STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355123	A. BUILDING _____ FEB 28 2011 B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey and complaint investigation, started on January 24, 2011 and completed on January 27, 2011, the sample included four (4) residents for complete review, nine (9) residents for focused review, and three (3) closed records for review. The investigation substantiated the complaint issues.	F 000	**This plan of correction is our allegation of compliance.** **Submission of this Plan of Correction is not an admission by Bethany on 42nd that the Statement of Deficiencies cited are accurate in any respect.**	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	1. Corrective action for Resident #14 is unable due to the resident being discharged since events noted in medical record. 2. All residents admitted and currently residing at Bethany on 42nd have the potential to be affected by this practice due to the potential of residents to have a change in condition. 3. Bethany on 42nd will implement the following changes to assist staff with notification of physicians and families for residents experiencing a change in condition: A. Physician Notification Tool has been developed (Attachment A). This form will prompt nurses as to when to notify the provider for a change in condition. B. Shift to Shift Report will now include printing a "24 Hour Report" (Attachment B for example from one household) from our electronic medical record. This added information will enable our nurses to improve the continuity of care by knowing what previous shifts have observed/charted. C. Educational Blitz for all staff using the slogan, "When in DOUBT, give the provider and family a SHOUT". (Attachment C) D. Policy regarding Physician Notification has been developed. (Attachment D) E. Nurses will receive a laminated "Change in Condition" key chain attachment. (Attachment E).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: President and CEO — (X6) DATE: 2-24-2011

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 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, professional standards review, and staff interview, the facility failed to immediately consult with the resident's physician and notify the primary contact when a resident experienced a change in physical condition which may have required physician intervention for 1 of 1 closed record resident (Resident #14). Failure to immediately notify the physician and family members resulted in Resident #14 experiencing chest pain, discomfort, nausea, and vomiting. Findings include The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding notification of the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status, such as a deterioration in health, mental, or psychosocial status in either life-threatening conditions (such as heart attack or stroke) or clinical complications. In the case of a competent individual, the facility must still contact the resident's physician and notify interested family members, if known. That is, a family that wishes to be informed would designate a member to receive calls. Even when a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally.	F 157	F. Structured Physician Update Progress notes were updated to reflect use of the Physician Notification Tool and updating of families (Attachment F) G. Posters related to "When/What to report to the nurse" will be utilized for CNA's and CMA's (Attachment J) 4. The Unit Managers and Quality Department will conduct audits including, but not limited to: auditing 24 Report/Progress Notes to check that they are printed and reviewed, they will also audit Physician Notification Tools for provider and family notification. Education will be provided in a variety of ways: Mandatory Educational Meeting with Power Point notes for all Nurses, CMA's and Unit Clerks on 2/24/2011 (Attachment G). There will also be a Self Study for nurses to practice using the Physician Notification Tool. (Attachment H). Posters related to "When in DOUBT give the family and provider a SHOUT" will be placed in all nurses stations and will be placed in our Bi-Weekly staff Newsletter (Attachment C). This will also be a standing item for the remainder of Unit Meetings in 2011. Unit Meetings for March meetings are 3/9/2011 and :3/16/2011. Other 2011 dates have yet to be set. (Attachment I) Posters related to "When/What to report to the nurse" will be utilized for CNA's and CMA's (Attachment J) Quality Monitoring will be completed by the Unit Managers daily for a period of two weeks, and then three times per week for a period of two weeks, and then one time per week for a period of two weeks. (Attachment K) Based on compliance, the audits would then be moved to our Quality program for monitoring and review at our monthly Quality Meeting. 5.	3/3/2011

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F 157	Continued From page 2	F 157		

Review of Resident #14's closed record occurred on 01/27/11. The record identified the facility admitted Resident #14 on 10/26/10 after hospitalization for a myocardial infarction (heart attack) and congestive heart failure. Review of the hospital discharge summary identified the physician discussed the resident's cardiac function with the patient and family and it was decided to treat her with medical management. The physician also discussed the possibility of hospice and told the family that they can contact hospice at any point that they are ready to do so.

Resident #14's care plan identified the need to "maintain and encourage [resident] to continue with independent decision making and goal setting as able. She is supported by her daughter . . . that lives in town, is very involved, & [and] is her primary contact. . . . Interventions: . . . Inform [resident and daughter] of all changes in [name of resident] current condition/status. . . . The care plan also identified the resident had verbalized she was depressed and her family expressed concerns about the decline in her mood.

Resident #14's Progress Notes identified the following:
10/27/10
*4:57 p.m. - Social Services Note - "states that she has been feeling more depressed lately . . . she does not feel motivated to do anything at this time because she "feels depressed. . . . Did state that she 'didn't care much' about what her goals were. . . ."

10/31/10
*2:37 a.m. - Nurses Note - "States that she is having chest pain. Offered reassurance and 1:1

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F 157	Continued From page 3 time. Administered 1300 mg of APAP (Tylenol) and 2L [Liters] of O2 [oxygen] per nasal canual (sic). At [3:00 a.m.] [name of resident] stated that she was feeling better but the pain was still there. . . ." *6:53 a.m. - Nurses Note - ". . . was experiencing some mild chest pain throughout the night. She states that this has been happening quite frequently during the night. Never during the day or evening, only at NOC [night]. . . . Note left for provider. Awaiting response." *10:36 p.m. - Nurses Note - "[name of resident] c/o [complains of] chest pain, . . . denied being SOB [short of breath] . . . did not want to go to ER [emergency room], ask for Tylenol. Will have next shift monitor." The facility uses "Practitioner Communication" notes to communicate with the provider. Nursing staff place these notes in the practitioner's file at the facility and the practitioner views the notes when he/she is at the facility making rounds. The staff nurse left a communication note for the practitioner the morning of 10/31/10. The medical record provided no evidence the practitioner viewed the note, and no evidence staff attempted call or follow up with the physician. The medical record provided no evidence facility staff notified Resident #14's daughter regarding the resident's chest pain. 11/01/10 *1:13 a.m. - Nurses Note - "[name of resident] continues to complain of chest pain the (sic) is consistent. Does not want to go to the ER tomorrow. Note left for provider to follow up. Administered oxygen at 2L/min [liters per minute] via nasal cannual (sic). . . . Will continue to monitor."	F 157		

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F 157	Continued From page 4 *1:17 a.m. - Nurses Note - "At [12:45 a.m.] [resident] stated that there is no relief from the chest pain that she is having." *6:50 a.m. - Nurses Note - "Oxygen at 2L/minute PRN [as needed] by nasal cannula." *7:06 a.m. - Nurses Notes - "[Resident] was having episode of nausea and vomiting. 1 large emesis, 2 small ones an (sic) felt nauseated for the rest of the night. Low grade fever, 99.0. Left note for provider. . . ." (Nausea and chest pain can be symptoms of a heart attack.) The medical record lacked evidence facility staff notified Resident #14's daughter regarding the consistent chest pain, nausea, and vomiting the resident experienced during the early hours of 11/01/10. Nursing staff left a communication note for the practioner the morning of 11/01/10. During interview the morning of 01/27/11, an administrative nurse (#2) stated the practitioner usually comes to make rounds in the afternoon. *7:27 p.m. - Physician's Orders - "Order: . . . Change diet to LGD NAS [liberal geriatric diet - no added salt], 1.5 L [liter] fluid restriction per day. . . . lipid, amylase, CK-MB with troponin [lab tests used for persons who have had chest pain to diagnose whether they have had a heart attack]. . . ." *7:31 p.m. - Nurses Note - Family Communication - "Daughter . . . came to visit [resident] today and was concerned with [resident's] chest pain during the night. At her request, called on call physician to obtain an order for nitroglycerine. 0.4 mg [milligrams] Nitroglycerine ordered every 5 minutes for chest pain PRN. Notified daughter regaurding (sic) new order for nitro. She is happy that we took the time to get the order."	F 157		

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F 157	Continued From page 5 11/02/10 *12:40 p.m. - Nurses Note - Lab - " . . . Contacted PA [physician's assistant] regarding the results. The PA state that she [the resident] most likely has had another heart attack . . . He recommended to contact family about whether to have her transferred to ER for further evaluation, but that she is already on as many medications as they can prescribe for heart attack." *12:46 p.m. - Nurses Note - Family Communication - "Contacted daughter. . . She state that she does not wish to have [resident] transferred to the hospital as [resident] does not wish to go. She was seen by a cardiologist about 1 week ago and there is very little left that they would be able to do for her." The facility's Care Plan for Resident #14 encouraged her to be independent in her decision making, along with support from her daughter who is her primary contact. Care plan interventions included informing the resident and her daughter of all changes in her current condition and status. The facility failed to notify Resident #14's daughter of the resident's chest pain on 10/31/10 and her un-relieved, consistent chest pain, along with nausea and vomiting the morning of 11/01/10. The facility also failed to immediately notify the physician of the the chest pain, nausea and vomiting. Facility staff left communciation notes for the physician, however it was more than 30 hours from the initial onset of symptoms (2:37 a.m. on 10/31/10) until the time the HCP evaluated Resident #14 on 11/01/10. These failures limited the HCP's ability to treat the resident's pain, nausea, and vomiting on a timely basis and to determine if alternative and/or further treatment was needed and limited the daughter's ability to consider alternative treatments.	F 157		

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F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on record review, observation, review of facility policy, and family interview, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being for 1 of 1 sampled resident (Resident #2) who experienced uncontrolled pain and 1 closed record resident (Resident #14) who experienced un-relieved chest pain. Failure to evaluate and re-assess pain and implement pain management interventions for Resident #2 and #14 resulted in the residents experiencing prolonged episodes of pain. Findings include: Review of facility policy, "PAIN ASSESSMENT" occurred on 01/27/11. This policy, dated August 2009, stated, ". . . PROCEDURE: 1. Ask the resident to describe his/her pain. 2. Ask the resident to identify which "Box" or "Number" of pain level best describes his/her pain. 3. Provide pain relief modalities as outlined in the resident's care plan. 4. After a suitable time frame (dependent on the modality used), evaluate the effect of the pain relief modality by repeating 1 and 2 above. 5. Document results, including any	F 309	1. Corrective action for Resident #14 is unable due to the resident being discharged since events noted in medical record. Resident #2 is also currently hospitalized due to an unrelated surgical procedure. 2. Any resident currently residing at Bethany on 42nd or newly admitted could potentially be affected dependent on their current level of pain. 3. Bethany on 42nd will implement the following changes to assist in the evaluation and reassessment of pain management interventions: A. Bethany will now utilize a shift to shift "24 Report" from our electronic medical record.(Attachment B) This will allow our nurses to closely monitor those residents who are experiencing pain. B. Our Pain Policy has been updated to prompt nursing staff to use the Physician Notification Tool if a resident has utilized scheduled, PRN and non-pharmacologic medications for twenty-four hours as it prompts the nurses on how to address uncontrolled pain. (Attachments A&M) C. Pain Progress Structured Notes have been updated (Attachment N) to encourage a clearer rating of pain after medications have been given. D. Our pain assessment has been updated to reflect the use of the Physician Notification Tool and our policy changes related to pain control (Attachment O) 4. The Unit Managers and Quality Department will conduct audits of the 24 Report/Progress Pain Notes and Physician Notification Tools for proper interventions and notifications. (Attachment L) Education will be provided in a variety of ways: Mandatory Educational Meeting for all Nurses, CMA's and Unit Clerks on 2/24/2011 (Attachment G). There will also be a Self Study for all nurses (Attachment H). Education will also be provided to discourage using anti anxiety medications at the same time pain medications are given. (Attachment H)	

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F 309	Continued From page 7 pain relief modalities used. 6. PRN [as needed] pain medications may be ordered initially to determine if a pattern or specific schedule would be appropriate. 7. If a pattern is identified scheduling pain medications should be considered. . . ." Review of Resident #2's medical record occurred on January 24-27, 2011. The record identified an admission date of 01/12/11 and medical diagnoses including lumbago (pain in the lower back), vertebroplasty of the T12 spine, and a non-healing ulcer to her left heel/achilles area. Review of Resident #2's hospital discharge summary, dated 01/12/11, stated, ". . . 1. Acute compression fracture of T12 confirmed . . . underwent vertbroplasty. . . . still having a fair amount of pain. We tried Lortab, which caused confusion, Tramadol, which did not give enough pain control, and then we will start her on a fentanyl patch. . . ." Medications ordered for Resident #2 on admission for pain included Celebrex 200 milligrams (mg) per day, Fentanyl 12.5 microgram (mcg) patch to skin every 72 hours, Tylenol 650 mg every 4 hours PRN, and Tramadol (Ultram) 50 mg 1-2 tablets (tabs) every 6 hours PRN. The physician also ordered Ativan 0.5 mg PRN on admission for anxiety. Resident #2's care plan for pain, initiated 01/16/11, stated ". . . experiences pain frequently related to recent vertebroplasty of the T12 spine and pressure ulcer to left achilles tendon. . . . Interventions: . . . Assess c/o [complaints of] pain promptly and administer medication as appropriate. . . . Assess for non-verbal signs of pain (grimacing, moaning, guarding, diaphoresis,	F 309	Quality Monitoring of pain notes and Physician Notification Tools will be completed by the Unit Managers daily for a period of two weeks, and then three times per week for a period of two weeks, and then one time per week for a period of two weeks. (Attachment L) Based on compliance, the audits would then be moved to our Quality program for monitoring and review at our monthly Quality Meeting. 5.	3/3/2011

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F 309	Continued From page 8 etc.) Medications as ordered. Monitor [resident's] response to pain management regularly. . ." Resident #2's care plan for mood and behavior, initiated 01/21/11, stated, "Trouble falling or staying asleep & [and] yelling out & restlessness. . . . Interventions: Assess for unmet physical/psychosocial needs (pain . . .)" Resident #2's Progress Notes and Medication Administration Record (MAR) identified the following: 01/13/11 *3:55 p.m. - ". . . Verbally stated 10/10 (pain level of 10 on a scale of 1-10) lower back pain. . . . PRN Tramadol administered as ordered at 0700 [7:00 a.m.] per her request. Continued to c/o 5/10 pain but refused to have anything else. . . ." MAR: Ativan - 1:55 a.m. Tramadol 2 tabs - 6:56 a.m. and 10:02 p.m. 01/14/11 *12:53 a.m. - Nurses Note - Pain: LLE [left lower extremity]. Verbalization of pain to area, rubbing and holding leg. . . Tramadol 2 tabs. . . . stated she is feeling better . . . " *1:02 a.m. - ". . . seemed very anxious. [family members] suggested to have Ativan scheduled due to her anxiety. . . . also c/o pain to LLE. . . ." MAR: Ativan - 3:55 p.m. Tramadol 2 tabs - 12:22 a.m. 01/15/11 *07:06 a.m. - "Pain: lower back - pain rating scale of 8/10, grimacing with movement, decreased bed mobility noted. . . PRN Ultram administered . . . at 0300 [3:00 a.m.]. Response:	F 309		

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F 309	Continued From page 9 post administration, . . . stated that she felt relief with pain rated a 5/10 but she further stated that she didn't feel she would be able to fall back asleep and requested medication that would alleviate anxious symtoms (sic) and assist her to sleep. PRN Ativan administered . . ." *12:00 noon - "Having pain in her left ankle. Wincing, verbal complaints . . . Tramadol administered . . ." * 4:00 p.m. - "Type of Fall: . . . unattended. Time of fall: 1045 [10:45 a.m.] . . . found on her back approximately 3-4 feet from her chair. Large bump on back of head. . . Fax sent to providor (sic). . . ." *11:34 p.m. - "Pain - Left LE [lower extremity]. Verbally stated 'ouch . . .' Verbally stated 8/10 pain. . . . PRN Ulram (sic) administered . . . at 1939 [7:39 p.m.]. . ." MAR: Ativan - 3:38 a.m. and 7:21 p.m. Tramadol 2 tabs - 3:04 a.m., 12:04 p.m. and 7:39 p.m. 01/16/11 A Pain Assessment for Resident #2, dated 01/16/11, identified the following: "Current orders - Celebrex, Fentanyl, Tylenol PRN, Ultram PRN. . . . Non-Pharmacological Interventions - repositioned, warm blanket, elevate leg. . . Frequency of Pain - daily. . . Are you requesting medication change/additions at this time: No. Is the resident having pain - Yes - on scheduled pain medications . . ." *4:01 a.m. - ". . . she did complain of mild back pain just now in which Ultram was administered . . ." *5:28 a.m. - "lower back. . . . pain rating scale 8/10, grimacing with repositioning, stated, "it's not that bad' . . ."	F 309		

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F 309	Continued From page 10	F 309		

*12:29 p.m. - ". . . still c/o back pain at this time."

*1:17 p.m. - ". . . has been having back pain which she rates 9/10. She does not show any signs of accute (sic) distress . . . but is moving in her chair very frequently. Tramadol was administered with little effect. Talked to [family member], regarding above. . . ."

*1:22 p.m. - "Pain: upper back. . . . moving in her chair frequently trying to reposition. She states her pain is 9/10 . . . Tramadol did not seem to be effective in relieving pain. Will continue to monitor and try other interventions."

*5:48 p.m. - "[Resident] c/o 8/10 pain to lower back this shift. [Resident] stated that the tramadol she has ordered for PRN pain is ineffective. [Resident's family member] suggested to writer to see if there is anything else that we could get ordered for her to help with pain. Writer called on-call and received order to increase Fentanyl patch to 25 mcg/hr every 3 days and Lortab 5/325 mg every 4 hours PRN. [Resident] . . . with an ice pack to back. Will continue to monitor and treat pain accordingly."

Facility staff did not call the physician regarding Resident #2's pain until the family suggested to call for something to help with her pain.

MAR:
Ativan - *6:56 p.m.
Tramadol 2 tabs - 3:50 a.m., 10:04 a.m., and *6:56 p.m.
*Ativan given at the same time as the Tramadol

01/17/11

*1:43 a.m. - "Back pain. Verbalization of 8/10 pain. . . ."

*3:09 a.m. - "lower back and abdominal pain. . . . pain rating scale of 8/10, holding abdomen with repositioning, grimacing and squinting with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355123	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11	F 309		

movement, states, 'I think I better take something before it gets worse'. . ."

*5:33 a.m. - Location of Pain: LLE venous ulcer . . . pain rating scale of 10/10, grimacing with movement/repositioning. . . PRN Lortab administered . . . per request. Response: current time is [5:30 a.m.] . . . soundly sleeping. . ."

*6:43 a.m. - "[Resident] has been restless since administration of Lortab around [4:00 a.m.]. She did state that she was feeling anxious. . . . PRN Ativan administered . . ."

*8:56 a.m. - ". . . c/o 10/10 pain to area upon dressing change. . . ."

*12:49 p.m. - ". . . She c/o pain to her LLE. . .

*1:03 p.m. - "Location of Pain: lower back. . . was grimacing, stating she was in pain and request a pain pill. . . ."

*4:10 p.m. - "Location of Pain: Left lower leg. . . . Verbally stated 10/10 pain to left lower leg. . . . Lortab administered . . . Response: Stated relief of 5/10 one hour after administration. . . ."

MAR:
Ativan - 5:50 a.m., *1:30 a.m., and 5:15 p.m.
Tramadol 2 tabs - 1:18 a.m., 9:04 a.m. and 7:39 p.m.
Lortab - 4:07 a.m. and *1:30 p.m.
*Ativan given at the same time as the Lortab

01/18/11

*1:26 a.m. - "Location of Pain: Unable to specify where pain is located, very restless at this time. . . . Resident is very restless and unable to settle. Unable to tell writer where she is having pain. . . . PRN Lortab . . . Response: Has calmed down some but is continuing to say that she's having pain.

*6:57 a.m. - "Location of Pain: Back and left leg. . . . Resident stated 'my back hurts, oh my back hurts so bad, so does my leg.' Writer asked

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	355123	A. BUILDING _____ B. WING _____	C 01/27/2011

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F 309	Continued From page 12 her to rate her pain using 0-5 scale, unable to follow direction. She just kept telling the writer how bad it hurt. . . . PRN Tramadol, 2 tabs administered. Response: Still very restless, unable to settle down at this time." *7:00 a.m. - "Psychotropic medication in Use: Ativan. Diagnosis for Use: anxiety . . . Behaviors or symptoms being treated: Unable to settle, has been up all night very restless stating that she is in pain. Administered pain medications x2 this early morning, not proven to be effective. Unable to calm her anxiety. . . In summary, this medication has not proven to be effective for this resident at this time. She is still awake and having anxiety." *4:08 p.m. - "Location of Pain: Back and Left leg. . . . Wincing, frequent repositioning, states having pain. . . . Lortab and tramadol administered. Response: Pain medications do not seem to be effective at this time. Requesting to have pain medications scheduled." *8:43 p.m. - "Location of Pain: Complained of back pain and leg pain. Asked resident to rate and resident continued to voice 'Its just horrible' [at] [3:00 p.m.] and again at [4:00 p.m.]. . . . Facial grimacing, Curling body inward, Calling out for help and grabbing at lower back and left lower extremity. . . . PRN Lortab given at [3:00 p.m.] and PRN Tramadol 2 tabs given at [4:00 p.m.] after Lortab still not noted to be effective. Response: At [7:00 p.m.] resident seem much more relaxed and did not have complaints of pain . . . " MAR: Ativan - 5:16 a.m. and 9:30 a.m. Tramadol 2 tabs - 2:47 a.m., 3:56 p.m. Lortab - 12:31 a.m., 10:06 a.m., and 2:50 p.m. 01/19/11	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355123	A. BUILDING _____ B. WING _____	C 01/27/2011

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F 309	Continued From page 13 *1:54 a.m. - "Location of Pain: Unable to say where she is having pain. . . . tossing and turning in bed groaning, saying "God, please help me I hurt" . . . PRN Lortab. Response: No effect on [resident] at this time, also states that she's feeling itchy." *4:46 a.m. - ". . . is extremely restless this evening and into the early morning. She is complaining of pain, unable to verbalize where this pain is located however. She keeps saying 'God, please help me' . . . PRN medications including Lortab for pain, Ativan for anxiety and tramadol for continued pain, all of which seem to be ineffective. . . Unable to settle at this point, she has not slept at all during this shift. Will continue with interventions and medications to try to give her comfort . . ." *7:18 p.m. - "Tramadol . . . helped provide relief after Lortab." *7:19 p.m. - "Lortab . . . did seem to provide some relief as resident was not c/o pain as much." *10:33 p.m. - "Location of Pain: Lower left leg and back [at] [8:30 p.m.]. . . Facial grimacing and restlessness. . . . PRN Lortab . . . Response: Noted to be slightly effective at [9:30 p.m.]. Resident in room resting but still tossing at times and calling out occasionally but is not calling out in pain at this time." MAR: Ativan - *1:03 a.m. and 3:53 p.m. Tramadol 2 tabs - 2:26 a.m., 10:04 a.m. Lortab - *1:03 a.m., 8:42 a.m. and 8:32 p.m. *Ativan given at the same time as the Lortab 01/20/11 *6:19 a.m. - "Unable to explain where pain is located, [resident] was lying in her bed repeating 'Oh god, please help me' . . . She was moving	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355123	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

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F 309	Continued From page 14 around in her bed, not listening to reassurance and direction given by staff, unredirectable and irritable. Administered PRN Ativan . . . PRN Tramadol. . ." *7:41 p.m. - "Location of Pain: Lower back and shoulders. . . . [Resident] is moaning, grimacing, and c/o pain. . . . can not really rate her pain when ask (sic), she just states her back hurts. . . . Tramadol. Response: . . . did not stop moaning." MAR: Ativan - *12:47 a.m., *10:05 a.m. and 6:30 p.m. Tramadol 2 tabs - *12:47 a.m. and 5:27 p.m. Lortab - *10:05 a.m. Ativan given at the same time as the Tramadol and Lortab 01/21/11 *6:52 a.m. - "Behavior noted/What was observed: Upon entering [resident's] room at [5:15 a.m.] . . . she was crying out that 'I just can't catch my breath' and rocking back and forth in her bed. . . . Interventions: PRN Ativan . . . and PRN Ultram . . ." *10:57 a.m. - "Daughter . . . called this AM requesting to have pain medications scheduled and to 'throw out the Tylenol' She stated her mother is generally stoic and does not complain of pain. Since she has been complaining of pain, family would like that under control. Action: Call placed to [name of physician] nurse with above info. . . ." *11:51 a.m. - MDS [Minimum Data Set] Summary- ". . . During pain interview [resident] c/o moderate back pain. Currently medications are being adjusted and include a 25 mcg Fentanyl patch, and PRN Lortab and Ultram. . . . Will request that physician schedule Lortab or Ultram for better pain management. Recent vertebroplasty noted. . . ."	F 309		

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	355123	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

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F 309	Continued From page 15 *4:18 p.m. - ". . . has a necrotic tissue pressure wound to left achilles tendon and continues to c/o severe pain. Fax sent to provider requesting a change in analgesics per daughter [name] request." Facility staff did not call the physician regarding Resident #2's pain until the family suggested they call for a change in analgesics. MAR: Ativan - *6:02 a.m. and 6:39 p.m. Tramadol 2 tabs - *6:02 a.m. *Ativan given at the same time as the Tramadol 01/22/11 *4:10 p.m. - "Left achilles teneon (sic) wound . . . [Resident] has complained of pain to area and PRN analgesics were administered . . . and appear to be ineffective. In contact with physician regarding pain control. . . ." *4:37 p.m. - "Order: Fentanyl Patch 37 mcg/hour . . . Topical: Change every 72 hours. . . Notification: Daughter [name] notified of above orders as she called asking about them. She would like staff to monitor her pain level and update provider if it does not appear effective." *5:11 p.m. - "Location of Pain: Lower back and left LE. . . . Very anxious, unable to redirect, continuously states 'help me, I hurt'. . . PRN Lortab administered . . . Response: Lortab does not appear effective as she continues to complain of pain. Will continue to monitor." MAR indicated staff administered the Lortab at 1:35 p.m. *7:25 p.m. - Location of pain: lower back. . . . grimacing, and crying out stating she was in pain. . . . Tramadol. Response: [Resident] is quite (sic) not c/o pain." The MAR does not indicate Resident #2 received Tramadol at this time. MAR: Ativan - *1:35 p.m. and 10:55 p.m.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355123	A. BUILDING _____ B. WING _____	C 01/27/2011

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BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

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F 309	Continued From page 16 Tramadol 2 tabs - 12:48 a.m. and 4:07 p.m. Lortab - *1:35 p.m. *Ativan administered at the same time as the Lortab. 01/23/11 *8:42 a.m. - ". . . LLE dressing was changed this AM. . . complained of pain during procedure. . . ." *10:29 a.m. - "Location of Pain: Lower Back. . . . was grimacing and moaning her back hurt. . . Pharmacologic interventions used for relief: Norco (sic). Response: sleeping" *2:00 p.m. - "Left achilles tendon . . . [Resident] complained of pain to area and received PRN analgesics. . . ." *2:08 p.m. - "Location of Pain: Lower back. . . . c/o pain in her lower back. . . Pharmacologic interventions used for relief: Tramadol. Response: resting." *11:36 p.m. - "Location of Pain: Low back. . . . Verbalization of 7/10 pain, slow movements, facial grimacing. . . ." MAR: Ativan - *9:16 a.m. and *10:37 p.m. Tramadol 2 tabs - 12:27 p.m. and *10:37 p.m. Lortab - *9:16 a.m. and 3:25 p.m. *Ativan administered at the same time as the Lortab and Tramadol 01/24/11 *2:49 a.m. - ". . . PRN ativan and tramadol for increase restless (sic), repeating "God please help me" and complaints of back pain. . . . PRN ativan and tramadol seem to be effective, as been resting comfortable in her recliner . . ." *6:56 a.m. - "Location of Pain: Legs bilaterally and both shoulders. . . . States that she hurts really bad, repeating 'oh God, please help me, I	F 309		

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	355123	A. BUILDING _____ B. WING _____	C 01/27/2011

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BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

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F 309	Continued From page 17 hurt' fidgeting in bed. Unable to relax and sit still. . . . PRN Tramadol . . . Response: States that it still hurts but it does feel better." *8:36 a.m. - "Dressing was changed to left achilles. . . . some discomfort noted. . . ." *5:00 p.m. (Late Entry) - "Behavior noted/What was observed: Repetitive verbalization - 'what's wrong, something must be wrong, where are my kids, God help me' Very anxious and restless. . . . Ativan and pain medication given. . . ." *8:05 p.m. - "Location of Pain: Lower back. . . . [Resident] was grimacing, moaning and c/o lower back pain . . . Pharmacologic interventions . . . Tramadol. Response: resting." MAR: Ativan - *4:45 p.m. and *11:06 p.m. Tramadol 2 tabs - 5:38 a.m., *4:45 p.m. and *11:06 p.m. Tylenol 650 mg - 8:36 a. m. *Ativan administered at the same time as the Tramadol 01/25/11 *1:37 a.m. - "Location of Pain: Back pain. . . . Facial grimacing, and the patient saying 'Oh it hurts' repeatedly, demonstrated anxious behaviors . . . Tramadol . . . and Ativan . . . were administered at [11:06 p.m.] for pain and anxious manifestations exhibited. Response: Patient appears to be sleeping comfortably at this time." *5:34 a.m. - "Location of Pain: Patient verbalizes she has generalized pain. . . verbalized she hurts repeatedly. . . . Lortab 5/325 was administered . . . Response: Pt [patient] appears to be sleeping . . ." *12:58 p.m. - "Acetaminophen . . . resident was less restless and c/o pain much less." MAR: Ativan - *10:46 p.m.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355123	A. BUILDING _____ B. WING _____	C 01/27/2011

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BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

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F 309	Continued From page 18 Tylenol 650 mg - 7:30 a.m., 1:02 p.m. and *10:45 p.m. Tramadol 2 tabs - 8:05 p.m. Lortab - 3:17 a.m. *Ativan given at the same time as the Tylenol Observation of staff toileting Resident #2 occurred at 10:30 a.m. on 01/25/11. Resident #2 complained of left leg pain and back pain throughout the entire observation, saying "it hurts so bad" and requesting to have her back rubbed. Observation of toileting on 01/26/11 at 7:45 a.m. showed Resident #2 complaining of back pain, and saying "God help me, God help me." At 8:30 a.m., a nurse (#3) changed the dressing on resident's left leg. Resident #2 was weepy and complained of back pain and leg pain during the procedure. During interview, on 01/27/11 at 8:30 a.m., Resident #14's family member (#1) stated she is concerned about her mother's pain and wants to get this controlled so that she will be comfortable. The family member stated she wants her mother to have pain medications on a scheduled basis because otherwise the pain goes on too long and gets out of control. The family member stated "Tylenol is worthless" when staff give it to her mother for pain. She also stated she did not want her mother to have Lortab, as it makes her confused. The family member stated her mother's recent MRI (01/26/11) indicated her back is "screwed up again" and thinks that it happened when her mother fell. A "Nursing Narrative" dated 01/26/11 at 5:26 p.m. stated, "Interventional radiology called regarding earlier MRI performed and stated that [resident] does have a compression fracture in her upper	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355123	A. BUILDING _____ B. WING _____	C 01/27/2011

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BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

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F 309	Continued From page 19 spine. They are going to contact the daughter and discuss options and then get back to us with the decision. Resident #2's family expressed concern about pain control on 01/16/11 and 01/21/11 and requested that changes be made to get the resident's pain under control. On 01/16/11, the physician added another PRN pain medication (Lortab) and increased the dosage of the Fentanyl patch to 25 mcg. On 01/22/11, the physician increased the Fentanyl dosage to 37 mcg. Despite these medication changes, Resident #2 continued to experience uncontrolled pain and required various PRN medications (Tylenol, Lortab, Tramadol) every day. In addition, on 12 separate occasions, facility staff administered Ativan for anxiety at the same time as they administered pain medications, making it difficult to determine the effectiveness of each of these medications. Failure to comprehensively assess the resident's pain to determine patterns and effectiveness of interventions resulted in Resident #2 experiencing uncontrolled pain and discomfort. - Review of Resident #14's closed record occurred on 01/27/11. The record identified the facility admitted Resident #14 on 10/26/10 after hospitalization for a myocardial infarction (MI) and congestive heart failure. Review of the hospital discharge summary identified the physician discussed the resident's cardiac function with the patient and family and it was decided to treat her with medical management. Resident #14's Progress Notes identified the following:	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355123	A. BUILDING _____ B. WING _____	C 01/27/2011

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F 309	Continued From page 20	F 309		

10/31/10

*2:37 a.m. - Nurses Note - "States that she is having chest pain. Offered reassurance and 1:1 time. Administered 1300 mg of APAP (Tylenol) and 2L of O2 [oxygen] per nasal canual (sic). At [3:00 a.m.] [name of resident] stated that she was feeling better but the pain was still there. . . ."

*6:53 a.m. - Nurses Note - ". . . was experiencing some mild chest pain throughout the night. She states that this has been happening quite frequently during the night. . . . Note left for provider. Awaiting response."

*10:36 p.m. - Nurses Note - "[name of resident] c/o [complains of] chest pain, . . . denied being SOB [short of breath] . . . did not want to go to ER [emergency room], ask for Tylenol. Will have next shift monitor."

11/01/10

*1:13 a.m. - Nurses Note - "[name of resident] continues to complain of chest pain the (sic) is consistent. Does not want to go to the ER tomorrow. Note left for provider to follow up. Administered oxygen at 2L/min [liters per minute] via nasal cannual (sic). . . . Will continue to monitor."

*1:17 a.m. - Nurses Note - "At [12:45 a.m.] [resident] stated that there is no relief from the chest pain that she is having."

*7:06 a.m. - Nurses Notes - "[Resident] was having episode of nausea and vomiting. 1 large emesis, 2 small ones an (sic) felt nauseated for the rest of the night. Low grade fever, 99.0. Left note for provider. . . ."

*7:31 p.m. - Nurses Note - Family Communication - "Daughter . . . came to visit [resident] today and was concerned with [resident's] chest pain during the night. At her

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BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

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F 309	Continued From page 21 request, called on call physician to obtain an order for nitroglycerine. 0.4 mg [milligrams] Nitroglycerine ordered every 5 minutes for chest pain PRN. Notified daughter regaurding (sic) new order for nitro. She is happy that we took the time to get the order." 11/02/10 *12:40 p.m. - Nurses Note - Lab - " . . . Contacted PA [physician's assistant] regarding the results. The PA state that she [the resident] most likely has had another heart attack . . . " 11/08/10 *7:58 a.m. - Nurses Notes - "Location of Pain: Chest pain. . . . stated her chest hut (sic), . . . rated her pain at a 6 on scale of 0-10. . . head of bed raised, [resident] was resposition (sic), was advise (sic) to rest. Tylenol . . . Response: feeling a little better. *8:07 a.m. - "At [7:00 a.m.] [resident] c/o chest pain vitals . . . P [pulse] 115 R [respirations] 22 . . . Tylenol was given and [resident] was started on 1.5 L of O2." *8:29 a.m. - "Data: [Resident's] daughter called and stated that she will be transferring her mother to [name of another skilled nursing facility] at noon today. . . ." *10:40 a.m. - (Telephone Order) - "Order: To send [resident] to ER [emergency room] per family request . . . Reason for Order: Chest pain . . . *10:44 a.m. - "Transfer to ER. . . ." Resident #14 experienced chest pain that was not relieved by Tylenol on 10/31/10, 11/01/10, and again on 11/08/10. Facility staff failed to comprehensively assess this resident's complaint of chest pain. Failing to assess the resident's	F 309		

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F 309	Continued From page 22 pain, notify the physician, and then implement the appropriate treatment may have resulted in Resident #14 experiencing another heart attack. 2. Based on record review, family interview, and staff interview, the facility failed to ensure the provision of care and services for 1 of 1 sampled resident (Resident #2) regarding follow-up of a wound specimen culture and sensitivity result and 1 of 1 closed record resident (Resident #14) regarding prompt attainment of an ordered lab specimen. Failure to provide the care and services related to prompt attainment of lab specimens and prompt follow-up regarding lab results resulted in a delay of antibiotic treatment for Resident #2 and Resident #14. Findings include: Review of the medical record, on all days of survey, identified the facility admitted Resident #2 on 01/12/11 after discharge from the hospital. Resident #2's medical diagnoses included peripheral vascular disease and Pseudomonas infection in left leg ulcer. Review of Resident #2's hospital discharge summary, dated 01/12/11, stated, ". . . 6. Left leg ulcer. . . . She did have a culture of her wound, which did grow some Pseudomonas, sensitivities are pending. . . . Contact [name of physician] . . . when the sensitivities of the left leg culture come back. . . ." Resident #2's hospital discharge "New Prescriptions" form stated, "When sensitivities on culture of L [left] leg available, call [name of physician] at [name of clinic] for antibiotic orders."	F 309	1. Corrective action for Resident #14 is unable as the resident has since been discharged. For Resident #2, the culture reports were obtained and antibiotics started. 2. All current residents and newly admitted residents to Bethany on 42nd have the potential to be affected by this practice if they have laboratory work ordered. 3. Bethany on 42nd will initiate the following system changes to enhance lab specimens are collected and followed up on: A. We will initiate use of an ALERT system from our electronic medical record. This report will alert staff of pending lab work, or follow up needed. (Attachment P is an example of an ALERT report) B. We currently use a stamper that helps nurses with the steps needed when completing a medical order. We've added a spot on this stamper that prompts the nurse to initiate an ALERT if appropriate. (Attachment Q) C. We have changed our policy related to obtaining Urinalysis'. We will now have a 12 hour limit for obtaining a UA, if unable to obtain in 12 hours, we will need to follow our facility protocols in obtaining specimen via straight cath. (Attachment R & S)) 4. The Unit Managers and Quality Department will conduct audits including, but not limited to: auditing lab orders received and correlating completion of ALERT reports. Education will be provided in a variety of ways: Mandatory Educational Meeting for Nurses, CMA's and Unit Clerks on 2/24/2011 (Attachment G). There will also be a Hands On Order Entry In-Service held on 2/24/2011 to educate nurses on the process for entering ALERTS. (Attachment T)	

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F 309	Continued From page 23 Review of Resident #2's Progress Notes identified the following: 01/13/11 *3:28 p.m. - "Dressing changed to left achilles tendon . . . Area has necrotic tissue noted throughout with small yellow/green sloughing tissue in the middle. Noxious odor noted. . . . states she was having pain to that area during the dressing change. . . ." 01/16/11 *1:11 p.m. - "Data: reported by previous staff member that daughter brought forth concerns that her mother should be treated with IV [intravenous] antibiotics for her left leg ulcer. Writer observed in H&P [history and physical] in chart from [name of hospital] that they had obtained a culture but were awaiting the sensitivities report. Action: Writer phoned [name of hospital] lab and had them fax over the results of the C&S [culture and sensitivity] report . . . . Action: noted and faxed to [clinic name] will have day shift staff call on-call MD [medical doctor] in the AM to see if they would like to initiate antibiotic treatment. . . ." Review of the C&S report identified the culture sensitivities were available on 01/13/11. 01/17/11 *8:56 a.m. - ". . . The dressing to [resident's] left achilles tendon was changed . . . Moderate amount of brown drainage noted . . . Necrotic tissue around sloughing tissue. . . . c/o 10/10 pain to area . . . ." *1:27 p.m. - ". . . Dressing changed to LLE. Site is necrotic and sloughing. Moderate odor noted. Moderate amount of drainage and sloughing noted . . ." 01/18/11	F 309	Quality Monitoring of Lab orders and ALERT reports as well as Stamper Use will be completed by the Unit Managers daily for a period of two weeks, and then three times per week for a period of two weeks, and then one time per week for a period of two weeks. (Attachment U) Based on compliance, the audits would then be moved to our Quality program for monitoring and reviewing at our monthly Quality Meeting. 5.	3/3/2011

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F 309	Continued From page 24 *1:13 p.m. - "Order: Clindamycin 300 mg PO [by mouth] QID [four times a day] x 10 days. Zosyn 3.375 mg IV q [every] 6 hours x 10 days. . . ." *4:47 p.m. - "Type of Wound: Vascular. Location: Left achilles. Size: 5cm [centimeters] x7 cm. Stage: Unstageable . . . Most severe tissue type: Eschar. Drainage: Moderate amount of brownish drainage noted. Odor: mild odor noted. . . ." 01/21/11 *4:18 p.m. - "[Resident] has a necrotic tissue pressure wound to left achilles tendon and continues to c/o severe pain. . . . Strong noxious odor to wound with moderate drainage noted. . . . Location/Type of Infection: Pseudomonas to left achilles tendon. . . ." During interview, on 01/27/11 at 8:30 a.m., Resident #2's family member (#1) stated her mother had an infection in her foot prior to admission to the nursing facility and "she was supposed to be on antibiotics for her leg." The family member stated "the ball got dropped" and her mother didn't get started on antibiotics until 01/18/10 (five days after the culture sensitivities were available). - Review of Resident #14's closed record, on 01/27/11, revealed the facility admitted the resident on 10/26/10. Resident #14's care plan, initiated 10/27/10, stated ". . . has altered urinary elimination pattern related to . . . Hx [history] of incontinence. . . . leaks urine when she sneezes or coughs and she also has urgency. . . . utilizes Detrol [a medication used to treat overactive bladder symptoms of urinary frequency, urgency, and incontinence.] . . . Interventions: . . . Monitor	F 309		

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F 309	Continued From page 25 for signs of infection. . . ." Review of Resident #14's admission Minimum Data Set, dated 11/02/10, identified the resident as occasionally incontinent of urine and required extensive assistance of one staff member for toilet use and transfers. Resident #14's Nursing Progress Notes identified the following: 11/01/10 *7:06 a.m. - "Data: [Resident] was having episodes of nausea and vomiting. . . . felt nauseated for the rest of the night. Low grade fever, 99.0. . . . Note left for provider." *7:27 p.m. - "Order: . . . UA/UC [urine analysis/urine culture] . . ." 11/02/10 *11:29 p.m. - "Data: [Resident's] daughter called this AM inquiring about the labs that were ordered yesterday. She also had concerns that [resident] told her . . . that nobody has been in to assist with cares. . . ." 11/03/10 Review of laboratory results identified the following: *3:59 p.m. - Urine specimen collected *8:50 p.m. - Urine specimen received in the lab *9:08 p.m. - Urinalysis results reported. *10:31 p.m. - Nurses Note - "Data: UA Received. Clarity - Cloudy, Nitrite - Positive . . . Action: Waiting for UC results. Response: UC pending for results." 11/05/10 *11:23 p.m. - "Data: . . . Urine Culture results: Isolate . . . Klebsiella pneumoniae . . . Response: New orders received for antibiotics."	F 309		

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F 309	Continued From page 26 *12:07 p.m. - "Order: Keflex 500 mg PO BID [twice a day] for 10 days. . . . Reason for Order: UTI [urinary tract infection]. . . " During interviews, the morning of 01/27/11, two administrative nurses (#1 and #2) stated they did not know why it took staff approximately 20 hours after it was ordered to collect the urine sample for Resident #14. Resident #2's Pseudomonas infection and Resident #14's urinary tract infection required antibiotic treatment. Failure of staff to promptly follow up on laboratory test results for Resident #2 and failure to promptly collect a lab specimen for Resident #14 resulted in a delay of antibiotic treatment for both residents (5 days and 2 days respectively). Delay in treatment may have also contributed to the increased pain experienced by Resident #2. 3. Based on record review, review of facility policy and procedure, review of professional references, and staff interview, the facility failed to ensure the provision of necessary care and services for 4 of 4 sampled diabetic residents (Resident #3, #7, #12, and #13) regarding high and low blood glucose parameters and when to contact a physician. Failure to establish high and low blood glucose parameters and when to contact a physician placed all diabetic residents at risk and limited the physicians' ability to ensure the quality of care. Findings include: "Managing Diabetes in the Long-Term Care Setting," Clinical Practice Guideline, 2002, American Medical Directors Association, pages	F 309	1. For residents #3, #7, #12 and #13 we will initiate a Blood Glucose Clarification Form to create parameters regarding when to contact a physician. 2. All diabetic residents have the potential to be affected by this practice. 3. Bethany on 42nd will initiate the following changes to glucose parameters and the physician communication processes for diabetic residents: A. Changes have been made to our policy for Blood Sugar Monitoring (Attachment V). We've included Symptoms of hypo and hyperglycemia in the policy. We've also made a poster that will be placed on all nursing units related to signs and symptoms of hypo/hyperglycemia. (Attachment V) B. Initiated a Blood Glucose Clarification Form that will be utilized for diabetic residents. (Attachment W)	

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F 309	Continued From page 27 27-30, states "When to Call the Physician, A systematic facility approach to diabetes management can streamline day-to-day care and reduce the frequency of episodes of hypoglycemia [low blood glucose], hyperglycemia [high blood glucose], and other acute metabolic complications. The following are steps that facilities may consider implementing. . . . Develop protocols that guide first-line caregivers (nurses and nursing assistants) in deciding when a prompt physician referral is necessary for a diabetes-related problem. Make use of standing orders that are approved by the primary care physician when the patient is admitted. For example, the physician may write an order stating that he or she is to be notified when an individual patient's blood glucose values are outside of a specified range. When patients' blood glucose levels are poorly controlled and when patients are extremely frail or cognitively impaired, the physician may wish to note specific individual blood glucose or symptom parameters in the orders. These parameters should be transcribed to the Medication Administration Record and the patient's care plan. Treating Hypoglycemia . . . Hypoglycemia is the most feared short-term complication of treatment for diabetes. If not promptly recognized and treated it can result in long-term disability, particularly in cognitively impaired individuals. . . ." Review of the facility policy/procedure titled "BLOOD SUGAR MONITORING" occurred on 01/27/11. This policy, revised February 2010, stated, "PROCEDURE . . .	F 309	C. Individualized parameters for glucose monitoring will be placed on the residents' Accucheck orders (both prn and scheduled Accucheck orders). 4. The Health Information Coordinator s and Quality Department will conduct audits including, but not limited to: auditing diabetic residents for completion of the Blood Glucose Clarification Form and correct entering of parameters on the MAR or EMAR. Education will be provided in a variety of ways: Mandatory Educational Meeting for all Nurses, CMA's and Unit Clerks on 2/24/2011 (Attachment G). There will also be a Hands On Order entry Inservice held on 2/24/2011 to educate nurses on the process for entering Blood Glucose parameters on the EMAR or MAR. (Attachment T) Quality Monitoring of Glucose Clarification Forms and parameters will be completed by the Health Information Coordinator and Quality Department daily for a period of two weeks, and then three times per week for a period of two weeks, and then one time per week for a period of two weeks. (Attachment Y) Based on compliance, the audits would then be moved to our Quality program for monitoring and review at our monthly Quality Meeting. 5.	3/3/2011

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F 309	Continued From page 28 NOTES: * If the blood test result is lower than 20 mg/dL [milligrams per deciliter], "Lo" will appear on the meter display. This indicates severe hypoglycemia (low blood sugar). Immediately treat the resident's hypoglycemia as recommended by physician/extender or facility protocol. * If the blood test result is higher than 600 mg/dL, "Hi" will appear on the meter display. This indicates severe hyperglycemia (high blood sugar). Immediately treat the resident's hyperglycemia as recommended by physician/extender or facility protocol . . . GENERAL DOCUMENTATION GUIDELINES (Key Issues to be Considered) Complete documentation in Point Click Care [computer charting] . . . * If blood glucose level is above or below normal range, document the time the physician was notified . . . NOTE: BLOOD GLUCOSE LEVELS FOR RESIDENTS WITH DIABETES VARY, DEPENDING ON FOOD INTAKE, INSULIN DOSE, AND EXERCISE. TARGET GLUCOSE LEVELS SHOULD BE ESTABLISHED BY THE RESIDENT'S ATTENDING PHYSICIAN." Review of the Physician Standing Orders for the F-M (Fargo-Moorhead) area nursing facility residents, dated December 2009, regarding diabetes monitoring and/or treatment, stated, "Facility Protocol. If no protocol: 1. Blood glucose check PRN [as needed] nurse discretion. 2. Glutose 1/2 - 1 tube oral. Repeat in 10 minutes as needed. 3. Glucagon 1 mg subcutaneous X 1 [one time] for symptomatic hypoglycemia plus BS [blood	F 309		

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F 309	Continued From page 29 sugar] < [less than] 50 and notify physician/extender of results. Re-check blood glucose within one hour and notify physician or [sic] results." - Review of Resident #3's medical record occurred on January 24-27, 2011. The facility admitted the resident in 07/10. Current diagnoses included post-operative hip replacement, pressure ulcers to both feet on admission, and diabetes mellitus. Physician orders included daily blood sugar checks, scheduled insulin injections four times each day, and daily sliding scale insulin at the time of the blood sugar checks. The sliding scale identified the amount of insulin to be given beginning with a blood sugar of 141 mg/dl and ended with instructions to call the physician if blood sugar level was greater than 401 mg/dl. Resident #3's medical record lacked sliding scale insulin instructions or parameters for blood sugar levels of 140 mg/dl or below. Resident #3's nurse's notes identified the following: *07/15/10, 4:11 p.m. - "At 11:30 [Resident #3] came back from therapy stating that he was not feeling well. . . . BS [Blood sugar] was checked and was 39 [mg/dl]. Snack of OJ [orange juice], peanut butter toast and a banana given. He ate sme [sic] lunch and rechecked BS at 1345 [1:45 p.m.] and was 140 [mg/dl]. Snack given at 1400 [2:00 p.m.] Will monitor. Pm [Evening] nurse aware." *07/21/10 - A blood glucose level of 63 mg/dl. *11/26/11 - A blood glucose level of 454 mg/dl. Resident #3's medical record lacked evidence the facility staff contacted the resident's physician/extender for any of the three incidents	F 309		

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F 309	Continued From page 30 previously identified; and, that the facility followed the Physician Standing Orders for F-M Nursing Homes on 07/15/10. During interview, on 01/26/11 at 3:30 p.m., a supervisory nursing staff member (#2) reported Resident #3's physician ordered a hemoglobin A1c laboratory test (measures average blood glucose over the previous two to three months) on 07/28/10, days after the incidents on 07/15/10 and 07/21/10. No additional information was provided regarding these incidents of hypo and hyperglycemia. - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included diabetes mellitus. The resident's physician ordered blood glucose monitoring four times a day. The resident experienced the following high blood glucose levels: *01/25/11 - 407 mg/dL *12/17/10 - 404 mg/dL *11/26/10 - 453 mg/dL The facility staff did not notify the physician of the resident's increased blood glucose level on any of the three occasions. - Review of Resident #12's medical record occurred on January 26-27, 2011. Diagnoses included diabetes mellitus. The resident's physician ordered daily blood glucose monitoring at 7:00 a.m. Current medications included 25 units of Lantus insulin daily with no parameters for notifying the resident's physician regarding high and low blood glucose levels. - Review of Resident #13's medical record occurred on January 26-27, 2011. The facility admitted the resident in 05/10. Current diagnoses	F 309		

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F 309	Continued From page 31 included diabetes mellitus. Current physician orders included glipizide, 5 mg each day (a medication to lower the blood glucose level of non-insulin dependent diabetics) and blood glucose checks three times each week with no parameters for notifying the resident's physician regarding high and low blood glucose levels. During interview, on 01/27/11 at 2:30 p.m., an administrative nursing staff member (#1) and two supervisory nursing staff members (#2 and #4) reported the facility follows the Physician Standing Orders for F-M Nursing Homes regarding blood glucose levels and facility residents do not have individual parameters or instructions for physician contact regarding incidents of hypo or hyperglycemia. The medical records for Resident #3, #7, #12, and #13 lacked blood glucose parameters and guidelines for notifying the residents' physicians regarding high and low blood glucose levels. The facility failed to ensure target blood glucose levels were established for diabetic residents, as identified in its policy and procedure. Failure to ensure each diabetic resident's medical record contained the recommended parameters and guidelines limited the facility's ability to accurately control the residents' blood glucose level, placed all diabetic residents at risk, and limited the physicians' ability to ensure the quality of each individual resident's care.	F 309		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333	1. Corrective action for resident #16 had been implemented immediately upon notification of incorrect medication. 2. All residents would have the potential for medication errors secondary to their need for medications and the possibility of human error associated with order entry.	

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F 333	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure 1 of 1 closed resident record (Resident #16) who received the medication potassium chloride, remained free from significant medication errors. Failure to ensure medications are given accurately and appropriately may jeopardize the health and safety of the residents. Findings include: Review of Resident #16's medical record occurred on 01/27/11. Diagnoses included atrial fibrillation, edema, and congestive heart failure. Review of Resident #16's lab results showed the following potassium levels: *09/10/10 - 3.6 (reference range 3.5-5.3 mmol/L (millimole per liter)) *09/16/10 - 3.2 (low) *09/23/10 - 3.1 (low) *09/30/10 - 3.4 (low) Review of Resident #16's physician's orders showed a telephone order, dated 09/16/10, which stated, "Potassium chloride [used to prevent or treat low levels of the electrolyte potassium in the blood] 20 meq [milliequivalents] PO [by mouth] daily. Re-check BMP [basic metabolic panel] in 1 week." Review of Residents #16's Medication Administration Record identified on 09/17/10 the facility administered 10 meq of Potassium Chloride daily. The facility staff failed to administer the correct dose of 20 meq daily as ordered by the nurse practitioner on 09/16/10.	F 333	3. The following changes and additions have been implemented to decrease the likelihood of medication errors. A. Bethany has a policy that addresses Medication Administration—we have made one addition that covers the 7 Rights for medication administration.. This will be reviewed at our Mandatory Educational meeting for nurses and CMA's, and added to our Annual Skills Fair. (Attachment Z) B. We will provide a Hands-on Order Entry educational opportunity as this medication error stemmed from incorrect order entry/transcription error. (Attachment T) C. Education regarding the thorough use of the stamper when completing all orders. The stamper is a step-by- step process system that will enhance the order entry process. (Attachment T) D. Changes made to Stamper will enhance the night nurse "double check" process. (Attachment Q) E. Changes made to our Medication Variance Policy to address immediate intervention/education for medication errors. (Attachment AA) 4. The Unit Managers and Quality Department will conduct audits including, but not limited to: auditing orders received for accuracy. We also monitor the use of the Stamper, by both our nurses who sign off the order initially, and then the night nurse who double checks the order for accuracy. Education will be provided at our Mandatory Educational meeting for nurses, CMA's and Unit Clerks (Attachment G). We will have several order entry stations for nurses to enter a realistic scenario of orders. Several Unit Managers and Health Information Coordinators will be available to provide immediate feedback on this. (Attachment T) We also will have nurses, and CMA's complete a Self Study regarding Medication Administration. (Attachment BB)	

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	355123	A. BUILDING _____ B. WING _____	C 01/27/2011

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F 333	Continued From page 33 Review of a nurse practitioner's progress note, dated 09/22/10, stated, " . . . In addition, she [Resident #16] has significant lower extremity edema. [Name of physician] had seen her a few weeks ago and changed her Lasix to Bumex [a diuretic - helps decrease fluid in the body]. This dose was actually increased to 1 mg [milligram] p.o. [by mouth] b.i.d. [twice daily] since she had a weight loss of approximately 12 pounds since September 14th. She reports that the edema in her lower extremities has improved significantly and nearly resolved. She states that her breathing overall is feeling improved . . . In addition, nursing staff reported to me today that although I increased her potassium about a week ago because her potassium was low at 3.2, they did not do this and this is a medication error per the nursing home. Therefore, we will need to recheck lab work tomorrow as she has not been getting the correct dose of potassium that was ordered. . . . Plan . . . 2. CBC [complete blood count] and Renal panel in AM. 3. Decrease Bumex to 1 mg daily. 4. Continue daily wts [weights] . . ." A nurse practitioner's order for Resident #16, dated 09/23/10, stated, "Increase Potassium Chloride to 20 meq BID [twice daily]. Recheck Potassium in one week." The facility administered Resident #16 the incorrect dose of Potassium Chloride for five days. Failure to administer the correct dose could cause adverse health affects, such as muscle weakness and abnormal heart rhythms. The facility provided no further information.	F 333	Quality Monitoring will be completed by the Unit Managers, Health Information Coordinators, and Quality Department daily for a period of two weeks and then three times per week for a period of two weeks, and then one time per week for a period of two weeks. Based on compliance the audits would then be moved to our Quality program for monitoring and review at our monthly Quality meeting. (Attachment U) 5.	3/3/2011
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431	1. No residents were found to have been affected by the deficient practice of not having temperatures in medication refrigerators between 36-46.	

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F 431	Continued From page 34 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 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, record review, review of facility policy, review of manufacturer's instructions, review of professional literature, and staff interview, the facility failed to store all	F 431	2. All residents at Bethany on 42nd and all new admissions who have medications refrigerated would have the potential to be affected by this practice. 3. Bethany on 42nd will implement the following changes to assist staff with accurately recording medication refrigerator temperatures and the reporting of the temperatures if they vary from the 36-46 standard. A. Medication Refrigerator logs have been changed to include the range we want the temperatures to be and what to do if the temperature is outside of the specified range. (Attachment CC) B. The Refrigerator policy has been changed to reflect the temperature ranges, and to reflect the process that should be initiated if a temperature is outside of the range. (Attachment DD) C. Refrigerator thermometers were replaced. We now have thermometers that we are able to calibrate. 4. The Unit Managers and Quality Department will conduct audits including, but not limited to: auditing Medication Refrigerator logs. Education will be provided on these changes at our Mandatory Educational meeting for nurses. A Self-Study will also be required of all nurses to enhance understanding of the policy changes and log changes. (Attachment EE) Quality Monitoring will be completed by the Unit Managers and Quality Department daily for a period of two weeks, and then three times per week for a period of two weeks, and then one time per week for a period of two weeks. Based on compliance, the audits would then be moved to our Quality program for monitoring and review at our monthly Quality Meeting. (Attachment FF) 5.	3/3/2011

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F 431	Continued From page 35 medications under proper temperature controls, in 3 of 6 medication refrigerators (Sterling House, River Terrace, and Transitional Care unit). Failure to maintain the temperature within an acceptable range has the potential to affect the potency and efficacy of the medication. Findings include: Diabetes Care by the American Diabetes Association, Inc., January 2004, Vol. 27, Supplement 1, stated, ". . . Insulin Administration. . . Storage. . . Extreme temperatures ([less than] 35 [degrees Fahrenheit]) should be avoided to prevent loss of potency, clumping, frosting, or precipitation. Specific storage guidelines provided by the manufacturer should be followed. . . ." Review of the facility policy titled "Refrigerator - Medication Storage" occurred on the afternoon of 01/26/11. This policy, dated revised on 01/2011, stated, "The Nursing department will be responsible to monitor medication fridge temps. A. Guidelines for monitoring medication room refrigerator temps. 1. Refrigerator temperatures should be maintained between 36 [degrees] F [Fahrenheit] and 46 [degrees] F for medication safety. 2. Bethany will provide a thermometer for this purpose. 3. Consistent results outside this range should be reported to the Nurse Manager/Unit Manager and Building Services." - Observation of the medication room refrigerator in the Sterling House household, at 8:25 a.m. on 01/26/11, showed the temperature at 32 degrees Fahrenheit (F) and the following medications in	F 431		

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BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

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F 431	Continued From page 36 the refrigerator: * 12 Novolog Flex Pens, the manufacturer's instructions identified, " . . . stored in a refrigerator between 36 F to 46 F. Do not freeze Novolog and do not use if it has been frozen." * 9 Lantus Solostar Pens, the manufacturer's instructions identified, " Do not Freeze, store refrigerated at 36 - 46 F." * 7 Levemir Flex Pens, the Nursing 2011 Drug Handbook, 31rst Edition, Lippincott Williams and Wilkins, page 1067 states, "Store . . . between 36 and 46 F. Don't freeze. Don't use insulin . . . if it has been frozen." * 4 Novolog Mix 70-30 Flex Pens, the manufacturer's instructions identified, "avoid freezing." - Observation of the medication room refrigerator in the River Terrace household, at 12:40 p.m. on 01/26/11, showed the temperature at 28 degrees F and the following medications in the refrigerator: * 1 vial of Levemir, the manufacturer's instructions identified, "store 36 - 46 F, Avoid Freezing." * 2 vials of Novolog, the manufacturer's instructions identified, "Avoid Freezing." * 2 vials of Novolin 70/30, the manufacturer's instructions identified, "Avoid Freezing." * 1 vial of Humulin R, the manufacturer's instructions identified, "Do not Freeze." - Observation of the medication room refrigerator in the Transitional Care Unit (TCU), at 12:56 p.m. on 01/26/11, showed the temperature at 32 degrees F and the following medications in the refrigerator: * 3 Humalog Pens, the Nursing 2011 Drug Handbook, 31rst Edition, Lippincott Williams and	F 431		

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F 431	Continued From page 37 Wilkins, page 1076 states, "store . . . insulin at 36 to 46 F. . . . not to freeze." * 1 Lantus Pen * 1 vial of Humulin N, the Nursing 2011 Drug Handbook, 31rst Edition, Lippincott Williams and Wilkins, page 1076 states, "store . . . insulin at 36 to 46 F. . . . not to freeze." * 1 Novolog Flex Pen On 01/26/11, an administrative nurse (#1) provided the "Med Room Fridge Temperature Checklist" for the months of October 2010 - January 2011 for the 3 households identified. The Med Room Fridge Temperature Checklists lacked a recommended refrigerator temperature range. The check lists showed the following Fahrenheit temperatures: * Sterling House - January 2011, temperature 32 degrees on 2 of 26 days recorded. * River Terrace - January 2011, temperatures ranged from 20-34 degrees on 10 of 25 days recorded. December 2010, temperatures ranged from 25-34 degrees on 18 of 29 days recorded. October 2010, temperatures ranged from 28-30 degrees on 2 of 24 days recorded. * TCU - January 2011, temperatures ranged from 30-34 degrees on 23 of 23 days recorded. December 2010, temperatures ranged from 28-35 degrees on 24 of 25 days recorded. November 2010, temperatures ranged from 30-34 degrees on 20 of 20 days recorded. October 2010, temperatures ranged from 30-34 degrees on 22 of 22 days recorded. The temperatures identified above registered lower than the recommended temperatures identified by the manufacturers for the	F 431		

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F 431	Continued From page 38 medications located in the medication refrigerators. The facilities failure to maintain the refrigerator temperatures between 36-46 degrees F had the potential for the insulins to freeze and lose their potency. During an interview on 01/26/11 at 3:10 p.m., an administrative nurse (#1) confirmed the medication room refrigerator temperatures "should be in the range of 36-46 degrees F."	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 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.	F 441	1. Corrective action for residents #2 and #3 involved coaching and return demonstration for accuracy by the one nurse involved. 2. All residents who have dressings over wounds would have the potential to be affected. 3. Bethany on 42nd will implement the following changes: A. Re-education on the infection control/dressing change policy at Nursing Mandatory inservice. B. A competency form was developed to audit proper technique with all new nurses and will be utilized for all nurses annually during our Skills Fair. (Attachment GG) C. Current nurses will be required to do a dressing change during our Mandatory Educational In-Service. 4. The Unit Managers and Quality Department will conduct audits including, but not limited to: auditing dressing changes. (Attachment GG) Again, Education will be provided at our Mandatory Educational meeting for all nurses. (Attachment G)	

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F 441	Continued From page 39 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of policy and procedure, and staff interview, the facility staff failed to ensure a safe and sanitary environment to help prevent the development and spread of infection for 3 of 4 dressing changes observed for Resident #2 and #3. Failure to ensure proper glove usage placed Resident #2 and #3 at risk of continued infection and potential transmission of infection to other residents, staff, and visitors. Findings include: Review of the facility policy and procedure, Infection Control - Standard Precautions, occurred on 01/27/11. This document, revised 02/10, stated "RESPONSIBILITY, Standard Precautions apply to the care of all persons in all healthcare settings, regardless of the suspected or confirmed presence of an infectious agent. PURPOSE . . . All residents will be cared for using standard precautions for the prevention of infection. . . . PROTECTIVE BARRIERS . . . A. GLOVES, 1. Gloves are to be worn by all employees when:	F 441	Quality Monitoring will be completed by the Unit Managers and Quality Department and will consist of monitoring of three dressing changes per week/floor for a total of two weeks, and then 2 dressing changes per week/floor for a total of two weeks and then 1 dressing change per week/floor for two weeks.. Based on compliance, the audits would then be moved to our Quality program for monitoring and reviewing at our monthly Quality Meeting. 5.	3/3/2011

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F 441	Continued From page 40 a. Direct contact with . . . moist body substances (body fluids, secretions and excretions) or contaminated items or surfaces is anticipated. . . . 4. Gloves are to be removed: . . . b. Before touching non-contaminated items or surfaces. . . ." Review of the facility policy and procedure, Infection Control - Contact Precautions, occurred on 01/27/11. This document, revised 02/10, stated . . . RESPONSIBILITY, All Staff . . . PROCEDURE . . . GLOVES: . . . Change gloves after having contact with infective; material that may contain high concentrations of microorganisms (fecal material and wound drainage). . . ." Review of facility policy "DRESSING CHANGE (CLEAN)" occurred on 01/27/11. This policy, dated 08/09, stated, "EQUIPMENT: 1. Dressings or dressing tray. 2. Prescribed cleaning solution(s). . . . 6. Clean gloves (two pair). . . PROCEDURE: 1. Wash hands with soap and water, and dry thoroughly. . . . 4. Open dressing pack. 5. Put on first pair of disposable gloves. 6. Remove soiled dressing and discard in plastic bag. 7. Dispose of gloves in plastic bag. 8. Put on second pair of disposable gloves. 9. Pour prescribed solution onto gauze to be used for cleaning, if required. 10. Cleanse wound with prescribed solution. . . ." - Review of Resident #2's medical record occurred on all days of survey. The facility admitted Resident #2 on 01/12/11 with an open ulcer to her left achilles tendon area. On 01/16/11, the facility received information from the lab regarding the results of a culture and sensitivity report. This report identified a wound	F 441		

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F 441	Continued From page 41 infected with Pseudomonas aeruginosa Strain 1, Staphylococcus aureus, and Pseudomonas aeruginosa Strain 2. Resident #2's physician ordered a 10 day course of an oral antibiotic and a 10 day course of an intravenous antibiotic to treat the wound infection. Observation on all days of survey identified a "Contact Isolation" sign on Resident #2's door. Observation on 01/26/11 at 8:15 a.m. showed a nursing staff member (#3) changed a dressing on Resident #2's left achilles ulcer. The staff member (#3) washed his hands with soap and water, donned disposable gloves, and cleaned the surface of the resident's bedside table with a "CaviWipe" towelette (a surface disinfectant) and placed the dressing change supplies on the table. The staff member removed the self-adherent Coban wrap from around Resident #2's foot and then the xeroform dressing from the ulcer. Observation showed a large piece of eschar hanging from the open ulcer and a moderate amount of brownish drainage. The staff member removed the eschar hanging from the ulcer by cutting it with a scissors. Without changing gloves, the staff member opened the xeroform dressing package and applied the new dressing to the wound bed. The staff member (#3) opened the package of gauze dressing, wrapped it around the wound, and then applied the Coban wrap. At the end of the entire procedure, the staff member removed his gloves and washed his hands. - Review of Resident #3's medical record occurred on January 24-27, 2011. The facility admitted the resident in 07/10. Current diagnoses included diabetes mellitus, bilateral lower extremity ulcers prior to admission, and cellulitis	F 441		

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F 441	Continued From page 42 of the left foot (01/24/11). The resident's medical record identified "Standard Precautions" regarding infection control. Resident #3's Nurse's Notes and Communication notes, dated January 23 and 24, 2011, identified his left second toe as "edematous, bright red, and purulent drainage." Physician's orders included dressing changes to both feet two times each day and, dated 01/24/11, an antibiotic for left second toe "infection." The resident's care plan, dated 09/27/10, stated "Focus, Pressure Ulcer: [Resident #3] has a stage III pressure ulcer to left heel and stage III pressure ulcer to the right heel. [Modified] 12/28[/10], 2 Diabetic ulcers to bottom of L [left] foot near toes located in plantar area of foot. . . . Interventions . . . Treatment as ordered. . . .," and dated 01/25/11, stated "Focus, Infection related to cellulitis of the left second toe . . . Interventions, Administer antibiotics as ordered . . . treatments as ordered . . ." Observation showed a licensed nursing staff member (#3) performed dressing changes to Resident #3's feet with the resident seated in his wheelchair in his private room, and the following: *01/25/11, 8:50 a.m. - Staff member (#3) closed the door to the room, washed his hands, donned clean gloves, wiped the the bedside table with Cavi wipes, and placed a plastic tub containing the resident's dressing materials on the bedside table. The staff member (#3) removed the resident's left sheepskin boot, removed a dry gauze dressing from the left foot, revealing open areas at the left heel, the plantar surface of the foot and the top of the second toe. The staff member (#3) sprayed gauze pads with Cavilon	F 441		

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F 441	Continued From page 43	F 441		

cleanser, and wiped the open areas. Wearing the same gloves, the staff member (#3) opened a jar of Aquaphor ointment, dipped his gloved hand into the jar to remove ointment, applied Aquaphor to the intact skin areas of the left foot, applied Santyl ointment to the open areas, dry gauze pads to the open areas, roller gauze to the left foot, a gauze pad to the left toe, and the sheepskin boot to the left foot. The staff member (#3) then removed his gloves, washed his hands, and donned a clean pair of gloves.

The staff member (#3) removed the dressing from the right foot, revealing healed areas on the plantar surface and an area on the heel with a thin layer of skin and no open areas. The staff member (#3) sprayed Cavilon cleanser on gauze pads and wiped the heel. Wearing the same gloves, the staff member (#3) dipped his gloved hand into the Aquaphor ointment and applied Aquaphor, roller gauze, and the sheepskin boot to the right foot. The staff member (#3) then removed his gloves and washed his hands.

*01/26/11, 7:40 a.m. - Staff member (#3) completed Resident #3's dressing change to the left foot, applied roller gauze to the left foot, a gauze pad to the left toe, a sock to the left foot, and applied a sheepskin boot to the left foot. The staff member (#3) then removed his gloves and washed his hands. The staff member (#3) reported he performed the dressing changes, including applying the cleanser to the open areas and the Aquaphor ointment to the left foot, as he did during the observation on 01/25/11 at 8:50 a.m.

The staff member (#3) then donned clean gloves, removed Resident #3's right sheepskin boot,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355123	A. BUILDING _____ B. WING _____	C 01/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 44 sock, roller gauze dressing, and wiped the heel area with Cavilon cleanser. Wearing the same gloves, the staff member (#3) dipped his gloved hand into the Aquaphor ointment, applied Aquaphor to the foot, applied the roller gauze, sock, and sheepskin boot to the right foot. The staff member (#3) then removed the gloves and washed his hands. During these observations staff member (#3) failed to wash his hands and change his gloves after contact with the infected left foot and toe, before using the Aquaphor ointment, and before applying the clean dressings to the left foot. This failure potentially continued to re-introduce the infectious organism to the left foot, delaying healing of the left foot, potentially contaminated the Aquaphor ointment, and contributing to infection of the right foot. During interview, on 01/27/11 at 2:30 p.m., an administrative nursing staff member (#1) and two supervisory nursing staff members (#2 and #4) confirmed and agreed staff member (#3) should have changed gloves after removing the residents' dressings, eschar, and cleansing the ulcers.	F 441		