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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355047	A. BUILDING _____ B. WING _____	05/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD ON BROADWAY	1351 BROADWAY FARGO, ND 58102

(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 May 17, 2010, and completed on May 20, 2010, the sample included 5 residents for complete review, 15 residents for focused review, and 3 closed records for review. In addition, 3 residents were added to the sample to verify specific concerns during the survey.	F 000		
F 241	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/30/09. Based on observation, record review, professional literature, and staff interview, the facility failed to provide care in a manner which enhanced the individual resident's dignity for 3 of 20 sampled residents (Resident #12, #17, and #19). Failure to provide residents with draping during bathing, failure to change wet garments, and failure to address residents in a respectful manner does not promote care in a dignified manner. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding privacy and confidentially which states	F 241	F 241 1 Educate RA's involved in Resident #5, #12, #17, #19 care on enhancing the Residents dignity. 2. All residents are identified as having potential to be affected. 3 Educate all staff on Rosewoods Standards of Care in dignity and privacy. 4. Date of correction is 6-27-10 5. The Quality Nurse will monitor monthly X 3 months and than quarterly X2 than PRN. The QA Nurse will submit a report of monitoring to the QA quarterly meeting.	6/27/10 6/27/10 6/27/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: President & CEO (X6) DATE: 7/19/2010

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 241	Continued From page 1 personal privacy includes accommodations, medical treatment and personal care. Facility staff must examine and treat residents in a manner that maintains the privacy of their bodies. A resident must be granted privacy when going to the bathroom and in other activities of personal hygiene. If an individual requires assistance, authorized staff should respect the individual's need for privacy. Staff should pull privacy curtains, close doors, or otherwise remove residents from public view and provide clothing or draping to prevent unnecessary exposure of body parts during the provision of personal care and services. - Observation on 05/20/10 at 9:00 a.m. showed a certified nurse assistant (CNA) (#5) provided a bed bath to Resident #17 in bed in her room. After Resident #17 washed her face and arms, the CNA (#5) then removed the resident's gown, leaving Resident #17 totally exposed throughout the remainder of the bath. During the bath the CNA (#5) left the resident's bedside five times to dispose of soiled linens, obtain clean wash cloths, or wash her hands between tasks. At one point a knock occurred at the door and the resident attempted to cover herself with the bed protector she was lying on. Observation showed the resident used her arms to cover her chest, the CNA failed to offer any draping. At another point, Resident #17 hugged herself, stating she was getting cold, and was not offered any cover up by the CNA (#5). During an interview with Resident #17 on 05/20/10 at 11:20 a.m., Resident #17 stated, "They usually give me a warm towel to cover up with, but did not today. It was a little chilly with the air conditioner blowing on me."	F 241		

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F 241	Continued From page 2 During an interview with an administrative staff member (#2) on 05/20/10 in the afternoon, the staff member stated the CNA should have covered the resident during the bathing procedure. - Resident #12's record review occurred on May 18-20, 2010 and indicated diagnoses including moderate mental retardation and episodic mood disorder. The resident's Minimum Data Set (MDS) indicated moderate impairment with decision making requiring cues and supervision, short term memory loss, mood and behavior problems, and persistently seeks attention. The current care plan indicated "Focus- . . . history of socially inappropriate with yelling at times, Hx [history] of verbal and physical abuse. Interventions- If [resident #12's name] is verbally and/or physically abusive, . . . inform her that her behavior is not appropriate." Observation on 05/18/10 at 7:55 a.m. showed two CNAs (#5) and (#14) provided toileting and incontinence cares for Resident #12. Observation showed the resident yelling and using profanity. The CNAs assisted the resident in to bed with a Hoyer lift (a total lift device), following toileting, applied a new brief, and dressed the resident. The resident stated, "It's all wet here, it's all wet." The resident identified the bed surface beneath her. The CNA (#5) observed the resident's pants wet and stated, "Now we're going to have to change her pants." The CNAs (#5 and #14) turned the resident from side to side, removed a (urine soaked) turning blanket and placed a new blanket beneath the resident. The CNAs failed to change the resident's urine soaked pants.	F 241		

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F 241	Continued From page 3 The resident stated she wanted to get up. The CNA (#5) stated, "No, you're going back to bed." The resident stated she did not want to go back to bed and asked why she had to. The CNA (#5) stated, "Because you're crabby." Failing to change Resident #12's urine soaked clothing, and identifying Resident #12 as "crabby" is not dignified. - Observation on 05/20/10 at 9:00 a.m. showed a CNA (#5) provided a bed bath to Resident #19. The CNA removed the resident's top bed sheet and gown. The resident's entire body remained exposed throughout the bath, including when the CNA left the bedside, on a number of occasions to obtain bath items or to wash her hands. The CNA did not attempt to cover the resident's body at any time. An interview with an administrative nursing staff member (#2) occurred on the morning of 05/20/10. The staff member agreed facility staff should not expose a resident during bathing, and should not have left Resident #12 in wet garments.	F 241		
F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		6/27/10

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F 279	Continued From page 4 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policies and procedures, review of professional literature and staff interview, the facility failed to develop and/or review and revise the residents' comprehensive plan of care to address specific problems for 3 of 20 sampled residents (Resident #1, #4, and #5). Failure to develop, review and revise the residents' care plans limits the staff's ability to communicate changes in the residents' status and care, and to ensure continuity of resident care. Findings include: Review of the facility policy titled "Infection control documentation" occurred on 05/20/10. The policy, dated 05/20/96, revised January of 2010, stated, - "POLICY: All residents who experience symptoms of infection will receive appropriate treatment and follow up. Infection report forms will be initiated by the nurse at the onset of symptoms and the care plan initiated. . . . 3) All nurses will: A. Enter additional symptoms on the infection care plan form as they arise, revise the charting schedule and infection	F 279	F 279 1 Revise and update the care plans for Residents #1, #4, and #5. 2. All residents are identified as having potential to be affected. 3. Revise the care plan policy and Educate all care planning staff (Nursing, Case Management, Dietary) 4) Date of correction is 6-27-10 5. The Quality Nurse will monitor monthly X 3 months and than quarterly X2 than PRN. The QA Nurse will submit a report of monitoring to the QA quarterly meeting.	6/27/10 6/27/10

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F 279	Continued From page 5 care plan as necessary. . . . 5) The nursing manager/clinical support nurse on each floor will monitor for appropriate completion of forms, . . ." - Resident #1's medical record reviewed on all days of survey, indicated the resident had returned from the hospital stay on 04/30/10. Progress notes dated 04/30/10 at 17:59,[military time] [5:59 p.m.] stated, ". . . MRSA noted in nares on 04/26, . . . Wear gloves and gown only for cares that will require contact with the skin/bedding due to shingles that have some areas of weeping still. 22:00 [military time] [8:00 p.m.] ". . . Shingles to (L) [left] axilla and upper back. Back has areas that are open with some drainage noted." Resident #1's current care plan, dated 04/14/06, and reviewed by the facility staff on 04/30/10, failed to address the MRSA and weeping shingle lesions. The care plan lacked infection control interventions for staff to follow when providing care for Resident #1. During an interview with an administrative staff member (#3) on 05/19/10 at 2:45 p.m., she verified the care plan did not address MRSA, or the necessary precautions for staff to follow when providing cares to Resident #1. -The American Medical Directors Association, Managing Diabetes in the Long-Term Care Setting, Clinical Practice Guideline, 2002, page 16, stated "Develop an individualized care plan and define treatment goals. The physician and nursing staff, with input from all disciplines, should coordinate development of the care plan related to diabetes management. It is important	F 279		

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F 279	Continued From page 6 that the patient's individual goals and preferences are incorporated into the care plan. . . . Key components of the care plan (e.g., glucose monitoring, meal plan, activity and physical therapy, treatment with oral antidiabetic agents and/or insulin, foot/wound care, and pain management) should be clearly documented in the physician's orders." Review of Resident #4's medical record occurred May 17-20, 2010. The care plan, dated 04/15/10, identified the following: "Focus: Alteration in Nutrition; dx [diagnosis] of IDDM [insulin dependent diabetes mellitus] - refuses diabetic diet, . . . Goals: Intake will remain 75-100% most meals and snacks. Blood glucose levels will be acceptable to MD [medical doctor]. . . . Interventions: Description: . . . SF [sugar free] condiments. . . ." Resident #4's care plan interventions failed to address the monitoring of the resident's blood sugars, yet states in the goals the MD will find the the resident's blood sugars acceptable. The care plan fails to identify: * established acceptable blood sugar parameters (either following facility protocol, or acceptable levels per the MD) * observing for signs and symptoms of hypo- or hyper-glycemia, * the resident's risk for developing symptomatic/asymptomatic hypoglycemia. - Review of Resident #5's medical record occurred May 18-20, 2010. The resident's diagnoses included diabetes type II, left heel pressure ulcer stage II, chronic kidney disease, glaucoma with vision loss, and mild cognitive	F 279		

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F 279	Continued From page 7 impairment. The facility admitted the resident in November 2009 with physician's orders including, "use standing orders" for diabetes monitoring and/or treatment. Resident #5's medication administration record (MAR) identified the resident received Levemir insulin until 12/05/09. Then the physician ordered Amaryl (an oral hypoglycemia medication) 2 milligrams (mg) from 12/05/09 until 12/09/09. The physician reduced the Amaryl to 1 mg on the afternoon of 12/09/09 and discontinued the Amaryl on 12/10/09. A physician's order, dated 12/07/09, stated, "Levaquin 500mg po [by mouth] QOD [every other day] (Q 48 hrs) [every 48 hours] x [times] 1 more week- pneumonia." The physician discontinued the Levaquin on 12/10/09 due to the potential adverse reaction of hypoglycemia. Each of these medication changes occurred in relation to low blood sugar readings obtained by facility staff. The resident's current care plan, initiated and revised on 12/02/09, stated the following: "FOCUS- NIDDM [non-insulin dependent diabetes mellitus] and Chronic Kidney Disease stage 3-4. GOAL- Blood sugars will remain at levels acceptable to provider. INTERVENTIONS- Blood sugars as ordered. Lab work as ordered. Medications as ordered. Diet as ordered. Observe for signs and symptoms of hypo-hyper glycemia and treat per orders/facility protocol. Consult provider as needed." The resident's care plan failed to identify acceptable blood sugar parameters (either following facility protocol, or acceptable levels per the MD), identify what signs and symptoms this resident displayed with hypo-hypglycemia, how to approach this problem, and measures facility staff should implement.	F 279		

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F 279	Continued From page 8 Refer to F 309.	F 279		
F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional literature, and staff interview, the facility failed to provide the necessary care and services for 1 of 4 sampled diabetic residents (Resident #5) who experienced severe hypoglycemic reactions. This resulted in delayed treatment from the onset of a recognized symptomatic hypoglycemic reaction, and the administration of oral glucose interventions to Resident #5 during an unresponsive, hypoglycemic episode. In addition, this has the potential to affect all residents (specifically diabetic) at risk for hypoglycemic reactions residing in the facility. Findings include: Review of the facility standing orders titled "Diabetes Monitoring and/or Treatment" occurred on 05/20/09. The standing orders, dated June 2009, stated, "Facility protocol. If no protocol: 1. Blood glucose check PRN [as needed] nurse discretion. 2. Glutose 1/2 - 1 tube oral. Repeat in	F 309	F 309 1 Educate the Nurses that care for Residents ~~#4, and~~ #5 about Hypoglycemia. 2. All Diabetic residents are identified as having potential to be affected. 3. Revise Diabetes monitoring policy and Educate Nursing Staff. 4. Date of correction is 6-27-10 5. The Quality Nurse will monitor monthly X 3 months and than quarterly X2 than PRN. The QA Nurse will submit a report of monitoring to the QA quarterly meeting.	6/27/10 6/27/10

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F 309	Continued From page 9 10 minutes as needed. 3. Glucagon 1 mg [milligram] subcutaneous x 1 for symptomatic hypoglycemia plus BS [blood 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 the facility guidelines titled "Guidelines for Hypoglycemia" occurred on 05/20/09. The guidelines, undated, stated: "Symptoms of Hypoglycemia: Dizzy or shaky, Sweating, Nervous, Weakness, Headache, Hunger, Trouble Speaking Advanced Symptoms (BS 50 or less): Confusion, Drowsiness, Coma, Seizure Treatment of Hypoglycemia: If blood sugar falls below 70 ml [sic] [milliliters]/dl [deciliter] and is symptomatic treat with a fast-acting 15 g [grams] of carbohydrates: - 1/2 cup (4 oz. [ounces]) fruit juice or regular soda - two jelly packets (Don't use cookies, ice cream, sherbet, sandwich, etc. as sugar combined with fat or protein absorbs too slowly) If resident can't or won't take oral treatment or is not responding to oral treatment, glucagon should be administered. Once the acute episode has been treated and if it is > [more than] 30 minutes to next meal or snack, a long-acting carbohydrate should be consumed such as 1/2 sandwich, toast [with] cheese, etc. If symptoms continue, call the doctor." The 29th edition of The Nursing 2009 Drug handbook by Lippincott, Williams & Wilkins, pages 1055-1056 identified Glucagon as indicated for hypoglycemia and defined the	F 309		

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F 309	Continued From page 10 following nursing considerations: "Use drug only in emergency situations. Monitor glucose level before, during, and after administration. ALERT: Arouse patient from coma as quickly as possible, and give additional carbohydrates orally to prevent secondary hypoglycemic reactions. . . . PATIENT TEACHING . . . Explain importance of calling prescriber immediately in emergencies. Teach patient and caregivers how to prevent hypoglycemia." Managing Diabetes in the Long-Term Care Setting, Clinical Practice Guideline, American Medical Directors Association (AMDA), 2002, stated ". . . Treating Hypoglycemia, Hypoglycemia is defined as a blood glucose level less than 60 mg/dl [milligrams per deciliter]. Symptoms may or may not be present . . . Hypoglycemia is the most feared short-term complication of treatment for diabetes. If not properly recognized and treated it can result in long-term disability, particularly in cognitively impaired individuals. . . . It is recommended the physician be called as soon as possible when: The patient has a blood glucose value < [less than] 60 mg/dL OR <75 mg/dL if the patient has signs and symptoms suggestive of hypoglycemia. (Treatment of symptomatic hypoglycemia should not be delayed.) . . . The patient has not eaten well or consumed sufficient fluids for 2 or more days and has one or more of the following additional symptoms: fever, hypotension, lethargy or confusion, abdominal pain, or respiratory distress. When the patient shows a consistent pattern of poorly controlled or deteriorating blood glucose levels, notify the physician . . ." The 29th edition of The Nursing 2009 Drug	F 309		

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F 309	Continued From page 11 handbook by Lippincott, Williams & Wilkins, pages 215-218, indicated a potential metabolic adverse reaction for Levaquin is hypoglycemia. - Review of Resident #5's medical record occurred May 18-20, 2010. The resident's diagnoses included diabetes type II, left heel pressure ulcer stage II, chronic kidney disease, glaucoma with vision loss, and mild cognitive impairment. The facility admitted the resident in November 2009 with physician's orders including, "use standing orders" for diabetes monitoring and/or treatment. The resident's current Minimum Data Set (MDS), dated 03/02/10, identified the resident with short term memory problems and moderately impaired in daily decision making. Resident #5's medication administration record (MAR) identified the resident received Levemir insulin until 12/05/09. Then the physician ordered Amaryl (an oral hypoglycemia medication) 2 mg starting on 12/06/09. The physician reduced the Amaryl to 1 mg on the afternoon of 12/09/09 and a physician order discontinued the Amaryl on 12/10/09. A physician's order, dated 12/07/09, stated, "Levaquin 500 mg po [by mouth] QOD [every other day] (Q 48 hrs) [every 48 hours] x [times] 1 more week- pneumonia." The physician discontinued the Levaquin on 12/10/09 due to the potential adverse reaction of hypoglycemia. The resident's current care plan, initiated and revised on 12/02/09, stated the following: "FOCUS- NIDDM [non-insulin dependent diabetes mellitus] and Chronic Kidney Disease stage 3-4. GOAL- Blood sugars will remain at levels acceptable to provider. INTERVENTIONS- Blood sugars as ordered. Lab work as ordered. Medications as ordered. Diet as ordered. Observe	F 309		

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F 309	Continued From page 12 for signs and symptoms of hypo-hyper glycemia and treat per orders/facility protocol. Consult provider as needed." Resident #5's Dietary Progress Notes, dated 12/08/09 at 11:28 a.m., stated "Providing res. [resident] with regular diet order instead of AQDA [sic] to encourage acceptance of food. Res commented to me at brunch that she didn't know what she was eating d/t [due to] poor sight." Resident #5's progress (nurses) notes stated the following on 12/08/09: * 6:05 a.m.: "Data: Blood sugar 66. Action: Gave 5 oz [ounces] orange juice. Response: 0640 [6:40 a.m.] Blood sugar 106. * 11:50 p.m. ". . . res [residents] blood sugar at 4 pm [p.m.] was 58, resident had 120 ml of orange juice, resident had staff sit with her at evening meal, resident finished less than 25% of meal, stating 'i have no appetite', residents blood sugar after evening meal was 63, resident c/o [complains of] 'feeling tired', staff sat with resident for hs [bedtime] snack of toast with peanut butter, and 240 ml of orange juice, resident needed much encouragement to eat snack. . . ." Resident #5's progress notes stated the following on 12/09/09: * 10:20 p.m., "At 4 pm residents blood sugar was 47, resident was alert and oriented. Orange juice and 2 sugar packets give [sic] to resident, at 5:30 blood sugar up to 70 and at 6:30 up to 90. At 9:30 pm resident found unable to verbally respond to questions, eyes open, pupils reactive, unable to follow simple commands. Glucagon [injection used for the emergency treatment of hypoglycemia] given IM [intramuscularly] for blood sugar of 42. At 10 pm Blood sugar was up to 90	F 309		

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	355047	A. BUILDING _____ B. WING _____	05/20/2010

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F 309	Continued From page 13 and at 10:20 pm up to 118. Resident was alert and oriented, able to verbally respond appropriately and did not remember the earlier events. Resident stable at this time. Will continue to monitor and assess closely. . . Action: Glucagon 1 mg given Im [IM], and buccal [sic]. Resident's daughter . . . notified. DC'd [discontinued] Amaryl 1 mg per family request. . . . Response . . . daughter . . . requested that PA [physician's assistant] get in touch with her on . . . 12/10/09." Resident #5's progress notes stated the following on 12/10/09: * 3:41 a.m.: "0150 [1:50 a.m.] RA reported res not responding verbally, eyes open, offered water et res blew into straw rather than sucked. 0155 [1:55 a.m.] BS 35, res [resident] eyes open not focusing on this nurse, Glucagon 1 mg given IM . . . checked BS 0200 [2:00 a.m.] 33, gave 3 cc [cubic centimeters] glucose SL [sublingual]. 0210 [2:10 a.m.] BS 50 beginning to make some eye contact. 0215 [2:15 a.m.] BS 77 making good eye contact no words but making verbal noise, gave remainder of glutose gel to swallow. 0230 BS 103 res alert responding verbally et denies pain, informed her of what was happening, 0250 gave 6 oz skin [sic] milk to drink and 3 squares of cheese to eat. 0330 had drank 3 oz of milk and ate 1 square of cheese refuse [sic] remainder BS 133 . . ." * 6:48 a.m., "BS @ 0600 46 8 oz glass of OJ given 0630 BS 78." * 1:45 p.m., "Data: Resident was hypoglycemic during the morning. Blood sugar was taken at 9 am [a.m.] and it was 42, resident was unresponsive, mumbled speech, lethargic, sweaty, ect [sic]. Was able to get in some jelly and sugar but swallowing was weak. Raised the	F 309		

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F 309	Continued From page 14 blood sugar to 57 at 9:35, resident was able to move hands, squeeze my hands, and was able to swallow a little better. At 9:50 resident was still hypoglycemic, gave 1/2 tube of Glutose 15. At 9:55 am resident still was not responding well and gave the other 1/2 tube of Glutose 15. At 10:06 blood sugar was 51. At 10:10 am gave shot of glucagon. At 10:15 blood sugar was 73, resident was responding well and was holding a drink in hand and drinking it herself slowly. . . . Action: No glucagon was in house, ordered from pharmacy immediately and needed STAT [very immediate], attempted to give jelly resident unable to swallow, sugar was given under the tongue, glutose 1/2 tube was given, after 10 minutes other 1/2 was given, glucagon given at 9:50 am, resident responded. Response: See physician orders, family updated, will continue to monitor." The progress notes identified the physician orders included to discontinue the Levaquin and Amaryl and "Reason for order: hypoglycemic reactions, family request." The physician progress notes, dated December 14, 16, and 21, 2009, failed to address the above incidents of hypoglycemia. Observation on the afternoon of 05/18/10 identified the Emergency Kit (emergency medication kit) utilized by the facility contained two doses of injectable Glucagon. An interview with an administrative staff member (#16) occurred the afternoon of 05/18/10. The staff member stated the only emergency medication box containing Glucagon for the facility was at the nurses station on the second floor (the facility has three floors). When asked if	F 309		

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F 309	Continued From page 15 she knew how many diabetics lived in the facility, she stated she only knew of the diabetics on her unit. The staff member agreed two Glucagon for the entire facility was likely insufficient. An interview occurred on 05/20/10 at 10:30 a.m. with an administrative staff member (#2). She stated medications are available from an off site pharmacy 24/7 (24 hours per day and 7 days per week). The staff member stated she recalled the incident when the facility ran out of Glucagon. She stated at the time of the incident, she believed the facility stocked one Glucagon in the emergency kit and after the incident, the facility began stocking two Glucagon. The facility failed to recognize risk factors related to Resident #5's use of injectable and oral diabetic agents, poor oral intake, and recurrent low blood sugar recordings between December 08-10, 2009. The facility expended all available stock of Glucagon after administering two injections and failed to ensure immediate access for additional Glucagon during a third episode of severe hypoglycemia experienced by Resident #5 in less than a 24 hour period. This resulted in delayed treatment (between 50 and 70 minutes) from the onset of a recognized symptomatic hypoglycemic reaction at 9:00 a.m. on 12/10/09, and the administration of oral glucose interventions to Resident #5 during an unresponsive, lethargic, hypoglycemic episode.	F 309		
F 356	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date.	F 356		

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F 356	Continued From page 16 o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the total number and the actual hours worked by licensed and unlicensed staff directly responsible for resident care and failed to post the resident census observed for 4 of 4 days of survey (May 17-20, 2010). Findings include: Observations on all days of survey (May 17-20,	F 356	F 356 1) Correction to posting of Nurse Staffing made 2) All residents are identified as having potential to be affected. 3) Staffing Coordinator was educated on the required information needed in the posting. 4) Date of correction is 5-21-10 5) The Quality Nurse will monitor monthly X 1 months and than quarterly X2 than PRN. The QA Nurse will submit a report of monitoring to the QA quarterly meeting.	5/21/10 6/27/10

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F 356	Continued From page 17 2010) identified staffing data posted near nursing stations on each floor included first names of nursing staff and staff not directly responsible for resident care, such as housekeeping staff. An interview with a nursing service manager (#15) occurred on 05/18/10 at 2:00 p.m. The staff member (#15) verified the facility did not post the total number and actual hours worked by licensed and unlicensed staff nor the resident census as required. During an interview on 05/20/10 at 10:30 a.m., an administrative staff member (#2) agreed the facility failed to maintain the required posting of staff.	F 356		
F 369	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide plate guards in the correct position on 3 of 3 days observed (May 18-20, 2010) for 3 sampled residents (Resident #14, #18, and #20) and one supplemental resident (Resident #26) who utilize plate guards to aid in feeding themselves. Failure to position the plate guards correctly has the potential to contribute to possible weight loss and to negatively impact a residents dignity from spilling food off their plate. Findings include:	F 369		6/27/10

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F 369	Continued From page 18 A Plate Guard is an assistive device used to scoop food on to a utensil. The guard attaches to most plates and is commonly used by people who have controlled movement with only one hand. Food is pushed by a utensil against this wall-like device that curves along the edge of one side of the plate. During the survey, review of the medical records for Resident #14, #18, #20, and #26 identified the following: Quarterly Minimum Data Sets (MDSs) completed for Resident #14 on 02/18/10 and Resident #18 on 02/15/10 identified these residents utilized a plate guard under section K: Nutrition. Resident #14's current care plan, revised on 02/18/10, identified right sided weakness after a CVA (cerebrovascular accident) and a history of weight loss. Interventions identified at "self care deficit" stated "Eating: Resident eats in main dining room. Requires set up and uses plate guard." Resident #18's current care plan, revised on 02/22/10, identified right sided weakness secondary to a CVA and "a hx [history] of spilling food from plate and need adaptive equipment to help me to feed myself independently and with dignity. . . use . . .a plate guard w/ [with] meals." Resident #20's Occupational Therapy's (OT) "Therapy Daily/Weekly Documentation" identified the initiation of a plate guard on 03/19/10. Resident #20's current care plan, initiated on 03/16/10, identified a "CVA . . . resulting in (R) sided weakness . . ."	F 369	**F 369** **1.** Diet cards for resident #14, #18, #20, and # 26 were updated to indicate proper placement of plate guard. Staff serving meals to resident #14, #18, #20 and #26 will be educated on proper plate guard placement. **2.** All residents using a plate guard have the potential to be affected by improper placement. **3.** Policy on diet cards written to include information on the proper placement of plate guard. Staff members will be educated on proper placement of plate guard. **4.** The dietary coordinator will have audits completed on proper plate guard placement. These audits will be completed monthly for three months and quarterly thereafter for 6 months. If concerns are identified, immediate corrective action will be implemented. The dietary coordinator will report on the audits at the Quality Meeting. **5.** All Plan of Correction dates are indicated above.	6-22-10 6-22-10 6-18-10 6-22-10 6-27-10

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F 369	Continued From page 19 Resident #26's current care plan, revised on 03/18/10, identified ". . . right side flaccid after CVA . . . Uses plate guard. . ." The following observations identified staff's failure to position plate guards opening to the left side of the plate to accommodate the resident's use of their left hand for eating: On 05/18/10 at 10:40 a.m. - Resident #26 used a spoon and reached over the plate guard with her left hand to access her food. Staff positioned the opening of the plate guard to the right side of the plate. On 05/18/10 at 4:40 p.m. - Resident #26 used her left hand to reach over the plate guard for the food on her plate. Staff positioned the opening of the plate guard to the bottom right side of the plate. On 05/18/10 at 4:40 p.m. - Resident #20 reached over the plate guard with her left hand to obtain her food. Staff positioned the opening of the plate guard to the bottom right side of the plate. This positioning contributed to Resident #20 pushing some of the rice from her plate onto the table. On 05/19/10 at 4:25 p.m. - Resident #20's plate failed to have a plate guard on the plate throughout the meal. On 05/19/10 at 4:20 p.m. - Staff positioned Resident #18's plate guard with the opening to the top of the plate. Staff failed to position the plate guard to accommodate the use of Resident #18's left hand. On 05/19/10 at 4:30 p.m., Resident #14 used her	F 369		

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F 369	Continued From page 20 fork with her left hand and reached over the plate guard to access her food. Staff positioned Resident #14's plate guard with the opening to the top of the plate. On 05/20/10 at 10:15 a.m. - Staff positioned Resident #18's plate guard with the opening positioned to the right bottom of the plate. On 05/20/10 at 10:40 a.m. - Staff positioned Resident #20's plate guard with the opening positioned to the right side of the plate. During an interview on 05/20/10 at 10:30 a.m. and at 10:40 a.m., a dietary staff member (#1) observed the placement of the plate guards for Resident #18 and Resident #20 and confirmed the inaccurate positioning.	F 369		
F 425	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		6/27/10

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F 425	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility protocols, review of professional literature, and staff interviews, the facility failed to ensure the availability of Glucagon (used for the emergency treatment of hypoglycemia) for 1 of 1 sampled diabetic resident (Resident #5) who experienced a symptomatic hypoglycemic, diabetic reaction. Delayed acquisition of a medication impeded timely administration and could adversely affect a resident's condition. This places all resident at risk of harm requiring emergency medications for life saving events. Findings include: Facility standing orders, revised June of 2009, stated "Diabetes Monitoring and/or Treatment: 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 if needed. 3. Glucagon 1 mg [milligram] subcutaneous x 1 [one time] for symptomatic hypoglycemia plus BS (blood sugar) <50 and notify physician/extender of results. Re-check blood glucose within one hour and notify physician or [sic] results." The 29th edition of The Nursing 2009 Drug handbook by Lippincott, Williams & Wilkins, pages 1055-1056 identifies Glucagon indicated for hypoglycemia and identified the following	F 425	F 425 1) Educate the Nursing Staff that provide care for Resident #5 on the reporting procedure for emergency medications. 2) All residents are identified as having potential to be affected. 3) The reordering procedure will be will educated to all Nurses. 4) Date of correction is 6/27/10 5) The Quality Nurse will monitor monthly X 1 months and than quarterly X2 than PRN. The QA Nurse will submit a report of monitoring to the QA quarterly meeting.	6/27/10

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F 425	Continued From page 22 nursing considerations: "Use drug only in emergency situations. Monitor glucose level before, during, and after administration. ALERT: Arouse patient from coma as quickly as possible, and give additional carbohydrates orally to prevent secondary hypoglycemic reactions. . . . PATIENT TEACHING . . . Explain importance of calling prescriber immediately in emergencies. Teach patient and caregivers how to prevent hypoglycemia." - Review of Resident #5's medical record occurred May 18-20, 2010. The resident's diagnoses included diabetes type II and chronic kidney disease. Review of Resident #5's progress (nurses') notes identified the resident experienced hypoglycemic reactions on the following occasions: * On 12/09/09 at 4:00 p.m., record review showed a blood sugar of 47. At 9:30 p.m. ". . . resident found unable to verbally respond to questions, eyes open, pupils reactive, unable to follow simple commands. Glucagon given IM [intramuscularly] for BS of 42. . . ." * On 12/10/09 at 1:50 a.m.: "RA [restorative aide] reported res [resident] not responding verbally, eyes open, offered water et [and] res blew into straw rather than sucked. 0155 [1:55 a.m.] BS 35 Res eyes open not focusing on this nurse. Glucagon 1 mg given IM to right deltoid at 0155 [1:55 a.m.] . . ." * On 12/10/09 at 1:45 p.m.: "Resident was hypoglycemic during the morning. Blood sugar was taken at 9 am and it was 42, resident was unresponsive . . . lethargic, sweaty, ect [sic]. Was able to get in some jelly and sugar but swallowing was weak. . . . At 9:50 resident was still hypoglycemic, gave 1/2 tube of Glutose 15. At	F 425		

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F 425	Continued From page 23 9:55 am resident still was not responding well and gave the other 1/2 tube of Glutose 15. . . At 10:10 am gave shot of glucagon . . . Action: No glucagon was in house, ordered from pharmacy immediately and needed STAT [very immediate], attempted to give jelly resident unable to swallow, sugar was given under the tongue, glutose 1/2 tube was given, after 10 minutes other 1/2 was given, glucagon given at 9:50 am, resident responded. . . ." An interview with an administrative staff member (#16) occurred the afternoon of 05/18/10. The staff member stated the only emergency medication box containing Glucagon for the facility was located at one nurses station, on second floor. When asked if she knew how many diabetics lived in the facility, she stated, she only knew of the diabetics on her unit. The staff member agreed two Glucagon for the entire facility was likely insufficient. An interview occurred on 05/20/10 at 10:30 a.m. with an administrative staff member (#2). The staff member stated medications were available from an off site pharmacy 24/7 (24 hours per day and 7 days per week), and that pharmacy does deliveries to the facility every afternoon at about 2:00 p.m. The staff member stated she recalled the incident when the facility ran out of Glucagon. She stated, at the time of the incident, she believed the facility stocked one Glucagon in the emergency kit, and after the incident, the facility began stocking two Glucagon. Observation on the afternoon of 05/18/10 identified the Emergency Kit (emergency medication kit) utilized by the facility contained two doses of injectable Glucagon.	F 425		

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F 425	Continued From page 24 Failing to ensure the facility maintained an adequate supply and/or prompt replacement of a stock emergency drug, specifically glucagon, in this case, resulted in delay, and unsafe emergency measures, by facility staff providing care for Resident #5. This impeded timely administration of the emergency drug.	F 425		
F 441	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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		6/27/10

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	355047	A. BUILDING _____ B. WING _____	05/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD ON BROADWAY	1351 BROADWAY FARGO, ND 58102

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F 441	Continued From page 25 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 facility policy, review of professional literature, and staff interview, the facility failed to implement infection control practices consistent with facility policy and procedures for 1 of 1 sampled residents (Resident #1) reviewed for contact precautions, and 1 of 10 sampled residents (Resident #12) observed receiving incontinent cares. Failure to implement infection control practices has the potential to spread disease, and affect the health and safety of facility residents, staff, and visitors. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding infection control which states . . . Hand hygiene continues to be the primary means of preventing the transmission of infection. . . . Standard precautions include but are not limited to hand hygiene, and the proper use of gloves and gowns. Equipment or items in the resident environment likely to have been contaminated with infectious fluids or other potentially infectious matter must be handled in a manner so as to prevent transmission of infectious agents and must be properly cleaned before use on another	F 441	F 441 1) The Nursing Staff that provide care for Resident #1 and #12 will have infection control practices reviewed. 2) All residents are identified as having potential to be affected. 3) The Infection Control policy will be revised and all staff will be educated. 4) Date of correction is 6/27/10 5) The Quality Nurse will monitor monthly X 1 months and than quarterly X2 than PRN. The QA Nurse will submit a report of monitoring to the QA quarterly meeting.	6/27/10

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F 441	Continued From page 26 resident. . . . Review of the facility policy titled "Herpes Zoster" occurred on 05/20/10. This policy, dated February 2010, stated, "POLICY: Precautions will be observed for residents and staff to provide maximal protection from Herpes Zoster. . . . PROCEDURE: 1) Good handwashing is a must to prevent the lesions from becoming infected. . . . 4) The extent of the lesions has a direct bearing on how communicable the disease is. The more lesions the resident has the more potential there is for transmission. . . ." Review of the facility policy titled "Isolation Precautions (Transmission based precautions)" occurred on 05/20/10. This policy, dated November 2009, stated, "POLICY: Appropriate isolation precautions (transmission based precautions) will be followed according to current regulatory guidelines. OBJECTIVES: To reduce the transmission of pathogens from both 1) All residents will be cared for following "Standard Precautions" at all times. . . . 2) Transmission based precautions will be used for the care of specified residents with documented or suspected infections from highly transmissible or epidemiologically significant pathogens for which additional precautions beyond Standard Precautions are needed to interrupt the transmission of the pathogen. . . . C) Contact Isolation: Reduce the risk of transmission by direct skin-to-skin contact or indirect contact with a contaminated intermediate object (usually inanimate). . . . 2) Wear gloves when in direct contact with resident or contaminated materials. 3) Change gloves after having contact with infective material that may contain high concentrations of microorganisms. (fecal material	F 441		

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F 441	Continued From page 27 . . .). 4) Remove gloves before leaving the room. 5) Wash hands immediately. . . . 7) Wear a gown when entering th e room if: a. You anticipate that your clothing will have substantial contact with the resident, environmental surfaces, or items in the room. . . . 11). . . If use of common equipment is unavoidable, adequately clean and disinfect items before use on another resident. . . ." Review of the facility policy titled "Infection control documentation," occurred on 05/20/10. This policy,dated January 2010, stated; "POLICY: All residents who experience symptoms of infection will receive appropriate treatment and follow up. Infection report forms will be initiated by the nurse at the onset of symptoms and the care plan initiated. Clinical support nurses will assure that infection report forms are available on each nursing unit. . . . OBJECTIVES: 1) To assign accountabilities for infection reporting form and infection log. . . PROCEDURE: 1) Infection report forms are available in the file drawer on each unit for each of the following categories: . . . C. Skin . . . 2) The nurse who identifies the first signs of possible infection will: A. Initiate the infection care plan B. Make an entry for follow-up charting on the charting schedule. C. Place the infection report form in the treatment book. D. Enter the name of the resident on the report log. 3) All nurses will: A. Enter additional symptoms on the infection care plan form as they arise, revise the charting schedule and infection care plan as necessary. . . . 5) The nursing manager/clinical support nurse on each floor will monitor for appropriate completion of forms, . . ." - Review of Resident #1's medical record occurred May 17-20, 2010. The medical record indicated Resident #1 returned from the hospital	F 441		

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F 441	Continued From page 28 on 04/30/10 with methicillin resistant staphylococcus aureus (MRSA) in the nares and weeping shingles on left chest, axilla, and back. The medical record lacked evidence that nursing staff completed a skin infection assessment upon return from the hospital. Review of facility's infection log for April and May of 2010 identified Resident #1 had a respiratory infection which required contact precautions. The log failed to identify the presence of a skin infection, specifically for shingles. Resident #1's quarterly Minimum Data Set (MDS), dated 05/13/10, indicated the resident required extensive assistance with mobility and activities of daily living (ADL's), and a diagnosis of herpes zoster. The current care plan dated 04/30/10, failed to address precautions for the weeping lesions from the shingles. During a tour of the facility on 05/17/10 at 1:00 p.m., observation showed no evidence of contact precautions implemented for Resident #1. An administrative staff member (# 3) present at this time, failed to provide information regarding Resident #1's draining shingle lesions. Observation on the morning of 05/18/10 showed isolation supplies hanging on Resident #1's door. At 8:55 a.m., observation showed a certified nurse aide (CNA #4) removed her gown and gloves, and exited Resident #1's room to obtain a box of gloves. The CNA (#4) failed to wash her hands or perform hand hygiene before exiting the room. At 9:10 a.m., a CNA (#4) removed the mechanical lift from Resident #1's room without cleaning it with a recommended disinfectant. Observation showed the CNA transported the	F 441		

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F 441	Continued From page 29	F 441		

mechanical lift to Resident #2's room, and utilized it to assist Resident #2 into her chair. Review of Resident #2's care plan, dated 12/31/09, stated, "Please wash/santize [sic] your hands and equipment before working with me . . ." The facility staff failed to follow the care plan for Resident #2 addressing infection control.

On 05/18/10, at 9:20 a.m., observation showed a licensed staff nurse (#8) performed a dressing change to Resident #1's coccyx area. The licensed staff nurse (#8) donned gloves only. The licensed nurse leaned over the bed, and touched her uniform on the bed sheets. Observation showed visible drainage from shingle lesions on the bed sheets.

In an interview on the afternoon of 05/19/10, an administrative staff nurse (#3) verified the care plan failed to address interventions for Resident #1's skin infection. The staff nurse verified a skin infection assessment had not been completed when Resident #1 returned from the hospital. This staff nurse agreed staff should wash their hands before leaving the room, disinfect the mechanical lift before removing it from the room and using it on another resident, and don a gown when performing dressing changes.

In an interview on the morning of 05/20/10, an administrative staff nurse (#6) stated nursing is responsible to fill out the infection control assessments when an infection is identified. The nurse stated the data is collected monthly from the units and reviewed by the infection control nurse.

- Review of Resident #12's medical record occurred May 17-20, 2010. Medical diagnoses

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F 441	Continued From page 30 included multiple sclerosis, chronic allergic conjunctivitis, and allergic rhinitis. A Minimum Data Set (MDS), dated 02/24/10, identified the resident as requiring total assist of two or more persons with all ADL's. Observation on 05/18/10 at 3:30 p.m., showed CNAs (#12 and #13) transferred Resident #12 from a wheelchair to bed with a Hoyer lift (a total lift device). The CNAs removed the resident's pants, and CNA (#13) then removed Resident #12's urine soaked brief, without wearing gloves. The CNAs assisted the resident onto the toilet with the Hoyer lift. Resident #12 asked the CNAs if the facility had any Dr. Pepper soda. CNA (#13) exited the room without washing his hands and returned to Resident #12's room and stated that there was no Dr. Pepper, just rootbeer. Resident #12 is currently being treated with antibiotics for a contagious eye infection. Failure of the CNA (#13) to wash his hands following incontinence cares has the potential to spread infection to other residents, visitors, and staff.	F 441		