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OCT 26 2011
Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	09/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 09/26/11 and completed on 09/28/11, the sample included five residents for complete review, 15 residents for focused review, and three closed records for review. The sample included one additional resident to verify specific concerns during the survey.	F 000	The plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to follow professional standards of practice for 1 of 2 residents observed receiving insulin (Resident #19). Failure to ensure consistency between medication labels and medication administration records has the potential to result in medication errors. Findings include: Review of the facility policy titled "Medication Administration-General" occurred on 09/28/11. This policy, dated September 2011, stated, "PURPOSE: Medications are administered as prescribed, in accordance with good nursing principles and practices . . . PROCEDURE: . . . 5. Prior to administration, the medication and dosage schedule on the resident's MAR [medication administration record] is compared	F 281	1. A new label was placed by pharmacy on resident #19's insulin pen on 9/29/11. The nurse was educated regarding the policy for medication administration. 2. All residents who receive insulin via insulin pen have the potential to be affected. 3. The "Medication Administration – General" policy was reviewed with no changes. The "Pharmacy Services" policy was reviewed with no changes. All nursing staff will be educated on both these policies at an in-service on October 26, 2011. 4. The Quality Assurance Coordinator will audit resident #19 for proper labeling of the insulin pen and administration of insulin weekly x1 month, monthly x3 months and quarterly thereafter. Residents who	

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

10-24-11

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

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F 281	Continued From page 1 with the medication label. If the label and MAR are different, the physician's orders are checked for the correct dosage schedule. . . ." Observation during medication pass on 09/26/11 at 5:25 p.m. showed a nurse (#5) preparing Resident #19's insulin flexpen for administration. The physician's order and MAR identified 4 units of Novolog 70/30 insulin every evening, initiated on 07/24/11. The label on the Novolog 70/30 flexpen showed 7 units of insulin administered every evening. The nurse was unaware of the discrepancy until identified by the surveyor. During an interview on 09/28/11 at 10:45 a.m., an administrative nurse (#1) stated she expected the nurses to check medication labels with the MAR for accuracy prior to administering medications.	F 281	currently use an insulin pen will be audited in the same manner. Results will be immediately reported to the Director of Nursing. If concerns are identified immediate corrective action will be taken. The Quality Assurance Coordinator will report the results to the Quality Assurance Committee at each scheduled meeting. 5. See "Completion Date" column.	11/4/11
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 2 sampled residents (Resident #16 and #18) who received scheduled insulin and had blood sugar measures of 50 milligrams per deciliter	F 309	1. Residents #16 and #18 have fluctuating blood sugars. Nursing staff provided proper care in assessing them for hypoglycemia and treating it. Policy will be reviewed and education provided regarding documentation and follow up of hypoglycemic episodes. 2. All diabetics who receive scheduled insulin have the potential for hypoglycemia. 3. A meeting will be held on October 25, 2011 with the facility Medical Director to discuss setting up a facility protocol for diabetics and/or use	

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F 309	Continued From page 2 (mg/dl) or less received the care and services necessary regarding physician notification for low blood sugars (hypoglycemia) and elevated blood sugars (hyperglycemia). Failure to contact the resident's physician regarding hyper/hypoglycemia placed these residents and other diabetic residents at risk of complications and limited the physician's ability to ensure the quality of care. Findings include: Review of the facility's "Standing Orders" policy occurred on 09/28/11. This policy, revised June 2009, stated ". . . Diabetes Monitoring and /or Treatment, Facility Protocol. If no protocol: . . . 3. Glucagon 1 mg subcutaneous [times]1 for symptomatic hypoglycemia plus BS [blood sugar] [less] than 50 and notify physician/extender of results. Re-check blood glucose within one hour and notify physician of results." Review of the facility's "Medication Administration - General" policy occurred on 09/28/11. This policy, dated September 2011, stated, ". . .When PRN [as needed] medications are administered, the following documentation is provided: . . . date and time of administration, dose, route of administration (if other than oral), and if applicable, the injection site. Complaints or symptoms for which the medication was given. Be specific . . . Results achieved from giving the dose and the time results were noted . . ." The 2011 Nursing Drug Handbook stated the following regarding injectable glucagon ". . . For hypoglycemia, use drug only in emergency situations. Monitor glucose level before, during,	F 309	of the community standing orders. All nursing staff will be educated on any changes to policy(s) following this meeting at an in-service on October 26, 2011. 4. The Quality Assurance Coordinator will audit residents #16 and #18 for proper documentation of signs and symptoms of hypoglycemia on the MAR, time given and follow-up if gluagon or gluctose is given, physician notification and timely rechecking of blood sugars, weekly x1 month, monthly x3 months, and quarterly thereafter. Random audits on 5 additional diabetic residents receiving scheduled insulin will be conducted in the same manner. Results will be immediately reported to the Director of Nursing. If concerns are identified, immediate corrective action will be taken. The Quality Assurance Coordinator will report results to the Quality Assurance Committee at each scheduled meeting. 5. See "Completion Date" column.	11/4/11

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F 309	Continued From page 3 and after administration . . . " Review of Resident's #18 medical record occurred on 09/28/11. Current diagnoses included diabetes mellitus. The resident's current physician's orders for medications included: * Lantus insulin 10 units at bedtime, initiated on 02/02/11 * Novolog insulin 22 units at 8:00 a.m., initiated on 02/02/11 * Novolog insulin 8 units at 11:00 a.m., initiated on 02/02/11 * Novolog insulin 7 units at 5:00 p.m., initiated on 02/02/11 * Novolog Sliding Scale in addition to scheduled insulin TID (three times a day) at 8:00 a.m., 12:00 p.m., and 5:00 p.m. initiated on 02/21/11 * Physician's orders also included blood sugar accuchecks (blood sugar monitoring) TID. Resident #18's current care plan, stated "Problem, . . . diabetes. Approach: Insulin and accuchecks as ordered -- Monitor for s/sx [signs/symptoms] for hypoglycemia . . ." Resident #18's accuchecks for the period May 2011 - August 2011 identified eight accuchecks less than 50 mg/dl, ranging from 36 mg/dl to 49 mg/dl. The record identified facility staff administered glucagon on 05/01/11 for a blood sugar measure of 49 mg/dl. Review of the Resident #18's progress notes and prn medication administration record (MAR), dated 05/01/11, identified the facility staff, failed to identify the resident's signs and symptoms associated with the administration of glucagon, failed to identify the time of administration on the	F 309		

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F 309	Continued From page 4 MAR, failed to recheck the blood sugar one hour after administration of glucagon, and failed to contact Resident #18's physician or physician extender regarding the administration of glucagon. During an interview on 09/28/11 at 1:05 p.m., a unit manager nurse (#3) stated she would expect nurses to pass along at the change of shift any abnormal accuchecks and what treatment was done. - Review of Resident's #16 medical record occurred on 09/28/11. Current diagnoses included diabetes mellitus. The resident's current physician's orders for medications included: * Novolog, for blood sugar > 500, add 4 units to scheduled dose at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m., initiated on 01/10/11 * Levemir 36 units at 8:00 a.m., initiated on 12/30/10 * Novolog 14 units at 8:00 a.m., initiated on 12/13/10 * Novolog 3 units at 12:00 p.m., initiated on 12/13/10 * Novolog 8 units, Hold if BS < 300, at 5:00 p.m., initiated on 12/30/10 Resident #16's current care plan, stated "Problem: . . . has fluctuating glucose levels . . . Approach: Monitor blood glucose: accuchecks per order and PRN . . . Monitor for signs of hypoglycemia . . ." Review of Resident 16's progress notes, vitals reports, and prn MAR identified eleven accuchecks less than 50 mg/dl [ranging from 29 mg/dl to 49 mg/dl] for the period March 2011 -	F 309		

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F 309	Continued From page 5 September 2011. The record identified facility staff administered glucagon at the following times: * 03/03/11, related to an accucheck of 42 mg/dl at 11:15 a.m. with a repeat accucheck at 12:46 p.m. [1 hour 30 minutes] * 03/27/11, related to an accucheck of 29 mg/dl at 11:00 a.m. with a repeat accucheck at 1:00 p.m. [2 hours] * 05/02/11, related to an accucheck of 34 mg/dl at 4:50 p.m. with a repeat accucheck at 8:00 p.m. [3 hours 10 minutes] The facility failed to identify the signs/symptoms of hypoglycemia on the prn MAR prior to administering the glucagon per facility policy and failed to repeat accuchecks within one hour.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to maintain an environment free of hazardous chemicals on 3 of 3 days of survey (September 26-28, 2011). Accessible hazardous chemicals places cognitively impaired and wandering residents at risk for accidents/injury.	F 323	1. No resident were affected. Resident #11 is on the Memory Care Unit. 2. All residents with cognitive impairment and/or who wander have the potential to be affected. 3. All staff will be in-serviced on the general policy regarding a safe environment and storage of chemicals on October 26, 2011. 4. The Quality Assurance Coordinator will audit the laundry, soiled utility rooms, bathing areas, dining areas and construction areas for secure storage of hazardous chemicals weekly x1 month, monthly x3 months, and quarterly thereafter.	

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F 323	Continued From page 6 Findings include: Review of the facility policy titled "General" occurred on 09/28/11. This policy, dated July 2007, stated, "PURPOSE: To maintain surveillance of proper care of department equipment in ascertaining its safety and proper functions. To provide a safe environment for staff and a safe environment for residents and visitors . . . Policy: . . . 6. Spray cans are properly stored . . . 10. Detergents, disinfectants and other potentially toxic substances will be maintained in a locked cabinet." Observation throughout the survey showed Resident #11 frequently wandered throughout all areas of the facility, often visiting the special care unit. Observation of the environment on 09/26/11 at 1:00 p.m., 09/27/11 at 10:00 a.m., and 09/28/11 at 8:30 a.m. showed the following: *Five bottles of Ecolab Stainblaster on a rack on the wall in the laundry room; and one bottle of bleach, two bottles of Shout, one can of Comet, one bottle of Windex, three cans of Lysol, one can of Febreeze, and one bottle of Ecolab Stainblaster located in an unlocked cabinet in the laundry room. Both doors going into the laundry room remain unlocked at all times. *Two cans of Lysol, one container of Maxim lemon detergent disinfectant, two spray bottles of Maxim disinfectant, and one bottle of Medco machine prewash agent located in an unlocked lower cupboard in the unlocked 4th Street soiled utility room. (Observed on 09/26/11) *One bottle of Apollo Cid-A-L II Disinfectant	F 323	Results will be immediately reported to the Director of Nursing. If concerns are identified immediate corrective action will be taken. The Quality Assurance Coordinator will report the results to the Quality Assurance Committee at each scheduled meeting. 5. See "Completion Date" column.	11/4/11

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F 323	Continued From page 7 and one bottle of Apollo Turboclean pre-disinfectant detergent stored in an unlocked cabinet located in the 4th Street bathing room. (Observed on 09/26/11 and 09/28/11) *One bottle of Maxim disinfectant on the kitchen counter near an uncovered tray of food and beverages in the Wheatland dining room. (Observed on 09/27/11) *One can of Lysol in a cabinet without a lock under the sink in the Little North dining room. (Observed on 09/27/11) *One can of TFP-500 Blazemaster CPVC Cement, with the lid off, sitting on a table near the walkway going to the special care unit. Observation showed residents walked past the area throughout the day, without staff present in view of the cement. (Observed on 09/27/11) During an interview on the morning of 09/28/11, a supervisory staff member (#4) stated staff should store hazardous chemicals in secure areas not accessible to residents.	F 323		
F 441 SS=B	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 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	1. Residents #1, #16, and #24 received new catheter bags. Staff providing primary care to residents #1, #16 and #24 were educated on the changes in the policy "Catheter-Leg Bags Attaching." 2. All residents who routinely change urinary drainage bags have the potential to be affected. 3. The policy "Catheter-Leg Bags Attaching" was reviewed and changes made based on current	

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F 441	Continued From page 8 (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 policy and procedure, and staff interview, the facility failed to follow acceptable standards of practice regarding infection control for 2 of 2 sampled residents (Resident #1 and #16) and 1 supplemental resident (Resident #24) who utilize indwelling Foley catheters. Failure to store the urinary drainage bags in a sanitary manner places the resident at risk of developing a urinary tract infection. Findings include:	F 441	practice. All nursing staff will be educated on the changes in the policy on October 26, 2011. 4. The Quality Assurance Coordinator will audit residents #1, #16, and #24 weekly x1 month, monthly x3 months and quarterly thereafter for proper cleaning and storage of urinary drainage bags. New Admissions who follow this practice will be audited in the same manner. Results will be immediately reported to the Director of Nursing. If concerns are identified immediate corrective action will be taken. The Quality Assurance Coordinator will report the results to the Quality Assurance Committee at each scheduled meeting. 5. See "Completion Date" column.	11/4/11

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F 441	Continued From page 9 Review of the facility policy titled, "Catheter Leg Bags - Attaching" occurred on 09/28/11, This policy, dated with a facility review date of September 2011, stated, "Purpose: To provide a catheterized resident with greater mobility while using good technique to prevent infection. . . . Procedure: . . . Changing from the catheter bag to a leg bag: . . . 5. Disconnect catheter tubing and apply protective tip. . . . Cleaning and storage of catheter bags: . . . 2. Empty urine from catheter bag and rinse with proper solution. a) Mix 1/2 cup of white vinegar (120 cc) with 1 cup (240 cc) of tap water. Fill the bag. b) Let set for 30 minutes and empty. c) Let the bag air dry. d) Cover the ends with the protective cap and store. . . ." - Observation, on 09/27/11 at 9:40 a.m., showed a certified nurse aide (CNA) (#2) change Resident #1's catheter bag to a leg bag. The CNA (#2) rinsed the catheter bag with a vinegar mixture, immediately emptied the mixture from the catheter bag and stored the catheter bag in a clear plastic bag on the hand rail next to the toilet. The CNA failed to let the vinegar mixture set in the catheter bag for 30 minutes, failed to let the bag air dry, and failed to cover the end of the catheter tubing with a protective cap prior to storing the catheter bag. Observation, on 09/28/11 at 11:00 a.m., showed Resident #1's catheter bag stored in the same manner and without a protective cap covering the end of the tubing. Review of Resident #1's medical record occurred on September 26-28, 2011 and identified insertion of Resident #1's indwelling catheter in	F 441		

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F 441	Continued From page 10 January 2011. Review of laboratory data identified, on 05/04/11, a urine culture showed Escherichia coli (E. coli) which required treatment. (E. coli is a bacteria normally present in the intestines and the most frequent cause of urinary tract infections). - The facility identified Resident #16 and #24 as having indwelling Foley catheters. Observation of Resident #16 and #24's bathroom, between 1:00 p.m. and 1:05 p.m. on 09/28/11, identified both resident's Foley catheter bags stored in a clear plastic bag near the toilet without the protective cap covering the end of the tubing. During interview, on 09/28/11 at 1:30 p.m., an administrative nursing staff member (#1) confirmed the end of the catheter tubing should be covered with a protective cap, and the vinegar mixture should set in the catheter bag for 30 minutes prior to emptying as per facility policy.	F 441		