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AUG 17 2010
Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355037	A. BUILDING _____ B. WING _____	07/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALOISIUS MEDICAL CENTER NURSING HOME	325 E BREWSTER ST HARVEY, ND 58341

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on July 26, 2010 and completed on July 28, 2010, the sample included four (4) residents for complete review, eleven (11) residents for focused review, and three (3) closed records for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	Names, addresses and telephone numbers of the State Survey and Certification Agency, the Protection and Advocacy Network and the Medicaid Fraud Control Unit are posted on both Unit A and B on the bulletin boards outside each Dining Room. All residents have the potential to be affected by failure to post this information. The Social Services Director will monitor for posting twice monthly for one quarter and do random monitoring for the remaining three quarters.	7-30-10

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

PRESIDENT / CEO — 8/16/10

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 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements	F 156		

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F 156	Continued From page 2 specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post the names, addresses, and telephone numbers of all pertinent State client advocacy groups including the State Survey and Certification Agency, the Protection and Advocacy Network, and the Medicaid Fraud Control Unit on 2 of 2 nursing units (Unit A and Unit B). Failure to provide this information has the potential to limit residents' and families' access to these agencies. Findings include:	F 156		

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F 156	Continued From page 3 Observations on July 26-28, 2010, showed the facility failed to visibly post the required information for the State Survey and Certification Agency, the Protection and Advocacy Network, and the Medicaid Fraud Control Unit on nursing units A and B. During an interview the afternoon of 07/28/10, an administrative staff member (#4) verified the facility failed to post the required contact information on Unit B. An interview occurred the afternoon of 07/28/10 with an administrative staff member (#5). The staff member (#5) verified the facility failed to post the required contact information on Unit A.	F 156		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, review of facility policy and procedure, review of professional literature, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 insulin dependent resident (Resident #11) who experienced a hypoglycemic reaction requiring transfer to the local emergency room.	F 309	1. Resident #11 had insulin time changed from 6:30 am to 8:00 am to be given with her breakfast. 2. All residents on insulin have potential to be affected; all were reviewed for proper time of administration in regard to meal time. 3. a. A Protocol for Hypoglycemia was developed with the LRD for staff to follow in regards to Hypoglycemia and accepted at the Medical Staff meeting on August 11, 2010. These will be posted on the MARS.	

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F 309	Continued From page 4 Findings include: Review of the facility's standing orders occurred on July 27-28, 2010. The standing orders, dated 12/09/09, stated, "BLOOD GLUCOSE MONITORING: If accucheck is less than 60 or greater than 400, notify health Care professional. NOTIFY HEALTH CARE PROFESSIONAL IF ANY OF THE ABOVE SIGNS/SYMPTOMS PERSIT (sic) OR WORSEN." The 29th edition of the Nursing 2009 Drug Handbook by Lippincott, Williams & Wilkins, pages 1056-1059, stated the following: "Novolog insulin for control of hyperglycemia in patients with diabetes . . . Give 5 to 10 minutes before start of meal by subcutaneous injection . . . because of its rapid onset of action . . . SubQ [subcutaneous] route, Onset = 15 minutes, Peak = 1-3 hr [hour], Duration = 3-5 hr . . . Contraindicated during episodes of hypoglycemia . . . assess patient and notify prescriber for signs and symptoms of hypoglycemia . . ." Managing Diabetes in the Long-Term Care Setting, Clinical Practice Guideline, American Medical Directors Association (AMDA), 2002, stated, ". . . 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 . . . It is recommended the physician be called as soon as possible when: . . . 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 . . . When the patient shows . . . deteriorating blood glucose levels, notify the physician . . ."	F 309	b. Standing Orders for Glucagon 1mg IM or SQ were approved at the Medical Staff meeting on August 11, 2010 for blood sugar under 45 or unresponsive. These will be posted on the MARS. c. The Consultant Pharmacist created a chart outlining actions of the variety of insulin used. These will be placed on the MARS. d. Nurses will be educated on the above protocols, standing orders and actions of insulin at Nurse's Meetings on August 16th and on August 17th and minutes will be posted. 4. Completed August 17, 2010. 5. A QI monitor will be placed to check MARS for any blood sugars below 60 and note if correct protocol was followed, weekly times four then monthly times 3 and reviewed at quarterly QI for need of ongoing monitor. The DON and QI nurse are responsible.	8-17-10

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F 309	Continued From page 5 Review of Resident #11's medical record, July 26-28, 2010, identified medical diagnoses which included diabetes type II, atrial fibrillation, and heart disease. Resident #11's Admission Minimum Data Set (MDS), dated 05/19/10, identified the resident with no short or long term memory problems, no cognitive problems, and moderate independence with decision making. Current medications ordered for diabetes management included: Novolog insulin 35 units SubQ AC (before meals) every morning (6:30 a.m.), Novolog insulin 20 units SubQ AC 11:00 a.m., Novolog insulin 30 units SubQ AC 5:00 p.m., Lantus insulin 36 units SubQ at H.S. (hour of sleep) (9:00 p.m.), and a Novolog insulin sliding scale as needed. Resident #11's Care Plan, dated 05/17/10, stated, "PROBLEM: Potential for hypoglycemia . . . APPROACHES: medication as ordered, accuchecks as ordered, observe for signs and symptoms of hypoglycemia, . . . diabetic diet as ordered, monitor meal and snack intake daily, insulin as ordered." Resident #11's Nurses Notes on 06/22/10, identified the following: "0900 Resident lethargic ate only 50% of breakfast. 1030 accu [check] 40 [,] PRN [as needed] glutose gel given @ [at] that time. 1100 accu [check] rechecked 33 [,] PRN glutose gel given again. Resident went to ER [emergency room] via cart. . . ." Resident #11's Nursing Progress Notes, (utilized by supervisory staff nurse), on 06/22/10 stated the following: * "10 am [Resident's physician's name] notified of residents BS of 40 [and] that resident had been given glucotrol. Orders rec'd [received].	F 309		

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F 309	Continued From page 6 * 1030 [a.m.] [Resident's physician's name] notified of residents BS of 30, second dose of glucotrol administered. Orders rec'd to transport res [resident] to ER. [Resident's daughter's name] aware. * 11am Rec'd orders from [Resident's physician's name] to admit resident to acute care." The ER record identified Resident #11 arrived in the ER at 11:08 a.m. and the physician arrived at 11:12 a.m. The ER record identified the following: ". . . Chief Complaint: (down arrow) Blood sugar . . . ASSESSMENT: Neurological: Drowsy . . . Respiratory: . . . shallow . . . snoring . . . Nurses Notes: . . . 11:17 [a.m.] Glucagon given IM [intramuscularly] R) [right] UA [upper arm] . . . 11:20 [a.m.] BS @ 64 . . . 11:29 [a.m.] BS @ 85 . . . 12:10 p.m. D10LR [Dextrose 10% in Lactated Ringers] (a type of intravenous solution) given @ 150/hr [150 milliliters per hour] IV [intravenous] . . . 12:45 [p.m.] Pt [patient] moved to med [medical] floor for admit." Resident #11's hospital Admission History and Physical, dated 06/22/10, stated, "CHIEF COMPLAINT: Low blood sugar . . . This morning he [sic] got her insulin at about 6:30 but didn't get her breakfast until about 8 and therefore she has hypoglycemia down to 39 on one occasion and then to 40 after that and then a few more times. I got a call from the head nurse, [name of nurse], over on long term care at about 10 o'clock and we talked about what would be important to manage the patient in the future. I did not receive a request for Glucagon or any IV [intravenous] or IM [intramuscular] glucose. Apparently during that time the nurses were trying to give the patient oral D50 because they did not have an order for Glucagon or IV Dextrose. Apparently there was a	F 309		

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F 309	Continued From page 7 conversation between the nursing supervisor at the time and a nurse [nurse's name] and apparently the nurse [nurse's name] said I would have to call and given [sic] an order for the Glucagon before she would give it. It is interesting that I was on the phone with her supervisor at the time all of this was going on. In addition I didn't know I needed to call to get the Glucagon on board. We will want to consider in the near future getting standing orders to include Glucagon and IV glucose. Once the patient was in the ER, we did get an IV and she was given Glucagon and her sugars began to rise. . . . IMPRESSION: #1 Hypoglycemia . . . PLAN: The patient is admitted to the medical floor. . . ." Resident #11's hospital Physician Progress Notes, dated 06/23/10, stated, "I have personally interviewed and examined our patient, [Resident #11's name], today, June 23rd, 2010 as part of acute rounds. In addition I have reviewed her record including labs, treatments, x-rays, vitals, orders. . . . The patient . . . presented yesterday morning with hypoglycemia. She received her morning insulin and apparently the breakfast was late and she didn't eat it and was hypoglycemic down to 39 for much of the morning. . . . The patient is more alert today. She ate some breakfast. . . . IMPRESSION: #1 Hypoglycemia . . ." Resident #11's medication administration record (MAR), dated 06/22/10, identified the following blood sugars: * 6:30 a.m. - blood sugar [BS] of 60 * 11:00 a.m. - BS of 33 * 11:30 a.m. - BS of 40 Resident #11's MAR, dated 06/22/10, also	F 309		

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F 309	Continued From page 8 identified staff administered the following medications: * 6:30 a.m. - 35 units Novolog insulin SQ (subcutaneous) * 10:40 a.m. - Glutose gel * 11:00 a.m. - Glutose gel A daily report sheet, dated 06/22/10, identified Resident #11's accucheck BS at 11:00 a.m. was 40. The treatment record also indicated grape juice with sugar but did not specify what time staff administered it to the resident. An interview with Resident #11's family member (family member #1) occurred on 07/27/10 at 5:05 p.m. The family member recalled the events of 06/22/10, and stated, "I can tell you exactly what happened that day. They gave [Resident #11] her insulin and then they didn't feed her until over an hour later. She ended up in the ER because of it." The family member stated she was disappointed about what had happened to Resident #11. During an interview with an administrative nursing staff member (#2) on 07/27/10 at 9:40 a.m., she stated a supervisory nursing staff member (#6)had informed her about the hypoglycemia episode on 06/22/10 involving Resident #11. The administrative nursing staff member (#2) stated she'd spoken to the nursing staff involved with administering the insulin and agreed a blood sugar of 60 was on the borderline for holding the insulin and contacting the physician, but was still within the facility's protocol for not calling the physician for BS less than 60. She verified that there were no standing orders for Glucagon administration for severe hypoglycemia. An interview with Resident #11's primary	F 309		

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F 309	Continued From page 9 physician (#18) occurred on 07/27/10 at 10:45 a.m. The physician stated he recalled the events of 06/22/10 in regards to Resident #11's hypoglycemic episode and resulting transfer to ER. He stated the resident was having blood sugars in the 30's when he spoke to a nursing supervisor. He stated, "She [Resident #11] was given her insulin and she was not awake enough to eat. They were giving her Glutose to try and raise her blood sugars. It's not a good idea to give someone something to drink or eat when they aren't fully conscious." When asked what the resident's state was upon arrival to the ER, he stated, "I was in the ER when [Resident #11] arrived. She was having trouble responding. Once we gave her the Glucagon and got the IV going, she began to respond." An interview with a nursing staff member (#7) occurred on 07/28/10 at 10:25 a.m. She stated she had assisted in caring for Resident #11 on the morning of 06/22/10. She stated the resident was very lethargic, but would open her eyes a little bit when they called her name. The staff member stated the resident was unable to make a sentence, but could respond to yes or no questions. She stated the resident did not choke when swallowing the oral Glutose gel either time it was given. The interviews with facility staff members, the family interview, and the documentation in the Nurses Notes, Nursing Progress Notes, MAR, Emergency Room record, and Physician's Progress notes provide conflicting information in regards to the timing and details of Resident #11's hypoglycemic episode on 06/22/10. The facility failed to recognize the risk factors	F 309		

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F 309	Continued From page 10 involved with insulin administration to a resident with a low blood sugar, and failed to ensure timely provision of a meal following administration of insulin. Failure to assess and then, implement the appropriate interventions, resulted in the resident's transfer to the ER for treatment of hypoglycemia.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of professional literature, the facility failed to provide adequate supervision and assistance devices (foot pedals) for 3 of 14 sampled residents (Resident #1, #12, #13) and 3 supplemental residents (Resident #20, #21, #22) who required assistance with wheelchair transportation. Failure of the facility to ensure staff properly use assistance devices placed residents at risk for possible accident and/or injury. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 8th Edition, Pearson/Prentice Hall, Upper Saddle River, New Jersey, page 1145, states, ". . . Transferring	F 323	1. Screens for OT or PT were sent for residents #1, 12, 13, 20, 21 and 22 on August 10th for evaluation of necessity of pedals on wheelchairs when transporting these residents. Any recommendations were implemented into the resident's Daily Plan of Care. 2. All residents using wheelchairs have potential to be affected. 3. a. A policy was developed by PT for wheelchair transportation. b. Unit meetings will be held for staff on August 16th and August 17th on the policy. Staff were educated to tell the resident to lift their feet during transport or obtain pedals and place on the wheelchair if they are unable to lift their feet.	

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F 323	Continued From page 11 Clients: . . . Elders: Since conditions of elders can change from day to day, always assess the situation to ensure that you have the right equipment . . ." - On 07/26/10 at 4:25 p.m., observation showed a nursing staff member (#1) transported Resident #12 in his wheelchair down the hallway to his room. Resident #12's shoes slid on the surface of the floor. The resident did not lift his feet. Another nursing staff member (#9) observed the situation, and from the nurses station called out to the resident to lift his feet. The nursing staff member (#1) continued to transport the resident down the hallway. Resident #12's feet caught on the linoleum, bounced, and caught again, bringing his wheelchair to a complete stop. The nursing staff member (#1) told the resident to lift his feet and resumed transport. Resident #12's feet continue to bounce on the linoleum. The staff member failed to ensure the resident's feet/shoes cleared the floor during transport. On 07/26/10 at 4:32 p.m., observation showed a nursing staff member (#1) pushed Resident #12 in his wheelchair, which lacked foot pedals, out of his room. The staff nurse (#1) failed to cue Resident #12 to lift his feet. As the nurse (#1) pushed Resident #12, his right knee bent as the wheelchair went forward and his foot remained planted on the floor. Resident #12's heel raised up off the floor as the wheelchair moved forward. This trapped Resident #12's foot under the wheelchair stopping the forward motion of the wheelchair. When cued by the nurse (#1), Resident #12 tried, but was unable to pull his foot out from under the wheelchair. The nurse (#1) pulled back on the wheelchair to free Resident #12's entrapped foot.	F 323	c. Residents will be assessed with quarterly MDS for wheelchair mobility/transport ability by OT/PT. 4. Completed by August 17, 2010. 5. QI will be done on residents being transported correctly when in wheelchair, monthly times three and review at quarterly QI for need of ongoing monitor. OT/PT will be responsible.	8-17-10

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	355037	A. BUILDING _____ B. WING _____	07/28/2010

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F 323	Continued From page 12 Review of Resident #12's medical record occurred on 07/28/10. Diagnoses for Resident #12 included Alzheimer's dementia and osteoarthritis. A quarterly Minimum Data Set (MDS), dated 05/06/10, identified long and short-term memory impairment, required extensive assistance of two staff members for locomotion, wheelchair as primary mode of locomotion, wheeled self, and other person wheeled. The Resident Assessment Protocol (RAP) for activities of daily living (ADL)/functional rehabilitation potential, dated 11/03/09, stated, ". . . [Resident #12] has had a decline in his ADL abilities as he has been requiring weight bearing assist with ambulation and has been using a w/c [wheelchair] that is pushed to destinations by staff. . . . " Review of the RAP for physical restraint, dated 11/03/09, stated, ". . . He also leans forward when pedaling self in w/c . . ." Record review showed Resident #12 propels himself when in the wheelchair, but requires staff assistance for specific destinations. The current care plan for Resident #12, initiated 11/03/08, stated "Problem: Impaired mobility [and] ADL deficit related to impaired balance [and] cognition . . . unable to initiate [and] does not know how to proceed [with] cares. . . . Approaches: . . . (11/11/09 changed to) W/C for distance, pain, or fatigue. . . . (added 09/14/09) Secure Care lok [sic] to w/c . . . (added 08/06/09) w/c with anti-rollbacks . . ." During an interview, on 07/28/10 at 1:15 p.m., a management nursing staff member (#2) and a physical therapy staff member (#3) confirmed it is	F 323		

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F 323	Continued From page 13 unsafe for Resident #12's feet to get trapped under the wheelchair when pushed by facility staff. The physical therapy staff member (#3) identified Resident #12 has footrests to use when the resident is not able to keep his feet up when cued. - On 07/26/10 at 12:13 p.m., observation showed a certified nursing assistant (CNA) (#12) transported Resident #21 in her wheelchair from the dining room down the hallway to her room. The heels of Resident #21's shoes slid on the surface of the floor. The resident did not lift her feet. Resident #21's shoes caught on the linoleum; bringing her wheelchair to a complete stop. The CNA (#12) asked the resident, "Are you okay?" She did not cue the resident to lift her feet before resuming transport. The staff member failed to ensure the resident's feet/shoes cleared the floor during transport and failed to remind her to lift her feet. Review of Resident #21's medical record occurred on 07/28/10. The resident's diagnoses included Alzheimer's dementia and osteoarthritis/osteoporosis. The resident's quarterly MDS, dated 07/01/10, identified problems with short/long term memory, moderately impaired daily decision making skills, extensive assist with locomotion on/off the unit, and wheelchair primary mode of locomotion. The RAP, dated 09/28/09, stated, "ADL Functional Rehabilitation Potential: . . . uses a w/c pushed by staff to get to destinations. She has degenerative changes in both hips that can affect her mobility with diagnosis of OA [osteoarthritis] and osteoporosis . . . Falls: . . . She has a diagnosis of Alzheimer's disease that affects her awareness of safety issues and need for assistance . . ."	F 323		

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F 323	Continued From page 14 - On 07/27/10 at 12:18 p.m., observation showed a nursing staff member (#16) transported Resident #13 in his wheelchair from the dining room down the hallway to his room. Resident #13's right shoe slid on the surface of the floor. The resident did not lift his foot, and the nursing staff member (#16) did not provide cues to do so. Resident #13's foot caught on the linoleum and bounced. The staff member failed to ensure the resident's foot/shoe cleared the floor during transport and failed to remind him to lift his foot. On 07/28/10 at 10:22 a.m., a CNA (#17) transported Resident #13 in his wheelchair from his room down the hallway, through the front entrance, to the outdoor patio. Resident #13's right shoe slid on the surface of the floor. The resident did not lift his foot, and the CNA (#17) did not provide cues to do so. Resident #13's foot caught on the carpeting and bounced, after which he briefly attempted to lift it. The staff member failed to ensure the resident's foot/shoe cleared the floor during transport and and failed to remind him to lift his foot. At 10:39 a.m., the same CNA (#17) transported Resident #13 in his wheelchair from the outdoor patio, through the front entrance, and down the hallway to his room. Resident #13's right shoe slid on the surface of the floor. The resident did not lift his foot, and the CNA (#17) did not provide cues to do so. The staff member failed to ensure the resident's foot/shoe cleared the floor during transport and failed to remind him to lift his foot. Review of Resident #13's medical record occurred on 07/28/10. The resident's diagnoses included osteoarthritis and bilateral knee pain.	F 323		

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F 323	Continued From page 15 The resident's quarterly MDS, dated 06/10/10, identified problems with short term memory, extensive assist with locomotion on/off the unit, and wheelchair primary mode of locomotion. The RAP, dated 12/08/09, stated, "ADL Functional Rehabilitation Potential: . . . osteoarthritis especially of knees . . . staff assist him for longer distances . . ." - On 07/27/10 at 12:08 p.m., observation showed a CNA (#13) transported Resident #20 in her wheelchair from the dining room down the hallway to her room. Resident #20's shoes slid along the surface of the floor, making an audible noise whenever they made full contact with the floor. The resident did not lift her feet, and the CNA (#13) did not provide cues to do so. The staff member failed to ensure the resident's feet/shoes cleared the floor during transport and failed to remind her to lift her feet. Review of Resident #20's medical record occurred on 07/28/10. The resident's diagnoses included osteoarthritis - generalized and status/post right hip fracture with pinning. The resident's quarterly MDS, dated 05/25/10, identified problems with short term memory, extensive assist with locomotion on/off the unit, and wheelchair primary mode of locomotion. The RAP, dated 02/24/10, stated, "ADL Functional Rehabilitation Potential: . . . uses the w/c out of the room [for] mobility . . . staff assist her with w/c mobility . . ." - On 07/27/10 at 2:30 p.m., observation showed a nursing staff member (#8) transported Resident #1 in his wheelchair from his room down the hallway to the commons area. The heel of Resident #1's left shoe slid on the surface of the	F 323		

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F 323	Continued From page 16 floor. The resident did not lift his foot, and the nursing staff member (#8) did not provide cues to do so. The staff member failed to ensure the resident's foot/shoe cleared the floor during transport and failed to remind him to lift his foot. Review of Resident #1's medical record occurred on July 26-28, 2010. The resident's diagnoses included dementia, pelvic fracture and healing left heel decubitus. The significant change Minimum Data Set (MDS), dated 05/10/10, identified problems with short/long term memory, moderately impaired daily decision making skills, extensive assist with locomotion on the unit, total assist with locomotion off the unit, and wheelchair primary mode of locomotion. - On 07/28/10 at 9:10 a.m., observation showed a nursing staff member (#14) stated, "Pick up your feet," as she transported Resident #22 in his wheelchair down the hallway to the Activity room. Resident #22's shoes slid on the surface of the floor. The resident did not lift his feet. The staff member failed to ensure the resident's feet/shoes cleared the floor during transport. Review of Resident #22's medical record occurred on 07/28/10. The resident's diagnoses included Parkinson's disease, dementia, and hip replacement. The resident's significant change MDS, dated 05/25/10, identified problems with short/long term memory, moderately impaired daily decision making skills, total assist with locomotion on/off the unit, and wheelchair primary mode of locomotion. The RAP, dated 05/24/10, stated, "ADL Functional Rehabilitation Potential: . . . Resident has highly impaired memory and no ability to problem solve or learn new tasks . . . A wheelchair is used for mobility and staff pushes	F 323		

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F 323	Continued From page 17 him to destinations. . . . Falls: . . . Safety interventions include . . . personal alarm and chair alarm . . . Resident has highly impaired cognition . . . and decision making related to his diagnosis of dementia and Parkinson's disease. He is unaware of safety . . ." During an interview on 07/28/10 at 2:40 p.m., a management nursing staff member (#2) reported, "We would expect residents who could lift their feet to lift them, and [foot] pedals to be used with those who cannot lift their feet. . . . We would expect OT/PT [occupational and physical therapy] to screen the residents and give us direction. . . . We don't have a policy and procedure for wheelchair transport." Failure of the facility to ensure staff properly used assistance devices (wheelchair foot pedals) placed residents at risk for possible accident and/or injury.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of professional standards, and staff interview, the facility failed to	F 371	1. a. The storage of raw animal foods were stored separately from cooked foods. b. Ventilation systems (fans/compressors) were cleaned. c. All raw eggs were stored in covered containers in the coolers. d. The Unit A kitchenette microwave was cleaned.	

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F 371	Continued From page 18 store food, dishware, and equipment under sanitary conditions in 1 of 1 kitchen and 1 of 2 nursing unit kitchenettes (Unit A). Failure to follow safe food sanitation practices has the potential to result in food borne illness and can affect all residents who consume food stored or prepared in these areas. Findings include: The FDA [Food and Drug Administration] 2005 Food Code Preface, page X [ten], states, ". . . An asterisk * after a tagline . . . indicates that all of the provision within that section are critical unless otherwise indicated . . ." The FDA [Food and Drug Administration] 2005 Food Code, Public Health Reasons, Chapter 3, Food, page 373-374, states, "Preventing Food and Ingredient Contamination 3-302.11. . . Protection Separation, Packaging, and Segregation.* . . . With regard to the storage of raw animal foods . . . it is the intent of this Code to require separation based on anticipated microbial load and raw animal food type (species). Raw animal foods shall be separated based on a succession of cooking temperatures since cooking temperatures . . . are based on thermal destruction data and anticipated microbial load. . . . Food that is inadequately packaged or contained in damaged packaging could become contaminated by microbes . . . by products or equipment stored in close proximity or by persons. . . opening packages or overwraps. These contaminants may be present on the outside of containers and may contaminate food . . . when the package is opened. . . ." The FDA 2005 Food Code, Public Health	F 371	2. All residents eating at the facility have the potential to be affected. 3. a. LRD and CDM will inform Dietary staff of keeping raw animal foods separate from cooked foods of which will be stored on the bottom shelf of the walk-in cooler. b. The Maintenance Department will be cleaning the ventilation system monthly. With the new installation of our work order software, Dietary will submit electronic work orders via computer to clean and monitor all ventilation systems monthly. c. LRD and CDM will inform Dietary staff to keep all raw eggs in covered containers in the coolers. d. The Unit A kitchenette microwave will be cleaned weekly by Dietary staff. 4. Corrective action will be taken	

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F 371	Continued From page 19 Reasons, Chapter 6, Physical Facilities, page 466, states, "6-601.14 Cleaning Ventilation Systems . . . Both intake and exhaust ducts can be a source of contamination and must be cleaned regularly. . . ." The main tour of the kitchen and nursing unit kitchenettes occurred on 07/28/10 at 9:45 a.m., along with two administrative dietary staff members (#10 and #11). Observation showed the following in the kitchen: * A metal pan of raw hamburger stored on an open shelf above ready-to-eat shelled hard-boiled eggs and uncovered fresh shell eggs in the walk-in cooler. * A metal pan of raw bacon stored on an open shelf above individually packaged butter containers. * A heavy accumulation of dirt/dust on the fan in the walk-in cooler. * Rusty areas and accumulation of dust on the exhaust hood above the stove area. * Uncovered fresh shell eggs stored on an open shelf above individually wrapped bagels in the reach-in cooler in the baking area. * A heavy accumulation of dirt/dust on the exhaust fan in the window above the clean dishware area in the dish washing room. Observation showed the following in Unit A kitchenette: * Interior surface of the microwave soiled with a build-up of food debris. During interview on the kitchen tour, an administrative dietary staff member (#10) confirmed raw animal products should not be stored above ready-to-eat foods and that the fans in the kitchen needed cleaning.	F 371	by September 1, 2010. 5. a. A QI monitor on storage of raw animal foods will be performed monthly for one year, and results will be reported quarterly to the QI committee at regularly scheduled meetings by the LRD. b. A QI monitor on cleaning of ventilation systems will be performed monthly for one year, and results will be reported quarterly to the QI committee at regularly scheduled meetings by the LRD. c. A QI monitor on storage of raw eggs will be performed monthly for one year, and results will be reported quarterly to the QI committee at regularly scheduled meetings by the LRD. d. A QI monitor on cleaning of Unit A's microwave will be performed monthly for one year, and results will be reported quarterly to the QI committee at regularly scheduled meetings by the LRD.	9-1-10

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional	F 431	1. Refrigerator on Unit B; dial on the refrigerator was adjusted and temperature obtained to proper degree. Maintenance slip sent to Maintenance for checking refrigerator for proper cooling. 2. All refrigerators holding medications have the potential for being affected. 3. A policy was developed to continue to check temperature of the refrigerators in the Medication Rooms daily with the narcotic count. The policy directs adjustment of the temperature of the refrigerator up or down in order to maintain a temperature between 36 and 46 degrees. A maintenance slip is to be sent if unable to maintain proper temperature. Nurses will be instructed on the policy at Nurse's meeting on August 16th and August 17th. 4. Completed August 17, 2010. 5. QI monitor will be placed to monitor refrigerator	

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F 431	Continued From page 21 literature, manufacturer's information, and staff interview, the facility failed to store refrigerated insulin medications under proper temperature controls for 1 of 2 (Unit B) medication refrigerators. Failure to store insulin at the proper temperature has the potential to affect the potency and stability 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. . . ." Observation of the Unit B medication refrigerator with a nursing staff member (#7), at 10:42 a.m. on 07/28/10, revealed a temperature of 34 degrees Fahrenheit (F). Observation showed the following medications stored in the refrigerator: * Multiple unopened Lantus Insulin Solo Star Pens. Manufacturer's insert stated: "Lantus should not be stored in the freezer and should not be allowed to freeze. Discard Lantus if it has been frozen. Unopened Lantus should be stored in the refrigerator 36 degrees F to 46 degrees F." * Multiple unopened Novolog Insulin Flex Pens 70/30 and multiple unopened Novolog Pens. Manufacturer's insert stated: . . . Unopened Novolog should be stored in the refrigerator 36 degrees F to 46 degrees F. Do not use if it has been frozen. Do not freeze or store next to the refrigerator cooling element." * Multiple Humalog 75/25 Pens. Manufacturer's insert stated: "Store all unopened [unused]	F 431	temperatures being kept between 36 to 46 degrees weekly times four, then monthly times two and review at quarterly QI for need of ongoing monitor. The DON will be responsible.	8-17-10

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F 431	Continued From page 22 Humalog in the original carton in a refrigerator at 36 degrees F to 46 degrees F. Do not freeze. Do not use Humalog that has been frozen. Protect Humalog from extreme heat, cold, or light." * 1 vial of Novolin 70/30 insulin. Manufacturer's insert stated: "Store at 36 degrees F to 46 degrees F. Do not let it freeze." Review of the Unit B medication refrigerator temperature logs dated June - July, 2010, identified the following daily temperatures below the recommended range: June 2010 * 6 temperature readings of 34 degrees F. * 5 temperature readings of 32 degrees F. July 2010 * 9 temperature readings of 34 degrees F. * 1 temperature reading of 33 degrees F. * 7 temperature readings of 32 degrees F. * 1 temperature reading of 30 degrees F. During an interview with a nursing staff member (#7), on 07/28/10 at approximately 11:05 a.m., the staff member (#7) confirmed the refrigerator temperature is colder than what is recommended for insulin.	F 431		