] the charge nurse . . . * Problem . . . Resident has history of falling. She has arthritis, osteoporosis as well as a seizure disorder [review of the medical record identified no seizures in the past year] that puts resident at risk for falls and injury . . . Approach . . . Resident most likely will not remember to use the call light when she wants to get up because she has dementia so if you see her transferring herself please go in and assist her . . ." Review of physician's orders identified the following medications: * Ambien (zolpidem) 2.5 mg [milligrams] PO [oral] Q [every] HS [hour of sleep] PRN [as needed] started on 08/07/13 for a diagnosis of insomnia. Changed to scheduled 5 mg at HS on 09/03/13. Increased to 10 mg at HS on 10/23/13. Current dose 12.5 mg at HS increased on 01/14/14. * Risperdal (risperidone) 1 mg PO BID [twice a day] increased on 05/30/13 for a diagnosis of dementia. The resident was admitted in December 2010 on 1 mg in a.m. and 0.5 mg at HS. * Ativan (lorazepam) 1 mg PO BID PRN started on 08/02/13 for a diagnosis of anxiety. * Zoloft (sertraline) 25 mg PO daily started on 06/25/13 for a diagnosis of depression. Review of the medical record showed a fax to the physician, from a Hospice nurse, dated 05/29/13, stated, "pt [patient] is having increasing agitation and yelling out, St. Luke's staff feels her behaviors are getting out of control. She currently is using Risperdal 1 mg every morning and 0.5 mg at bedtime. Also has PRN order for Ativan 1 mg every 4 hours as needed. Would you like to	F 329		

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F 329	Continued From page 32 change/increase any of these medications?" The physician responded by increasing Risperdal to 1 mg twice daily. The resident improved and was taken off Hospice on 06/14/13. The medical record lacked any further documentation supporting this dose of Risperdal. Review of Resident #2's Progress Notes/Behavior Notes from February 2013 through January 2014 identified the following: * 07/03/13 at 3:00 a.m. - "Resident has been screaming all nocs [night]. Res [resident] has call light on q [every] 5 min for minor tasks such as throwing something in trash, moving item to the left. CN [charge nurse] has been in residents room 15 times the past 3 hrs [hours], not to mention numerous times CNA [Certified Nursing Assistant] as well. Resident denies pain, discomfort, hunger. Fluids were offered several times et [and] accepted. Res has continous [sic] severe out-bursts of yelling at staff. CN redirected resident numerous times. Res does not voice what she wants or "why" she puts call light on so frequently. (0330 [3:30 a.m.]) Resident received PRN Ativan 1 mg PO. (0400 [4:00 a.m.]) Resident resting quietly in bed." * 07/19/13 (no time noted) - "Resident yells for help more than 10x [ten times]. She said we don't do anything for her and she is the last always." * 07/26/13 (no time noted) - "Constant pressing of light and yelling. Helped resident to the best of my ability but still attended to her 6 times." * 07/27/13(no time noted) - "Resident keep [sic] crying. She said it hurts her something and nobody listen's [sic] to her. She keeps calling help for more than 10x." * 07/28/13 (no time noted) - "Resident said we never do anything for her. She keeps yelling help	F 329		

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F 329	Continued From page 33 10x." * 07/29/13 (no time noted) - "Resident kept yelling for help more than 10x. I ask her what she needs. She said her stomach hurts." * 07/30/13 (no time noted) - "Resident keep [sic] yelling at mid-night she called seven times (7x) in about two hours. She wanted to get up about 1:00 am." (Ambien was initiated on 08/7/13 with no evidence of insomnia.) * 08/10/13 (no time noted) - "Resident hollared [sic] and screamed out for most of the PM shift. Very agitated. Could not re-direct. Reported to nurse. Behaviors continued throughout entire shift." * 08/29/13 at 9:50 a.m. - "Fax prepared for MD [medical doctor] reguarding [sic] resident continueing [sic] to be restless at NOC even after non-med [medications] interventions." (Ambien increased on 09/03/13 with no evidence of insomnia.) * 09/04/13 at 4:10 a.m. - "Resident to sleep @ [at] approx. [approximately] 2145 [9:45 p.m.] [after] receiving HS meds [medications]. She awoke around 1 am et 2:15 am for drink of water et to be repositioned. She awoke @ 0345 [3:45 a.m.] for the day. Has been pleasant et states she slept very well." * 09/06/13 at 6:05 a.m. - "Resident to sleep around 10 pm. Slept well all night, was up x2 [two times] for cares et water. Up @ 5 am for the day. She hollered x1 [one time] in the middle of the night." * 09/09/13 (no time noted) - "Resident was yelling "help me", multiple times throughout the shift. Resident was very agitated & [and] after you helped her & thought she was done screaming she would think of something else & start up again."	F 329		

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	355063	A. BUILDING _____ B. WING _____	01/16/2014

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F 329	Continued From page 34 * 09/26/13 (no time noted) - "Resident has been hollaring [sic] and screaming early in the morning. She was very disturbing to the to her residents. Resident pushed & forced herself to go through in between seated residents [in dining room], while CNA help has been offered and asked to wait a second. Resident has yanked the call light cable out of the box the second time, and it had to be repaired the first time (on 9/25/13)." * 10/08/13 (no time noted) - "Resident was yelling at me to hurry up with cares, and when I was feeding other residents in the dining [room], she yelled "help me". I approached her and assured her that I was going to assist. I think a lot of attention seeking could be a factor. She constantly wants everyone to focus on her only and gets angry when you assist others." * 10/08/13 at 3:52 a.m. - ". . . Resident continued on though hollering that she needed help. When approached in her room by the CN, she asked for something to help her sleep and began crying a little. CN tried to redirect res by sitting and talking to res for awhile, by offering some crackers, and by rubbing her back. None of these activities helped to relax her enough to fall back asleep. At 0130 [1:30 a.m.], 1 mg Ativan was given po. Res. is now asleep and has had no further c/o [complaints of] pain." * 10/11/13 (no time noted) - "Resident didn't sleep all night, she was yelling all night and was spilling water everywhere, she was also hitting the table hard." * 10/17/13 at 6:57 a.m. - "Res [resident] yelled out durning [sic] NOC shift. Started around 9 pm. She was given prn Ativan which did not settle her. Then she was screaming out very loudly that she was having severe pain. She was given 0.5 ml [milliliter] of morphine which did not help either. She was finally gotten up in her w/c [wheelchair]	F 329		

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F 329	Continued From page 35 around 0100 [1:00 a.m.] and was content until 4 am where she started yelling out again. She was toileted, repositioned, redirected, given a snack and fluids and no intervention seemed to help." * 10/20/13 at 10:12 p.m. - "post entrey [sic] res was up and wake [sic] all night SAT. [Saturday] 10/19-10/20 she would yell, cry, hit, the table, mak [sic] all kinds of noise, she had no c/o pain, discomfort, stated she could not sleep tried different [sic] ways to help nothing would work, giving a snack, tv, reposioning [sic], finaly [sic] put [in] wheelchair and then she was quiet 0330 [3:30 a.m.]." * 10/20/13 at 2:00 a.m. - "Res yelling has not selpt [sic] even after HS meds (given at . . . 2100) Res very restless" * 10/21/13 at 11:08 a.m. - "Sent fax to [name of provider] re: [regarding] resident not sleeping at night. Requesting a different sleeping med. or increase current." (Ambien increased on 10/23/13 with no evidence of insomnia.) * 10/23/13 at 3:30 a.m. - "Res has been calling out all night. Call light log was taken and she used her call light 10 times between 9 pm and 2 am. She has not slept at all and the only intervention that calmed her was getting her dressed and sitting up in her w/c." * 10/24/13 at 4:29 a.m. - "Res did not sleep well this NOC shift. She was yelling out all night and using her call light excessively. When approached resident could not make her needs known. With the new increase in her Ambien I did notice res slept very well until about 2400 [12:00 a.m.]." * 10/25/13 at 7:17 a.m. - "Res was unable to sleep for the most part of the NOC shift. She was on her call light several times." * 10/29/13 at 2:43 a.m. - "Res slept very well from	F 329		

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F 329	Continued From page 36 2100 [9:00 p.m.] until about 0200 [2:00 a.m.]. She then started using her call light excessively and yelling out. She was not easily redirected with food, water, bathroom, and repositioning. Will continue to monitor sleep." * 10/30/13 at 3:29 a.m. - "Res continued to yell out throughout the night and use her call light excessively. Interventions to redirect failed. These interventions included snacks, fluids, repositioning, toileting, and medication." * 11/12/13 at 3:40 a.m. - "Res yelled out very loudly up until midnight last night. She refused to stop screaming unless we got her in her w/c. Res was offloaded every hour and taken to the bathroom but stayed out of bed all night." * 11/18/13 (no time noted) - "Residen [sic] is crying for help all night long. She wanted her bottom teeth in, then she scream for help again cause she is itching, after few minutes she ring [sic] again and crying she said to raise her head up." * 11/19/13 (no time noted) - "Resident was screaming for help after breakfast, very very loud." * 11/21/13 at 2:05 a.m. - "Resident has been calling out for help all shift. Call light in reach, but has not been using it. Took all scheduled medications. Res has also been tearful at times and not able to explain why. Is able to be redirected but then calls out at times and is not able to voice what she wants. Shall cont [continue] to monitor." * 11/22/13 at 1:57 a.m. - "Resident was calling out and yelling at times, administered PRN Ativan 1 mg PO at 2324 [11:24 p.m.] and resident was transferred from bed to recliner and has been sleeping comfortably. Shall cont to monitor." * 11/23/13 (no time noted) - "Resident is yelling for help all night long. More than 50x [fifty times].	F 329		

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F 329	Continued From page 37 She wants every single thing at one time. She said she has been calling all night long and nobody came she started crying. She said nobody cares about her. She called again more than 5 times she wants to get up at 3:15 AM." * 11/24/13 at 1:59 a.m. - "Res was calling out wanting h2o [water], was itching, needed turned, hungery [sic], needed to urinate, wanted in her recliner then finaly [sic] was wanting to get up in wheel chair has been fighting sleep has not slelp [sic] yet" * 11/26/13 (no time noted) - "Resident has been yelling for help all night long-she wanted to get ready at 12:00 AM then she wanted food then called more that [sic] 15 times and ask for more food, to get up, lotion, and she kept calling for help and she did not sleep." * 11/27/13 (no time noted) - "Resident yelled for help at 12:00 AM and stayed up till 2:00 AM. She wanted to get ready for breakfast. She said I told her its [sic] to early to get up then she went to sleep and again yelled for help after 3 mins [minutes]. She wants to be covered." * 11/29/13 at 1:45 a.m. - "res [has] been yelling out this night, c/o itching been scrathing [sic] has marks on upper left arm, applied [sic] hydrocort [hydrocortisone] cream seemed to help just some. res has had a pass [sic] of ithcing [sic] and scrathing [sic], sending concern to dr." * 12/04/13 at 7:13 a.m. - "Resident was up throughout the night . . . She was assisted to the bathroom, redirected, given food and fluids. She was yelling and banging items against her bedside table, pushing her call light often. She was given Ativan at approximately 0330 [3:30 a.m.], this did help her calm down. She has been fairly quiet since about 0430 [4:30 a.m.]." * 01/09/14 at 1:43 a.m. - "Res has hollered out all evening/noc. Restless, unable to redirect, getting	F 329		

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F 329	Continued From page 38 in/out of bed, yelling. Admin [administered] PRN Ativan per orders. Will cont to monitor. * 01/10/14 at 2:04 p.m. - "Noted increased use of PRN Ativan between 2300 [11:00 p.m.] and 0100 [1:00 a.m.] nightly due to hollering out with increased anxiety and difficulty sleeping. Fax out to MD [provider] to update and advise of any medication changes." * 01/13/14 at 11:38 p.m. - "resident appeared to be restless and anxious, noted to be hollering for help and using call light every so often with no apparent reason. Unable to be redirected with all cares rendered. Medicated as per ordered. Will continue to monitor throughout the shift." * 01/14/14 at 2:23 p.m. - "Order given to increase Ambien to 12.5 mg [more than the maximum daily dose of 10 mg] every HS . . ." (Ambien increased on 01/14/14 with no evidence of insomnia.) * 01/15/14 at 3:53 p.m. - "NOC CNA reported that res barely slept all night. No adverse effects of Ambien was noted." Observations during the week of survey identified Resident #2 was lethargic as evidenced by her eyes closed and head down. Review of physician progress notes identified the following: * 06/11/13 - ". . . Patient appears stable. We will continue current medications . . ." * 10/13/13 - ". . . She also does have some dementia . . . Dementia appears stable . . ." * 12/03/13 - ". . . pt. and staff have no medical concerns, seems happy . . . Assessment Plan, Dementia . . . W/o [without] Behav [behavioral] Disturb [disturbances] . . . reviewed meds, vital signs stable . . ." The physician progress notes failed to identify	F 329		

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F 329	Continued From page 39 behaviors or rationale for the necessity of the dosage increases for Ambien and Risperdal. Review of Resident #2's medical record identified the following falls: * 06/16/13 at 3:45 p.m. - "Resident was sitting on her room floor attempted to transfer herself. No injuries, responsible party was notified via message on answering machine. Primary physician [name of physician] notified via fax. VS [vital signs] BP 140/70 [blood pressure] P 72 [pulse] R 20 [respirations] temp 97.2 [temperature] sats 92% [oxygen saturations] with oxygen on at 2 liters." (Risperdal increased to 1 mg BID on 05/30/13.) * 06/26/13 at 2:15 a.m. - "Res crawled out of her bed and sat on the fall mat by the bed. Res denies hitting head c/o slight pain on buttocks. Tiny scratch on the Rt. [right] shin. Bandaid [sic] applied. No other complaints. Res. helped up with Hoyer and 2 assist. Vitals T-97.5 [temperature], P-71, R-20, B.P. 118/62, O2 [oxygen] Sats 98% in [sic] 3L/NC [liters per nasal cannula]. Will monitor." *10/23/13 at 12:31 a.m. - "I was walking down the hall at 2415 [12:15 a.m.] to answer res call light and observed her slide herself from her bed to the floor mat next to the bed. She had been yelling out all night and very aggitated [sic]. She was previously given ativan which did not seem to be effective at this time. Res has no c/o [complaints of] pain, ROM [range of motion] and neuro [neurological checks] WNL [within normal limits]. Vital signs include BP 133/68, P 95, R 24, T 98.3, O2 98. Will continue to monitor." * 11/01/13 at 6:03 a.m. - "Res was observed sitting on the floor mat beside her bed. Res denies pain at the time of fall. No injuries observed. ROM + [and] Neurocheck WNL. Will	F 329		

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F 329	Continued From page 40 cont. to monitor" (Ambien increased to 10 mg at HS on 10/23/13.) * 01/16/14 at 2:33 a.m. - "Resident was not able to sleep whole night, keeps putting light on. Needs were provided by the CNA. Staff responded to call light in resident's room and observed observed [sic] resident sitting facing towards the door in front of recliner. Floor was dry and clean, free of clutter, call light was activated. Res screaming of pain, vital signs and neuro's initiated, ROM to all extremities with c/o pain to Left knee. 2 person assist with hoyer lift to recliner. Resident stated 'I was trying to standup and i fell on the floor, my knee hurts so bad' Alert to person, confused to time and place. Resident denies hitting her head and fall on her knees. [Name of provider] notified and received telephone order to send resident to ER [emergency room] for further evaluation of Left knee. [name of case worker] notified, CN [charge nurse] called the ER Nurse and sent resident to hospital via ambulance." (Ambien increased to 12.5 mg at HS on 01/14/14.) * 01/16/14 at 7:56 a.m. - "Spoke with ER nurse at [name of hospital]. [Resident #2] has a diagnosis of fractured left femur, and is being transferred to [name of another hospital] at this time, under the direction of [name of provider]. LM [left message] with case worker to return call so update can be made." Resident #2 started on Ambien 2.5 mg PRN on 08/07/13. The physician increased the dose to 12.5 mg at HS on 1/14/14 with lack of supporting documentation for the increased dose. Resident #2 was admitted to the facility in December 2010 on Risperdal 1 mg in the morning and 0.5 mg at HS. The physician increased the dose on 05/29/13 to 1 mg BID without supporting	F 329		

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F 329	Continued From page 41 documentation for the increased dose. Failure to thoroughly assess Resident #2's behaviors and sleeping patterns; develop individualized non-pharmacological interventions specific to the resident's insomnia, behaviors, and anxiety; and lack of supporting documentation for the indications of use for the Ativan, Ambien and Risperdal resulted in the use of unnecessary medications; increased somnolence during the day; avoidable falls; and a femur fracture on 01/16/14.	F 329		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	No resident's were specified in this deficiency. Insulin pens that were not dated were discarded. Resident's receiving insulin have the potential to be affected by this deficient practice. Nursing staff were re-educated on 2-13-14 and 2-17-14 regarding dating vials and insulin pens at time of initial use. Nursing staff were re-educated on 2-13-14 and 2-17-14 regarding dating vials and insulin pens at time of initial use. DNS or designee will audit insulin pens on each unit for open date weekly X 3 months for compliance starting 2/25/14. Areas of concern will be addressed immediately and reviewed in Quality Assurance Meeting monthly X 3 months, then PRN. Completion Date:	2/25/14

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F 431	Continued From page 42 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of manufacturer's instructions, and staff interview, the facility failed to date in-use insulin pens on 3 of 4 nursing units (2nd, 3rd, and 4th). Failure to identify an open date on insulin pens may result in use beyond manufacturer's recommendations and affect the potency and efficacy of the medication. Findings include: Review of the facility policy titled "Vials and Ampules of Injectable Medications" occurred on 01/16/14. This policy, dated September 2012, stated, ". . . Procedures . . . B. The date opened and the initials of the first person to use the vial are recorded on multidose vials (on the vial label or an accessory label affixed for that purpose). . . ." Manufacturer's instructions identified the following: *Levemir, dated 2009, ". . . PenFill cartridges, FlexPen or InnoLet After initial use, a cartridge or a prefilled syringe . . . may be used for up to 42 days if it is kept at room temperature . . . ." *Lantus, dated April 2010, " . . . The opened	F 431		

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F 431	Continued From page 43 (in-use) cartridge system must be discarded in 28 days after being opened . . . ." *NovoLog, dated 2011, " . . . How should I store NovoLog? . . . PenFill Cartridges or NovoLog FlexPen. Keep at room temperature . . . for up to 28 days . . . ." Observations of the four nursing units occurred on 01/16/14 at 9:00 a.m. with an administrative nurse (#1) and identified the following opened and undated insulin pens: *Unit 2 - one Lantus insulin pen *Unit 3 - one NovoLog and one Levemir insulin pens *Unit 4 - one Lantus and two NovoLog insulin pens During an interview on 01/16/14 at 9:30 a.m., an administrative nurse (#1) stated the nurses should date the insulin pens when using them for the first time.	F 431		
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 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	F 441	Residents #20 and #23 were affected by this deficient practice. Policy for Blood Sampling Capillary (Finger Sticks) was updated to include the Centers for Disease Control and Prevention's guidelines for appropriate products for cleaning and disinfection of blood glucose meters using a 10% bleach solution. Residents with physician orders for blood glucose testing have the potential to be affected by this deficient practice. Nursing staff	

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F 441	Continued From page 44 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, review of facility policy, review of professional literature, and staff interview, facility staff failed to properly disinfect the glucometer during 3 of 4 observations of blood glucose testing on 2 supplemental residents (Resident #20 and #23). Failure to correctly disinfect glucometers may result in the transmission of organisms and pathogens to other residents, staff, and visitors. Findings include: Review of the facility policy titled "Blood Sampling - Capillary (Finger Sticks)" occurred on 01/16/14.	F 441	were in-serviced on updated policy for Blood Sampling Capillary (Finger Sticks) on 2/13/14 and 2/17/14 to include the Centers for Disease Control and Prevention's guidelines for appropriate products for cleaning and disinfection of blood glucose meters using a 10% bleach solution. Nursing staff were in-serviced on updated policy for Blood Sampling Capillary (Finger Sticks) on 2/13/14 and 2/17/14 to include the Centers for Disease Control and Prevention's guidelines for appropriate products and procedure for cleaning and disinfection of blood glucose meters using a 10% bleach solution. DNS or designee will observe 3 nurses weekly X 3 months for glucometer disinfection to assure compliance. Areas of concern will be addressed immediately and reviewed at Quality Assurance Meeting monthly X 3 months, then PRN. Completion Date:	2/25/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355063	A. BUILDING _____ B. WING _____	01/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES HOME	242 10TH ST W DICKINSON, ND 58601

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F 441	Continued From page 45 This policy, revised August 2012, stated, ". . . Equipment and Supplies . . . 6. Approved EPA registered disinfectant for cleaning of sampling device . . . Steps in the Procedure . . . 6. Obtain the blood sample, following the manufacturer's instructions for the device . . . 8. Follow the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use. . . ." Review of the facility policy titled "Cleaning and Disinfection of Resident-Care Items and Equipment" occurred on 01/16/14. This policy, revised February 2012, stated, ". . . Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC [Centers for Disease Control] recommendations for disinfection . . . Policy Interpretation and Implementation . . . 1. The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in resident care: a. Critical items consist of items that carry a high risk of infection if contaminated with any microorganism. Objects that enter sterile tissue . . . or the vascular system . . . are considered critical items and must be sterile . . . 3. Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident. . . ." A Centers for Disease Control and Prevention publication titled "Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration," dated 03/08/11, stated, ". . . General: . . . Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per	F 441		

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F 441	Continued From page 46 manufacturer's instructions. . . . Blood Glucose Meters: 1. . . . Infectious agents, such as HBV [hepatitis B Virus] can be transmitted through indirect contact transmission, even in the absence of visible blood. . . . Healthcare personnel hands can become contaminated with blood at various points while performing assisted blood glucose monitoring including pricking the patient's finger or handling the test strip. Blood can then be transferred to the meter . . . 2. . . . FDA [Food and Drug Administration] has recently released guidance for manufacturers regarding appropriate products and procedure for cleaning and disinfection of blood glucose meters. . . . 'The disinfection solvent you choose should be effective against HIV, Hepatitis C, and Hepatitis B virus. . . . Please note that 70% ethanol (alcohol) solutions are not effective against viral bloodborne pathogens and the use of 10% bleach solutions may lead to physical degradation of your device. . . ." - Observation on 01/14/14 at 7:58 a.m. showed a nurse (#2) tested Resident #20's blood glucose with a glucometer. After testing the resident's blood glucose, the nurse (#2) did not disinfect the glucometer (shared with other residents) and placed it back in the medication cart. - On 01/14/14 at 11:43 a.m., a nurse (#2) tested Resident #23's blood glucose in the resident's room. The nurse (#2) placed a small biohazard sharps container and a basket containing lancets, alcohol pads, test strips, and the glucometer on the resident's bedside table. After testing Resident #23's blood glucose with a glucometer, the nurse wiped the glucometer off with an alcohol pad, not the bleach wipes as identified by facility staff.	F 441		

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F 441	Continued From page 47 - Observation on 01/14/14 at 12:18 p.m. showed a nurse (#2) tested Resident #20's blood glucose with a glucometer. After testing the resident's blood glucose, the nurse (#2) did not disinfect the glucometer and placed it back in the medication cart. During an interview on 01/15/14 at 3:40 p.m., an administrative nurse (#1) stated she expected staff to disinfect the glucometer after each use with bleach wipes.	F 441		