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

PRINTED: 02/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355123	A. BUILDING _____ B. WING _____	02/06/2014

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 started on 02/03/14 and completed on 02/06/14, the sample included 5 residents for complete review, 15 residents for focused review, and 3 closed records. The sample included 5 additional residents to verify specific concerns during the survey.	F 000	1. Immediate education and coaching was done with individual staff caring for residents # 12, #17, #24, and #25. Education was also completed through shift to shift report and with 1:1 education for staff working and administering insulin during the survey process. 2. Residents who receive insulin via Novolog Flex Insulin pens have the potential to be affected by this practice. 3. Bethany on 42nd will provide education to nurses and CMA's in the following matter: a. Healthcare Academy online education session developed for Nurses and CMAs. **(Attachment A)** This will be completed by March 13th, 2014 and then annually. b. Education will be provided at Unit Meetings on March 12th, 2014. **(Attachment B)** c. The policy on Insulin administration was changed to reflect updated priming instructions. **(Attachment C)** 4. Audits will be conducted 1x/week for 4 weeks by the Nurse Manager Team and then monthly by our Quality and Education Department. **(Attachment D)** 5. March 13th, 2014	
F 281 SS=B	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to properly administer medication during 6 of 7 observations of insulin administration (Resident #12, #17, #24, and #25). Failure of facility staff to follow the manufacturers's instructions of properly "priming" (a procedure to expel the air from the needle) the insulin pen (a small pen shaped device prefilled with insulin) prior to giving the injection has the potential for residents to receive the incorrect dose of insulin. Findings include: Review of the "Prefilled Insulin Delivery Device User Manual," occurred on 02/06/14. These manufacturer's instructions, dated April 17, 2009, stated, " . . . follow all of these instructions carefully. If you do not follow these instructions completely, you may get too much or too little insulin. . . . Hold the Pen with the needle pointing	F 281		

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

CEO | 2-20-14

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 281	Continued From page 1 up and remove the outer needle shield. . . . Remove the inner needle shield . . . Prime every time. The Pen must be primed to a stream of insulin (not just a few drops) before each injection to make sure the Pen is ready to dose. Turn the dose knob clockwise until the number '2' is seen in the dose window. . . . Hold your Pen with the needle pointing straight up. . . . You should see a stream of insulin come out the tip of the needle. . . ." - On 02/03/14 at 5:28 p.m., observation showed a licensed nurse (#1) obtained Resident #12's NovoLog 70/30 FlexPen, attached a needle, dialed the dose to two units, pointed the insulin device approximately 10 degrees downward from a horizontal position, and pushed the button to complete the air shot (primed the device). Resident #12's dose of 65 units required two injections. Following the first injection of 60 units, the nurse (#1) attached a new needle to the FlexPen, dialed the dose to two units, held the device horizontally, and pushed the button to complete the air shot. - On 02/03/14 at 5:40 p.m., observation showed a licensed nurse (#3) prepared Resident #17's NovoLog FlexPen, attached a needle, dialed the dose to two units, held the insulin device horizontally, and pushed the button to complete the air shot. - On 02/03/14 at 5:52 p.m., observation showed a licensed nurse (#1) obtained Resident #25's NovoLog FlexPen, attached a needle, dialed the dose to two units, held the insulin device horizontally, and pushed the button to complete the air shot.	F 281		

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F 281	Continued From page 2 The nurses (#1 and #3) failed to point the FlexPen in an upward direction when performing the air shots, which failed to ensure the expulsion of air bubbles within the insulin. - On 02/04/14 at 8:10 a.m., observation showed a certified medication aide (CMA) (#4) prepared Resident #24's Levemir FlexPen, attached a needle, dialed the dose to two units, held the insulin device horizontally, and without removing the needle cap pushed the button to complete the air shot. - On 02/04/14 at 8:15 a.m., observation showed a CMA (#4) prepared Resident #24's NovoLog FlexPen, attached a needle, dialed the dose to two units, pointed the insulin device approximately 10 degrees downward from a horizontal position, and without removing the needle cap pushed the button to complete the air shot. The CMA (#4) failed to point the FlexPen in an upward direction when performing the air shots, which failed to ensure the expulsion of air bubbles within the insulin; and failed to remove the needle cap to visualize the insulin at the needle tip. During an interview on 02/05/14 at 8:05 a.m., a nurse manager (#2) stated staff are to prime a FlexPen by dialing two units and expel the air while holding the pen upright.	F 281		