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Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355051	A. BUILDING _____ B. WING _____	02/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTON PRAIRIE VILLAGE	950 DAKOTA AVE HATTON, ND 58240

(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 February 27, 2012 and completed on February 29, 2012, the sample included two residents for complete review, eight residents for focused review, and one closed record for review. The sample included one additional resident to verify specific concerns during the survey.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's recommendations, review of facility policy and procedure, and staff interview, facility staff failed to properly administer medication to 1 of 1 sampled resident (Resident #3) who received insulin via an "insulin pen" (a small pen shaped device which contains prefilled amounts of insulin). Failure of facility staff to follow the manufacturer's recommendation of properly "priming" (a procedure to expel the air from the needle attached to the insulin pen) prior to giving Resident #3 her scheduled insulin injections has the potential for this resident to receive the incorrect dose of insulin. Findings include: Review of the facility policy titled "Injection (Subcutaneous)" occurred on 02/28/12. This undated policy stated, ". . . Procedure . . . 8.	F 281	**Plan of Correction F281** 1. Nurses will be retrained on the proper steps of preparing insulin FlexPens for administration to residents. Training will be done by the FlexPen's manufacturer's representative (Novo Nordisk). Following training, each nurse will be assessed in the proper technique of preparing insulin FlexPens for administration to residents. 2. All residents that have physician's orders for insulin FlexPen have the potential to be affected. Currently, only one resident has physician's orders for insulin FlexPen.	03/07/12 03/23/12 03/07/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cynthia Kraebel	Administrator	3/19/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 Expel air from syringe. . . ." Review of the FlexPen manufacturer's instructions, provided by the facility, occurred on 02/28/12. These instructions, dated October of 2006, stated, "4 Simple Steps for Use . . . Step 2. Performing the Airshot Before Injection *Turn the dose dial to 2 units. *Holding the . . . FlexPen with the needle pointing up, tap the reservoir gently with your finger a few times. *With the needle still pointing up, press the push button as far as it will go until a drop of insulin appears at the needle tip. This is called an airshot. . . ." Observation of a nurse (#1) during medication pass, on 02/27/12 at 4:48 p.m., showed the nurse primed the FlexPen by dialing the number of units to 2, pointing the FlexPen needle downward, and pushing the button to expel air/insulin onto a paper tissue. Pointing the FlexPen downward versus upward for the air shot has the potential to trap air bubbles in the needle. During an interview on 02/28/12 at 2:55 p.m., an administrative nursing staff member (#2) stated she would expect staff to follow the manufacturer's instructions for priming the FlexPen.	F 281	3. Nurses will be retrained on the proper steps of preparing insulin FlexPens for administration to residents. Training will be done by the FlexPen's manufacturer's representative (Novo Nordisk). Following training, each nurse will be assessed in the proper technique of preparing insulin FlexPens for administration to residents. 4. Nurses will be audited and evaluated weekly for one month to see that the proper technique for insulin FlexPens is being used by nurses, Quality Assurance Committee will review weekly audits to assure proper technique for insulin FlexPens is being used by nurses.	03/07/12 03/23/12 ~~04/20/12~~