STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355033	A. BUILDING _____ B. WING _____	C 07/19/2012

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 and complaint survey started on July 16, 2012 and completed on July 19, 2012, the sample included three (3) residents for complete review, twelve (12) residents for focused review, and three (3) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	1 *F157* It is the practice of St. Catherine's Living Center to immediately inform the resident; consult with the resident's physician; and if known the residents legal representative or an interested family member when there is an accident involving the resident which results in injury or has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or commence a new form of treatment); or a decision to transfer or discharge the resident from the facility. All staff that care for Resident #1 will receive "just-in-time" education on adhering to appropriate time parameters regarding notification of physician/physician extender related to a fall involving the resident which results in injury and has the potential for requiring physician intervention.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 8/29/2012

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 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to immediately notify the resident's physician for 1 of 1 sampled resident (Resident #1) who experienced bruising, neck pain, and headache after she hit her head during a fall and for 3 of 3 sampled residents (Resident #10, #11, and #14) with blood glucose monitoring (BGM) results ranging from 31-35 milligrams/deciliter (mg/dl) and who exhibited signs and symptoms of hypoglycemia. Failure to promptly notify the physician about Resident #1's head injury resulted in delayed treatment and delayed identification of a C2 (cervical neck, second vertebrae) fracture, placing the resident at risk of serious injury or harm. Failure to notify Resident #11, #10, and #14's physician regarding episodes of unresponsive and symptomatic low blood sugars does not allow the physician an opportunity to adjust the diabetic plan of care for these residents and places them at risk for continued episodes of hypoglycemia. Findings include: - A Progress Note, dated 04/09/12 at 3:12 p.m. identifed Resident #1 fell and hit her head.	F 157	2 All residents who experience a fall that results in an injury requiring physician intervention have the potential to be affected by this issue. Licensed Nursing Staff will be re-educated regarding timely notification of the physician/physician extender following a resident fall that results in injury and has the potential for requiring physician intervention. All residents who experience a fall that results in injury and has the potential for requiring physician intervention will be audited for adherence to regulations for physician/physician extender notification by the Quality Assurance Coordinator or designee weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012. Resident #14's physicians orders related to diabetes management will be reviewed/clarified with resident #14's physician.	09-05-2012

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F 157	Continued From page 2 The "Event Report" from the fall on 04/09/12, completed by a nursing staff member at 3:26 p.m. on 04/09/12, identified the resident complained of pain to head following the fall, and sustained bruising, a bump and swelling. This "Event Report," further stated, ". . . NOTIFICATION GUIDELINES: Notify MD/NP[nurse practitioner]/PA [physician's assistant] immediately by phone or beeper for any of the following. - Suspected head injury/abnormal neuro checks from resident baseline. . . . [NOTE: The nurse checked the box which indicated the MD/NP/PA should be notified immediately]. NOTIFICATIONS: Attending Faxed: No. Physician Notified: Yes Date/Time: 4/15/2012 [five days later] 6:11 a.m. Family Notified: Yes. Date/Time: 4/15/2012 [five days later] 6:11 a.m. . . ." Refer to F309 for additional informtion pertaining to Resident #1's fall from on 04/09/12. On 04/11/12, the medical record identified Resident #1's health care provider (HCP) as present in the facility that afternoon and ordered a pain medication (Tramadol) for the resident. Review of a "Physician/NP/PA Communication" form, dated 04/11/12 identified the following: "Has had large increase in falls over the past month, resulting in several mild injuries. She states that often these falls are d/t [due to] dizziness, has had some BP [blood pressure] readings that have noted drop from laying to standing. Will be monitoring ortho [orthostatic] BP's Q [every] shift x [times] 3 days. However, noted more confusion, sleepiness, etc over past month or so. Can we trial a decrease in her Tramadol at this time? She has had an increase in falls since this was	F 157	3 Resident's #10, #11 and #14 blood glucose results indicative of the need for notification of the physician/physician extender and implementation of interventions will be completed per physicians order/ recognized protocols. All staff that care for Resident's #10, #11 and #14 will receive "just-in-time" education on adhering to protocols regarding blood glucose results indicative of the need for notification of the physician/physician extender and implementation of interventions. All residents with accu-check/blood glucose results indicative of the need for notification of the physician/physician extender and implementation of interventions have the potential to be affected by this issue. Standing orders related to protocols for hyper/hypoglycemia will be updated and approved for use in the facility. Licensed Nursing Staff will be educated regarding timely notification of resident accu-check/blood glucose results indicative of the need for notification of the physician/physician extender and implementation of interventions per physicians order/ recognized protocols.	

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F 157	Continued From page 3 increased from 100 mg bid to 100 mg TID [three times a day] in December." NOTE: The HCP responded to the facility's above concern on the "Communication Form" with an order for "Tramadol 100 mg bid." The written communication on 04/11/12, however, failed to indicate staff notified the HCP of the specific fall on 04/09/12, in which the resident hit her head, resulting in a 4 inch by 4 inch black and blue lump on the side of her head, nor does it identify the resident's neck pain or headache since the fall. Although the assessment data on Resident #1's Event Report, completed shortly after Resident #1's fall on 04/09/12, identified symptoms which indicated an immediate call to the physician (suspected head injury, sluggish pupils, bruising and swelling on the head), facility staff failed to notify the physician. Documentation in the medical record showed communication with a HCP on 4/11/12 (2 days after the fall), but the documentation failed to indicate the HCP was informed of the specific fall on 04/09/12 in which the resident hit her head. Resident #1 continued to complain of pain in the neck area, and staff sent the resident to the clinic for x-rays on 4/12/12, three days after she fell and hit her head. Failure to immediately notify the physician caused a delay in treatment interventions and a delay in the identification of a C2 fracture. During interview, the morning of 07/19/12, two administrative staff members (#11 and #12) agreed staff should have immediately called the physician after Resident #1 fell and hit her head. - Review of the facility's standing orders, revised	F 157	4 Residents identified with current blood glucose/accu-check results indicative of the need for notification of the physician/physician extender and implementation of interventions per physicians order/ recognized protocols will be audited by the Quality Assurance Coordinator or designee weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012.	09-05-2012

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F 157	Continued From page 4 in October 2006, included the following: "DIABETES MONITORING and/or TREATMENT. Follow facility protocol. If no protocol: 1) Blood glucose check pm nurse discretion. 2) Glucose 1/2 -1 tube orally for symptomatic hypoglycemia plus BS < 50. Repeat in 10 minutes as needed. 3) Glucagon 1 mg 1M X 1 for symptomatic hypoglycemia plus BS < 30 and notify physician/extender [sic] of results." - Review of Resident #10's medical record occurred on July 16-19, 2012. Resident #10's physician's order, dated 05/22/12, stated, "Lantus [insulin] injection 30 units subcutaneous [SQ] [beneath skin] BID [twice a day]." Resident #10's physician's orders included the facility's standing orders for Diabetes Monitoring and/or Treatment, dated 09/13/10. Review of Resident #10's nurses' note, dated 03/11/12 at 6:30 p.m., stated, "At 5 p.m. resident's BS was 35 [mg/dl]. She was unresponsive and diaphoretic [sweating]. Glucogon [sic] [hormone used to raise very low blood sugar] 1 mg SQ given. At 5:30 p.m. resident was more alert with BS at 97 and with much encouragement from son ate over 75% of her supper." Review of Resident #10's medical record showed facility staff failed to notify Resident#10's physician regarding the above unresponsive episode as per facility policy. Failure to notify the physician did not allow the physician to assess the need for an adjustment in Resident #10's insulin.	F 157	5	

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F 157	Continued From page 5 - Review of Resident #11's medical record occurred on July 16-19, 2012. Medical diagnoses for Resident #11's included diabetes mellitus. Resident #11's physician orders included the facility's standing orders. The medical record lacked individualized low blood sugar parameters for physician notification. Resident #11's Progress Notes stated the following: *12/01/11, 5:15 p.m., "Res. [Resident] very sweaty and clamy [sic]. Responding only to name. BS is 31 [mg/dl]. Gave res. 120 cc [cubic centimeters] orange juice, res. barely responded to this. Tried to give res food but she kept coughing this up. Res. would put head to the side and slipping into unresponsive stage. Wheeled res. to n [nurse's] station and administered glucogon [sic] im [intramuscularly] to L [left] deltoid area." Resident #11 experienced a hypoglycemic episode with symptoms of unresponsiveness on 12/01/11. Facility staff administered orange juice and then administered intramuscular glucagon. The facility staff failed to notify the physician or extender, limiting their ability to ensure the quality of resident care. - Review of Resident #14's medical record occurred on July 18-19, 2012. Medical diagnoses for Resident #11's included diabetes mellitus, seizure disorder, and hemiplegia. Resident #14's physician orders, in addition to the facility standing orders pertaining to diabetes,	F 157	6	

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F 157	Continued From page 6 included: -07/28/09 -"Do not hold Lantus [type of insulin injection] d/t [due to] low food intakes unless instructed by the MD [medical doctor]. Report any changes in appetite or low blood sugar to MD prn." -04/08/11 -"Give NovoLog after resident eats, NOT BEFORE, HOLD NovoLog if intakes at meal time are less than 50%." -10/06/11 -"Accuchecks four times a day at 5:30 a.m., 10:30 a.m., 4:30 p.m., and 7:30 p.m. and "Special instructions" to "Call MD if blood sugars > [greater than] 300." -04/05/12 -"NovoLog insulin -four units SQ twice a day at 11:00 a.m. and 5:30 p.m" and "Special Instructions" to "DO NOT GIVE UNTIL RESIDENT HAS EATEN! HOLD IF INTAKES ARE <50%. NovoLog insulin six units SQ daily at 7:30 a.m." and "Special Instructions" to "DO NOT GIVE UNTIL RESIDENT HAS EATEN! HOLD IF INTAKES ARE <50%. Lantus insulin 15 units SQ every AM at 7:30 a.m." Review of the Resident #14's blood sugar records from April-July 2012 identified the following blood sugar levels: 31 mg/dl on 04/16/12 at 8:00 p.m. 340 mg/dl on 05/08/12 at 4:29 p.m. 47 mg/dl on 05/28/12 at 10:30 a.m. Resident #14 experienced symptomatic hypoglycemia on April 16 and the medical record lacked evidence facility staff notified a health care provider (HCP). On the evening of 05/08/12, Resident #14's blood sugar reading exceeded 300 mg/dl. Resident #14's medical record lacked evidence the facility informed the HCP. On	F 157	7	

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F 157	Continued From page 7 05/28/12, Resident #14 exhibited symptomatic hypoglycemia and facility staff provided oral intake while the resident was "very listless" instead of implementing the physician protocol.	F 157	8	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225	F225 It is the practice of St. Catherine's Living Center that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility will maintain evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations will be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	

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F 225	Continued From page 8 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to investigate a bruise for 1 of 1 sampled resident with an injury of unknown origin (Resident #7). Failure to investigate the injury of unknown origin placed Resident #7 and all facility residents at risk of potential abuse and injuries. Findings include: Review of the facility policy and procedure, "Abuse Prevention Plan," occurred on 07/19/12. This document, revised 01/11/12, stated "FACILITY PHILOSOPHY AND PLAN OBJECTIVES . . . this Abuse Prevention Plan establishes policies and procedures for protecting vulnerable adults who live at our facility. . . . The objectives of this plan are: To protect vulnerable adults cared for at our facility from maltreatment. . . ." Review of Resident #7's medical record occurred on July 16-19, 2012. The facility admitted the resident in June 2005. Current diagnoses included osteoporosis and peripheral vascular disease. The resident's quarterly Minimum Data Set (MDS), dated 07/05/12, and the annual MDS, dated 04/04/12, identified short and long term memory problems, wandering did not occur, required extensive assistance of one person for	F 225	9 Facility policies/protocols were reviewed and updated related to injuries of unknown origin to include the timely reporting, notification and investigation of injuries of unknown origins. Resident #7's bruise/injury of unknown origin skin event from 04-05-12 was investigated for causal factors. Resident #7's family and physician were notified of said event. Resident's #7's plan of care was reviewed/updated by the IDT (Interdisciplinary Team). Staff that care for resident #7 will be provided "just in time" training regarding the Abuse Prevention Plan and appropriate protocols related to a bruise of unknown origin; including initiation of the investigative process and notification of resident's family members and physician. All residents are at risk for and have the potential to be affected by injuries of unknown origin. All staff will receive education on the Abuse Prevention Plan and protocols including the timely reporting, notification and investigation of injuries of unknown origin.	

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F 225	Continued From page 9 transfers and locomotion on and off the unit, and walking did not occur. Resident #7's care plan, dated 01/03/12, stated "Problem: . . . at risk for falling R/T [related to] history of falls and wandering behavior. . . . Approach: . . . Attempt to keep resident in areas of facility where she can be closely monitored by staff when up in wheelchair. . . .;" and, dated 01/18/11, "Problem: Resident has socially inappropriate/disruptive behavioral symptoms as evidenced [by] her wandering and going into others room and taking their candy. . . . Approach: Assess whether the behavior endangers the resident and/or others. . . ." Resident #7's medical record included a Skin Integrity Event report, dated 04/05/12 at 10:28 a.m., which stated "Staff notified me of bruise on right anterior upper foot. Measures 12 cm [centimeters] by 8 cm. No pain or discomfort noted. Unable to tell us how she got it. Will continue to monitor." The report identified the facility staff did not notify the resident's family members or physician regarding the bruise. The Skin Integrity Event report identified the facility staff continued to monitor the bruise on 04/12/12, 04/16/12, 04/18/12. On 04/28/12, the report stated "No bruising noted at this time. Healed." The report identified Resident #7 did not complain of pain related to the bruise. An interview occurred on the morning of 07/18/12 with an administrative nursing staff member. This staff member stated the facility had not completed an investigation of how the bruise occurred and the facility had no additional	F 225	10 All residents sustaining an injury of unknown origin will be audited for adherence to protocols including the timely reporting, notification and investigation of injuries of unknown origin by the Quality Assurance Coordinator or designee weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012.	09-05-2012

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F 225	Continued From page 10 information regarding Resident #7's bruise.	F 225	11	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/31/11. Based on observation, record review, and staff interview, the facility failed to ensure reasonable accommodation of individual needs regarding positioning at the dining room table for 3 of 14 sampled residents (Resident #2, #12, and #13) observed with inappropriate positioning during meals. Failure to provide a dining room table at an appropriate height to meet individual needs and failure to position residents appropriately at the dining room table limited the residents' access to meal items and may contribute to weight loss, limited the quality of the dining experience, and may cause discomfort related to improper positioning. Findings include: - Observations in the dining room showed the following: * On 07/17/12 at 12:30 p.m., 07/18/12 at 7:45	F 246	F246 It is the practice of St. Catherine's Living Center to assure the right to reside and receive services in the facility with reasonable accommodations of individual need and preferences, except when the health or safety of the individual or other residents would be endangered. Residents #2, #12 and #13: Therapy will review/implement necessary adjustments for proper wheelchair positioning in the dining room including – providing dining room tables at appropriate heights to meet individual needs; and positioning residents #2, #12 and #13 appropriately at the dining room table to enable access to meal items Staff that care for residents #2, #12 and #13 will be provided "just in time" training on necessary adjustments for residents #2, #12 and #13 to enable proper wheelchair positioning in the dining room. Therapy will observe/implement necessary adjustments for proper wheelchair positioning in the dining room for all residents utilizing wheelchairs in the dining room.	

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	355033	A. BUILDING _____ B. WING _____	C 07/19/2012

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 246	Continued From page 11 a.m., and 07/19/12 at 8:00 a.m., Resident #12 sat in her low wheelchair at a dining room table. Resident #12 fed herself following tray set-up. She leaned forward to access the items on her plate, with her forearms on the table and her shoulders elevated. Observation showed the table at the level of her upper chest. During the noon meal on 07/17/12, Resident #12 dropped food items in her lap. Record review for Resident #12 occurred on July 18-19, 2012. Medical diagnoses included dementia and weakness. The quarterly Minimum Data Set (MDS), dated 07/12/12, identified severe cognitive impairment and independence with eating with setup help only. The Care Area Assessment (CAA) for Nutritional Status, dated 10/20/11, stated, ". . . Requires continued redirection r/t [relating to] confusion. . . ." Resident #12's current care plan stated the following, ". . . Problems: . . . ADL'S [Activities of Daily Living] . . . Approaches: . . . Eating: Independent with set up . . ." The "Mini-Nutritional Assessment," dated 07/17/12, identified ". . . Current Intake: Fair 50-75% . . . < [less than] 10% weight change in 6 months." - Observations in the dining room showed the following: * On 07/17/12 at 12:30 p.m. and 07/18/12 at 7:45 a.m., Resident #13 sat in her low wheelchair approximately 6-8 inches from the dining room table. Resident #13 fed herself following tray set-up. She leaned forward to access the items on her plate, with her forearms on the table and	F 246	12 Staff responsible for positioning of residents at dining room tables will receive education regarding appropriate wheelchair positioning to include: having dining room table at an appropriate height to meet individual needs; and positioning residents an appropriate distance from the dining room table to enable access to meal items. Residents utilizing wheelchairs in the dining room will be audited for proper wheelchair positioning in the dining room *by* the Quality Assurance Coordinator or designee weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012.	09-05-2012

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F 246	Continued From page 12 her shoulders elevated. Observation showed the table at the level of her upper chest. During the noon meal on 07/17/12, Resident #13 dropped food items on to the table top. She picked the items up and either ate them or placed them back on her plate. * On 07/19/12 at 8:00 a.m., an unidentified certified nurse assistant (CNA) spoke with Resident #13 as she delivered her tray, and locked her left wheelchair break prior to leaving the table. Resident #13 sat in her low wheelchair approximately 6-8 inches from the dining room table. She leaned forward with her arms fully extended to access the items on her plate. Observation showed the table at the level of her upper chest. During the meal, Resident #13 requested additional napkins after dropping food items on to her lap. Record review for Resident #13 occurred on July 18-19, 2012. Medical diagnoses included depression, macular degeneration, and pain. The quarterly MDS, dated 04/27/12, identified moderate cognitive impairment and independence with eating with setup help only. The CAA for Nutritional Status, dated 10/26/11, stated, ". . . Leaves > [greater than] 25% food/fluid uneaten at meals. . . . Has experienced non-significant decrease [in weight] over past 3 and 6 months. . . ." Resident #13's current care plan stated the following, ". . . Problems: . . . Nutritional Status . . . Approaches: . . . Resident to be seated at assisted table during meal times to facilitate maximum oral intake of foods/fluids. . . ." The "Mini-Nutritional Assessment," dated	F 246	13	

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F 246	Continued From page 13 05/08/12, identified ". . . Current Intake: Fair 50-75% . . . Weight Loss During Last 3 Months: 2.2-6.6 lbs [pounds]. . . ." During an interview on 07/19/12 at 9:25 a.m., two administrative staff members (#11 and #12) agreed Resident #12 and #13 sit low in relation to the dining room table. They also agreed Resident #13 should be placed closer to the table prior to locking the break on her wheelchair. - Observation on 7/16/12 at 5:45 p.m. showed Resident #2 seated in a low Broda wheelchair in the dining room, with the back of the chair reclined at approximately a 70 degree angle. Resident #2's wheelchair sat approximately 6-8 inches from the dining room table. Observation showed the resident leaning forward and reaching out his arm for food items on his plate. The resident ate fruit chunks and bread stuffing/dressing with his fingers, with some of the food items falling on to his lap. During interview the morning of 07/19/12, two administrative staff members (#11 and #12) agreed staff should place the resident's wheelchair closer to the table and place the back-rest in an upright position during meals.	F 246		
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.	F 250	F250 It is the practice 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.	

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F 250	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to provide medically-related social services to 1 of 2 sampled residents (Resident #11) who was verbally abusive towards other residents and 1 closed record (Resident #17) regarding financial exploitation. Failure to provide these services placed other facility residents at risk for verbal abuse and financial exploitation and limited the residents' ability to attain or maintain their highest practicable physical, mental, and psychosocial well-being possible. Findings include: Review of the facility policy and procedure, "Abuse Prevention Plan," occurred on 07/19/12. This document, revised on 01/11/12, stated "FACILITY PHILOSOPHY AND PLAN OBJECTIVES . . . Each resident has the right to be free from verbal . . . physical and mental abuse, financial exploitation . . . KEY COMPONENT #3: IDENTIFY, A. The facility creates and maintains a proactive approach for identifying individual resident risk factors that may constitute or contribute to abuse and neglect. This includes: . . . 3. Development of intervention strategies to prevent occurrences. . . . B. . . . The individualized care plan will be identified as such, so that measures can be taken to minimize the risk of abuse, and will include: . . . 2. Documentation of a goal and specific measures to minimize the identified risks. . . ." - Review of Resident #11's medical record occurred on July 16-19, 2012. The facility	F 250	15 Resident #11: Resident #11 will continue to reside in a private room per her/family request; thereby eliminating outbursts specifically related to roommate scenarios. Members of the Interdisciplinary Team (IDT) will: o assess the circumstances of resident #11's behavior; o review and update the care plan by 09-05-2012 to reflect appropriate interventions, to minimize inappropriate behaviors towards other residents by 09-05-2012; o Observe for effectiveness of interventions; review/update the care plan with exacerbation of behaviors and quarterly. Staff that care for resident #11 will be provided "just in time" training regarding the Abuse Prevention Plan; and appropriate interventions per care plan to minimize Resident #11's inappropriate behaviors towards other residents. All residents are at risk for and have the potential to be affected by verbally abusive/threatening behaviors of other residents.	

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F 250	Continued From page 15 admitted the resident in May 2011, transferred the resident to an inpatient psychiatric treatment facility in February 2012, and readmitted the resident in March 2012. Initial admission diagnoses included dementia and psychosis. The resident's quarterly Minimum Data Set (MDS), dated 06/21/12, identified moderate cognitive impairment, verbal behaviors occurred one to three days of seven day assessment period, and required extensive assistance for transfers, walking, locomotion, and dressing. Resident #11's current care plan identified the following: *Dated 06/01/11,"Problem: Resident recieves [sic] Anticonvulsant, Antidepressant, and Antipsychotic related to agitation and anxiety at times, secondary to dx. [diagnosis] of Confusion and Acute Agitation. . . . Approach: Administer medications as ordered. . . . Psych [Psychiatric] eval [evaluation] and treat. Update physician of any adverse effects or changes in symptoms or behaviors. . . .;" *Dated 08/23/11, "Problem: COMMUNICATION: . . . needs to be addressed directly and clearly, her responses are slow and often gives 1-2 word answers. . . . Approach: 1. Make sure you have [Resident #11's] attention before you speak. 2. Speak slowly and clearly and directly to her. 3. Repeat messages, ask simple questions [sic]. 4. Allow her time to respond. 5. Offer choices. . . .; Problem: COGNITIVE: . . . decision making skills are moderately impaired and needs cues, reminders, and supervision to daily routine. . . .;" and, *Dated 11/23/11, "Problem: MOOD and BEHAVIORS: . . . is resistive to cares and she is rude and verbally [sic] abusive to others, hrr [sic]	F 250	16 Members of the Interdisciplinary Team (IDT) will initiate, review and update care plans for residents identified to exhibit verbally abusive/threatening behaviors towards other residents; upon admission, quarterly and with exacerbation of behaviors. All staff will receive education on the Abuse Prevention Plan; and implementation of appropriate interventions per resident care plans to minimize resident's verbally abusive/threatening behaviors towards other residents. Residents identified to exhibit verbally abusive/threatening behaviors towards other residents will be audited for staff implementation and effectiveness of interventions per care plan by the Quality Assurance Coordinator or designee weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012. Resident #17 was discharged from the facility 05-11-2012.	09-05-2012

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F 250	Continued From page 16 speech is guttural [sic] and she talks loudly and she is difficult to understand. . . . Goal . . . will accept care and interact with others appropriately as noted [by] her behaviors and responses. . . . Approach: 1. Firm positive approach. 2. Inform her what you need to do and why. 3. Allow her time when she is angry and reapproach. 4. Scheduled appointments with psychiatrist. . . ." Resident #11's medical record included psychiatric consultations and medication adjustments, including Seroquel (antipsychotic) and antidepressants (Paxil and Trazodone). Resident #11's Progress Notes for the period August 01, 2011 to February 06, 2012, identified the resident's verbally abusive and threatening behaviors towards other residents. Examples include the following: *08/07/11, 7:30 a.m. - ". . . A resident at her table said Good Morning to resident, she told them, "Shut the hell up." . . . Will continue to monitor." *08/07/11, 8:30 a.m. - ". . . Very nasty to anyone who walks by her. Swearing at them and telling them to shut up, get the hell out of here. States, 'I not a child.' Will continue to monitor." *10/12/11, 1:49 p.m. - "Resident stated, 'Roommate's cancer is contaigious [sic] and told roommate to pack up her stuff and get the HELL OUT. . . .' Roommate yelled back you can go jump off a bridge, I'm not going anywhere and cancer is not contaigious. Will continue to monitor." *10/13/11, 5:33 p.m. - Informed [Resident #11 and family member] of room mate change today and asked [Resident #11] to be nice to her as she is a nice lady . . ." *11/12/11, 9:05 p.m. - ". . . Has been very mean	F 250	17 All residents are at risk for and have the potential to be affected by resident's behaviors of asking other resident's for money. Members of the Interdisciplinary Team (IDT) will initiate, review and update care plans for residents identified to exhibit behaviors of asking other residents for money to minimize this behavior towards other residents; upon admission, quarterly and with exacerbation of behaviors. All staff will receive education on the Abuse Prevention Plan; and implementing appropriate interventions per resident care plans to minimize resident's behaviors of residents asking other residents for money. Residents identified to exhibit behaviors of asking other residents for money will be audited for staff implementation and effectiveness of interventions per care plan by the Quality Assurance Coordinator or designee weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012.	09-05-2012

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F 250	Continued From page 17 to her room mate. Was talked to about this situation, only gets angry, 'Tells everyone including room mate to get the Hell out of her room.' Will continue to monitor." *11/14/11, 4:27 p.m. -". . . has been verbally abusive to roommate . . . had her and room mate in my office and we discussed the problem . . . said she wants a room by herself . . . told her the room mate has rights too . . . she agreed to try. . . ." *11/15/11, 4:39 p.m. - "[Family member] visited today and I informed her of the problems with [Resident #11] and her room mate . . . said she needs to get use to having a room mate as she is not able to pay private room rate." *11/17/11, 9:03 p.m. - ". . . Refusing to allow staff to help resident with HS [bedtime] cares. Resident could be heard down hallway yelling at staff . . . Resident is sleeping in clothes . . . Will continue to monitor." *11/20/11, 8:21 p.m. - ". . . hollering at roommate accusing her of stealing her pants . . . Reassured this resident that those pants are her roommate's . . . Roommate wanted privacy and wanted curtain pulled, this resident continued to pull curtains all the way back to wall being able to see roommate sitting on her bed, therefore she would not get ready for bed d/t [due to] her being able to watch. Informed/educated resident . . ." *11/21/11, 7:00 a.m. - "CNA [Certified nursing assistant] reported and nurse intervened with res. [resident] and roommate [sic] argueing [sic]. Res. accusing roommate of taking her clothes and hollering at her, would not leave room, sat and watched roommate . . ." *11/22/11, 1:47 a.m. - "Resident has been very verbally abusive to her roommate. Roommate is afraid of her. Will continue to monitor."	F 250		

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F 250	Continued From page 18 *11/23/11, 7:25 a.m. - ". . . hollering and throwing clothes on floor, c/o [complaints of] roommate taking her clothes and going into things. . . . hollering at roommate . . . to closet and was pulling at her clothes, tried throwing walker at CNA when finally could get in to doorway, CNA eventually had to come and help roommate with cares to keep res away." *11/23/11, 10:33 a.m. - "Received fax from [physician] to start Seroquel 50 mg [milligrams] bid [two times each day] and prn [as needed] . . ." *11/24/11, 10:02 a.m. - ". . . Continues to swear at staff and roommate. Is very verbally abbusive [sic] with roommate." *12/30/11, 8:04 p.m. - ". . . continues to have behaviors this shift. While ambulating to supper resident made an inappropriate gesture at another resident and now at this time is yelling at snack care attendant. . . ." *02/05/12, 10:24 a.m. - ". . . Made such a scene in dining room had to be removed . . . Very verbally aggressive [sic] with other resident at her table and on the way out of the dining room, throwing her arms around telling other residents to 'Get the hell out of my way.' ". . ." The facility staff reported Resident #11 did not have a roommate from December 28, 2011 to February 06, 2012. The facility's response to Resident #11's verbally abusive and threatening behaviors towards other residents was limited to talking to the resident and her family member, monitoring, medications, and removal from situations. Resident #11's medical record lacks evidence the facility developed effective approaches to minimize other residents' fears and protect them from Resident	F 250	19	

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F 250	Continued From page 19 #11's threats and verbal outbursts. - Review of Resident #17's closed medical record occurred on 07/19/12. The facility admitted the resident in February 2012 and discharged the resident in May 2012. Diagnoses included anxiety. The resident's admission MDS, dated 02/21/12, identified cognitively intact and no behaviors demonstrated. Resident #17's care plan, dated 02/20/12, stated "Activities: . . . May be demanding. . . .;" and, dated 02/28/12, "Problem: Resident receives antidepressant, anxiolytic, and sedative medication R/T [related to] inability to sleep and feelings of sadness and anxiety . . . Approach . . . Psychiatric consults as needed. . . ." Resident #17's Progress Notes stated the following: *03/17/12, 8:24 p.m. - ". . . Resident . . . asked nurse if staff could go out and buy cigaretters [sic] for her since she ran out. Nurse stated that staff can not run to the gas station for this. Then another resident was going to go and walk to gas station to buy cigarettes for this resident but was detered [sic] by nurse . . ." The medical record did not identify the resident who was going to walk to the gas station. *03/17/12, 9:30 p.m. - "Resident has been asking numerous staff repeatedly this evening to go buy her cigarettes since she has none left. Resident also accepted $5 in cash from [resident number] this evening so that she could get cigarettes. . . . Nurse took money and returned it to [resident number] . . . This resident was instructed to not be asking other residents for money or for cigarettes and that she would have to ask	F 250		

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F 250	Continued From page 20 activities tomorrow to purchase cigarettes for her." Resident #17's medical record lacked approaches and interventions for staff regarding the resident's behaviors of asking another resident for money. During interview, on 07/19/12 at 9:30 a.m., additional information regarding the facility's approaches regarding Resident #11's and #17's behaviors was requested from two supervisory nursing staff members (#9) and (#10). No additional information was provided.	F 250		
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, review of professional reference, and staff interview, the facility failed to follow professional standards for essential components of physician orders pertaining to dosages of medications for 2 of 15 sampled residents (Resident #6 and #9). Failure to follow standards for complete physician orders could cause confusion with interpretation of these orders and result in medication errors. Findings include: Berman, Snyder, Kozier, and Erb, "Fundmentals of Nursing, Concepts, Process and Practice," 9th edition, Pearson-Prentice Hall, New Jersey, page	F 281	F281 It is the practice of St. Catherine's Living Center to ensure services provided or arranged by the facility meet professional standards of quality regarding professional standards for essential components of physician orders pertaining to dosages of medications. Resident #6's Vicoprofen order was clarified to include the specific dose of Hydrocodone and Ibuprofen. Resident #9's order for calcium w/ Vitamin D was clarified to include the dosage of Calcium. All residents receiving medications have the potential to be affected by this issue.	

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F 281	Continued From page 21 853 stated, ". . . Essential Parts of a Drug Order:. . . The dosage of the drug includes the amount, the times or frequency of administration, and in many instances the strength . . . The nurse should always question the primary care provider about any order that is ambiguous, unusual . . . ." - Resident #6's medical record included a physician order, dated 04/12/12, which stated, "Vicoprofen [one] po [oral] TID [three times daily] PRN [as needed]." Observation of Resident #6's PRN Medication Administration Record (MAR) listed Vicoprofen - one tablet TID for pain. Observation of the medication cassette showed a pharmacy label which stated "Hydrocodone 7.5 mg/Ibuprofen 200 mg [one] po TID PRN." Observation of the facility's "Narcotic Sign Out" form (a form used to account for and track the use of controlled medications) stated, "Name of Drug: Hydrocodone - Directions for use: [one] TID PRN . . . ." The MAR and the current physician order's identified the medication's brand name of "Vicoprofen." The facility ' s narcotic sign out form listed the generic name of "Hydrocodone/Ibuprofen" and failed to specify the dosage of Hydrocodone and Ibuprofen. During a telephone interview on 07/18/12 at 9:30 a.m., a pharmacist (#22) stated she expected the MAR to list the drug as "Vicoprofen" or if using the generic name, to include the specific dose of Hydrocodone and Ibuprofen. - Resident #9's medical record listed a diagnosis of osteoporosis. Review of Resident #9's current physician order's included an order for "Calcium w/ [with] Vitamin D 600 IU po [oral] BID [twice daily]." This ordered failed to specify the dosage	F 281	Licensed staff were provided in-service education regarding the proper transcription of medications including the inclusion of dosages with medications per established protocols. All resident's current medications will be audited by the Quality Assurance Coordinator or designee to ensure the inclusion of dosages per established protocols. All resident's new/revised medications will be audited by the Quality Assurance Coordinator or designee to ensure the inclusion of dosages per established protocols by the Quality Assurance Coordinator or designee weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012.	09-05-2012

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F 281	Continued From page 22 of Calcium to be administered.	F 281		
F 309 SS=G	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: 1. Based on observation, review of professional literature, record review, and staff interview, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #1) who experienced bruising, neck pain, and headache after she hit her head during a fall. Failure to promptly notify the physician about Resident #1's head injury resulted in delayed treatment and delayed identification of a C2 (cervical neck, second vertebrae) fracture, placing the resident at risk of serious injury or harm. Findings include: The American Academy of Orthopedic Surgeons website, at orthoinfo.aaos.org, states the following information regarding cervical fractures: "The seven bones in the neck are the cervical vertebrae. They support the head and connect it to the shoulders and body. . . . Any injury to the vertebrae can have serious consequences because the spinal cord, the central nervous	F 309	F309 It is the practice of St. Catherine's Living Center to ensure each resident receives 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. All staff that care for Resident #1 will receive "just-in-time" education on adhering to appropriate time parameters regarding notification of physician/physician extender related to a fall involving the resident which results in injury and has the potential for requiring physician intervention. All residents who experience a fall that results in an injury requiring physician intervention have the potential to be affected by this issue. Licensed Nursing Staff will be re-educated regarding timely notification of the physician/physician extender following a resident fall that results in injury and has the potential for requiring physician intervention.	

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F 309	Continued From page 23 system's connection between the brain and the body, runs through the center of the vertebrae. Damage to the spinal cord can result in paralysis or death. Injury to the spinal cord at the level of the cervical spine can lead to temporary or permanent paralysis of the entire body from the neck down. . . ." Review of Resident #1's medical record occurred on all days of survey. Resident #1's medical diagnoses included dementia, osteoarthritis, degenerative joint disease, and history of frequent falls. Observations of Resident #1 on all days of survey showed the resident wearing a cervical brace around her neck. "Resident Progress Notes," dated 04/09/12 at 3:12 p.m., stated, "Guest was here walking by resident's room. Saw resident fall forward on to her head. Went to room did full range of motion no complaints. Resident only complaint was that her head hurt. Large 4 inch by 4 inch lump on left side of temple. starting to get black n [and] blue. resident was able to answer simple questions. Sat resident up on buttocks, and no pain noted. got resident into bed. She was able to stand and walk to bed. No complaints at that time." The "Event Report" from the fall on 04/09/12, completed by a nursing staff member at 3:26 p.m. on 04/09/12, identified the following: ". . . PAIN ASSESSMENT: Does resident exhibit or complain of pain related to the fall? If so describe location. Yes - head. . . . BODY ASSESSMENT: Note any injury to the head, extremities, or trunk. - Bruising, Bump, Swelling. .	F 309	All residents who experience a fall that results in injury and has the potential for requiring physician intervention will be audited for adherence to regulations for physician/physician extender notification by the Quality Assurance Coordinator or designee weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012. Resident #14's physicians orders related to diabetes management were reviewed/clarified with residents physician. Resident's #11 and #14 blood glucose results indicative of the need for notification of the physician/physician extender and implementation of appropriate interventions will be completed per physicians order/ recognized protocols. All staff that care for Resident's #11 and #14 will receive "just-in-time" education on adhering to protocols regarding blood glucose results indicative of the need for notification of the physician/physician extender and appropriate implementation of interventions.	09-05-2012

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F 309	Continued From page 24 . NEUROLOGICAL CHECK . . . Left Eye - Pupil Response/Shape - Round/Sluggish . . . Right Eye - Pupil Response/Shape - Round/Sluggish . . . NOTIFICATION GUIDELINES: Notify MD/NP[nurse practitioner]/PA [physician's assistant] immediately by phone or beeper for any of the following. - Suspected head injury/abnormal neuro checks from resident baseline. . . . (NOTE: The nurse checked the box which indicated the MD/NP/PA should be notified immediately). NOTIFICATIONS: Attending Faxed: No. Physician Notified: Yes Date/Time: 4/15/2012 6:11 a.m. Family Notified: Yes. Date/Time: 4/15/2012 6:11 a.m. . . ." Review of "Resident Progress Notes" after the fall continue as follows: 04/09/12 *8:05 p.m. - ". . . did complained (sic) of neck pain later in the evening gave PRN [as needed] Tylenol. . . ." 04/10/12 *1:44 a.m. - "Had a hard time getting resident to open her eyes to check her pupils. Pupils are reactive to light, no C/O [complaints of] pain at this time . . ." *9:41 a.m. - Resident complained of neck pain, gave scheduled tramadol. . . ." *9:06 p.m. - "Resident very confused on PM shift. . . . Resident C/O headache from fall and Tylenol was given. This seemed to help for the pain. . . ." 04/11/12 *1:47 p.m. - "Resident C/O mild headache this shift but when offered prn analgesics refused, stated they made her feel worse. . . ." *10:19 p.m. - "[Name of health care provider (HCP)] here this afternoon, Tramadol 100 mg [milligrams] BID [twice a day] ordered; . . ."	F 309	25 All residents with accu-check/blood glucose results indicative of the need for notification of the physician/physician extender and implementation of interventions have the potential to be affected by this issue. Standing orders related to protocols for hyper/hypoglycemia will be updated and approved for use in the facility. Licensed Nursing Staff will be educated on protocols regarding timely notification of resident accu-check/blood glucose results indicative of the need for notification of the physician/physician extender and implementation of interventions per physicians order/ recognized protocols. Residents identified with current blood glucose/accu-check results indicative of the need for notification of the physician/physician extender and implementation of interventions per physicians order/ recognized protocols will be audited by the Quality Assurance Coordinator or designee weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012.	09-05-2012

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F 309	Continued From page 25 NOTE: A "Physician/NP/PA Communication" form, dated 04/11/12 identified the following: "Has had large increase in falls over the past month, resulting in several mild injuries. She states that often these falls are d/t [due to] dizziness, has had some BP [blood pressure] readings that have noted drop from laying to standing. Will be monitoring ortho [orthostatic] BP's Q [every] shift x [times] 3 days. However, noted more confusion, sleepiness, etc over past month or so. Can we trial a decrease in her Tramadol at this time? She has had an increase in falls since this was increased from 100 mg bid to 100 mg TID [three times a day] in December." NOTE: The HCP responded to the above concern on the "Communication Form" with an order for "Tramadol 100 mg bid." The written communication on 04/11/12, however, failed to identify staff notified the HCP of the specific fall on 04/09/12, in which the resident hit her head, resulting in a 4 inch by 4 inch black and blue lump on the side of her head, nor does it identify the resident's neck pain or headache since the fall. 04/12/12 *12:12 p.m. - "C/O pain on C-spine [cerebral spine] area on backside of neck to PT [physical therapy]. Noted large, (sic) firm nodule to area. States that it has been much worse since last fall. MSG [message] left to update RN [registered nurse] and MD [medical doctor]." *1:19 p.m. - "Per [name of health care provider] to send to ER [emergency room] for X-rays of Spine and eval [evaluation] of neck pain." *8:00 p.m. - "Resident returned . . . Resident has C-2 Fx [fracture] . . . new orders: Tylenol 650 mg po Q 6 hours prn. PT eval and TX [treatment]. . . Fall precautions. C-Collar [cervical collar] to be	F 309	26 Resident #10 will be administered oxygen per physician order and plan of care. Resident #10's respiratory status will be monitored by licensed nursing to ensure oxygen is appropriately administered while in bed. All staff that care for Resident #10 will receive "just-in-time" education on adhering to physician's orders and plan of care for appropriate administration of oxygen while in bed. All residents with physician orders for administration of oxygen have the potential to be affected by this issue. Nursing staff will be educated regarding protocols for appropriate administration of oxygen per physician's orders and plan of care. Residents identified with physician orders for administration of oxygen will be audited for adherence to protocols for appropriate administration of oxygen per physician's orders and plan of care by the Quality Assurance Coordinator or designee to ensure compliance weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012.	09-05-2012

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F 309	Continued From page 26 worn continuously except to sleep and to wash. No falls at all, if possible. F/U [follow-up] in Neuro surgery clinic . . ." Although the assessment data on Resident #1's Event Report, completed shortly after Resident #1's fall on 04/09/12, identified symptoms which indicated an immediate call to the physician (suspected head injury, sluggish pupils, bruising and swelling on the head), facility staff failed to notify the physician. Documentation in the medical record showed communication with a HCP on 4/11/12 (2 days after the fall), but the documentation failed to indicate the HCP was informed of the specific fall on 04/09/12 in which the resident hit her head. Resident #1 continued to complain of pain in the neck area, and staff sent the resident to the clinic for x-rays on 4/12/12, three days after she fell and hit her head. Failure to immediately notify the physician caused a delay in treatment interventions and a delay in the identification of a C2 fracture. During interview, the morning of 07/19/12, two administrative staff members (#11 and #12) agreed staff should have immediately called the physician after Resident #1 fell and hit her head. THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/31/11. 2. Based on record review, review of the facility's standing orders, review of professional reference, and staff interview, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being regarding episodes of low blood sugar levels (hypoglycemia) and/or	F 309		

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F 309	Continued From page 27 high blood sugar levels (hyperglycemia) for 2 of 3 sampled residents (Resident #11 and #14) with a diagnosis of diabetes mellitus (DM). Failure to follow the facility's protocol for hypoglycemic episodes and failure to establish individualized high and low blood sugar parameters for each diabetic resident (and notify the physician when results are outside these parameters) placed these residents and all diabetic residents at risk of complications. Findings include: The American Medical Directors Association, "Managing Diabetes in the Long-Term Care Setting, "Clinical Practice Guideline, 2002, pages 27-29, states, "WHEN TO CALL THE PHYSICIAN. . . Develop protocols that guide first-line care givers (nurses and nursing assistants) in deciding when a prompt physician referral is necessary for a diabetes-related problem. . . When patients' blood glucose levels are poorly controlled and when patients are extremely frail or cognitively impaired, the physician may wish to note specific individual blood glucose or symptom parameters in the orders. . . . It is recommended that the physician be called as soon as possible when: The patient has a blood glucose value < [less than] 60 mg/dl [milligrams per deciliter] or < 75 mg/dl if the patient has signs and symptoms suggestive of hypoglycemia. (Treatment of symptomatic hypoglycemia should not be delayed.) TREATING HYPOGLYCEMIA Hypoglycemia is defined as blood glucose level < 60 mg/dl. Symptoms may or may not be present.	F 309		

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F 309	Continued From page 28 . . . The same threshold should be used to diagnose hypoglycemia in patients with dementia as in those who are not cognitively impaired. . . . Hypoglycemia is the most feared short-term complication of treatment for diabetes. If not promptly recognized and treated it can result in long-term disability, particularly in cognitively impaired individuals. . . . It is recommended that all long-term care facilities develop and implement a policy and procedures for treating hypoglycemia. . . . Patients who are obtunded (incoherent but not comatose) may be treated with oral glucose paste rubbed onto the buccal mucosa, intramuscular glucagon, or intravenous 50% dextrose. . . . Administration of 1 mg glucagon can achieve sufficient clinical recovery to enable safe consumption of oral carbohydrates . . ." - Review of the facility policy and procedure, "Hypoglycemia" occurred on July 18-19, 2012. This document, revised in October 2011 stated, "OBJECTIVE: To provide appropriate interventions with hypoglycemic episode. Hypoglycemic symptoms may include: Weakness, sweating, tachycardia, palpitations, tremor, nervousness, irritability, tingling in the mouth and tongue, hunger, nausea (unusual) and vomiting (unusual), headache, hypothermia, visual disturbances, mental dullness, confusion amnesia, seizures, coma. Follow facility standing orders unless otherwise specified by the physician: 1. If resident is feeling or presents with symptoms of hypoglycemia, test blood sugar. 2. If blood sugar is low: Provide resident with carbohydrate and	F 309	29	

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F 309	Continued From page 29 protein . . . if resident able to eat/drink. Give glutose 1/2 -1 tube orally for symptomatic hypoglycemia plus BS [blood sugar] < [less than] 50. Repeat in 10 minutes as need. [sic] Give glucagon 1 mg [milligram] IM [intramuscular] x [times] 1 for symptomatic hypoglycemia plus BS <30 and notify physician/extender of results. 3. Monitor resident - retest blood sugar. 4. If blood sugar continues to be low, call medical doctor according to orders or if unable to increase blood sugar to acceptable level for that resident." Review of the facility's standing orders, revised in October 2006, included the following: "DIABETES MONITORING and/or TREATMENT. Follow facility protocol. If no protocol: 1) Blood glucose check pm nurse discretion. 2) Glucose 1/2 -1 tube orally for symptomatic hypoglycemia plus BS < 50. Repeat in 10 minutes as needed. 3) Glucagon 1 mg 1M X 1 for symptomatic hypoglycemia plus BS < 30 and notify physician/extender [sic] of results." - Review of Resident #11's medical record occurred on July 16-19, 2012. Admission diagnoses included DM. The resident's quarterly Minimum Data Set (MDS), dated 06/21/12, identified moderate cognitive impairment. Resident #11's medications included scheduled and sliding scale insulin. Resident #11's physician orders included the facility's standing orders. The medical record lacked individualized low blood sugar parameters for physician notification.	F 309	30	

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F 309	Continued From page 30 Resident Progress Notes stated the following: *12/01/11, 5:15 p.m., "Res.[Resident] very sweaty and clamy [sic]. responding only to name. BS is 31 [mg/dl]. Gave res. 120 cc [cubic centimeters] orange juice, res. barely responded to this. Tried to give res food but she kept coughing this up. res. would put head to the side and slipping into unresponsive stage. Wheeled res. to n [nurse's] station and administered glucogon [sic] im [intramuscularly] to L [left] deltoid area." *12/01/11, 5:20 p.m., "Res. responded to glucagon im. Now talking to nurse and holding head up. Ate about 25% of her food and drank another 120 cc of orange juice." *12/01/11, 7:00 p.m., "Res. BS up to 100 [mg/dl] at this time. CNA [Certified nursing assistant] fed res. pudding at this time." Resident #11's care plan, dated 06/01/11, stated "Problem: Resident receives Insulin related to risk for hyperglycemia secondary to dx. [diagnosis] of Diabetes Mellitus . . . Approach: Administer insulins as ordered. Monitor blood sugars as ordered;" and dated 08/18/11, "Problem; Nutrition: Receives therapeutic diet r/t [related to] dx DM with mechanically altered textures. . . . Approach . . . Monitor for excessive coughing when drinking fluids. . . ." Resident #11 experienced a hypoglycemic episode with symptoms of unresponsiveness on 12/01/11. The resident's history included excessive coughing when drinking liquids. Facility staff initially administered orange juice and attempted to give food for a BS of 31[mg/dl] (instead of the protocol to administer 1/2 to 1 oral glucose tube for symptomatic hypoglycemia < 50	F 309		

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mg/dl). After the resident did not respond to the orange juice and became unresponsive, staff administered intramuscular glucagon.

The staff failed to follow the facility protocol for symptomatic hypoglycemia with a BS < 50 mg/dl and failed to notify the physician or extender, limiting their ability to ensure the quality of resident care.

During interview, on 07/19/12 at 9:30 a.m., two supervisory nursing staff members (#9) and (#10) reported they would investigate this episode and provide additional information. These staff members failed to provide any documentation for further review.

- Review of Resident #14's medical record occurred on July 18-19, 2012. Admission diagnoses included diabetes mellitus, seizure disorder, and hemiplegia. The resident's quarterly MDS, dated 05/14/12, identified the resident as rarely or never understood, short and long-term memory impairment, received insulin injections, and physician's orders to change insulin dosage daily during the seven day look-back period.

Resident #14's physician orders in addition to the facility wide standing order pertaining to diabetes, included:

-07/28/09 -"Do not hold Lantus [type of insulin injection] d/t [due to] low food intakes unless instructed by the MD [medical doctor]. Report any changes in appetite or low blood sugar to MD prn."
-04/08/11 -"Give NovoLog after resident eats, NOT BEFORE, HOLD NovoLog if intakes at meal

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F 309	Continued From page 32 time are less than 50%." -10/06/11 -"Accuchecks four times a day at 5:30 a.m., 10:30 a.m., 4:30 p.m., and 7:30 p.m. and "Special instructions" to "Call MD if blood sugars > [greater than] 300." -04/05/12 -"NovoLog insulin -four units SQ twice a day at 11:00 a.m. and 5:30 p.m" and "Special Instructions" to "DO NOT GIVE UNTIL RESIDENT HAS EATEN! HOLD IF INTAKES ARE <50%. NovoLog insulin six units SQ daily at 7:30 a.m." and "Special Instructions" to "DO NOT GIVE UNTIL RESIDENT HAS EATEN! HOLD IF INTAKES ARE <50%. Lantus insulin 15 units SQ every AM at 7:30 a.m." Review of the Resident #14's blood sugar records from April-July 2012 identified the following blood sugar levels: 31 mg/dl on 04/16/12 at 8:00 p.m. 340 mg/dl on 05/08/12 at 4:29 p.m. 47 mg/dl on 05/28/12 at 10:30 a.m. Resident #14's Progress Notes stated the following: *04/16/12 at 9:31 p.m. "Blood sugar 31 at 8:00 p.m. Was awake and responsive so fed a container of chocolate pudding, ate without difficulty, skin diaphoretic [a sign/symptom of hypoglycemia] at this time. Rechecked blood sugar at 8:30 and was 47, HS [before bed] sanck [sic] fed to resident without difficulty, again ate an ensure pudding and 1/2 of his apple dessert." *05/08/12 -The record lacked an entry or evidence facility staff contacted/informed the health care provider of the blood sugar result of 340 mg/dl. *05/28/12 at 10:13 a.m. The facility staff held AM dose of NovoLog insulin due to the resident's	F 309		

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F 309	Continued From page 33 refusal to eat breakfast. At 10:30 a.m., an entry stated, "Reported by staff that resident juswt [sic] didn't seem right, color pale and very listless [sign/symptoms of hypoglycemia]. Accucheck 48. pudding fed to resident and he was able to swallow. Will recheck and observe." The record showed facility staff rechecked Resident #14's blood sugar at 10:41 a.m. and showed a reading of 61 mg/dl and noted "Resident more responsive but still sleepy. Will monitor." Facility staff obtained another blood sugar reading of 48 mg/dl at 10:45 a.m. Resident #14 experienced a symptomatic hypoglycemia episode (blood sugar 31 mg/dl and skin diaphoretic) on April 16, and facility staff failed to follow the established protocol of giving 1/2 to 1 oral glutose tube and repeat in 10 minutes as needed. In addition, the medical record lacked evidence facility staff notified a HCP. On the evening of 05/08/12, Resident #14's blood sugar reading exceeded 300 mg/dl. Resident #14's medical record lacked evidence the facility informed the HCP (Special Instructions on the Physician's orders stated "Call MD if BS >300"). On 05/28/12, Resident #14 exhibited symptomatic hypoglycemia and facility staff provided oral intake of pudding while the resident was "very listless" instead of implementing the physician protocol of oral glutose for symptomatic BS <50, repeat in 10 minutes as needed. 3. Based on observation, record review, professional literature review, family interview, and staff interview, the facility failed to ensure oxygen placement for 1 of 2 sampled residents (Resident #10) with a physician order for oxygen.	F 309	34	

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F 309	Continued From page 34 Failure to administer oxygen as ordered may result in complications such as hypoxia (insufficient oxygen anywhere in the body), shortness of breath, anxiety, and/or respiratory distress. Findings include: The Fundamentals of Nursing Concepts, Process, and Practice 8th Edition by Berman, Snyder, Kozier, and Erb copyright 2008 by Pearson Education, Inc, page 1372, stated, "Clients who have difficulty ventilating all areas of their lungs, those whose gas exchange is impaired, or people with heart failure may benefit from oxygen therapy to prevent hypoxia . . . Oxygen therapy is prescribed by the primary care provider, who specifies the concentration, method of delivery, and depending on the method, liter flow per minute . . ." During an interview on 07/16/12 at 5:35 p.m., a family member (#1) stated Resident #10 rarely received oxygen while in bed. The family member stated he/she discussed this concern with facility staff two or three months ago, however there has been no improvement. Review of Resident #10's medical record occurred on July 16-19, 2012. Diagnoses included end stage congestive heart failure (CHF), pulmonary hypertension, cardiomegaly, cardiac pacemaker, and anxiety. Resident #10's care plan, dated 05/23/12, stated: Problem: "Resident requires oxygen therapy R/T [related to] End Stage CHF." Approaches: "Administer oxygen at 2 lpm [liters	F 309		

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F 309	Continued From page 35 per minute] via nasal cannula while lying down in bed and q [every] hs [hour of sleep]." "Monitor respiratory status every shift. Ensure O2 [oxygen] on while in bed." Resident #10's physician orders, dated 03/27/12, stated, "O2 2 lpm QD [every day] while lying down and at HS." Observation on 07/17/12 at 3:40 p.m., showed a certified nursing assistant (CNA) (#2) transferred Resident #10 from her wheelchair and laid her down in bed. The CNA (#2) failed to apply the resident's oxygen. The resident remained in bed without oxygen from 3:30 p.m. to 5:25 p.m. During an interview on 07/19/12 at 9:05 a.m., two administrative nursing staff members (#3 and #4) stated nursing should monitor to ensure oxygen is applied and confirmed Resident #10's oxygen should be administered when she is in bed.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide the necessary services for 2 of 15 sampled residents regarding oral cares (Resident #6) and assistance with meals and toileting (Resident #7).	F 312	F312 It is the policy of St. Catherine's Living Center that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene. Resident #6 shall be provided oral cares to ensure oral hygiene per care plan. All staff that care for Resident #6 will receive "just-in-time" education on adhering to the care plan for provision oral cares/hygiene. All residents who require provision of oral cares/hygiene per care plan have the potential to be affected by this issue.	

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F 312	Continued From page 36 Failure to provide oral cares to Resident #6 did not ensure oral hygiene. Failure to provide Resident #7 assistance at meals did not ensure good nutrition. Failure to provide Resident #7 with toileting did not ensure personal hygiene. Findings include: - Review of Resident #7's medical record occurred on July 16-19, 2012. Current diagnoses included constipation. The resident's quarterly Minimum Data Set (MDS), dated 07/05/12, identified the resident rarely or never understood, sometimes understood others, had short and long term memory problems, required extensive assistance of one person for transfers and toileting, and supervision and set up help for eating. Resident #7's current care plan, dated 01/03/12, stated "Problem . . . extensive to total assist of 1 for all areas of ADL's [Activities of Daily Living] due to cognitive status . . . Approach . . . Cues to limited assist required for eating after setup. . . .;" and, dated 01/10/12, stated "Problem, NUTRITIONAL STATUS: Receives regular diet with nutritional supplements at meals. Receives mechanically altered textures. Leaves > [greater than] 25% food/fluid uneaten at meals. . . . Approach . . . Mechanical soft and/or pureed textures as [Resident #7] will accept. Provide 6.7 oz [ounce] juice-base nutritional supplement at meals TID [three times each day] (if resident would like more, she may have more). . . . Monitor weights and oral intakes at meals." Observation of Resident #7 during the supper meal on 07/16/12, the breakfast, brunch, and	F 312	37 Nursing staff will be educated regarding appropriate provision of oral care/hygiene per resident care plan. Residents identified to require provision of oral care/hygiene per care plan will be audited by the Quality Assurance Coordinator or designee to ensure compliance weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012. The following will be implemented for Resident #7: Nutritional supplement will be increased per LRD recommendations. The care plan will be reviewed/updated by members of the IDT (Interdisciplinary Team) regarding appropriate interventions with meals; and timely and appropriate toileting methods to ensure personal hygiene and effective response to toileting per care plan. All staff that care for Resident #7 received "just-in-time" education on adhering to the care plan to provide appropriate interventions with meals; and timely and appropriate toileting methods.	09-05-2012

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F 312	Continued From page 37 supper meals on 07/17/12, and the breakfast meal on 07/18/12, identified the resident seated at the dining room table in her wheelchair, with a juice supplement on the table. At each meal, facility staff served and set up her meal items and the resident independently consumed all of the juice. During these meal observations, facility staff members provided encouragement or assistance only as follows: *07/17/12 at 5:48 p.m., during the supper meal, Resident #7 independently ate chocolate ice cream from a individual serving container. A staff member served her meal of potato salad, bean casserole, and diced carrots and moved the ice cream out of the resident's reach. The resident picked at the meal items, did not eat any more ice cream, and facility staff failed to return to encourage her. *07/18/12 at 8:15 a.m., observation showed Resident #7 pushed her cold cereal away without eating any of it, spread jelly on her toast, poured water on her toast, and attempted to eat the toast. An unidentified staff member passing medications removed the water soaked toast and obtained fresh toast. The resident consumed approximately half of the toast and all of her milk. Facility staff failed to offer additional juice supplement, encouragement or assistance to Resident #7. Review of Resident #7's Intake Record for the period, July 02-18, 2012 (17 days, 51 meals) showed Resident #7 consumed 25% or less of her food items for 34 meals (66.7%) and 75% or more of her nutritional supplement for 50 meals (98%). The medical record did not identify Resident #7 experienced an illness or reduced	F 312	All residents who require provision of assistance with meals to ensure good nutrition; and toileting to ensure personal hygiene per care plan have the potential to be affected by this issue. Nursing staff will be educated regarding appropriate provision of assistance with meals to ensure good nutrition; and toileting to ensure personal hygiene per resident care plan. Residents identified to require provision of assistance with meals; and toileting per care plan will be audited by the Quality Assurance Coordinator or designee to ensure compliance weekly x2, then monthly x2 and quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012.	09-05-2012

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F 312	Continued From page 38 appetite during this period. For the meals observed, facility staff recorded the resident consumed 25% or less of her food items except breakfast on 07/18/12 when she ate half of her toast, no cereal, and 50% is recorded. Resident #7's medical record identified her weight has been stable, between 124 and 129 pounds, for the past year. The potential exists for Resident #7 to lose weight since staff do not monitor her eating practices and encourage her to eat. - Resident #7's current care plan, dated 01/03/12, stated "Problem . . . is incontinent of bowel and incontinent of bladder related to cognitive status . . . Approach . . . Commode over toilet. Toilet every 2 hours. . . .;" and "Problem . . . extensive to total assist of 1 for all areas of ADL's due to cognitive status . . . Approach . . . Transfers per 1 assist, stand and pivot with FWW [front wheeled walker] and gait belt. PAL [Stand lift model] prn [as needed]. . . ." Observation identified Resident #7 resided in a private room and shared the bathroom with the resident in the next room. The bathroom contained a wheeled commode over the toilet and a bedside commode. Observation identified certified nurse aides (CNAs) (#5 and #6) assisted Resident #7 to toilet on the bedside commode with a stand lift in her room on 07/17/12 at 9:35 a.m. and at 1:15 p.m. During these transfers Resident #7 followed the staff's instructions to hold the bars on the lift and assisted to stand with her legs. During interview, on 07/17/12 at 1:05 p.m., a CNA (#5) reported the facility staff transferred the	F 312		

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F 312	Continued From page 39 resident to the commode in her room with the stand lift for toileting before lunch. During interview, on 07/17/12 at 1:15 p.m., a CNA (#6) reported staff use the stand lift due to the resident's variable transfer ability and use the bedside commode because the stand lift does not fit into the bathroom. Observation on 07/18/12 identified CNAs (#7 and #8) assisted Resident #7 to stand and pivot transfer from her wheelchair to her bed at 9:25 a.m. and from her bed to the bedside commode at 10:40 a.m. Observation on 07/18/12 at 9:25 a.m. identified a CNA (#7) assisted Resident #7 from her wheelchair to her bed, checked the frontal area of her brief, stated the resident was "dry," and positioned her in bed for a nap. The CNA (#7) failed to check the backside of the brief for possible soiling, did not offer toileting, and reported Resident #7 would be toileted upon rising from her nap before lunch. Observation on 07/18/12 at 10:40 a.m. identified CNAs (#7) and (#8) placed the bedside commode in the resident's room, awakened the resident, assisted the resident to sit at the edge of the bed, placed a gait belt around the resident's waist, and identified stool leaking from the back of the resident's brief. Stool was present on the bed protector, the resident's clothing, and the gait belt. The staff members assisted the resident to stand and pivot, lowered her pants and brief, assisted her to sit on the commode. Facility staff used the stand lift to transfer	F 312		

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F 312	Continued From page 40 Resident #7 to the bedside commode and failed to attempt to transfer the resident to the wheeled commode over the toilet. Facility staff used the bedside commode for their convenience. Failure to attempt to provide toileting in the bathroom setting may limit the resident's response to toileting. The facility staff failed to provide Resident #7 toileting on 07/18/12 at 9:25 a.m. which may have prevented in an incontinent bowel movement at 10:40 a.m. Failure to provide Resident #7 the opportunity to use the use toilet did not encourage normal bowel habits and may have resulted in the episode of incontinence. During interview, on 07/19/12 at 9:30 a.m., two supervisory nursing staff members (#9) and (#10) confirmed facility staff should have assisted and encouraged Resident #7 in the dining room and should have toileted Resident #7 on 07/18/12 at 9:25 a.m. - Review of Resident #6's medical record occurred on July 16-19, 2012. The facility admitted the resident in August 2011. Current diagnoses include cerebrovascular accident (CVA) with right hemiplegia, dysarthria, osteoarthritis, and degenerative joint disease (DJD). The resident's quarterly MDS, dated 05/24/12, identified moderately impaired cognitive functioning, usually understood others, and required extensive assistance of one person for eating and personal hygiene. Resident #6's current care plan, dated 05/19/12, stated "Problem . . . ADL Function: Resident requires extensive to total assist with ADL's related to weakness, limitation to ROM [range of motion], immobility secondary to CVA,	F 312	41	

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F 312	Continued From page 41 osteoarthritis, DJD . . . Approach . . . dated 09/10/11, Provide orals [sic] cares after every meal r/t [related to] pocketing of food secondary to stroke . . . ." Review of the "Group A Assignment Sheet" (a form used by the CNAs which identified what ADLs staff need to assist residents with) stated, ". . . Oral Cares - Assist 1 - Provide oral cares after q [every] meal r/t to pocketing of food." Observation upon the completion of meals on 07/17/12 at 8:50 a.m. (breakfast) and 1:05 p.m. (lunch) showed certified nurse aides (CNAs) (#21 and #18) failed to provide oral care to Resident #6. Observation on 07/18/12 at 8:20 a.m., upon the completion of breakfast, showed Resident #6 seated in the recliner in his room. During interview on 07/18/12 at 9:45 a.m. a CNA (#21) stated staff provide/give Resident #6 his dentures in the morning to place in his mouth. When asked if she assists or cues the resident to complete oral cares after meals, this CNA (#21) stated "No," as "he [referring to Resident #6] wheels himself into the bathroom and rinses them [the dentures] by himself." During interview on afternoon 07/19/12 an administrative nurse (#11), confirmed she expected CNAs to complete oral cares for Resident #6 after meals as per the resident's plan of care and the CNA assignment sheet.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	F323 It is the practice 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.	

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F 323	Continued From page 42 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, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices for 2 of 12 sampled residents (Resident #2 and #8) and 2 supplemental residents (Residents #19 and #20) observed being transported by staff via wheelchairs with no foot pedals and 1 of 7 sampled residents (Resident #5) observed being transferred with a gait belt. Failure of the facility staff to ensure proper use of assistive devices (gait belt and/or wheelchair foot pedals) has the potential to cause residents unnecessary pain and placed them at risk for possible accident and/or injury. Findings include: Review of the facility policy titled "Resident Transfer Wheelchair" occurred on 07/19/12. This policy, reviewed by the facility on December 2002, stated, ". . . POLICY: . . . Staff will provide for safe transfer during transport per individual plan of care. . . . PROCEDURE: . . . 4. For residents with leg-rest bag on the back of the wheelchair: a. Utilize wheelchair pedals per residents plan of care, b. Attach leg rests to wheelchair prior to transport . . . 5. Resident, per	F 323	Resident's #2, #8, #19 and #20: Care plans will be reviewed and revised as needed for appropriate interventions for wheelchair transport by RCC's (Resident Care Coordinators). RCC's or delegate will assure availability of foot pedals per resident plan of care. RCC's or delegate will review for appropriate use of foot pedals to provide for safe transfer per established protocols and residents plan of care. Staff involved with the immediate care of Resident's #2, #8, #19 and #20 will receive "just in time" training regarding providing safe transfer during transport through utilization of foot pedals per established protocols and residents plan of care. All residents who have been identified by RCC's per resident care plans to require foot pedals for transport have the potential to be affected by this issue. Staff that transport residents will be re-educated regarding proper wheelchair transport to include use of foot pedals for transportation per individual resident care plan and established policies.	

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F 323	Continued From page 43 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. . . ." Review of the facility policy and procedure, "Transfer Belt Use" occurred on 07/19/12. This policy, dated 12/2002, stated, ". . . The purpose of a transfer belt (gait) is to provide support to residents who may be unsteady on their feet. The belt will protect the resident should they become weak or lose their balance when ambulating or transferring. Policy: Nursing staff will use a transfer belt when ambulating or transferring a resident. Procedure: . . . 6. Fasten transfer belt securely around waist . . .7. Grasp transfer belt at resident's side using an underhand grasp. 8. Using proper body mechanics by bending your knees and keeping your back straight, assist, resident to a standing position. 9. Allow resident to get and maintain standing balance . . . 10. Grasp transfer belt at the resident's back and walk at side resident, supporting hand and arm if necessary . . . ." - Review of Resident #2's medical record, on all days of survey, identified diagnoses including Parkinson's features with dementia. Resident #2's most recent MDS, dated 05/02/12 identified severely impaired cognition and extensive assistance of two persons for transfers and locomotion on unit. Observation on 07/17/12 at 9:45 a.m. showed a CNA (#19) transporting Resident #2 in his wheelchair down the hall. Resident #2's feet brushed along the floor, making an audible noise. The CNA reminded the resident to lift his legs, but his feet continued to brush along the floor.	F 323	All residents who have been identified by RCC/resident care plans to require foot pedals for transport will be audited for availability and appropriate use of foot pedals to provide for safe transfer by the Quality Assurance Coordinator or designee for adherence to established protocols and individualized care plans weekly x2, then monthly x2 and quarterly thereafter to ensure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012. Resident's #5 will receive proper use of assistive devices related the use of gait belt during transfers. Staff involved with the immediate care of Resident #5, will receive "just in time" training regarding providing safe transfer through utilization of gait belt per established protocols and residents plan of care. All residents who have been identified by RCC's per resident care plans to require gait belts for transfers have the potential to be affected by this issue.	09-05-2012

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	355033	A. BUILDING _____ B. WING _____	C 07/19/2012

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F 323	Continued From page 44 Observation on 07/17/12 at 1:50 p.m. showed 2 CNA's (#19 and #20) transporting Resident #2 in his wheelchair down the hall towards his room. Resident #2's feet brushed along the floor, making an audible noise. Both CNA's encouraged the resident to lift his feet, but the resident did not lift them. The CNA (#20) then lifted the resident's legs just before they reached his room. After toileting the resident, the CNA's (#19 and #20) transferred Resident #2 back to his wheelchair. The CNA (#20) transported Resident #2 from his room to the TV room, his feet again brushing the top of the carpet on the floor. The CNA (#20) stated Resident #2 does not have foot pedals for his wheelchair. During an interview on 07/19/12 at 9:25 a.m., two administrative staff members (#11 and #12) agreed staff should have utilized assistive devices (wheelchair foot pedals) during transport. - Resident #8's medical record, reviewed July 16-19, 2012, identified diagnoses including anxiety, dementia, depression, osteopenia, and history right hip fracture and compression fracture. The resident's significant change MDS, dated 07/01/12, identified extensive assistance of one person required for locomotion on/off unit. Resident #8's current care plan stated the following, ". . . Problems: . . . ADL'S [Activities of Daily Living] . . . Approaches: . . . Foot Pedals: On for transport only. . . ." Observation on 07/18/12 at 5:26 p.m. showed a CNA (#13) talking with another CNA (#14) as she transported Resident #8 in her wheelchair down the hallway towards her room. Resident #8's left	F 323	Staff that transfer residents through the use of gait belts will be re-educated regarding proper use of gait belts for transfer per resident care plans and established protocols. All residents who have been identified by RCC's/resident care plans to require gait belts for transfers will be audited for appropriate use of gait belts to provide for safe transfer by the Quality Assurance Coordinator or designee for adherence to established protocols and individualized care plans weekly x2, then monthly x2 and quarterly thereafter to ensure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012.	09-05-2012

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F 323	Continued From page 45	F 323		

foot/shoe caught on the flooring and the top of her foot/shoe drug under the wheelchair as staff transported her down the hallway. Resident #8 pulled her left foot/shoe forward and raised both feet for the remainder of the transport. Resident #8's foot pedals were located in a bag behind her wheelchair.

- Resident #19's medical record, reviewed July 18-19, 2012, identified diagnoses including poor memory skills, moderately impaired decision making skills, history of cerebrovascular accident (CVA), cataract and blind left eye, and impaired hearing. The resident's annual MDS, dated 05/27/12, identified supervision required for locomotion on unit. Resident #19's current care plan stated the following, ". . . Problems: . . . ADL'S . . . Approaches: . . . Locomotion: On unit 1 assist . . ."

Observation following breakfast on 07/19/12 showed a CNA (#15) transporting Resident #19 in her wheelchair down the hallway towards her room. Resident #19's left foot/shoe caught on the flooring and the top of her foot/shoe drug under the wheelchair as staff transported her down the hallway. Resident #19 pulled her left foot/shoe forward and raised both feet for the remainder of the transport.

- Resident #20's medical record, reviewed July 18-19, 2012, identified diagnoses including anxiety, depression, osteoarthritis, and pain. The resident's quarterly MDS, dated 06/09/12, extensive assistance of one person required for locomotion on/off unit. Resident #20's current care plan stated the following, ". . . Problems: . . . ADL'S . . . Approaches: . . . Locomotion: W/C

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F 323	Continued From page 46 [wheelchair] pedals for transport only . . ." Observation following breakfast on 07/19/12 showed an unidentified CNA transporting Resident #20 in her wheelchair down the hallway towards her room. The toes of Resident #20's feet/shoes slid along the surface of the flooring as staff transported her to her room. Staff members failed to place the residents' foot pedals on their wheelchairs, cue the residents to lift their feet/shoes, and ensure the residents' feet/shoes cleared the floor during transport to avoid catching the residents' feet on the flooring. - Review of Resident #2's medical record, on all days of survey, identified diagnoses including Parkinson's features with dementia. Resident #2's most recent MDS, dated 05/02/12 identified severely impaired cognition and extensive assistance of two persons for transfers and locomotion on unit. Observation on 07/17/12 at 9:45 a.m. showed a CNA (#19) transporting Resident #2 in his wheelchair down the hall. Resident #2's feet brushed along the floor, making an audible noise. The CNA reminded the resident to lift his legs, but his feet continued to brush along the floor. Observation on 07/17/12 at 1:50 p.m. showed 2 CNA's (#19 and #20) transporting Resident #2 in his wheelchair down the hall towards his room. Resident #2's feet brushed along the floor, making an audible noise. Both CNA's encouraged the resident to lift his feet, but the resident did not lift them. The CNA (#20) then lifted the resident's legs just before they reached his room. After	F 323		

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F 323	Continued From page 47 toileting the resident, the CNA's (#19 and #20) transferred Resident #2 back to his wheelchair. The CNA (#20) transported Resident #2 from his room to the TV room, his feet again brushing the top of the carpet on the floor. The CNA (#20) stated Resident #2 does not have foot pedals for his wheelchair. During an interview on 07/19/12 at 9:25 a.m., two administrative staff members (#11 and #12) agreed staff should have utilized assistive devices (wheelchair foot pedals) during transport. - Review of Resident #5's medical record occurred on July 16-19, 2012. Medical diagnoses for Resident #5 include Alzheimer's disease and open reduction internal fixation to left hip secondary to a fall on 04/25/12. Resident #5's annual MDS, dated 05/09/12, identified the resident displayed severe cognitive impairment and required extensive two person physical assistance with transfers. Review of the facility's "Group Assignment Sheet" (a form used by CNAs which identified the level of assistance required by residents) identified Resident #5 needs the assistance of ". . . 1 assist w/ [with] walker [and] gait belt [every] 2 hrs [hours] . . . ." Resident #5's current care plan stated, " . . . Problem - Falls: Resident is at risk for falls related to the use of AD [assistive devices] when ambulating, self transfers, and use of antidepressant and antihypertensive secondary to dx [diagnoses] of Alzheimer's disease, HTN [hypertension], and depression. Approach: . . . 1 assist with FWW and gait belt for toileting . . .	F 323		

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F 323	Continued From page 48 transfers . . . ." On 07/17/12 at 7:50 a.m., observation showed Resident #5 seated on the toilet in the bathroom and her front wheeled walker (FWW) in front of her. A certified nurse aide (CNA) (#21) asked Resident #5 to stand up so the CNA (#21) could complete perineal cares. Resident #5 placed her hands on the FWW and attempted to stand on her own, but was unsuccessful at this attempt. On the second attempt, observation showed the CNA (#21) grabbed underneath Resident #5's right arm to assist the resident to a standing position. Observation showed the CNA (#21) failed to use the gait belt, noted to be around her (the CNA's) waist. On 07/17/12 at 9:08 a.m. a CNA (#18) entered Resident #5's room to assist her from her recliner into the bathroom. Observation showed the CNA (#18) applied a gait belt snuggly around Resident #5's waist. Resident #5 placed her hands on the FWW, attempted to stand up on her own, but failed. Observation showed the CNA (#18) placed her left hand around the gait belt and her right hand under the resident's arm as the Resident #5 made a second attempt to stand and failed. Next, observation showed the CNA (#18) placed both of her hands on the gait belt, and cued Resident #5 to attempt to stand up. This attempt was successful. On 07/17/12 at 9:40 a.m., a CNA (#21) placed a gait belt around Resident #5's waist and asked the resident to stand up. Observation showed Resident #5 unable to get out of the recliner without assistance. The CNA (#21) cued Resident (#5) to bend her legs, place one hand	F 323		

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F 323	Continued From page 49 on the FWW, the other hand on the arm of the recliner, and stand up. Observation showed the CNA (#21) grabbed underneath Resident #5's right arm and assisted the resident to a standing position. Resident #5 stated "ouch" as she stood up. On 07/18/12 at 8:45 a.m., a CNA (#21) placed a gait belt around Resident #5's waist and asked the resident to stand up. Observation showed the CNA grabbed underneath Resident #5's right arm rather than using the gait belt to provide assistance to stand. During interview on 07/18/12 at 4:40 p.m., an administrative nurse (#9) stated prior to providing physical assistance with transfers and/or ambulation of residents, she expected staff members to place a gait belt around a resident's waist and for staff members to utilize the gait belt when helping them to transfer or ambulate.	F 323		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility staff failed to offer fluids to 1 of 11 sampled residents dependent on staff for in-room fluids (Resident #7). Failure to offer Resident #7 fluids during cares and additional fluids at meals resulted in a lack of fluid intake for three and a	F 327	F327 It is the practice of St. Catherine's Living Center to provide each resident with sufficient fluid intake to maintain proper hydration and health. The following will be implemented for Resident #7: Nutritional supplement will be increased per LRD recommendations. The care plan will be reviewed/updated by members of the IDT (Interdisciplinary Team) regarding appropriate interventions with meals; interventions for the provision of fluids/snacks (that include fluids) throughout the day to enable staff to implement effective interventions to maintain resident #7's hydration status.	

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F 327	Continued From page 50 half to four and a half hours, may have contributed to four and five day periods without a bowel movement, and placed the resident at risk of dehydration. Findings include: Review of Resident #7's medical record occurred on July 16-19, 2012. Current diagnoses included constipation and anemia. The resident's quarterly Minimum Data Set (MDS), dated 07/05/12, identified rarely/never understood, sometimes understands others, short and long term memory problems, extensive assistance of one person for locomotion on and off the unit, supervision and setup assistance for eating, always incontinent of urine, and frequently incontinent of bowel. Resident #7's care plan, dated 01/03/12, stated "Problem . . . is incontinent of bowel and incontinent of bladder . . . Problem, Resident has potential for constipation . . . Goal . . . bowel movement [every] 3 days . . . Approach . . . Encourage fluids . . . Problem, Resident is at risk for skin breakdown . . . Approach . . . Encourage fluids . . . Problem, NUTRITIONAL STATUS: Receives regular diet with nutritional supplements at meals. Receives mechanically altered textures. Leaves > [greater than] 25% food/fluid uneaten at meals. . . . Goal . . . Consume at least 360 cc [cubic centimeters] fluid at each meal including hical [high calorie] nutritional supplement. . . . Accept between - meal snack BID [two times each day] (including 120 cc fluids with snacks) . . . Approach . . . Provide 6.7 oz [ounce] [approximately 201 cc] juice - base nutritional supplement at meals TID [three times each day] (if resident would like more, she may have more).	F 327	Staff that care for resident #7 will receive "just in time" education regarding appropriate interventions with meals; and interventions for the provision of fluids/snacks (that include fluids) throughout the day to maintain resident #7's hydration per facility protocol/ resident care plan. All residents who require provision of assistance with meals and the receipt of fluids throughout the day to maintain proper hydration per care plan have the potential to be affected by this issue. Residents will be offered fluids at meals per their individual preferences according to physician orders, LRD assessment and resident care plan. Staff will offer and encourage appropriate fluids per physician order/resident care plan as a part of daily interaction with the resident, unless fluids are restricted, a minimum of 2x per shift to include the following: Fluids will be available to residents with medication pass, while in therapy and at appropriate activities/events. Water is provided at bedside daily, unless fluids are restricted per resident care plan.	

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F 327	Continued From page 51 . . . Provide and encourage foods/fluids between meals. Resident may have high calorie nutritional supplement at any time throughout the day. . . ." Observation of Resident #7's activities and facility staff providing resident cares identified the following: *07/17/12, 8:58 a.m. - Certified nursing assistant (CNA) (#18) transported the resident from the dining room to activities where she watched a music video. Snacks and fluids were not observed offered. 9:35 a.m. - CNAs (#5) and (#6) wheeled the resident from activities to her room and provided toileting. The resident did not void or have a bowel movement. CNA (#5) reported the resident's pad minimally moist and did not change the pad. The CNAs transferred the resident to bed. The CNAs failed to offer fluids. Observation showed a 1000 cc container of water at the bedside. 1:00 p.m. - An Activities staff member (#16) wheeled the resident from the dining room to Activities and then to her room to wait for facility staff to provide cares. Staff member (#16) did not offer the resident fluids. 1:05 p.m. - CNA (#5) reported facility staff provided toileting for Resident #7, between 11:30 a.m. and 12:15 p.m. The CNA reported the resident was incontinent of urine and did not void on the commode. The CNA (#5) reported the staff wheeled the resident from her room to the dining room immediately after completion of toileting. 1:15 p.m. - CNAs (#5) and (#6) provided toileting for the resident, transferred the resident to bed and positioned her on her left side. The CNAs failed to offer fluids to the resident. The CNA (#6)	F 327	Hydration coolers will be maintained/available in the following areas: o Therapy Gym o North 1st unit o South Family Room o Special Care Unit The following will be in place as reminders to staff to offer fluids: o Visual cues will be placed in resident bathroom/rooms o Staff will be reminded at report to offer fluids. o Hydration reminders on group sheets All staff that care for residents will be educated on hydration protocols and appropriate provision of assistance with meals/ offering of food/fluids throughout the day to ensure good nutrition/hydration per facility protocol/residents plan of care. Residents identified to require provision of assistance with meals; offering of food/fluids throughout the day to maintain hydration will be audited by the Quality Assurance Coordinator or designee to ensure compliance weekly x2, then monthly x2 and quarterly thereafter to assure compliance.	

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F 327	Continued From page 52 reported the resident's brief was dry and the resident voided. 3:35 p.m. - Resident #7 remained in bed on her left side. A 1000 cc container of water with a straw in the paper wrapper was present on the chairside table. 4:25 p.m. - Observation identified Resident #7 in a wheelchair in the hall outside her room. During interview, the CNA (#17) reported she and another staff member transferred the resident from her bed to the wheelchair. The CNA reported the resident's brief was dry, and she did not offer Resident #7 a snack, as there was not a snack in the room. The CNA (#17) did not offer to obtain a snack for the resident. The 1000 cc container of water with a straw still in the wrapper, remained on the chairside table. Resident #7 propelled her wheelchair to the north unit lobby and remained there until the supper meal. *07/18/12, 7:40 a.m. - Resident #7 seated in wheelchair in hall outside Tub Room. 7:55 a.m. - Wheeled to dining room by facility staff. 9:00 a.m. - Wheeled from dining room to activities by facility staff. Snacks and fluids not offered. 9:25 a.m. - CNA (#7) wheeled resident from activities to her room, transferred the resident to her bed, checked her brief, reported she was "dry." The CNA failed to offer the resident fluids. During the five episodes of resident cares observed facility staff failed to offer fluids and/or snacks. Observation during the evening meal on 07/16/12, the breakfast, brunch, and supper	F 327	Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012.	09-05-2012

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F 327	Continued From page 53 meals on 07/17/12, and the breakfast meal on 07/18/12, identified Resident #7 consumed her juice supplement and small amounts of her other meal items and fluids. At no time during care observations or meal observations did facility staff offer Resident #7 additional juice supplements. Facility staff provided assistance or encouragement only during the breakfast meal on on 07/18/12. (Refer to F312.) Review of Resident #7's meal Intake Record for the period, July 02, 2012 - July 18, 2012 (17 days, 51 meals) showed the following fluid intakes: *nutritional supplement - 75% or more for 50 meals (98%) *milk - 50% or more for 11 meals (21.6%) *water - 50% or more for 16 meals (31.4 %) Review of Resident #7's bowel movement record, for the period May 03, 2012 through July 18, 2012 identified the following periods greater than three days between bowel movements: *May 10 to 15 (five days) *May 16 to 20 (four days) *May 21 to 25 (four days) *May 31 to June 04 (four days) During interview, on 07/19/12 at 9:30 a.m., two supervisory nursing staff members (#9) and (#10) agreed facility staff should have offered fluids during Resident #7's care episodes. The facility staff identified Resident #7 as dependent on staff for ADLs. Observation and meal intake records showed she consumed the nutritional supplement more than any other meal item. Food and fluid intakes are limited. Bowel movement records indicate a reduced frequency	F 327	54	

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F 327	Continued From page 54 in the past. Observed toileting showed limited voiding. Facility staff failed to offer Resident #7 additional nutritional supplements at meal time and throughout the day, failed to offer fluids during the day, and failed to provide snacks (including fluids). It is uncertain if Resident #7 could access or lift the 1000 cc water container in her room. Failure to provide fluids may have contributed to reduced frequency of bowel movements, may have resulted in reduced urinary output, and placed the resident at risk of dehydration.	F 327		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, record review, and staff interview, the facility failed to store, prepare, and serve food in a safe and sanitary manner in 2 of 2 kitchens (North and South Kitchens). Findings include: Review of the facility's policies, "Cleaning of	F 371	F371 It is the practice of St. Catherine's Living Center to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. The walk-in cooler in the South Kitchen wire shelving units used to store packaged food and containers of prepared food were cleaned to assure food is stored in a safe and sanitary manner. The microwave in the North kitchen and one microwave in the South kitchen interior surfaces were cleaned to assure food is prepared in a safe and sanitary manner. Sanitary conditions must be present in health care food service settings to promote safe food handling for all residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355033	A. BUILDING _____ B. WING _____	C 07/19/2012

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 371	Continued From page 55 Microwaves," and "Cleaning of Shelving,"occurred on the afternoon of 07/18/12. These policies, dated 09/11/07, stated, "Policy: It is the policy of the Dietary Department to maintain a sanitary food service operation, which includes the cleanliness of equipment." The policy, "Cleaning of Microwaves," stated, "Procedure: 1. Wipe out spills and splatters with detergent solution as they occur daily. . . . 6. Frequency of cleaning - weekly, and wipe out after each use, daily. . . ." The policy, "Cleaning of Shelving," stated, "Procedure: 1. Splashes and spills should be wiped off as they occur. . . ." An initial tour of the facility's kitchens occurred on 07/16/12 at 1:40 p.m. with an administrative dietary staff member (#1). Observation of the walk-in cooler in the South kitchen showed two wire shelving units used to stored packaged food and containers of prepared food. The surfaces of both shelving units showed scattered black residue. The exterior of three gallon containers of condiments stored on a shelf showed scattered black residue. When interviewed during the initial dietary tour, the administrative dietary staff member (#1) confirmed the black residue was "mold." This staff member stated the facility had "no cleaning system/rotation" for the walk-in cooler shelves. A dietary tour of the facility's kitchens occurred on 07/18/12 at 9:20 a.m. with an administrative dietary staff member (#1). Observation showed one microwave in the North kitchen and one	F 371	The walk-in cooler wire shelving units in the North and South Kitchens and the interior surfaces of microwaves in the North and South kitchens have been placed on a cleaning schedule to be completed by dietary. Dietary staff will be educated on cleaning schedules to assure sanitary conditions to prevent the spread of foodborne illness and minimize food storage, preparation and handling practices that could cause food contamination and could compromise food safety; per established policies and procedures. The walk-in cooler wire shelving units in the North and South Kitchens and the interior surfaces of microwaves in the North and South kitchens will be audited for cleanliness/ sanitary conditions weekly x2, then monthly x2, then quarterly thereafter to assure compliance. Results of audits will be taken to the Quality Assurance Council for evaluation, and follow-up as needed by 09-05-2012.	09-05-2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355033	A. BUILDING _____ B. WING _____	C 07/19/2012

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 371	Continued From page 56 microwave in the South kitchen. Observation showed the interior surfaces of the microwaves soiled with a build-up of food debris. When interviewed during the dietary tour, the administrative dietary staff member (#1) confirmed the microwaves should be cleaned daily. Observation showed one fan in the South kitchen blowing air over food preparation areas and two fans in the South kitchen dishroom blowing over clean dishes. The fans contained a build-up of dust on their blades. When interviewed during the dietary tour, the administrative dietary staff member (#1) confirmed the fans should be cleaned. This staff member stated dietary staff did not clean the fans "on a routine schedule."	F 371	57	
F9999	FINAL OBSERVATIONS Based on review of facility policy and procedure, record review, and staff interview, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		