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

RECEIVED OCT 17 2011 Division of Health Facilities

PRINTED: 09/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355033	A. BUILDING ____ B. WING ____	C 08/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CATHERINES LIVING CENTER	1307 N 7TH ST WAHPETON, ND 58075

(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 and complaint surveys, started on 08/28/11 and completed on 08/31/11, the sample included 4 residents for complete review, 10 residents for focused review, and 3 closed records for review. The sample included 3 additional resident to verify specific concerns during the survey.	F 000	F246 It is the practice of St. Catherine's Living Center to assure the right to reside and receive services in the facility with reasonable accommodations of individual need and preferences, except when the health or safety of the individual or other residents would be in danger.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, the facility failed to ensure reasonable accommodation of individual needs and preferences regarding wheelchair positioning for 3 of 11 sampled residents (Resident #7, #11, and #14) observed seated in wheelchairs. Failure to ensure appropriate wheelchair positioning placed residents at risk of deformity, limited the residents' ability to achieve their greatest independent functional and physical well being possible, and has the potential to cause shoulder discomfort for Resident #7. Findings include:	F 246	Resident #4 was evaluated by therapy to include completion of a wheelchair seating evaluation including appropriate resident arm position/arm rest supports, and potential for shoulder discomfort related to proper positioning in the dining room on 10-6-11. Resident provided with lower w/c and arm rests – Functional Maintenance Plan for resident to transfer to dining room chair for meals. Resident #11 was evaluated by therapy to include completion of a wheelchair seating evaluation including the appropriate resident arm position/arm rest supports, potential for shoulder discomfort and risk of increased pain related to proper positioning in the dining room on 10-6-11. Resident was provided with a thicker cushion in the wheelchair-table was adjusted to appropriate height.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Emmaline C Trulte (signature) — TITLE: CEO \ Administrator — (X6) DATE: 10/10/11 per Kim DON

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 246	Continued From page 1 Observation in the facility's North dining room during all three meals on 08/29/11, breakfast and noon meals on 08/30/11, and the noon meal on 08/31/11 identified the following: *Resident #7 - seated in a wheelchair with armrests at approximately the height of the mid-upper arm, the resident unable to position her arms on the arm rests, and the resident's arms unsupported at her sides. *Resident #11 - seated in a wheelchair with arms on the wheelchair arm rests, elbows elevated with elbows out at sides. *Resident #14 - seated in a wheelchair alternating arms on arm rests, elbows elevated with elbows out at sides. - Review of Resident #7's medical record occurred on August 29-31, 2011. The facility admitted the resident in August 2010. Current diagnoses included osteoporosis and low back pain. The resident's significant change and annual Minimum Data Sets (MDSs), dated 05/13/11 and 08/12/11, respectively, identified the resident is cognitively intact, required assistance of two or more persons for bed mobility and transfers, and has occasional moderate pain limiting activities. The facility identified the resident was interviewable. Observation throughout the survey showed Resident #7 independently shifting her weight in the wheelchair and unable to rest her arms on the wheelchair arm rests due to the arm rests too high. During interview, on 08/31/11 at 10:00 a.m., Resident #7 reported her shoulders do become uncomfortable when seated in the wheelchair	F 246	Resident #14 was evaluated by therapy to include completion of a wheelchair seating evaluation including the appropriate resident arm positioning/arm rest supports related to proper positioning in the dining room on 10-6-11. Resident provided with lower w/c and desk arm rests – Functional Maintenance Plan for resident to transfer to dining room chair for meals. All residents utilizing wheelchairs in the dining room will be screened by therapy for proper wheelchair positioning including - appropriate resident arm positions/arm rest support related to proper positioning at dining tables by 10-10-11 and quarterly thereafter. Therapy In-service Education regarding appropriate wheelchair positioning at dining room tables - including resident's arm positioning/arm rest support to ensure proper positioning at dining tables will be completed by 10-12-11.	

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F 246	Continued From page 2 without arm rest support. When questioned, Resident #7 agreed lowered arm rests would be of benefit to her. - Review of Resident #11's medical record occurred on August 30-31, 2011. The facility admitted the resident in August 2009. Current diagnoses included spinal compression fracture, back ache, and history of fractured femur prior to admission. The resident's physician orders included Tylenol 500 milligrams, two tablets, three times each day for pain. Review of the medical record failed to identify the facility completed a wheelchair seating evaluation including the resident's arm rest positions. - Review of Resident #14's medical record occurred on August 30-31, 2011. The facility admitted the resident in December 2010. Current diagnoses included a history of pelvic fracture following a fall in the facility on 03/01/11. The resident's physician orders included Tylenol 650 milligrams, two tablets, three times each day for pain. Review of the medical record failed to identify the facility completed a wheelchair seating evaluation including the resident's arm rest positions. During observation of the noon meal on 08/31/11, a supervisory nursing staff member (#6) agreed Resident #7, #11, and #14's wheelchair seating failed to provide these residents with appropriate arm rest support. During interview, on 08/31/11 at 2:20 p.m., this staff member (#6) confirmed the facility failed to evaluate Resident #7, #11, and #14 regarding wheelchair arm rest positions.	F 246	Residents in wheelchairs in the dining room will be audited for proper wheelchair positioning related to appropriate resident arm positioning/arm rest support related to proper positioning at dining tables quarterly according to the care conference schedule and as deemed necessary: i.e. significant change by 10-12-11, then weekly x2, monthly x2 then quarterly thereafter. The Director of Therapy or designee shall be responsible to monitor and assure the completion of audits. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed by 10-12-11	10-12-11

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F 246	Continued From page 3 Failure to evaluate these residents has the potential to cause Resident #7 to experience shoulder discomfort and placed Resident #11 and #14 at risk of increased pain.	F 246		
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: 1. Based on record review, review of professional reference, review of facility policy and procedure, and staff interview, the facility failed to ensure services were provided or arranged according to professional standards of quality regarding following physician orders and frequency of laboratory testing for 1 of 14 sampled residents (Resident #7). Failure to follow physician orders and standards of quality resulted in Resident #7 experiencing unnecessary needle punctures and blood tests. Findings include: The internet site for the National Institutes of Health, National Diabetes Information Clearinghouse, www.niddk.nih.gov, defines hemoglobin A1C as ". . . measures your average blood glucose (sugar) over the last 3 months. . . ." Review of the facility policy and procedure "Physician Orders in Clinical Software" occurred on August 30-31, 2011. This document, dated 07/01/05, stated, ". . . RESPONSIBLE PARTY: Licensed Nurses, PROCEDURE:	F 281	F281 It is the practice of St. Catherine's Living Center to ensure services provided or arranged by the facility meet professional standards of quality regarding following of physicians orders and frequency of laboratory testing. Resident #7 Lab Physicians Orders will be clarified with the attending physician - Interdisciplinary Team will review and update the Resident Lab Tracker for Resident #7 to ensure resident labs are scheduled to be drawn as ordered by 10-12-11. Requested review of all resident lab orders per resident's physician/designee to include clarification of lab frequency as needed on 9-12-11. Resident Lab Tracking System implemented by IDT for all residents to ensure labs are scheduled and drawn as ordered by 10-12-11. Resident Lab Tracking System in-service was provided to all licensed nursing and support staff on 9-20-11.	

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F 281	Continued From page 4 Physician/Designee generates the order document . . . The Licensed Nurse receives the order from the Physician/Physician Designee . . . If needed, clarification is obtained from the physician/nurse practitioner. . . ." Review of the facility policy and procedure "Laboratory Services" occurred on August 31, 2011. This undated document stated "STANDARD, The facility must provide or obtain medically necessary, quality, timely laboratory services as ordered by the physician or physician designee to meet the diagnosis, treatment, prevention or assessment needs of its residents . . . POLICY . . . 3. . . . a. Timely means that laboratory tests are completed and results are provided to the facility (or resident's physician) within timeframes normal for appropriate intervention. 4. The facility must: a. Provide or obtain laboratory services when ordered by the a [sic] physician or physician designee. . . ." - Review of Resident #7's medical record occurred on August 29-31, 2011. The facility admitted the resident in August 2010. The resident's current diagnoses included diabetes mellitus. The resident's current care plan, initiated 09/01/10 and updated 08/24/11, stated "Problem, Resident takes oral antidiabetic medication and Insulin related to increased blood sugars secondary to Dx. [diagnosis] of DM [diabetes mellitus] type II. . . . Approach . . . Monitor labs/accuchecks as ordered." Resident #7's physician orders, dated 10/14/10 and periodically updated by the physician or designee, stated ". . . Hgb [Hemoglobin] A1C q [every] 3 months." (Hgb A1C scheduled January	F 281	All residents with physician/designee ordered labs will be audited by the Quality Assurance Coordinator or designee to ensure labs are scheduled to be drawn as ordered by 10-12-11. Scheduled labs within the auditing time frame will then be audited weekly x2, monthly x2 then quarterly thereafter to ensure continued compliance. Resident #18's insulin via Flex Pen is administered per manufacturer's recommendations as of 09-01-11. Licensed staff that administers insulin via Flex Pen to Resident #18 were provided "just-in-time" education regarding administration recommendations on 8-30-11. Policies and procedures regarding administration of insulin via Flex Pen were reviewed and updated by the IDT on 9-30-11. All residents receiving insulin per Flex Pen will be administered insulin per manufacturer's administration recommendations. Licensed staff were provided in-service education regarding manufacturer's recommended administration of insulin via Flex Pen on 9-15-11	

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F 281	Continued From page 5 2011, April 2011, July 2011, and October 2011.) Resident #7's Progress Notes and Physician Orders identified the following: *03/29/11 - Physician rounds and orders for Hgb A1C. (Approximately two weeks ahead of schedule.) *05/11/11 - Physician extender orders for Hgb A1C. (Approximately six weeks since previous test.) Test results received 05/12/11, 8.2%, (range 3.0 - 6.2%.) *05/23/11 - Physician orders for Hgb A1C. (12 days since previous test.) Test results received 05/26/11, 6.5% *08/15/11 - Physician extender orders for Hgb A1C. (Approximately three months since previous test.) Test results received 08/15/11, 7.0 % *08/25/11 - Hgb A1C blood sample drawn. (10 days since previous test.) Test results received 08/25/11, 6.8% During interview, on 08/31/11 at 2:20 p.m., a supervisory nursing staff member (#6) confirmed the Hgb A1C tests on 05/11/11 and 05/23/11 and 08/15/11 and 08/25/11 were too close together to be of benefit to Resident #7. This staff member confirmed the facility staff should have informed the physician of the Hgb A1C completed on 05/11/11 and attributed the tests completed on 08/15/11 and 08/25/11 to a "transcription error." Failure to clarify the physician's order on 05/23/11 and the physician extender's order on 08/25/11 resulted in Resident #7 experiencing unnecessary blood draws and potential charges for unnecessary services, not in accordance with accepted professional standards.	F 281	All residents receiving physician ordered insulin via Flex Pen will be audited by the Quality Assurance Coordinator or designee to ensure insulin is administered per manufacturer's recommended administration by 10-12-11, then weekly x2, monthly x2 then quarterly thereafter to ensure continued compliance. The Quality Assurance Coordinator or designee shall be responsible to monitor and assure the completion of audits. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed by 10-12-11.	10-12-11

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F 281	Continued From page 6 2. Based on observation, record review, and review of manufacturer's recommendations, facility staff failed to properly administer medication to 1 of 1 supplemental resident (Resident #18) 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 "priming" (a procedure to expel the air from the needle attached to the insulin pen) prior to giving Resident #18 his scheduled insulin injections did not provide this resident with the exact amount of insulin as prescribed. Findings include: Review of the manufacturer's medication package insert for NovoLog Flex Pen stated, ". . . Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: . . . E. Turn the dose selector to select 2 units. F. Hold your NovoLog Flex Pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of cartridge. G. Keep the needle pointing up, press the button all the way. The dose selector turns to zero. A drop of insulin should appear at the needle tip. If not, change the needle, and repeat the procedure . . . ." Observation of medication pass on 08/29/11 at 10:55 a.m. with a nurse (#7) showed the nurse obtained Resident #18's NovoLog (insulin) Flex Pen from the medication refrigerator, attached a new needle to the top of the insulin pen, and turned the "dose selector or dose knob" on the	F 281		

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F 281	Continued From page 7 pen to the number of units prescribed by the provider. The nurse entered the resident's room and administered the insulin injection to the resident. The nurse failed to "prime" or expel the air from the attached needle on the NovoLog Flex Pen. Observation of medication pass on 08/30/11 at 10:35 a.m. with a nurse (#5) showed the nurse obtained Resident #18's NovoLog (insulin) Flex Pen from the medication refrigerator, attached a new needle to the top of the insulin pen, and turned the "dose selector or dose knob" on the pen to the number of units prescribed by the provider. The nurse entered the resident's room and administered the insulin injection to the resident. The nurse failed to "prime" or expel the air from the attached needle on the NovoLog Flex Pen.	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, review of facility policy and procedure, review of professional reference, and staff interview, the facility failed to ensure 2 of 4 sampled diabetic residents (Resident #7 and #12) received the care and services necessary	F 309	F309 It is the practice of St. Catherine's Living Center to ensure each resident receive and the facility 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; to include physician notification and blood sugar rechecks per recognized protocols.	

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F 309	Continued From page 8 regarding physician notification for low blood sugars (hypoglycemia) and elevated blood sugars (hyperglycemia). Failure to contact the physician placed Resident #7 and #12 at risk of complications and limited the physicians' ability to ensure the quality of care. Findings include: Review of the facility's policy and procedure "Blood Glucose Testing" occurred on 08/31/11. This undated document stated, "OBJECTIVE: Monitor resident's blood glucose and provide appropriate interventions with hypoglycemic episodes via glucometer per physician orders and PRN [as needed] per nurse discretion. . . . PROCEDURE: . . . 10. Notify physician/physician designee of all blood sugars > [greater than] 300 mg/dl [milligrams per deciliter] unless otherwise indicated by physician/physician designee. Follow standing order protocol for hypoglycemic episodes." Review of the facility's "Standing Orders" occurred on 08/31/11. This document, revised October 2006, stated ". . . DIABETES MONITORING and/or TREATMENT, Follow facility protocol. If no protocol: 1) Blood glucose check prn nurse discretion. 2) Glutose 1/2 - 1 tube orally for symptomatic hypoglycemia plus BS [blood sugar] < [less than] 50 [mg/dl]. Repeat in 10 minutes as needed. 3) Glucagon 1 mg [milligram] IM [intramuscular] x [times] 1 for symptomatic plus BS < 30 and notify physician/extender of results. . . ." The internet site for the National Institutes of Health, National Diabetes Information	F 309	Resident #7's blood glucose results indicative of the need for notification of the physician/physician extender, implementation of interventions and blood sugar rechecks will be completed per physicians order/ recognized protocols. Resident #12's accucheck results indicative of the need for notification of the physician/physician extender, implementation of interventions and accucheck rechecks will be completed per physicians order/ recognized protocols. All resident accucheck/blood glucose results indicative of the need for notification of the physician/physician extender, implementation of interventions and accucheck rechecks will be completed per physicians order/ recognized protocols. Licensed Nursing Staff were re-educated regarding timely notification of the resident accucheck/blood glucose results indicative of the need for notification of the physician/physician extender, implementation of interventions and accucheck rechecks per physicians order/ recognized protocols on 10-06-11.	

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F 309	Continued From page 9 Clearinghouse, www.niddk.nih.gov, states "Diabetes related Hypoglycemia . . . To treat hypoglycemia, people should have a serving of a quick-fix food, wait 15 minutes, and check their blood glucose again. . . ." Review of Resident #7's medical record occurred on August 29-31, 2011. The facility admitted the resident in August 2010. Current diagnoses included diabetes mellitus. The resident's current physician's orders for medications included 10 units of Levemir insulin each morning initiated on 05/24/11 and Glucophage 500 mg, one tablet, three times each day initiated on 08/19/11. Physician's orders also included blood sugar accuchecks three times a day, three days each week. Resident #7's current care plan, initiated September 2010 and updated August 2011, stated "Problem, Resident takes oral antidiabetic medication and insulin related to increased blood sugars secondary to Dx. [diagnosis] of DM [diabetes mellitus] type II. . . . Approach, Administer medications as ordered. Monitor labs/accuchecks as ordered." Resident #7's accuchecks for the period May 01 - August 29, 2011 identified 53 of 283 (18.7%) accuchecks greater than 300 mg/dl, ranging from 300 mg/dl to 441 mg/dl. Review of the Resident Progress Notes identified the facility staff contacted Resident #7's physician or physician extender regarding six of these blood sugars over 300 mg/dl. The medical record lacked information the facility staff contacted the physician or physician extender regarding the remaining 47 blood glucose readings greater than 300 mg/dl.	F 309	Residents identified with current blood glucose/accucheck results indicative of the need for notification of the physician/physician extender, will be audited by the Quality Assurance Coordinator or designee to ensure notification of the physician/physician extender, implementation of interventions and accucheck/blood glucose rechecks per physicians order/ recognized protocols weekly x2, then monthly x2 and quarterly thereafter to assure compliance. The Quality Assurance Coordinator or designee shall be responsible to monitor and assure the completion of audits. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed by 10-12-11.	10-12-11

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F 309	Continued From page 10 Resident #7's medical record lacked evidence the facility staff implemented any interventions or rechecked the resident's blood sugar after the elevated readings or after the next meal. Failure to contact Resident #7's physician or physician extender regarding the accucheck readings greater than 300 mg/dl limited the health care providers' ability to ensure quality care. Failure to recheck Resident #7's blood sugars after the elevated accuchecks placed the resident at risk of episodes of hyperglycemia and hypoglycemia. - Review of Resident #12's medical record occurred on August 30-31, 2011. Current diagnoses included diabetes mellitus. The resident's current physician's orders for medications included Lantus 8 units at bedtime, Novolog 2 units three times a day, and Novolog sliding scale three times a day each initiated on 08/24/11. Physician's orders also included daily blood sugar accuchecks four times a day and as needed. Resident #12's current care plan, initiated 10/05/10, stated "Problem, Resident has potential for hypo/hyperglycemia [low/high blood sugar levels] r/t [related to] diabetes mellitus. Resident is frequently noncompliant with diabetic regimen and will often times refuse accuchecks/insulin and/or request accuchecks/insulin at times other than ordered. . . . Approach, Administer hypoglycemics as ordered. Monitor blood glucose as ordered and prn [as needed]. . . ." Review of Resident #12's accuchecks and	F 309		

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F 309	Continued From page 11 progress notes for the period of May 01 - August 31, 2011 identified three accuchecks less than 50 mg/dl. The medical record lacked information the facility staff contacted the physician or physician extender regarding the following blood glucose levels: *05/07/11, 5:02 a.m., 29 mg/dl, Glucagon (hormone to raise blood sugar levels) IM (intramuscular injection) per physician's standing order. A communication form, signed 10/14/10 by the physician's assistant, stated, "If he refuses insulin - don't call." Review of Resident #12's accuchecks for the period of May 01 - August 31, 2011 identified 32 accuchecks greater than 300 mg/dl, with no evidence in the progress notes of Resident #12 refusing medications/insulin. The medical record lacked information the facility staff contacted the physician or physician extender regarding the following elevated blood glucose levels. During an interview on 03/31/11 at 4:10 p.m., administrative nursing staff members (#1 and #3) confirmed individualized high and low parameters for contacting the physician regarding blood sugars should be included in Resident #12's physician's orders.	F 309		
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.	F 332	F332 It is the practice of St. Catherine's Living Center to ensure that the facility is free of medication error rates of five percent or greater, to include administration of medications within established parameters.	

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F 332	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent during observation on 1 of 2 days of medication pass (08/30/11). Failure to administer medications at the correct time may result in decrease efficacy. Twelve errors occurred during staff administration of 46 medications, which resulted in a 26 percent error rate. Findings include: Review of the facility policy "Medication Administration: Medication Pass" occurred on 08/31/11. This policy, dated October 2006, stated, ". . . Purpose: To assure that residents receive ordered medications in a timely manner . . . Procedure: . . . 9. Medications are to be given within one hour prior to or after time ordered . . ." - Observation of the medication pass occurred on 08/30/11 at 4:47 p.m. with a licensed nurse (#4). The nurse dished medications from the medication cart and administered them to Resident #19. Review of the resident's physician's orders identified the following medications and time of administration: * Iron, 7:30 p.m. * Acetaminophen, 7:30 p.m. * Citalopram, 8:00 p.m. * Mirtazapine, 8:00 p.m. The nurse (#4) administered Resident #19's above medications approximately two and a half hours before the scheduled time for administration.	F 332	Medications for Resident #19 and Resident #20 are administered within appropriate time parameters for administration of medications. All staff that care for Resident #19 and Resident #20 received "just-in-time" education on adhering to appropriate time parameters for administration of medications on 8-30-11. All residents who have medications administered have the potential to be affected by this issue, and will be audited for adherence to administration within appropriate time parameters. Medication 101 in-service was presented by the Pharmacy Consultant and DON to all licensed nurses and C.M.A.'s on 9-7-11, including re-education of adherence to administration of medications within appropriate time parameters. All residents will be audited for administration of medications within appropriate time parameters weekly x2, then monthly x2 and quarterly thereafter to assure compliance with professional standards regarding administration of medications within appropriate time parameters.	

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F 332	Continued From page 13 - Observation of the medication pass occurred on 08/30/11 at 4:55 p.m. with a licensed nurse (#4). The nurse dished medications from the medication cart and administered them to Resident #20. Review of the resident's physician's orders identified the following medications and time of administration: * Lactulose, 7:30 p.m. * Ocular, 7:30 p.m. * Senna Plus, 7:30 p.m. * Acetaminophen, 7:30 p.m. * Tramadol, 7:30 p.m. * Actos, 7:30 p.m. * Tamsulosin, 7:30 p.m. * Mirtazapine, hour of sleep (HS) * Simvastatin, HS The nurse (#4) administered Resident #20's above medications approximately two and a half to three hours before the scheduled time for administration. During an interview on the morning of 08/31/11, an administrative nurse (#3) agreed the nurse administered Resident #19 and #20's medications at the incorrect time.	F 332	The Quality Assurance Coordinator or designee shall be responsible to monitor and assure the completion of audits. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed by 10-12-11.	10-12-11
F 441 SS=D	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	F 441	F441 It is the policy of St. Catherine's Living Center to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection through following proper infection control procedures- including hand washing/sanitizing, proper use of gloves, appropriate sanitizing of equipment and appropriate cleansing of wounds related to dressing changes.	

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F 441	Continued From page 14 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 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 product label, and staff interview, the facility failed to follow proper infection control procedures for 2 of 3 sampled residents (Resident #8 and #12) observed during dressing changes. Failure to follow infection control procedures related to hand hygiene and glove usage has the potential for contamination and the spread of infection to other residents.	F 441	Practices identified including proper use of gloves, hand washing and appropriate cleansing of wound related to dressing changes were corrected for resident #8 Practices identified including hand washing/sanitizing, proper use of gloves and appropriate sanitizing of equipment related to dressing changes were corrected for resident #12. Infection Control – Wound Care in-service was presented by the Wound Nurse Consultant and DON to all licensed nurses including following proper infection control procedures- including hand washing/sanitizing, proper use of gloves, appropriate sanitizing of equipment and appropriate cleansing of wounds related to dressing changes, on 9-20-11. All residents with dressing changes will be audited for proper infection control procedures- including hand washing/sanitizing, proper use of gloves, appropriate sanitizing of equipment and appropriate cleansing of wounds related to dressing changes weekly x2, then monthly x2 and quarterly thereafter to assure compliance.	

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F 441	Continued From page 15 Findings include: Review of the facility policy titled "Glove Use" occurred on 08/31/11. This policy, dated 2006, stated, "PURPOSE: To prevent the spread of infection . . . Hand-washing should occur after removal of gloves. Fresh gloves are utilized between soiled care delivery and clean care procedures." Review of the facility policy titled "Aseptic Dressing Change" occurred on 08/31/11. This policy, revised in 2000, stated, "PURPOSE: Aseptic dressing change is done to protect the wound, prevent irritation and to prevent infection . . . PROCEDURE: 2. Wash hands. 3. Don clean gloves. 4. Remove old dressing and discard dressing and old gloves in appropriate receptacle. 5. Wash hands. 6. Don clean gloves. 7. Clean wound with normal saline or wound cleanser ordered by physician/designee. 8. Apply new dressing to affected area and secure as appropriate . . ." Review of the Skintegrity Hydrogel Dressing directions stated to thoroughly cleanse the wound with wound cleanser before applying the dressing. - Review of Resident #8's medical record occurred on August 29-31, 2011. Medical diagnoses included quadriplegia, bowel incontinence, urinary tract infection (UTI), sepsis, methicillin resistant staphylococcal aureus (MRSA), and sacral/buttock ulcers. A physician's order, dated 08/02/11, stated, "Cleanse left ischium per protocol. Apply Hydrogel gauze to left	F 441		

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F 441	Continued From page 16 ischium wound bed . . ." The resident's annual Minimum Data Set (MDS), dated 07/18/11, identified extensive assistance with toilet use and personal hygiene and a Stage II pressure ulcer. Observation on 08/30/11 showed the licensed nurse (#2) carried a box containing dressing supplies into Resident #8's room and placed it on the bed. She applied clean gloves and removed the supplies needed for the dressing change and placed them on the bed. Resident #8 rolled onto his left side and observation showed a draw sheet soiled with a green discharge, blood, and feces. The nurse (#2) removed the soiled dressing, exposing a foul smelling open area which measured approximately six centimeters by seven centimeters, and applied a Hydrogel dressing to the wound. The nurse discarded the soiled dressing and her gloves, washed her hands, collected the box containing the dressing supplies, and exited the room. The nurse (#2) failed to wash her hands when she entered Resident #8's room, failed to wash her hands and don clean gloves after removing the soiled dressing, failed to cleanse Resident #8's wound per protocol. During an interview on the morning of 08/31/11, an administrative nurse (#3) stated she expected facility nurses to follow proper infection control procedures during dressing changes. - Review of Resident #12's medical record occurred on August 30-31, 2011. The resident's diagnoses included an unstageable heel pressure ulcer. In addition, observation on 08/31/11 showed a pressure ulcer on Resident #12's right	F 441		

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F 441	Continued From page 17 ankle. A physician's order, dated 08/24/11, stated to apply Xeroform (antimicrobial) dressing to the resident's right heel, cover with 4 X 4 [four inch by four inch] gauze, and wrap with Kerlix gauze roll. A physician's order, dated 08/24/11, stated to apply Aquacel (antimicrobial) dressing to the resident's right ankle and cover with a Duoderm dressing. Observation on 08/24/11 at 11:45 a.m., showed a nursing staff member (#2) entered Resident #12's room to complete the resident's dressing changes. This nursing staff member (#2) failed to wash her hands before donning gloves. The staff member removed a scissor from her uniform pocket and used it to cut the Aquacel dressing from the resident's right ankle. Observation showed this dressing contained drainage from the open ulcer. The staff member failed to remove her gloves and sanitize her hands before cleansing and applying the Aquacel and Duoderm dressings to the resident's right ankle ulcer and applying the Xeroform dressing and gauze to the resident's right heel. The staff member then returned the scissor to her uniform pocket. The nurse failed to sanitize this scissor before or after use. The nurse failed to remove her contaminated gloves, sanitize her hands, and apply clean gloves before she applied the clean dressings to Resident #12's wounds. During an interview on the morning of 08/31/11, an administrative nurse (#3) stated she expected facility nurses to follow proper infection control procedures during dressing changes.	F 441		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 18 Based on observation, record review, staff interview, and resident and family interview, the complaint issues investigated in conjunction with the standard Medicare/Medicaid survey were not substantiated.	F9999		