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	355033	A. BUILDING _____ B. WING _____	11/03/2010

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 survey, started on 11/01/10 and completed on 11/03/10, the sample include 4 residents for complete review, 11 residents for focused review, and 3 closed records for review.	F 000		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, review of policy and procedure, and review of professional literature, the facility failed to provide medically related social services to ensure 2 of 6 (Resident #4 and #6) sampled residents who exhibited behaviors towards other residents attained or maintained the highest mental and psychosocial well-being possible. Failure to provide these services resulted in resident behaviors [kissing, hugging, pinching, touching, grabbing, groping, luring into a private room, kicking, and name-calling] towards other residents, limiting their physical, mental, and psychosocial well-being. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standard of practice regarding social services; stating the facility must assure that sufficient and appropriate social	F 250	F250 It is the policy of St. Catherine's Living Center to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Resident #4: The Interdisciplinary Team (IDT) will review for ongoing behaviors review and update the care plan to reflect appropriate interventions to minimize the risk of sexually aggressive behaviors, and monitor for the effectiveness of interventions by. The IDT will document identification of residents to whom behaviors were directed with regards to prior noted incidents in resident #4's record by 12-8-10. Resident #6: The Interdisciplinary Team (IDT) will update the care plan to reflect appropriate interventions to minimize the risk of behaviors towards others, and monitor for the effectiveness of interventions by 12-8-10. The IDT will document identification of residents to whom behaviors were directed with regards to prior noted incidents in resident #6's record by 12-8-10. Identification of residents with regards to concurrent issues will also be documented. Resident #6 was moved from the North to the South building on 11-8-10 to decrease the ability for resident	

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

Cornelia C Smith — 11-24-10

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 250	Continued From page 1 services are provided to meet the resident's needs. This requirement specifies that facilities aggressively identify the need for medically-related social services, and pursue the provision of these services. Medically-related social services include through the assessment and care planning process, identifying and seeking ways to support residents' individual needs, and finding options that most meet the physical and emotional needs of each resident. Types of conditions to which the facility should respond with social services by staff or referral include: behavioral symptoms, if a resident with dementia strikes out at another resident (The facility is responsible for the safety of any potential resident victims while it assesses the circumstances of the residents behavior.), presence of a chronic disabling medical or psychological condition such as Alzheimer's disease or schizophrenia, depression, and difficulty with personal interaction and socialization skills. Review of the facility's policy, titled "Resident Behavior Policy" occurred on 11/03/10. This policy, dated 06/01/09, stated, "It is the policy of St. Catherines Living Center to evaluate resident's behaviors to assure the resident does not display a pattern of decreased social interaction . . . Individual objectives on the care plan will be periodically evaluated to assure resident's needs are met with alternative treatment approaches developed to maintain mental and/or psychosocial functioning." - Resident #4's medical record, reviewed on November 01-03, 2010, identified the facility admitted the resident on 12/10/09. The resident's medical diagnoses included: Alzheimer's disease,	F 250	#6 to interact with resident #14. Staff involved with the immediate care of Resident #6 and #14 have received communication that these residents will not be left unsupervised should there be an event where they could interact. Resident #14: The IDT will document identification of residents involved and directed behaviors towards him by Resident #6 with regards to prior noted incidents in resident #14's record by 12-8-10. Concurrent issues will also be documented. All residents are assessed for behaviors upon admission, and quarterly thereafter. Residents who develop behaviors are reviewed with care plans updated to reflect appropriate interventions as they relate to identified incidents by the IDT on an individual basis. Care plans for all residents who have been identified per the IDT team to exhibit behaviors will be reviewed and revised to include appropriate interventions related to behaviors that may affect other residents by 12-8-10. Staff providing/involved in the care of residents who exhibit behaviors towards other residents will be re-educated regarding the need to follow the residents care plans by 12-8-10.	

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F 250	Continued From page 2 dementia with behavioral disturbance, and episodic mood disorder. Prior to his admission, Resident #4 resided in the [Name of Healthcare Facility - Nursing Home]. According to a Progress Note, dated 12/07/09, the healthcare facility staff met with family "to discuss the appropriateness of placement for [Resident #4] with regards to the sexually aggressive behaviors demonstrated by [Resident #4] since admission. Incident's [sic] involving [Resident #4] entering other resident's room in the evening, unwanted kissing of a female resident, and unwanted sexually inappropriate touching of a resident. . . . [Resident #4] does not display remorse for behaviors. Resident has been confronted and educated several times by NH staff re [regarding] making inappropriate sexual remarks and touching staff [and] residents inappropriately. . . . Discussed at meeting the need for 1:1 supervision to ensure the safety of other residents who live in the NH [nursing home] as [Resident #4] displayed sexual aggression toward other resident (at the nursing home where he was previously residing) when a nurse was in the room with her back turned. . . . [Resident #4] is being discharged to his home because the safety of the individuals in the facility is endangered. . . ." Resident #4's Pre-admission Screening/Evaluation Form, dated 12/09/09, identified: diagnosis of Alzheimer's disease or related dementia, independently mobile through ambulation or wheelchair, resident wanders, resident is socially inappropriate or disruptive, and resident is at risk for elopement. The healthcare practitioner, nurse, and social worker completing the pre-admission screening process made no	F 250	The IDT will review/revise Pre-Admission Screening Protocols to ensure the healthcare practitioner, nurse, and social worker completing the pre-admission screening process include documentation of behaviors by 12-8-10 Staff involved in the Pre-admission Screening process will be educated on protocols to include documentation of behaviors by 12-8-10. The Interdisciplinary Team will complete audits of care plans for all residents determined to exhibit behaviors towards other residents to assure appropriate interventions are in place - weekly x4weeks, then monthly x3 months and quarterly thereafter to assure continued compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed. The Quality Assurance Coordinator or designee shall be responsible to monitor and assure the completion of audits and reporting of results as stated on the Quality Council Meeting Agenda monthly. Facility will be in compliance by 12-8-10	

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F 250	Continued From page 3 mention of the resident's sexually aggressive behaviors on the form. During an interview on 11/02/10 at 4:05 p.m., an administrative nursing staff member (#1) confirmed the facility had knowledge of Resident #4's sexually aggressive behaviors prior to admission. Resident #4's annual Minimum Data Set (MDS), dated 03/10/10, identified problems with short term memory, moderately impaired daily decision making skills, reduced social interaction, socially inappropriate/disruptive, behavioral symptoms, resists care, and conditions/diseases make cognitive, ADL [activities of daily living], mood or behavior patterns unstable. Resident #4's Resident Assessment Protocol (RAP) summary, dated 03/16/10, stated, ". . . [Resident] wandering in the unit. This is not detrimental to him or others. . . . [Resident #4] can be socially inappropriate at times but does stop and redirect easily. He does see the psychiatrist and is [sic] medication. He does get cues and supervision from the staff. . . . " The resident's current care plan, dated 09/07/10, stated, ". . . Problem: . . . ACTIVITIES: . . . 4. Needs supervision around female residents as he will act out inappropriately. . . . Approach: . . . 8. Re-direct and intervene with resident when exhibiting inappropriate behaviors: (Females). Monitor often for these behaviors. . . ." During an interview on 11/03/10 at 2:30 p.m., the administrative nursing staff member (#1) confirmed the facility staff failed to address the resident's sexually aggressive behaviors on his	F 250		

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F 250	Continued From page 4 current plan of care. The Psychiatric Evaluation, dated 12/22/09, identified ". . . He [Resident #4] has been trying to lure female residents into his room. He will pat them on the hand or the butt. He has also been making suggestive comments to the nursing staff and the staff is very concerned about some of his behaviors. . . We will start a trial of Climara [estrogen/progestin] . . . as there is a good chance that this will help to diminish his inappropriate behaviors . . ." Resident #4's Physician Orders, dated 05/01/10-11/01/10 identified: * Celexa [antidepressant]: 10 mg [milligram] tablet orally once a day * Climara: 0.05 mg/24 hours extended release transdermal film once a day on Thursdays * Risperdal antipsychotic]: 0.25 gm [gram] tablet orally twice a day During an interview on 11/02/10 at 4:05 p.m., an administrative nursing staff member (#1) stated the Celexa and Climara had a start date of 12/22/09, and the Risperdal had a start date of 01/26/10. The administrative nursing staff member (#1) confirmed the facility had knowledge of Resident #4's sexually aggressive behaviors prior to admission and stated, "That is why we started his medications." Resident #4's Vulnerable Adult Assessment, dated 09/02/10, identified the resident had a history of abuse towards others, had behaviors which increase his risk of abuse to others, and had been "Socially inappropriate. Talks nasty, hollers at times . . . hug, kisses and grabby at times."	F 250		

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F 250	Continued From page 5 Resident #4's Interdisciplinary Progress Notes, dated 12/13/09 - 09/25/10, identified Resident #4 displayed the following sexually aggressive behaviors towards other female residents on the Special Care Unit: * Kissed a resident on the forehead or lips; seventeen times * Hugged or put his arms around a resident's shoulders; three times * Pinched and/or touched a resident between their legs or on their buttocks; four times * Grabbed, pinched and/or touched a resident's breast; seven times * Groped a resident; two times * Lured a resident into his room; seven times The Interdisciplinary Progress Notes did not identify the female residents or their response to his aggressive behaviors. Staff attempted to remind, redirect, and/or remove Resident #4 from the situation. Progress Notes stated he would often repeat his actions. In addition, several entries identify the resident displayed these same behaviors towards female staff members. During an interview on 11/03/10 at 10:15 a.m., when asked how the female residents respond to Resident #4's behaviors, a certified nursing assistant (CNA) (#13) stated, "That depends on the resident. Some don't like his advances and some don't respond at all. I'm not aware of any extreme responses." During an interview on 11/03/10 at 10:20 a.m., when asked how the female residents respond to Resident #4's behaviors, a CNA (#16) stated, "That depends on the resident. Some will correct him, some don't like his advances, and others will go with him willingly."	F 250		

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F 250	Continued From page 6 During an interview on 11/03/10 at 2:15 p.m., when asked if sexually aggressive behaviors are addressed during the pre-admission screening process, a Social Services managerial staff member (#10) stated, "It should have been on there [Pre-admission Screening/Evaluation Form]." When discussing Resident #4's behaviors, she stated, "That's his personality; huggy person, affectionate. He wouldn't have done those things with the ladies before [his dementia]. He didn't try any medication before that [admission to Special Care Unit]. He's gotten better. They will redirect and he usually stops. He still has some days. That's why he is in the Unit. [Resident #5] seeks him out. It's not all his fault." The Social Services managerial staff member (#10) further confirmed the resident's sexually aggressive behaviors were not addressed on his current plan of care, and stated, "[Staff] should have written one [care plan]." During an interview on 11/03/10 at 2:30 p.m., two administrative nursing staff members (#1 and #11) stated, based on the resident's previous sexually aggressive behaviors, they "would expect staff to care plan for his behaviors." The facility failed to adequately assess ongoing behaviors, develop and consistently implement appropriate interventions, and monitor the effectiveness of these interventions for Resident #4 to minimize the risk of his sexually agressive behaviors. - During an initial tour of the facility on 11/01/10 at 1:50 p.m., interview of an administrative nursing staff member (#6), identified Resident #6 "kicks and calls names" at Resident #14. Observation	F 250		

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F 250	Continued From page 7 during the initial tour revealed Resident #6 and Resident #14 residing in adjacent rooms with a shared bathroom. Review of Resident #6's medical record occurred on November 01-03, 2010. The resident's diagnoses included noncommunication and mental retardation. The resident's Minimum Data Sets (MDS), dated 09/19/10 and 06/19/10, identified short term and long term memory problems, moderately impaired daily decision making, verbally abusive behaviors occurred 1-3 days in last 7 days, walked in room independently, walked in the corridor with supervision, and completed locomotion on the unit with a wheelchair independently. Review of Resident #14's medical record occurred on November 01-03, 2010. The resident's diagnoses included cognitive disorder, manic depression, and schizophrenia. The resident's MDS, dated 08/24/10, identified long and short term memory problems, moderately impaired daily decision making, walked in room/corridor and completed locomotion on the unit with a wheeled walker independently. Review of Resident #14's record, including the nurses' notes and care plan, lacked documentation of the directed behaviors towards him by Resident #6. Resident #6's Resident Assessment Protocol Summary (RAPS), dated 06/28/10, identified resident will stick out his tongue, spit, hold up his fist at you [staff], and call names [resident and staff]. The resident's current care plan lacked interventions for addressing these behaviors other than medications. Review of Resident #6's Nurses' Notes identified	F 250		

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F 250	Continued From page 8	F 250		

verbal and physical behaviors towards another unidentified resident, the Nurses' Notes failed to identify the resident whom these behaviors were directed, as follows:

*05/09/10 - " Resident to DR [dining room] for breakfast, turned in w/c [wheelchair] and started to make faces and rude noises at another resident behind him . . .
*05/20/10 - " . . . resident has been trying to trip another resident in the dining room of whom is ambulatory, also making negative statements towards him in DR. . . seating chart will be changed as to try to decrease behaviors . . ."
*08/30/10 - ". . . [Resident] kicked another resident's walker from under him while resident was getting a drink of water. Res redirected to leave other resident alone . . ."
*10/02/10 - "It was told to this nurse that resident has been kicking at another resident and bullying him. Activities staff and other residents have noted this behavior happening. . . ."
*10/29/10 - "Resident was observed by staff to be kicking another resident in the day area. Resident was informed that was unacceptable behaviors. [Resident] stated "shut up" "I don't like him he stinks . . . other resident was asked if was ok, he stated yes and did leave the day room."

On 11/02/10 at 10:00 a.m., interview of an activity staff member (#7) identified Resident #6 and Resident #14 attended activities in the activity room on Mondays only because of Resident #6's activity preferences and she observed no problems "because supervised."

Observation of the afternoon coffee and dessert time in the dining room, scheduled from 1:30 to 2:00 p.m. daily, showed Resident #6 and

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F 250	Continued From page 9 Resident #14 seated across at right angle from each other at the same table. Observation showed Resident #6 kicking a leg towards Resident #14 and smiling. Resident #14 exited the dining room through a second door without passing by Resident #6. During an interview on 11/03/10 at 2:00 p.m. with CNAs (#8 and #9), they confirmed Resident #6 and Resident #14 sit at the same table most of the time in the dining room for afternoon snack. The CNA (#8) stated the residents "sit at the same table but kitty corner probably to keep an eye on each other." Resident #6 sits at the table first and Resident #14 sits at the table after him to sit with the men rather than the women. During an interview on 11/03/10 at 1:45 p.m., a social services staff member (#10) confirmed the resident involved in the verbal and physical behaviors as Resident #14 and identified she had visited with Resident #14 who stated he did not want to be by Resident #6. The staff member confirmed the above observation of the residents at snack time as aggravating behavior and identified these residents shouldn't be sitting together. The staff member identified Resident #14 had moved to the room adjacent to Resident #6's room at the end of August. The staff member confirmed Resident #14 and Resident #6 should not have been moved to adjacent rooms and should be moved apart. This staff member agreed potentially unsupervised interactions between these residents could result in harm to Resident #14. Interview of two administrative nursing staff members (#1 and #11) occurred on 11/03/10 at 2:15 p.m. The staff members agreed nurse's	F 250		

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F 250	Continued From page 10 notes regarding behaviors should include identification of the residents involved, the residents' care plans should include interventions to prevent these behaviors, and Resident #6 and Resident #14 should be moved from adjacent rooms sharing bathrooms and a dining room.	F 250		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, facility policies and procedures, review of professional literature, and staff interview, the facility failed to develop and review/revise the residents' comprehensive plans of care for 4 of 15 sampled resident (Resident #4, #5, #6 and #14). Failure to develop, and	F 279	F279 It is the policy of St. Catherine's Living Center to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Resident #4: The Interdisciplinary Team (IDT) will review for ongoing behaviors, adequate bowel elimination and use of foot pedals during transport. The IDT will review and update the care plan to reflect appropriate interventions to minimize the risk of sexually aggressive behaviors, ensure adequate bowel elimination and use of foot pedals by 12-8-10.	

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F 279	Continued From page 11 review/revise the resident's care plan limits the staffs' ability to communicate changes in the resident's status and care, and to ensure continuity of resident care. Findings include: The Centers for Medicare and Medicaid Services (CMS) state the facility should develop quantifiable objectives for the highest level of functioning the resident may be expected to attain. Facility staff will use these objectives to monitor resident progress. Review of the facility's policy, titled "Resident Behavior Policy" occurred on 11/03/10. This policy, issued 06/01/09, stated, ". . . Individual objectives on the care plan will be periodically evaluated to assure resident's needs are met with alternative treatment approaches developed to maintain mental and/or psychosocial functioning." Review of the facility's policy, titled "Hardened Fecal Matter" occurred on 11/03/10. This policy, issued December 2002, failed to address implementation of interventions to prevent the reoccurrence of severe constipation. Review of the facility's policy, titled "Resident Transfer Wheelchair" occurred on 11/03/10. This policy, issued December 2002, identified interventions as "per care plan." - Review of Resident #4's medical record occurred on November 01-03, 2010. Medical diagnoses included: Alzheimer's disease, dementia with behavioral disturbance, episodic mood disorder, constipation, benign prostatic hypertrophy, chronic obstructive pulmonary	F 279	Resident #5 The Interdisciplinary Team (IDT) will review for potential for urinary tract infection and use of foot pedals during transport. The IDT will review and update the care plan to reflect appropriate interventions to minimize the risk of developing UTI's and ensure use of foot pedals by 12-8-10 Resident #6: The Interdisciplinary Team (IDT) will review for ongoing behaviors and update the care plan to reflect appropriate interventions to minimize the occurrence of behaviors towards other residents by 12-8-10. Resident #14 The IDT will review and update the care plan with regards to recognizing behaviors directed towards him by other residents and ensuring his safety by 12-8-10. Care plans for all residents who have been identified per the IDT team to exhibit behaviors will be reviewed and revised as needed to include appropriate interventions related to behaviors that may affect other residents by 12-8-10. Care plans for all residents who have been identified per the IDT team to be at risk for constipation will be reviewed and	

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F 279	Continued From page 12 disease (COPD) and arthritis. Prior to his admission, Resident #4 resided in the [Name of Healthcare Facility - Nursing Home]. According to a Progress Note, dated 12/07/09, the healthcare facility staff "met with family . . . Discussed . . . the need for 1:1 supervision to ensure the safety of other residents who live in the NH [nursing home] as [Resident #4] displayed sexual aggression toward other resident . . ." During an interview on 11/02/10 at 4:05 p.m., an administrative nursing staff member (#1) confirmed the facility had knowledge of Resident #4's sexually aggressive behaviors prior to admission. During an interview on 11/03/10 at 2:15 p.m., the Social Services managerial staff member (#10) confirmed the resident's sexually aggressive behaviors were not addressed on his current plan of care, and stated, "[Staff] should have written one." During an interview on 11/03/10 at 2:30 p.m., two administrative nursing staff members (#1 and #11) stated, based on the resident's previous sexually aggressive behaviors, they "would expect staff to care plan for his behaviors." The administrative nursing staff member (#1) confirmed the resident's previous episode of sexually aggressive behaviors had not been addressed on his current plan of care. Resident #4's Interdisciplinary Progress Notes identified the following: * 02/07/10 "Res having troubles passing stool. Gave enema and suppository with no results. BM [bowel movement] is impacted in anus. Tried to	F 279	revised as needed to include appropriate interventions related to constipation by 12-8-10. Care plans for all residents who have been identified per the IDT team to require foot pedals for transport will be reviewed and revised as needed to include appropriate use of foot pedals by 12-8-10. Care plans for all residents who have been identified per the IDT team be at risk for developing UTI's related to history of such will be reviewed and revised as needed to include appropriate interventions related to prevention of UTI's by 12-8-10. The IDT will develop Communication Protocols to include notification of LRD or designee regarding changes in resident's status and care as related to bowel issues to ensure continuity of care by 12-8-10. Policies and procedures regarding Bowel Elimination/Constipation, Resident Transport, Resident Behaviors and Prevention of UTI's will be reviewed and updated by the IDT by 12-8-10 All staff will be re-educated regarding proper transport with use of foot pedals for transportation and appropriate interventions related to behaviors that may affect other residents	

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F 279	Continued From page 13 digitally remove hard stool but was unsuccessful. Patient expresses pain while trying to pass a BM. Anus is open with large hard stool in. On-call physician was notified and we will try Miralax and another suppository if unsuccessful. Patient refused dinner and PM meds. Had a large emesis and states 'he's very tired and doesn't feel well. . . ." The resident's current care plan, dated 09/07/10, stated, ". . . Problem: Resident experiences bladder incontinence possibly r/t [related to] diagnoses of dementia, behaviors and dx [diagnosis of] BPH [benign prostatic hypertrophy] . . . Approach: . . . Ensure adequate bowel elimination; administer laxatives/cathartics as ordered and/or per facility protocol." During an interview on 11/03/10 at 10:50 a.m., a managerial dietary staff member (#12) stated she was unaware that Resident #4 experienced any episodes of severe constipation. She further indicated the "LRD [License Registered Dietitian] had not been notified of the fecal impaction. During an interview on 11/03/10 at 10:50 a.m., administrative nursing staff members (#1 and #11) stated, based on the episode of severe constipation, they "would expect them [staff] to care plan constipation", and "would expect to see dietary interventions" put in place. The administrative nursing staff member (#1) confirmed the resident's previous episode of severe constipation had not been addressed on his current plan of care. Observation on 11/01/10 at 5:05 p.m. and on 11/02/10 at 7:40 a.m., showed the certified nurse assistants (CNAs) (#15 and #16) transported	F 279	per individual resident care plan by 12-8-10 Licensed Nursing Staff will be re-educated regarding Bowel Elimination/ Constipation and Prevention of UTI's per individual resident care plan and Communication Protocols regarding notification of LRD by 12-8-10. The Interdisciplinary Team will complete audits of care plans for all residents determined to exhibit behaviors towards other residents, identified per the IDT team be at risk for developing UTI's related to history of such, be at risk for constipation, and identified per the IDT team to require foot pedals for transport to assure appropriate interventions are in place - weekly x4weeks, then monthly x3 months and quarterly thereafter to assure continued compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed. The Quality Assurance Coordinator or designee shall be responsible to monitor and assure the completion of audits and reporting of results as stated on the Quality Council Meeting Agenda monthly. Facility will be in compliance by 12-8-10	

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F 279	Continued From page 14 Resident #4 in his wheelchair down the hallway to the dining room. On 11/01/10 Resident #4's feet slid along the surface of the floor making an audible noise. He did not lift his feet. The staff members failed to cue the resident to lift his feet/shoes, and ensure the resident's feet/shoes cleared the floor during transport. The resident's current care plan, dated 09/07/10, failed to address the use of foot pedals during transport. During an interview on 11/03/10 at 2:30 p.m., administrative nursing staff members (#1 and #11) stated, they "would expect them [staff] to use footrests [when transporting residents]." Failure to develop, and review/revise Resident #4's care plan limited the staffs' ability to communicate changes in his status and care, and to ensure continuity of care related to his sexually aggressive behaviors, severe constipation and locomotion on the Unit. - Review of Resident #5 medical record occurred on November 1-3, 2010. Medical diagnoses included: history urinary tract infections, ORIF [open reduction internal fixation] LT [left] hip, and joint effusion to knees bilaterally. The Infection Report, dated 10/22/10, identified Resident #5 developed a urinary tract infection. The questions on the report pertaining to cultures and/or the development of a care plan remained blank. During an interview on 11/03/10 at 2:30 p.m., an administrative nursing staff member (#1) confirmed the resident's 10/22/10 urinary tract	F 279		

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F 279	Continued From page 15 infection was not addressed on her current plan of care. Observation on 11/02/10 at 9:45 a.m. and 2:50 p.m., showed the CNAs (#13 and #14) transported Resident #5 in her wheelchair down the hallway to her room. The staff members failed to place the resident's foot pedals (located in a bag attached to the back of her wheelchair) on her chair, cue the resident to lift her feet/shoes, and ensure the resident's feet/shoes cleared the floor during transport. The resident's current care plan, dated 08/19/10, failed to address the use of foot pedals during transport. Failure to develop, and review/revise Resident #5's care plan limited the staffs' ability to communicate changes in her status and care, and to ensure continuity of care related to her UTI and locomotion on the Unit. - Review of Resident #6's medical record occurred November 01-03, 2010. The resident's diagnoses included noncommunication and mental retardation. Resident #6's nurses' notes identified verbally and physically abusive behavioral symptoms of calling names and kicking Resident #14. Observation of the afternoon coffee and dessert time in the dining room from 1:30 to 2:00 p.m. daily, showed Resident #6 and Resident #14 seated across at a right angle from each other at the same table. Observation showed Resident #6 kicking a leg towards Resident #14.	F 279		

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F 279	Continued From page 16 Resident #6's plan of care failed to address these behavioral symptoms. - Review of Resident #14's medical record occurred November 01-03, 2010. The resident's diagnoses included cognitive disorder, manic depression, and schizophrenia. The medical record, including the care plan, failed to identify Resident #14 as the individual Resident #6 targeted with his verbal and/or physical behaviors. Interview of two administrative nursing staff members (#1 and #11) occurred on 11/03/10 at 2:15 p.m. The staff members agreed the Resident #6 and #14's care plans should include interventions for behaviors. Failure to develop, and review/revise Resident #6 and #14's care plans limited facility staff's ability to reduce the occurrence of physical and/or verbal behaviors and any resulting potential injury to these residents.	F 279		
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, staff interview, review of facility policy and procedure, and review of professional literature, the facility failed to	F 309	F309 It is the policy of St. Catherine's Living Center that each resident 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.	

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F 309	Continued From page 17 implement effective interventions to maintain normal bowel elimination patterns for 1 of 1 sampled resident (Resident #4) who the facility identified as experiencing severe constipation. This failure resulted in Resident #4 experiencing discomfort; digital removal of stool, pain and emesis. Findings include: Review of the facility's policy, titled "Hardened Fecal Matter" occurred on 11/03/10. This policy, issued December 2002, addressed the use of laxatives, digital removal of the hardened feces, and physician notification. The policy failed to address reassessment or implementation of interventions to prevent the reoccurrence of severe constipation. Review of Resident #4 medical record occurred on November 1-3, 2010. The resident's medical diagnoses included: Alzheimer's, dementia with behavioral disturbance, episodic mood disorder, benign prostatic hypertrophy (BPH), chronic obstructive pulmonary disease (COPD) and arthritis. Resident #4's Interdisciplinary Progress Notes identified the following: * 01/04/10 "Res [resident] given Dulcolax suppository to promote BM [bowel movement] following two small hard stools. Result was sm [small] to med [medium] very hard stool. . . ." * 01/17/10 ". . . Resident has very hard stool and has difficulty passing them." * 02/07/10 "Res having troubles passing stool. Gave enema and suppository with no results. BM is impacted in anus. Tried to digitally remove hard stool but was unsuccessful. Patient expresses	F 309	Resident #4: The Interdisciplinary Team (IDT) will review for adequate bowel elimination, and review and update the care plan to reflect appropriate interventions to prevent the reoccurrence of severe constipation by 12-8-10. Care plans for all residents who have been identified per the IDT team to be at risk for constipation will be reviewed and revised as needed to include appropriate interventions related to constipation by 12-8-10. Policies and procedures regarding Bowel Elimination/Constipation, will be reviewed and updated by the IDT by 12-8-10. The IDT will develop Communication Protocols to include notification of LRD or designee regarding changes in resident's status and care as related to bowel issues to ensure continuity of care by 12-8-10. Licensed Nursing Staff will be re-educated regarding Bowel Elimination/ Constipation per individual resident care plan and Communication Protocols regarding notification of LRD by 12-8-10. The Interdisciplinary Team will complete audits of care plans for all residents determined to be at risk for constipation	

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F 309	Continued From page 18 pain while trying to pass a BM. Anus is open with large hard stool in. On-call physician was notified and we will try Miralax and another suppository if unsuccessful. Patient refused dinner and PM meds. Had a large emesis and states 'he's very tired and doesn't feel well. . . ." No further entries were made regarding the results/outcome of the Miralax or suppository. * 02/11/10 "Res given supp [suppository] to promote bm [and] large hard formed stool resulted." * 03/19/10 ". . . Had large hard BM but took all bowel meds [medications] . . ." Resident #4's annual Minimum Data Set (MDS), dated 03/10/10, identified problems with short term memory, moderately impaired daily decision making skills, required extensive assistance with toilet use, and bowel elimination pattern regular - at least one movement every three days. The resident's current care plan, dated 09/07/10, stated, ". . . Problem: Resident experiences bladder incontinence possibly r/t [related to] diagnoses of dementia, behaviors and dx [diagnosis of] BPH [benign prostatic hypertrophy] . . . Approach: . . . Ensure adequate bowel elimination; administer laxatives/cathartics as ordered and/or per facility protocol." The Bowel Assessment, dated 05/31/10, listed Resident #4's current diagnoses affecting bowel function including; systemic neurologic disease and Alzheimer's dementia, and listed his risk factors for bowel incontinence including; extensive assistance to total dependence and BPH. The assessment further indicated the resident took antipsychotics/antidepressants, and had been included in a scheduled defecation	F 309	to assure appropriate interventions are in place - weekly x4weeks, then monthly x3 months and quarterly thereafter to assure continued compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed. The Quality Assurance Coordinator or designee shall be responsible to monitor and assure the completion of audits and reporting of results as stated on the Quality Council Meeting Agenda monthly. Facility will be in compliance by 12-8-10	

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F 309	Continued From page 19 program. Resident #4's Bowel Movement Record, dated 02/01/10 to 10/02/10, identified the following: * 01/31/10 - 02/08/10; 8 days between bowel movements * 02/11/10 - 02/16/10; 5 days between bowel movements * 03/01/10 - 03/06/10; 5 days between bowel movements * 03/26/10 - 03/31/10; 5 days between bowel movements Resident #4's Medication Administration Record (MAR), dated 02/10/10-02/28/10, identified the following: * Enablex [spasmolytic] tablet, extended release; 15 mg [milligrams]; oral once a day * Lasix [diuretic] tablet; 20 mg. oral once a day * Zocor [antilipemic] tablet; 20 mg; oral Q [every] pm - once an evening * Risperdal [antipsychotic] tablet; 0.25 mg; oral TID [three times a day] The Nursing 2009 Drug Handbook, 29th Edition, p. 346, 517, 860 and 1244, identified Enablex, Lasix, Risperdal and Zocor as having "adverse GI [gastrointestinal] effects including . . . constipation . . ." Resident #4's PRN [as needed] Medication Flowsheet, dated 02/01/10-02/28/10, identified the following: * 02/02/10 at 6:10 p.m. and 02/07/10 at 8 p.m., Milk of Magnesia (MOM); 30 cc The PRN Medication Notes did not show result/outcome for the prn MOM. * 02/06/10, Bisacodyl suppository The PRN Medication Notes conflicted with the	F 309		

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F 309	Continued From page 20 PRN Medication Flowsheet indicating a Glycerine suppository had been given on 02/07/10 at 7:40 p.m., and did not show result/outcome for the prn suppository. * 02/07/10 at 7:10 p.m., Fleet enema The PRN Medication Notes did not show result/outcome for the prn enema. * 02/07/10 at 8:30 p.m., MiraLax; powder The facility did not provide the PRN Medication Notes for this Flowsheet. * 02/16/10 at 8:00 a.m. and 02/17/10 at 5 p.m., Milk of Magnesia (MOM); 30 cc The PRN Medication Notes did not show result/outcome for the prn MOM. On 02/16/10, the note read, ". . . Results/Outcome: check bm log . . ." During an interview on 11/02/10 at 4:05 p.m., administrative nursing staff member (#1) stated the MOM was inititated 12/10/09 and the Bisacodyl was initiated 02/28/10. Both were discontinued 03/01/10 when [Resident #4] went to the hospital, and initiated again on 05/27/10. A one time order was given 02/07/10 for Miralax. It was initiated again on 03/18/10, and the dose was increased on 05/06/10. During an interview on 11/03/10 at 10:50 a.m., a managerial dietary staff member (#12) stated she was unaware that Resident #4 experienced any episodes of severe constipation. She further indicated the "LRD [License Registered Dietitian] had not been notified of the fecal impaction", as was reflected in her "monthly nutrition note documented just days following the impaction." During an interview on 11/03/10 at 10:50 a.m., administrative nursing staff members (#1 and #11) stated, based on the episode of severe	F 309		

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F 309	Continued From page 21 constipation, they "would expect them [staff] to care plan constipation", and "would expect to see dietary interventions" put in place. The administrative nursing staff member (#1) confirmed the resident's previous episode of severe constipation had not been addressed on his current plan of care. The facility failed to ensure Resident #4 received effective interventions to maintain normal bowel elimination patterns to prevent constipation which resulted in Resident #4 experiencing discomfort; digital removal of stool, pain and emesis. No dietary approaches/interventions were implemented on his revised care plan to minimize the side effects (which include constipation) of his prescribed medications.	F 309		
F 323 SS=D	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, review of facility policy, and review of professional literature, the facility failed to provide adequate supervision and assistance devices (foot pedals) for 3 of 7 sampled residents (Resident #4, #5, and #15) who required assistance with wheelchair transportation. Failure of the facility to ensure staff properly use	F 323	F323 It is the policy of St. Catherine's Living Center that the facility 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 Resident's #4, #5 and #15: The Interdisciplinary Team (IDT) will review for use of foot pedals during wheelchair transport and review and update the care plans to reflect	

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F 323	Continued From page 22 assistance devices placed residents at risk for possible accident and/or injury. Findings include: The Centers for Medicare and Medicaid Services (CMS) state the facility must ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. Assistive devices for mobility include wheelchairs. Factors that are associated with an increased accident risk related to the use of assistive devices include resident condition. Lower extremity weakness, gait disturbances, decreased range of motion, and poor balance may affect some residents. These conditions combined with cognitive impairment can increase the accident risks of using mobility devices. Review of the facility's policy, titled "Resident Transfer Wheelchair" occurred on 11/03/10. This policy, issued December 2002, stated, ". . . POLICY Residents using a wheelchair will be evaluated by the Interdisciplinary Team for the need to use leg rests during transport. A bag to store leg rests will be attached to the back of residents wheelchairs for residents deemed appropriate. Staff will provide for safe transfer during transport per individual plan of care. . . . PROCEDURE . . . 4. For residents with leg-rest bag on back of the wheelchair: a. Attach leg rests to wheelchair prior to transport. . . . 5. Residents, per care plan, that do not need leg rests for transport: a. Go slowly and give the resident a break when you are going long distances. b. Explain what you are doing prior to transport."	F 323	appropriate interventions to ensure use of foot pedals by 12-8-10 Staff involved with the immediate care of Resident #4, #5 and #15 received communication on 11-3-10 that these residents are to be transported per wheelchair with appropriate adaptive equipment, including foot pedals or be given appropriate cues to lift feet during transport if pedals not indicative per individual resident plan of care. Care plans for all residents who have been identified per the IDT team to require foot pedals for transport will be reviewed and revised to include appropriate interventions for wheelchair transport by 12-8-10. Policies and procedures regarding Resident Wheelchair Transport, will be reviewed and updated by the IDT by 12-8-10 All staff will be re-educated regarding proper wheelchair transport with use of foot pedals/verbal cues to lift feet for transportation per individual resident care plan and Resident Wheelchair Transport Policy by 12-8-10 The Interdisciplinary Team will complete audits of care plans for use of foot pedals and/or verbal cues per Resident Wheelchair Transport Policy for all	

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F 323	Continued From page 23 - On 11/02/10 at 9:45 a.m., observation showed a certified nurse assistant (CNA) (#13) transported Resident #5 in her wheelchair down the hallway to her room. Resident #5's foot pedals remained in the bag attached to the back of her chair. She did lift her feet approximately one inch off the ground when the chair began moving. The staff member failed to place the resident's foot pedals on her chair, cue the resident to lift her feet/shoes, and ensure the resident's feet/shoes cleared the floor during transport. - On 11/02/10 at 2:50 p.m., observation showed a nursing staff member (#14) transported Resident #5 in her wheelchair down the hallway to her room. Resident #5's foot pedals remained in the bag attached to the back of her chair. Her feet slid along the surface and caught/bounced on the flooring. She did lift her feet approximately one inch off the ground after her feet caught/bounced a second time. The staff member failed to place the resident's foot pedals on her chair, cue the resident to lift her feet/shoes, and ensure the resident's feet/shoes cleared the floor during transport. Review of Resident #5 medical record occurred on November 1-3, 2010. The resident's medical diagnoses included: ORIF [open reduction internal fixation] LT [left] hip, joint effusion to knees bilaterally, and peripheral vascular disease. Resident #5's annual Minimum Data Set (MDS), dated 08/12/10, identified problems with short and long term memory, severely impaired daily decision making skills, total dependence with transfers, and moderate hip pain. Resident #5's Resident Assessment Protocol (RAP) summary, dated 08/16/10, stated, ". . .	F 323	residents identified per the IDT team to require foot pedals per individual plan of care or verbal cues per Resident Wheelchair Transport policy to assure appropriate interventions are in place/utilized weekly x4weeks, then monthly x3 months and quarterly thereafter to assure continued compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed. The Quality Assurance Coordinator or designee shall be responsible to monitor and assure the completion of audits and reporting of results as stated on the Quality Council Meeting Agenda monthly. Facility will be in compliance by 12-8-10	

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F 323	Continued From page 24 severely impaired decision making and resident requiring total assist with most ADLs. Resident requires assist with above r/t [related to] recent right [sic] ORIF, progression of dementia and Alzheimer's. . . . [Name] has little insight into her limitations, safety concerns, or understanding why she cannot do some things. . . . Staff need to provide her with cues, reminders, and supervision for daily routine . . . " The resident's current care plan, dated 08/19/10, stated, ". . . Problem: . . . Resident requires total assist with ADLs related to limited mobility, impaired cognition, weakness, pain . . . Approach: . . . w/c with 1 assist for locomotion . . . Problem: . . . Resident at risk for falling R/T . . . limited mobility and cognitive status . . . Approach: . . . 1/2 hour safety checks . . . unable to ambulate . . . " Her current plan of care failed to address the use of foot pedals during locomotion on the Unit. - On 11/01/10 at 5:05 p.m., observation showed a CNA (#15) transported Resident #4 in his wheelchair down the hallway to the diningroom. Resident #4's feet slid along the surface of the floor making an audible noise. He did not lift his feet. The staff member failed to cue the resident to lift his feet/shoes, and ensure the resident's feet/shoes cleared the floor during transport. - On 11/02/10 at 7:40 a.m., observation showed a CNA (#16) transported Resident #4 in his wheelchair down the hallway to the diningroom. Resident #4's feet slid along the surface of the floor. He did not lift his feet. The staff member failed to cue the resident to lift his feet/shoes, and ensure the resident's feet/shoes cleared the floor during transport.	F 323		

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F 323	Continued From page 25 Review of Resident #4 medical record occurred on November 1-3, 2010. Resident #4's annual Minimum Data Set (MDS), dated 03/10/10, identified problems with short term memory, moderately impaired daily decision making skills, extensive-to-total assist of two plus persons with transfers and locomotion on unit. The resident's current care plan, dated 09/07/10, stated, ". . . Problem: . . . Resident has the potential for decline in ADL ability . . . Decline in ability is expected as dementia progress [sic]. . . . Approach: . . . Locomotion: Assist of 1 as needed. . . . Problem: Resident at risk for falling . . . Approach: . . . Hourly safety checks. . . ." His current plan of care failed to address the use of foot pedals during locomotion on the Unit. During an interview on 11/03/10 at 2:30 p.m., administrative nursing staff members (#1 and #11) stated, they "would expect them [staff] to use footrests [when transporting residents]." Failure of the facility to ensure staff properly used assistance devices (wheelchair foot pedals) placed residents at risk for possible accident and/or injury. - On 11/01/10 at 5:30 p.m., observation revealed an unidentified Certified Nursing Assistant (CNA) propelling Resident #15's wheelchair to the dining room. Observation identified the wheelchair without foot pedals and Resident #15's feet sliding on the floor. The CNA did not cue Resident #15 to lift her feet as she propelled the chair.	F 323		

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F 323	Continued From page 26 - On 11/03/10 at 9:30 a.m., observation showed two CNAs (#4 and #5) propelled Resident #15's wheelchair from the North nurse's station to her room. As the CNA's pushed the chair, Resident #15 lifted her toes, but her heels slid across the floor. The CNA's did not cue the resident to lift her feet. Review of Resident #15's care plan, on 11/03/10, identified the problem "[Resident #15] has short and long term memory recall problems related to dx [diagnoses] . . . Needs cues and supervision, and assist with all cares." Failure to place foot pedals on the chair or cue the resident to lift her feet placed the resident at risk for an injury and/or skin breakdown when her feet slid on the floor as staff propelled the wheelchair.	F 323		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, resident interview, and staff interview, the facility failed to provide colored dishes for 3 of 6 meals for 1 of 1 sampled resident (Resident #8) requiring adaptive equipment. Failure to provide colored dishes for a resident with visual deficits has the potential to contribute to possible weight loss and to negatively impact the resident's intake. Findings include:	F 369	F369 It is the policy of St. Catherine's Living Center that the facility provides special eating equipment and utensils for residents who need them. Colored dishes were purchased and provided for Resident #8 and utilized for all meals beginning 11-08-10. Residents identified by the IDT as requiring adaptive equipment per the	

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F 369	Continued From page 27 The facility policy "Adaptive Equipment," dated 12/2002, stated, ". . . The Interdisciplinary Team . . . will assess individual resident nutritional needs and make recommendations regarding approaches/adaptive equipment: The facility will provide adaptive equipment assistance with meals as indicated. . . ." - Observation of the evening meal for Resident #8, on 11/01/10 at 5:40 p.m. showed the meal served on a white plate. When asked how her meal was, Resident #8 stated, "everything was good except I was supposed to have a green plate because my eyes are so bad." Review of Resident #8's dining room tray card at the table stated, "special utensils - colored dishes." The resident roster, provided by the facility, identified Resident #8 as interviewable. During the survey, review of the medical record for Resident #8 identified the following: * A Nutritional Assessment, dated 07/27/10, identified adaptive equipment - colored dishes. * Resident #8's current care plan, revised on 10/26/10, identified diagnoses of macular degeneration and glaucoma. The care plan identified problems of "impaired vision R/T [related to] glaucoma and macular degeneration," and "Leaves [greater than] 25% food/fluid uneaten at meals." Approaches include "Provide adaptive equipment as outlined on dining room tray card." The following additional observations identified staff's failure to provide colored dishes to accommodate the resident's visual deficits:	F 369	resident's dining room tray card will be audited to assure appropriate adaptive equipment is provided by 12-8-10. Staff providing adaptive equipment to residents at meal times will been re-educated regarding the need to follow the residents care plans; which includes the information on the resident's dining room tray card for provision of adaptive equipment by 12-8-10. The Interdisciplinary Team will complete audits on all residents requiring adaptive equipment at mealtime 3x/day for all meals: (Continental Breakfast, Brunch, Supper) weekly x4weeks, then monthly x3 months and quarterly thereafter to assure continued compliance by 12-8-10. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed. The Quality Assurance Coordinator or designee shall be responsible to monitor and assure the completion of audits and reporting of results as stated on the Quality Council Meeting Agenda monthly. Facility will be in compliance by 12-8-10	

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F 369	Continued From page 28 * 11/02/10 at 7:45 a.m., breakfast served on a white plate. * 11/02/10 at 11:20 a.m., fruit served in a small white bowl. During an interview, on 11/02/10 at 9:40 a.m., Resident #8 stated she is "supposed to have colored dishes - lately haven't been getting them - have a hard time to see my food."	F 369		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure the removal of expired medications occurred in 1 of 3	F 425	F425 It is the policy of St. Catherine's Living Center that the facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement per federal regulation. The facility must employ or obtain the services of a licensed pharmacist who provide consultation on all aspects of provision of pharmacy services in the facility. Medications stored in the North Medication room were evaluated by the Resident Care Coordinator for expiration dates and expired medications were destroyed on 11-3-10. Expiration dates for all medications in all Medication Rooms will be evaluated for	

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F 425	Continued From page 29 medication rooms (located on the North Unit). Failing to ensure the removal of expired medications from the PRN (as needed) box has the potential to affect resident who may require treatments when having respiratory difficulties. Findings include: The facility policy "Medication Storage," dated 12/2002, stated ". . . Medications bearing an expiration date will not be dispensed or distributed beyond the expiration date. Authorized personnel should remove all expired, damaged, and/or contaminated medications, store them separately from medications available for administration and arrange for proper disposal. . . ." On 11/03/10 at 10:15 a.m., observation of the facility's medication room identified expired dates on five packages of inhalation medications in a plastic tub labeled "PRN drugs." Observation of the drugs inside the PRN box identified the following expired medications: * 27 vials of Albuterol Sulfate inhalation solution (bronchodilator) 3.0 mg (milligrams), expired 08/10 * 19 vials of Ipratropium Bromide 0.02% (bronchodilator), expired 09/10 * A partially filled bag containing vials of Albuterol Solution (bronchodilator) 0.083%, expired 09/10 * 55 vials of Ipratropium 0.5%/Albuterol 3.0 mg (bronchodilator), expired 04/10 * 35 vials of Albuterol 0.083% (bronchodilator), expired 08/10 Two nursing staff members (#2 and #3) confirmed the medications were expired.	F 425	expired dates and expired medications removed per Licensed Nurse and arrangements made for proper disposal by 12-8-10 Licensed Nursing Staff will be re-educated regarding timely identification and removal of all expired, damaged, and/or contaminated medications, store them separately from medications available for administration and arrange for proper disposal by 12-8-10. Licensed Nursing Staff will complete audits of medications in all Medication Rooms to identify expired, damaged, and/or contaminated medications, store them separately from medications available for administration and arrange for proper disposal weekly x4weeks, then monthly thereafter to assure continued compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed. The Quality Assurance Coordinator or designee shall be responsible to monitor and assure the completion of audits and reporting of results as stated on the Quality Council Meeting Agenda monthly.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	Facility will be in compliance by 12-8-10	

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F 431	Continued From page 30 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, staff interview, and review of professional reference, the facility failed to	F 431	F431 It is the policy of St. Catherine's Living Center that drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principals, and include the appropriate accessory and cautionary instructions, and expiration date when applicable. Expiration dates for all medications on 3 of 3 medication carts (located on the north, south, and special care units) will be evaluated for expired dates and DADs with expired labels returned to the pharmacy for proper labeling per Licensed Nurse by 12-8-10. The Director of Nursing notified the Pharmacy issuing medications in DADs with expired labels, that drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principals, and include expiration dates 11-3-10. The Director of Nursing will notify all Pharmacy's issuing medications in DADs to the facility, that drugs and biologicals	

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F 431	Continued From page 31 ensure medications were appropriately labeled with correct expiration dates in 3 of 3 medication carts (located on the north, south, and special care units). Failure to properly label medications may result in residents receiving outdated and potentially ineffective medications. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding the labeling and storage of drugs and biologicals. . . . 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, and lot number, and provides instructions as necessary for safe administration. The facility ensures that medication labeling in response to order changes is accurate and consistent with applicable state requirements. - Observation of the north unit medication cart occurred on 11/03/10 at 10:15 a.m.. The medication cart contained resident's medications, packaged by the pharmacy, in cassettes containing a 7 day supply. The following medications lacked a current/accurate expiration date: * Benztropine, exp., (expiration) date of 12/23/09 and 12/09 * Clozapine, exp. date of 01/21/10 * Zyprexa, exp. date of 12/23/09 * Atenolol/Chloride, exp. date of 12/23/09 * Divalproex ER, exp. date of 07/07/10 * Lisinopril, exp. date of 01/21/10 * Metformin, exp. date of 01/21/10 * Potassium Chloride, exp. date of 01/21/10	F 431	used in the facility must be labeled in accordance with currently accepted professional principals, and include expiration dates by 12-8-10. Licensed Nursing Staff will be re-educated regarding timely identification of all DADs with expired labels and arrange for return to pharmacy for proper labeling of such, by 12-8-10. Licensed Nursing Staff will complete audits of all DADs in 3 of 3 medication carts in all Medication Rooms to identify expired labels and arrange for return to pharmacy for proper labeling of such, weekly x4weeks, then monthly thereafter to assure continued compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed. The Quality Assurance Coordinator or designee shall be responsible to monitor and assure the completion of audits and reporting of results as stated on the Quality Council Meeting Agenda monthly. Facility will be in compliance by 12-8-10	

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F 431	Continued From page 32 * Furosemide, exp. date of 01/21/10 * Hydroxyurea, exp. date of 02/02/10 * Hydrocodone/Acetaminophen, had no exp. date listed on the label A nursing staff member (#2) confirmed these medications lacked proper expiration dates. - Observations of the special care unit medication cart occurred on 11/03/10 at 4:00 p.m. The medication cart contained resident's medications, packaged by the pharmacy, in cassettes containing a 7 day supply. The following medications lacked a current/accurate expiration date: * Pantoprazole, exp. date of 12/03/09 * Glipizide, exp. date of 01/21/10 * Namenda, exp. date of 01/14/10 (2 cassettes) * Carbamazepin, exp. date of 01/16/10 (3 cassettes) * Risperidone, exp. date of 01/02/10 * Risperidone, exp. date of 01/09/10 - Observations of the south unit medication cart occurred on 11/03/10 at 4:15 p.m. The medication cart contained resident's medications, packaged by the pharmacy, in cassettes containing a 7 day supply. The following medications lacked a current/accurate expiration date: * Actos, exp. date of 02/03/10 (2 cassettes) * Diovan, exp. date of 03/10/10 * Klor-Con, exp. date of 01/14/10 * Levothyroxin, exp. date of 01/14/10 * Furosemide, exp. date of 01/14/10 (2 cassettes) * Namenda, exp. date of 02/03/10 (2 cassettes) During an interview on 11/03/10 at 11:15 a.m., an administrative nurse (#1) stated she was aware of	F 431		

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F 431	Continued From page 33 the problem regarding the expiration dates and had notified the pharrmacies the facility utilized.	F 431		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of professional literature, the facility failed to implement effective interventions to maintain normal bladder function for 1 of 1 sampled resident (Resident #5) identified as having a urinary tract infection (UTI). Failure to provide these services placed the resident at risk of experiencing a prolonged infection and/or a worsening of symptoms, receiving unnecessary medications, and increasing her resistance to antibiotics. Findings include: The Centers for Medicare and Medicaid Services (CMS) state the facility must assure that the physician is notified of all lab results so that prompt, appropriate action may be taken if indicated for the resident's care. In their manuscript titled "Antibiotic Safety", the Association for Professionals in Infection Control and Epidemiology (APIC) at www.apic.org state, antibiotic resistance may result when antibiotics are used too often or inappropriately for infections. When resistance develops, the antibiotic is not able to kill the germs causing the infection. The infection may last longer, and	F 505	F505 It is the policy of the facility to promptly notify the attending physician of findings of lab results. Resident #5 The Interdisciplinary Team (IDT) will review and update the care plan to reflect appropriate interventions to minimize the risk of developing UTI's by 12-8-10 Residents identified with current lab/culture results indicative of the need for notification of the attending physician, will be audited by the Resident Care Coordinator or designee to ensure physician notification and assure the most effective interventions are provided by 12-8-10 Licensed Nursing Staff will be re-educated regarding timely notification of	

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 _____	11/03/2010

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

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F 505	Continued From page 34 instead of getting better the resident may get worse. Every time the resident takes an antibiotic incorrectly, it increases their chance of getting an illness someday that is resistant to antibiotics. Review of Resident #5 medical record occurred on November 1-3, 2010. The resident's medical diagnoses included: history urinary tract infections, agitation, anxiety; Alzheimer's, and dementia with behavioral disturbance. Resident #5's annual Minimum Data Set (MDS), dated 08/12/10, identified problems with short and long term memory, severely impaired daily decision making skills, total dependence with toilet use, bladder incontinence, deteriorated bladder continence and a urinary tract infection in the last 30 days. Resident #5's Resident Assessment Protocol (RAP) summary, dated 08/16/10, stated, ". . . Resident had a UTI during assessment period which probably increased her incontinence along with the decreased mobility r/t [related to] ORIF [open reduction internal fixation] [left hip] and her decreased cognitive level." The resident's current care plan, dated 08/19/10, stated, ". . . Problem: Resident is frequently incontinent of bladder . . . Resident is toileted every 2 hours and does wear incontinence products . . . Approach: . . . Assist with toileting every 2 hours and prn [as needed]. Incontinence care after each incontinent episode. Monitor for s/s [signs and symptoms] of skin breakdown. Use commode for toileting as needed. . . ." Her current plan of care did not address Resident #5's history of UTIs. The Infection Report, dated 10/22/10, identified	F 505	the attending physician of lab/culture results to assure the most effective interventions are provided by 12-8-10 The Quality Assurance Coordinator or designee will complete audits of lab/culture results indicative of the need for notification of the attending physician to ensure physician notification and assure the most effective interventions are provided weekly x4weeks, then monthly thereafter to assure continued compliance. Results of audits will be taken to the Quality Assurance Council for follow-up and revision as needed. The Quality Assurance Coordinator or designee shall be responsible to monitor and assure the completion of audits and reporting of results as stated on the Quality Council Meeting Agenda monthly. Facility will be in compliance by 12-8-10	

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F 505	Continued From page 35 Resident #5 developed a urinary tract infection. She showed signs and symptoms of frequency, pain and odor. The questions on the report pertaining to cultures and/or the development of a care plan remained blank. Resident #5's Physician Orders identified ". . . 10/22/10 - 10/28/10 . . . Cipro [ciprofloxacin] [antibiotic] capsule; 250 mg [milligrams] . . . oral . . . BID . . ." Resident #5's (urinary culture) Laboratory Results, faxed to the facility on 10/23/10, identified ". . . 10/23/10 . . . Organism: . . . Staphylococcus Sciuri . . . Rx: [Medication] . . . Ciprofloxacin . . . R [Resistant]" Resident #5's Interdisciplinary Progress Notes identified the following: * 10/22/10 at 1:07 p.m., "Cipro 250 mg po [by mouth] x 7 days, per Dr. [name]." * 10/23/10 at 3:32 a.m. - 10/27/10 at 7:04 p.m., Twelve entries stated the resident "continued on an antibiotic for a UTI; with no side effects noted". During an interview on 11/03/10 at 2:30 p.m., administrative nursing staff members (#1 and #11) stated, based on the (urinary culture) laboratory results, they "would expect the nurse to phone the physician regarding the [antibiotic] order." The administrative nursing staff member (#1) confirmed the resident's 10/22/10 urinary tract infection was not addressed on her current plan of care. The facility failed to ensure Resident #5 received the most effective antibiotic to treat her UTI, which may have resulted in the resident remaining symptomatic from the UTI.	F 505		

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