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
	355092	A. BUILDING _____ B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on February 18, 2014 and completed on February 20, 2014, the sample included 3 residents for complete review, 9 residents for focused review, and 1 closed record for review.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	F 225 1. Resident # 2's bruise to right forearm was noted and investigated. Resident stated he hit his arm on the corner as he was propelling self in wheelchair. No abuse suspected. An event on the bruise was completed in Matrix and resolution of the bruise was followed and documented. 2. All residents have the potential for being affected by this type of incident. 3. Education related to reporting changes to skin integrity provided ant CNA and Charge Nurse meetings on 3/18/2014 and 3/20/2014. Any change in skin integrity will be reported to the charge nurse on duty immediately. The charge nurse will assess and notify the DON of any changes of skin integrity of unknown origin. The DON will investigate	3/27/14

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

Administrator | 3-17-14

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

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F 225	Continued From page 1 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to investigate an injury of unknown origin for 1 of 1 sampled resident (Resident #2) with unexplained bruising. Failure to report and investigate an injury of unknown origin placed Resident #2 and other residents at risk for mistreatment and/or abuse, and did not allow the facility to determine causative factors for the injury and implement corrective action. Findings include: Review of the facility policy titled "Abuse Investigation" occurred on 02/20/14. This policy, revised January 2002, stated, ". . . Allegations of . . . injuries of unknown source will be thoroughly investigated and documented using established procedures. . . ." The policy titled "Abuse and Neglect Prohibition Policy," revised January 2002, stated, ". . . Alleged violations involving . . . injuries of unknown source . . . can be made, without fear or reprisal, by anyone . . . Any alleged violations should be recorded and reported immediately to the facility Administrator or his designated representative and to other officials through established procedures and in accordance with State law . . ."	F 225	causative factors and abuse risk and document in progress notes. 4. Twenty percent of residents will be assessed for skin areas of unknown origin every other week x 2 and monthly x 2 by Nursing Management. Findings will be reported to the QA Committee 5. Completion Date 3/27/2014	

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F 225	Continued From page 2 Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia without behaviors and unspecified intellectual disabilities. The current Minimum Data Set, dated 01/12/14, identified no behaviors, severely impaired cognition, extensive assistance from two or more people for transfers, and extensive assistance from one person for bed mobility, locomotion on the unit, dressing, and toileting. Observation of Resident #2's personal cares occurred on 02/18/14 at 1:55 p.m. Observation showed a large, purple bruise on the resident's right forearm. When asked, a certified nursing assistant (CNA) (#6) stated she did not know how the resident received the bruise. Record review showed no monitoring or investigation as to the possible cause of the bruise. During an interview on the morning of 02/20/14, a supervisory nurse (#7) stated staff should report the bruising to the charge nurse so an investigation can be done.	F 225		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280	F 280 1. Resident # 2's chair alarm was placed on the ADL flow sheet which is part of the resident care plan according to Hill Top Home of Comfort policy. Resident # 2 care	3/27/14

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F 280	Continued From page 3 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure care plans accurately reflected the resident's status for 1 of 12 sampled residents (Resident #2). Failure to include the use of a chair alarm, as well as dietary interventions for weight loss/wound management may result in omission of necessary interventions and does allow for continuity of care. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included a pressure ulcer, history of weight loss, and a history of falls. Observations throughout the survey identified a chair pad alarm in Resident #2's wheelchair. During an interview on the morning of 02/20/14, a certified nursing assistant (CNA) (#9) identified Resident #2 had a bed alarm as well as a chair alarm because he "tries to stand up all the time."	F 280	plan will be updated to reflect his dietary plan. 2. All resident's care plans should reflect care which is to be provided. 3. Care plans will indicate the location of specific care plan intervention documentation not listed specifically on the care plan form. All care plan interventions will be reviewed quarterly and updated as indicated. Resident ADL forms will be reviewed for interventions by the CNA Cares Committee. All alarm systems will be documented on ADL flow sheets. The dietician or dietary manager will document in Matrix when resident supplements are initiated, changed, or discontinued. 4. Seven resident care plans will be audited by the interdisciplinary team monthly x 3 for current interventions. Findings will be reported to the QA Committee. 5. Completion date 3/27/2014	

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F 280	Continued From page 4	F 280		

Observation of the evening meal on 02/19/14 showed Resident #2 received an eight ounce (oz) glass of the dietary supplement Diabetishield. On the morning of 02/20/14, a dietary staff member (#8) provided a list of residents who received supplements. The list identified Resident #2 received eight oz of Diabetishield with each meal, as well as four oz of Diabetishield in the evening and a "drumstix" (ice cream bar) with supper and the evening snack.

Resident #2's dietary progress notes stated the following:
*01/07/14 at 11:46 a.m.: ". . . Will increase 8 oz Diabetisheild [sic] to TID [three times per day] to help with weight maintenance . . . Care plan updated. . . ."
*02/18/14 at 3:39 p.m.: ". . . Continue with current supplement and increase to 4 oz Diabetisheild [sic] at HS [bedtime] with snack. . . ."

Resident #2's current care plan stated, ". . . 01/07/14 . . . often eats only dessert @ noon meal [and] drinks supplement per his preference. . . . Approach . . . To offer supplements [and] encourage nutri [nutritional] intake to maintain desired wt [weight] range. . . ."

Resident #2's care plan, as well as his "resident care information sheet" (used by CNAs to direct resident care), failed to include the use of a chair alarm, and also failed to identify his specific dietary interventions (i.e. 8 oz Diabetishield TID, the addition of 4 oz Diabetishield at HS, and the "drumstix") to help with weight maintenance.

During an interview on the morning of 02/20/14, a supervisory nurse (#7) agreed the care plan was

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F 280	Continued From page 5 not updated.	F 280		
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 medical record review, review of facility policy, and staff interview, the facility failed follow professional standards of care for 1 of 6 sampled residents (Resident #1) following an unwitnessed fall. Failure to ensure adequate monitoring (i.e. neurological assessment) after a possible head injury may cause a deterioration in condition to go unnoticed by staff. Findings include: The facility policy titled "Fall Assessment and Documentation" occurred on 02/20/14. This policy, dated 11/28/10, stated, ". . . Falls with a significant potential for head injury: 1. Continue to assess for injuries as above. 2. Initiate neurological checks. a. At the time of the fall b. After 1 hour c. Every 4 hours x 2 d. Then q [every] shift x 2 3. Document a. Response level b. Pupil size and reaction c. Limb movement d. Vital signs . . ." A facility document titled "Job Instruction	F 281	F 281 1. Resident #1 did not have any injury or neurological involvement from the fall on 8/20/2013. 2. Residents who have possible cranial involvement after a fall should have neurological checks completed. 3. When the nurse suspects a possible head injury neurological checks need to be initiated immediately following the fall and at intervals according to policy. Fall Assessment and Documentation Policy will be reviewed at the Charge Nurse meeting on 3/20/2014. 4. The QA coordinator will audit all resident falls for completion of neurological assessments with cranial involvement q month x 3. Findings will be reported to the QA Committee. 5. Completion date 3/27/2014	3/27/14

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F 281	Continued From page 6	F 281		

Breakdown Sheet," provided by staff, stated, ". . . Operation: Matrix [computer system] Events . . . Use For: Resident Falls . . ."

Review of Resident #1's medical record occurred on all days of survey. Diagnoses included: Alzheimer's disease, dementia with behaviors, nonorganic psychosis, and a history of falls.

Resident #1's nurse's note, dated 08/20/13 at 1:43 p.m., stated, ". . . Fall: Resident fell backward, in her chair, while in the dining room. Res. [resident] had just finished her meal when staff heard a noise and discovered this res. lying on the dining room floor. No injuries noted at this time. Assisted to her feet via stand-up lift and into w/c [wheelchair] as res. tired. 146/62 [blood pressure], 80 [pulse], 17 [respirations], T-98.0 [temperature], 95% O2 on ra [oxygen saturation on room air] . . ." The record lacked evidence of a neurological assessment after this fall.

During an interview on the morning of 02/20/14, a supervisory nurse (#7) confirmed staff did not witness the fall and referenced the Event Report for further information. Upon review of Resident #1's medical record, staff were unable to locate an Event Report for this fall. During an interview on 02/20/14 at 1:34 p.m., a supervisory nurse (#4) stated staff are supposed to complete event reports for falls, and "That's our procedure." The nurse (#4) also identified staff did not complete neurological checks for Resident #1's fall on 08/20/13 because she (nurse #4) had witnessed the fall. The nurse (#4) then provided a form titled "Resident Incident Report." The form contained the date and time of the fall, the resident's name, the location of the fall, and the charge nurse on duty. The form provided to the survey team did

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F 281	Continued From page 7 not identify if staff witnessed the fall and/or if Resident #1 hit her head. When asked to provide evidence that Resident #1 did not hit her head during the fall or that staff witnessed the fall, the facility provided no further information.	F 281		
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 and staff interview, the facility failed to provide care and services to treat a urinary tract infection (UTI) for 1 of 7 sampled residents (Resident #2) with a urinary catheter and a history of UTIs. Failure to provide prompt treatment of UTIs may result in discomfort, unresolved pain, and kidney infections. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia and a history of UTIs. The current Minimum Data Set (MDS), dated 01/12/14, identified a urinary catheter and frequent bowel incontinence. Resident #2's nurses' notes stated the following: *01/02/14 at 1:48 p.m.: ". . . Res. [resident] noted	F 309	F 309 1. Resident #2 was treated with AB therapy on 01/08/2014-01/17/2014 for urinary tract infection (UTI). No longer having any signs and symptoms of infection. 2. Residents who develop UTI's are at risk. 3. Urine culture results will be obtained in a timely manner from laboratory. A treatment order will be implemented into matrix for nursing to follow up on urine cultures sent to lab. Results from laboratory that indicate an active urinary tract infection with culture and sensitivity will be called to primary care provider and not faxed for a faster response. Changes in procedure will be addressed at the 3/20/2014 charge nurse meeting. 4. QA coordinator will monitor urine cultures sent in to the lab for timely response Q month x 3. Findings will be reviewed by the QA Committee. 5. Completion date 03/27/2014	3/27/14

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to have mod. [moderate] amnt. [amount] of blood in cath. [catheter] bag/tubing. Several elongated blood clot 'strings' were observed as well. . . ."
*01/03/14 at 5:21 a.m.: ". . . UO [urine output] cldy [cloudy] 200 cc [cubic centimeters] in bag when emptied at 0515 [5:15 a.m.] though as soon as res up at the edge of bed immed. [immediately] returns of burgandy [sic] colored urine. . . ."
*01/03/14 at 11:04 a.m.: ". . . Res. continues to have mod. amnt. of hematuria in tubing/cath. bag with long stringy clots. Urine color is dk. [dark] amber and cloudy in appearance. UA [urinalysis] obtained and new foley [catheter] re-inserted. . . ."
*01/06/14 at 12:50 p.m.: ". . . Recent UA obtained on 1/3/14 does show 90,000 col [colony] of E. coli [Escherichia coli, a type of bacteria commonly found in the lower intestine]. MD [medical doctor] faxed copy of culture will await his response. Resident has history of UTIs. . . ."
*01/07/14 at 1:33 p.m.: ". . . Currently has a UTI; awaiting orders from primary physician. . . ."
*01/08/14 at 10:52 a.m.: ". . . Order received per [physician name]: Start Cipro [ciprofloxacin, an antibiotic] BID [twice per day] x 10 days for UTI. . . ."

A laboratory report identified a urine culture performed on 01/03/14. The final report, dated 01/05/14 at 1:11 p.m., showed a positive result for E. coli bacteria. A physician's telephone order, dated 01/08/14, identified the initiation of the ciprofloxacin (three days after the final culture report).

During an interview on the afternoon of 02/20/14, a supervisory nurse (#13) stated she was unsure why antibiotics were not started until 01/08/14.

Failure to ensure Resident #2 received prompt

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F 309	Continued From page 9 treatment and follow up for a UTI may result in unnecessary pain/discomfort and worsening infection.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide necessary interventions to promote healing for 1 of 1 sampled resident (Resident #2) with a pressure ulcer. Failure to consistently provide a pressure-relieving (Roho) cushion and dietary supplements may delay healing and result in worsening pressure ulcers. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included diabetes and a history of pressure ulcers. Resident #2's current care plan stated, ". . . 2-10-14 superficial open area coccyx, optifoam [a type of adhesive dressing] qod [every other day] . . . Approach . . . Attempt to keep ROHO cushion in place to chair, [Resident #2] will remove and	F 314	F 314 1. Resident #2 has two roho cushions one in his chair and one in his recliner. Resident # 2 will have his evening supplement added to the MAR for documentation by the nurse or CMA. The employee who did not offer the resident his scheduled supplement was new and did not use the tray ticket properly. This employee was given instruction. 2. Residents who need interventions related to pressure are at risk. 3. Residents who are at risk for pressure areas and use more than one sitting surface will have cushions available for both surfaces. Residents who are at risk for pressure areas requiring supplement administration other than at meal times will be documented in the MAR. Dietary interventions for wound care will be on the care plan, resident tray tickets and dietary flow sheets and consumption will be documented in Point of Care. Dietary staff will review supplement offerings at the dietary meeting on 3/18/2014. Charge nurses will be	3/27/14

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F 314	Continued From page 10 refuse at times. . . Refer also to dietary for nutritional interventions as needed. . . ." The dietary care plan identified the approaches: "Offer supplements [and] encourage nutri [nutritional] intake to maintain desired wt [weight] range," and "Consistent carbohydrate diet." The dietary care plan lacked specific interventions related to Resident #2's wound healing. On the morning of 02/20/14, a dietary staff member (#8) provided a list of residents who received supplements. The list identified Resident #2 received eight ounces (oz) of Diabetishield [a nutritional supplement for people with diabetes] with each meal (implemented 01/07/14), as well as four oz Diabetishield in the evening (implemented 02/18/14). Nurses' notes identified an open area to Resident #2's coccyx on 10/22/13 which healed on 12/31/13. Nurses' notes further identified: *02/10/14 at 11:07 a.m.: ". . . Res [resident] has open areas to upper coccyx adjacent to each other of 0.3 cm [centimeters] each. . . . Continues with roho to chairs and pressure relieving mattress. . . ." *02/18/14 at 10:51 a.m.: ". . . Area on coccyx approx. [approximately] 0.4 cm and open . . ." Observation on 02/19/14 at 8:58 a.m. showed two certified nursing assistants (CNAs) (#11 and #14) transferred Resident #2 from his wheelchair to a recliner. Observation showed a Roho cushion on the resident's wheelchair; however, staff failed to move the cushion to the recliner. The resident remained in the recliner until 11:00 a.m., when staff transferred him back to his wheelchair.	F 314	informed of the documentation of Mar supplements for residents with wound care on 3/20/2014. 4. QA coordinator will monitor that pressure relieving surfaces are assigned to residents at risk q month x 3. The dietary manager will monitor dietary supplement offerings to ensure residents are offered the correct supplements every other week x 2, then q month x 2. Findings will be reported to the QA Committee. 5. Completion date 3/27/2014	

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F 314	Continued From page 11 Observation during the noon meal on 02/19/14 showed Resident #2 received milk, water, hot chocolate, and a six oz glass of clear juice with his meal tray. An unidentified CNA indicated the clear juice was Resident #2's supplement, and confirmed the glass was six oz. During an interview on 02/20/14 at 10:03 a.m., a supervisory dietary staff member (#15) stated Diabetishield is pink, not clear as observed on 02/19/14. Supplement intake charting (completed by dietary staff) for the noon meal on 02/19/14 identified 240 milliliters (ml) (eight oz) consumed by Resident #2, although observation showed six oz of a clear juice consumed by Resident #2. The charting also lacked evidence Resident #2 received four oz of Diabetishield on the evenings of 02/18/14 and 02/19/14, as implemented by the dietician on 02/18/14. During an interview on 02/20/14 at 10:03 a.m., a supervisory dietary staff member (#15) stated Diabetishield is implemented for additional calories, as well as "wound management for diabetics," and she expected staff to offer Diabetishield with all meals and the evening snack. During an interview on 02/20/14 at 12:17 p.m., a supervisory nurse (#7) stated staff are expected to use the Roho cushion in the recliner, as well as in the wheelchair.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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	355092	A. BUILDING _____ B. WING _____	02/20/2014

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F 323	Continued From page 12 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, manufacturer's instructions, and staff interview, the facility failed to ensure appropriate use of assistive devices for 2 of 3 sampled residents (Resident #5 and #7) whose care plans identified use of a stand lift. Failure to use the lift (Resident #5) or to assess the resident as appropriate for a stand lift (Resident #7) placed the residents at risk for an injury during transfers. Findings include: Review of the "EZ Stand Operating Instructions" occurred on 02/20/14. The manual stated, ". . . Stop lifting when the patient is in a standing position. With patient in the standing position, transfer to the desired location . . ." - Review of Resident #5's medical record occurred on all days of survey and identified diagnoses including Alzheimer's dementia and osteoarthritis. A quarterly Minimum Data Set (MDS), dated 12/03/13, identified the resident with moderate cognitive impairment and required extensive assistance with transfers. A "Quarterly Status Report," dated 12/03/13, stated, ". . . He has an unsteady gait and stooped posture . . . He requires a stand up lift for transfers. He does attempt to self transfer . . . He is at risk for falls. .	F 323	F 323 1. Resident # 7 completed an occupational therapy transfer evaluation and was determined inappropriate for a stand-up lift and was transitioned to a full lift for his safety. Resident #5 continues to use stand-up lift and staff have been informed and educated to follow current care plan. 2. All resident whom use a standup lift to assist with transfers are at risk. 3. Residents who are not able to stand and bear weight are not appropriate for a stand up lift. Nursing management assessments will be completed on any residents currently using stand up lifts. CNA Cares Committee will review all resident using a standup lift for appropriateness. If residents are no longer standing appropriately they will be reassessed. Resident standup lift transfers will be reviewed at the CNA and Charge Nurse meetings on 3/18/2014 and 3/20/2014. Resident Care Flow sheets and CNA pocket lists will be current with resident's appropriate method of transfer.	3/27/14

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F 323	Continued From page 13 . ." The resident's care plan, dated 09/02/13, stated, "[Resident#5] requires a stand up lift for all transfers. . . ." Observation, on 02/19/14 at 10:10 a.m. showed a licensed nurse (#1) and certified nursing assistant (CNA) (#2) accompanied Resident #5 to his room. The resident self propelled his wheel chair to the bed with the front of the chair facing the bed. Without using an assistive device, the CNA (#2) held the resident's right arm as he fell forward into the bed, face down on the pillow. During an interview, on 02/20/14 at 7:55 a.m., an administrative nurse (#4) stated staff are aware Resident #5 is a lift transfer and should have used the stand lift during the above observation. - Review of Resident #7's medical record occurred on February 18-20, 2014. Diagnoses included Alzheimer's dementia, osteoarthrosis, muscle weakness, neuropathy, foot deformity, toe amputation, foot ulcer, and history of falls and femur fracture. The quarterly MDS, dated 12/27/13, identified moderately impaired cognitive skills and extensive assistance required for transfers. The record further showed Resident #7's ability to safely transfer was last screened by Physical Therapy on 05/13/11. The current care plan identified, ". . . Problem: ADL [Activities of daily living] Functional/Rehabilitation Potential . . . Approach: . . . Transfer using stand up lift. . . ." The nurse's notes identifed the following: * 04/11/13 at 9:33 p.m., "Resident bumped left great toe on sit to stand after whirlpool hitting callus area on tip of toe causing it to crack and	F 323	4. Nursing management will observe each resident for transfer for appropriateness in the stand up lift monthly x 3. Resident care sheet and CNA pocket list will be audited for accuracy monthly x 3. Findings will be reported to the QA Committee. 5. Completion Date 3/27/2014	

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F 323	Continued From page 14 bleed." * 04/12/13 at 9:40 p.m., "Resident be [sic] transferred with sit to stand bumped 3rd toe on left foot hitting a dry area with dark center causing it to bleed. Band aid applied and foot rewrapped." * 04/19/13 at 1:26 p.m., ". . . during transfering [sic] with stand up lift resident kept pushing foot up against the lift. CNA continued to tell resident not to do this but he did reopen a scab and caused some minor bleeding. Foot was covered with telfa and bulky gauze to prevent further occurances. . . ." * 12/07/13 at 2:59 p.m., "CNA transferring res. in stand up lift from bathroom and L [left] elbow bumped door frame and received a small skin tear. area approx. [approximately] 2 cm [centimeters] and approximated well. ab oint [antibiotic ointment] applied and telfa. . . ." Observation showed the following: * On 02/18/14 at 3:14 p.m., two CNAs (#10 and #11) transferred Resident #7 from the toilet to his wheelchair using the stand lift. The CNAs (#10 and #11) placed the resident's feet on the foot board, placed the harness behind his back/around his torso, and cued him to hold onto the handle grips before raising the lift. The resident failed to bear weight and was in a seated position as he hung from the harness. As the harness straps pulled upward into Resident #7's axillae (armpits), his shoulders raised to ear level. The resident remained in this position throughout the transfer. * On 02/19/14 at 8:18 a.m. and 1:45 p.m., a CNA (#12) transferred Resident #7 from the toilet to his wheelchair using the stand lift. The CNA (#12) placed the resident's feet on the foot board, placed the harness behind his back/around his torso, and cued him to hold onto the handle grips,	F 323		

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F 323	Continued From page 15 before raising the lift. The resident failed to bear weight and was in a seated position as he hung from the harness. As the harness straps pulled upward into Resident #7's axillae (armpits), his shoulders raised to ear level. The resident remained in this position throughout the transfer. During an interview on 02/20/14 at 10:45 a.m., an administrative staff member (#7) stated she expected staff to ensure Resident #7 bears weight throughout the transfer. Staff's failure to cue Resident #7 to straighten his legs during the stand lift transfers, report the resident's inability to straighten his legs and bear weight during the transfers, and the facility's failure to re-assess and monitor the resident's appropriateness for stand lift transfers, placed him at risk of injury.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturers' instructions, and staff interview, the facility failed to ensure a medication error rate of less than five percent during 3 of 3 observations of insulin administration on 02/19/14. Failure to prime insulin pens as indicated in manufacturers' instructions may result in inaccurate doses of insulin. Three errors occurred during administration of 27 medications, resulting in an 11 percent error rate.	F 332	F 332 1. Resident #1 has insulin pen primed before administration of insulin by all nurses. 2. All residents receiving insulin by insulin pen have the potential to be affected. 3. Education for appropriate priming of insulin pens will be given at the 3/20/2014 charge nurse meeting. 4. Fifty percent of charge nurses will be audited for proper priming of insulin pens q month x 3 months. 5. Completion date 3/27/2014	3/27/14

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F 332	Continued From page 16 Findings include: The manufacturer's instructions for the Lantus Solostar pen, dated March 2007, stated, "Always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: * ensuring that the pen and needle work properly * removing air bubbles. A. Select a dose of 2 units by turning dosage selector . . . E. Press the injection button all the way in. Check if insulin comes out of the needle tip. . . ." The manufacturer's instructions for the Humalog KwikPen, dated September 6, 2007, stated, ". . . 2. Priming the KwikPen. Caution: if you do not prime before each injection, you may get too much or too little insulin. . . . B. Dial 2 Units by turning the Dose Knob. . . . E. With needle pointing up, push Dose Knob in until it stops and 0 is seen in the Dose Window. . . . Priming is complete when a stream of insulin appears from the needle tip and you have counted to 5 slowly. . . ." - On 02/19/14 at 7:20 a.m. observation showed a licensed nurse (#1) administered Lantus and Humalog insulin to Resident #1 using insulin pens. The nurse failed to prime the Lantus and Humalog pens prior to administering the insulins. - On 02/19/14 at 4:45 p.m. observation showed a licensed nurse (#3) administered Humalog insulin to Resident #1 using an insulin pen. The nurse failed to prime the Humalog pen prior to administering the insulin. During an interview, on 02/20/14 at 7:25 a.m., an administrative nurse (#5) agreed the nurses	F 332		

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F 332	Continued From page 17 should have followed the manufactures' instructions regarding priming the pens when administering insulin for Resident #1.	F 332		