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	345340	A. BUILDING _____ B. WING _____	03/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LEAF HEALTH CARE	2640 DAVIE AVENUE STATESVILLE, NC 28625

(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 An Amended Statement of Deficiencies was provided to the facility on 05/12/15 because of the results of the Informal Dispute Resolution (IDR) process with citations F-157, F-242, F-246 and F-325 being deleted. Also, the scope and severity of tag F-253 was reduced from a "E" level to a "D" level. Event ID# UKGG11.	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain wooden handrails that had chipped and peeling paint, failed to repair resident doors with splintered wood and broken laminate and failed to maintain floor molding that had pulled away from walls at floor level in the Alzheimer's Care Unit. The findings included: 1. On 03/16/15 at 9:15 AM during the initial tour of the Alzheimer's Care Unit revealed all handrails on both sides of the hallway had brown paint that was chipped and peeling and rough to touch. Observations on 03/19/15 at 10:30 AM revealed all handrails on both sides of the hallway in the Alzheimer's care unit had brown paint that was chipped and peeling.	F 253	F253 1. Corrective action was accomplished for the alleged deficient practice by the Maintenance Director coordinating the painting of wooden handrails, repairing the resident doors and repairing the floor molding in the Alzheimer□s Care Unit by 4 -16-15. 2. All residents residing on the Alzheimers Care Unit have the potential to be affected by this alleged deficient practice. An audit of all handrails, resident room doors, and floor molding in the Alzheimers Care Unit was conducted by the Maintenance Director and Division Maintenance Director by 4-16-15. A prioritized repair schedule was developed and implemented by the Division Maintenance Director by 4-16-15. 3. The Division Maintenance Director will	4/17/15

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

Electronically Signed | 04/16/2015

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F 253	Continued From page 1 Observations on 03/20/15 at 11:21 AM revealed all handrails on both sides of the hallway in the Alzheimer's care unit had brown paint that was chipped and peeling. During an interview on 03/20/15 at 11:41 AM with the Maintenance Director during an environmental tour of the Alzheimer's Care Unit he explained he used an epoxy paint to touch up the handrails but they needed to be repaired. He further explained about 3 weeks ago he had extra help and they went around and fixed what they could but he was short on time and there was still work that needed to be done. 2. a. Observations of 2 doors of the dining room in the Alzheimer's Care Unit during the initial tour of the facility on 03/16/15 at 9:15 AM revealed the doors had chipped wood and laminate on the bottom half of the front of the doors. There were rough edges at the hinge side below the door handle down to the floor level. Observations on 03/19/15 at 10:30 AM revealed 2 doors of the dining room in the Alzheimer's Care Unit had chipped wood and laminate on the bottom half of the front of the doors. There were rough edges at the hinge side below the door handle down to the floor level. Observations on 03/20/15 at 11:21 AM in the Alzheimer's Care Unit revealed 2 doors of the dining room had chipped wood and laminate on the bottom half of the front of the doors. There were rough edges at the hinge side below the door handle down to the floor level. b. Observations on 03/16/15 at 9:20 AM of the fire doors in the Alzheimer's Care Unit revealed chipped wood and rough edges on lower half of the doors on the hinge side and closure sides of	F 253	re-educate the Maintenance Director on timely completion of maintenance concerns. All Staff will be re-educated by the Maintenance Director or designee on recognizing and reporting a maintenance request for needed repairs. This education will be completed by 4-16-15. The Maintenance Director will monitor the handrails, resident room doors, and molding in the Alzheimers Care unit weekly for twelve weeks to identify any needed repairs and maintenance concerns. Opportunities will be corrected as identified. 4. Measures to ensure that corrections are achieved & sustained include: The results of these audits will be submitted to the QAPI Committee by the Maintenance Director for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 4-17-15.	

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the doors.
Observations on 03/19/15 at 10:35 AM of the fire doors in the Alzheimer's Care Unit revealed chipped wood and rough edges on lower half of the doors on the hinge side and closure sides of the doors.
Observations on 03/20/15 at 11:21 AM in the Alzheimer's Care Unit revealed the fire doors revealed chipped wood and rough edges on lower half of the doors on the hinge side and closure sides of the doors.

c. Observations on 03/16/15 at 9:22 AM revealed the door of resident room 307 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.
Observations on 03/19/15 at 10:37 AM revealed the door of resident room 307 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.
Observations on 03/20/15 at 11:21 AM in the Alzheimer's Care Unit revealed the door of resident room 307 had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.

d. Observations on 03/16/15 at 9:25 AM revealed the door of resident room 308 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.
Observations on 03/19/15 at 10:38 AM revealed the door of resident room 308 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.
Observations on 03/20/15 at 11:21 AM revealed

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the door of resident room 308 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.

e. Observations on 03/16/15 at 9:27 AM revealed the door of resident room 311 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.
Observations on 03/19/15 at 10:40 AM revealed the door of resident room 311 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.
Observations on 03/20/15 at 11:21 AM revealed the door of resident room 311 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.

f. Observations on 03/16/15 at 9:28 AM revealed the door of resident room 312 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.
Observations on 03/19/15 at 10:42 AM revealed the door of resident room 312 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.
Observations on 03/20/15 at 11:21 AM revealed the door of resident room 312 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.

g. Observations on 03/16/15 at 9:30 AM revealed the door of resident room 314 in the Alzheimer's

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Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.
Observations on 03/19/15 at 10:43 AM revealed the door of resident room 314 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.
Observations on 03/20/15 at 11:21 AM revealed the door of resident room 314 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.

h. Observations on 03/16/15 at 9:31 AM revealed the door of resident room 315 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.
Observations on 03/19/15 at 10:44 AM revealed the door of resident room 315 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.
Observations on 03/20/15 at 11:21 AM revealed the door of resident room 315 in the Alzheimer's Care Unit had chipped wood with splinters and the laminate was broken on the bottom half of the front of the door.

During an interview on 03/20/15 at 11:38 AM with the Maintenance Director during an environmental tour in the Alzheimer's Care Unit he acknowledged the chipped wood with splinters and broken laminate on the doors of the dining room, fire doors and resident room doors. He explained he could not patch the damage to the doors and they would need stainless steel door guards or would need to be replaced. He further

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explained he was surprised the resident doors did not have stainless steel door guards since resident rooms outside of the Alzheimer's Care Unit had them. He also confirmed the fire doors had a stainless steel guard on them but it did not extend to the corners where it needed to be.

During an interview on 03/20/15 at 12:50 PM the facility Administrator stated she was aware the doors in the Alzheimer's Care Unit were a problem and needed attention and would require capital expenditures to replace them.

3. a. Observations on 03/16/15 at 9:15 AM during the initial tour of the Alzheimer's Care Unit revealed the floor molding was pulled away from the wall in the hallway at resident room 307.
Observations on 03/19/15 at 10:30 AM in the Alzheimer's Care Unit revealed the floor molding was pulled away from the wall in the hallway at resident room 307.
Observations on 03/20/15 at 11:21 AM in the Alzheimer's Care Unit revealed the floor molding was pulled away from the wall in the hallway at resident room 307.

b. Observations on 03/16/15 at 9:15 AM during the initial tour of the Alzheimer's Care Unit facility revealed the floor molding was pulled away from the wall in the hallway across from the nurse's station.
Observations on 03/19/15 at 10:30 AM in the Alzheimer's Care Unit revealed the floor molding was pulled away from the wall in the hallway across from the nurse's station.
Observations on 03/20/15 at 11:21 AM in the Alzheimer's Care Unit revealed the floor molding was pulled away from the wall in the hallway across from the nurse's station.

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F 253	Continued From page 6 c. Observations on 03/16/15 at 9:15 AM during the initial tour of the Alzheimer's Care Unit revealed the floor molding was pulled away from the wall in the hallway in the dining room. Observations on 03/19/15 at 10:30 AM in the Alzheimer's Care Unit revealed the floor molding was pulled away from the wall in the hallway in the dining room Observations on 03/20/15 at 11:21 AM in the Alzheimer's Care Unit revealed the floor molding was pulled away from the wall in the hallway in the dining room. During an interview on 03/20/15 at 11:41 AM with the Maintenance Director during an environmental tour of the Alzheimer's Care Unit he acknowledged the molding was pulled away from the wall in the hallway at resident room 307, in the hallway across from the nurse's station and in the dining room and stated the molding needed to be repaired. He further explained about 3 weeks ago he had extra help and they went around and fixed what they could but there was still work that needed to be done.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		4/17/15

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F 279	Continued From page 7 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to develop a care plan to address weight loss for a resident with significant weight loss for 1 of 3 sampled residents (Resident #17). The findings included: Resident #17 was admitted to the facility on 08/16/10 with diagnoses that included dementia, anxiety and others. The most recent Minimum Data Set (MDS) dated 01/28/15 specified the resident had severely impaired cognition and had experienced significant weight loss not ordered by the physician. Review of Resident #17's medical record revealed that her care plan was reviewed and updated on 01/30/15 by the Interdisciplinary Team. Further review of Resident #17's care plan revealed the resident did not have a care plan to address the weight loss. On 03/18/15 at 4:00 PM the MDS Coordinator #1 was interviewed and reported that she was responsible for developing care plans. She	F 279	F279 1. Corrective action was accomplished for the alleged deficient practice by the Resident Care Management Director developing a care plan to address weight loss for the Resident #17 on 3-18-15. 2. All residents have the potential to be affected by this alleged deficient practice. The Resident Care Management Director and MDS Coordinator conducted an audit of all charts to ensure that residents with significant weight loss had a care plan to address weight loss. 3. The District Care Management Director has re-educated the Resident Care Management Director and the MDS Coordinator regarding developing care plans to address weight loss. This education was completed by 4-16-15. The Resident Care Management Director will randomly audit 3 residents with significant weight loss weekly for twelve weeks to ensure that residents with significant weight loss have a care plan in place to address weight loss.	

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F 279	Continued From page 8 explained that care plans were developed to address specific concerns with the resident such as risk for weight loss or actual weight loss. MDS Coordinator #1 added that care plans were reviewed every 90 days and as needed and that new concerns were developed during the care plan review process. MDS Coordinator #1 reviewed Resident #17's medical record and stated that the resident did not have a care plan to address weight loss noted on the MDS. MDS Coordinator #1 confirmed a care plan should have been developed to address weight loss for Resident #17.	F 279	Opportunities will be corrected as identified. 4. Measures to ensure that corrections are achieved & sustained include: The results of these interviews will be submitted to the QAPI Committee by the Resident Care Management Director for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 4-17-15.	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews the facility failed to monitor resident's blood sugars and failed to provide food after administration of short acting insulin for 3 of 4 residents reviewed to provide services to maintain well being (Residents #96, #155, & #27). The findings included: #1. Resident #96 was admitted to the facility on 01/20/15 with diagnoses which included diabetes	F 309	F309 1. Corrective action was accomplished for the alleged deficient practice by the Director of Nursing obtaining a physician□s order to adjusting the administration times for Residents #96, 155, and 27. 2. All residents receiving sliding scale insulin prior to meals have the potential to be affected by this alleged deficient practice. The Director of Nursing,	4/17/15

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F 309	Continued From page 9 dementia, and peripheral vascular disease. The most recent Minimum Data Set (MDS dated 02/26/15 indicated Resident #96 was severely impaired cognitively for daily decision making skills. The MDS further indicated Resident #96 required assistance with activities of daily living (ADLs) which included eating. The MDS coded Resident #96 for receiving insulin injections daily. A review of monthly physician orders 03/01/15 through 03/31/15 indicated the following medications in part: Fasting Blood sugar (FSBS) at 6:30 AM, 11:30 AM, & 4:30 PM Novolog (fast acting insulin) Sliding scale insulin (SSI) subcutaneous (SQ) ac meals at 6:30 AM range 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, >350=10 units 03/12/15 Discontinue house supplement due to resident refusal, start frozen nutritional treat twice daily with lunch and dinner. Puréed texture carbohydrate controlled diet A review of monthly Medication Administration Records (MAR) dated 03/01/15 through 03/31/15 indicated the following medications in part: FSBS at 6:30 AM Novolog SSI insulin give 4 units SQ for FSBS of 226 at 6:30 AM 4 ounce (oz) house supplement was discontinued on 03/12/15. A review of the care plans indicated a problem for Hypo (low blood sugar)/hyperglycemia (high blood sugar) related to diabetes dated 01/29/15. The goals indicated blood sugar ranges would remain stable through next review as ordered by the physician. The interventions included in part	F 309	Assistant Director of Nursing and Unit Manager conducted an audit to identify residents receiving sliding scale insulin in the morning and obtained physician□s orders to adjust the administration time. This audit will be completed by 4-16-15. 3. The Director of Nursing will re-educate all Licensed Nursing Staff on all aspects of insulin administration to include dosage scheduling and monitoring. This education will be completed by 4-16-15. Insulin administration times are now 8am, 12pm, 4pm and 8pm. The Director of Nursing, Assistant Director of Nursing or Unit Manager will review new physician□s orders for sliding scale insulin three times per week for twelve weeks to ensure appropriate administration times are documented on the Medication Administration Record. Opportunities will be corrected as identified. 4. Measures to ensure that corrections are achieved & sustained include: The results of these interviews will be submitted to the QAPI Committee by the Director of Nursing for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 4-17-15.	

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observing for signs and symptoms of high or low blood sugar, finger stick blood sugars as ordered, SSI insulin and medications as ordered, and notify the physician as indicated.

Review of a document titled Insulin Formulations indicated Novolog insulin was rapid acting insulin with onset of action starting within 15 minutes and peak action between ½ hour to 1.5 hours.

Review of DRUG HANDBOOK "NURSING 2014 DRUG HANDBOOK " by Lippincott, Williams & Wilkins revealed in part for Novolog insulin administration instructions : give Novolog insulin 5 to 10 minutes before start of the meals because of its rapid onset of action and short duration of action to prevent hypoglycemia.

Review of the dietary meal provision schedule revealed breakfast was to be served at 7:55 AM on the 200 hall where Resident #96 resided.

Review of the facility census record dated 03/30/15 indicated Resident # 96 resided in room 216.

During an interview on 03/18/15 at 6:05 AM Nurse #3 was making his morning rounds of checking Blood sugars and providing AM Insulin to Residents on the 200 hall. Nurse #3 stated he had already completed doing blood sugars and SSI for Resident #96 between 5:30 AM and 6:00 am. Nurse #3 further stated he normally started his morning rounds at 5:30 AM and it takes 2 hours to complete these rounds. Nurse #3 revealed he then finishes off his shift by doing documentation and giving report to the oncoming day shift nurse. Nurse #3 was not observed returning to Resident #96 after insulin was

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provided. Nurse #3 confirmed Resident #96's blood sugar was 226 and was given 4 units SSI.

During observations on 03/18/15 from 6:10 AM to 7:57 AM Resident #96 was in bed in her room on the 200 hall. Nurse aides (NA) were observed going to residents' rooms to check and change residents but there were no nurses observed going into resident #96's room during that time period.

During an observation on 03/18/15 at 7:45 AM Nurse #1 received report from Nurse #3. After the report was exchanged Nurse #3 was observed making nurses documentation at the nurse station and Nurse #1 was observed starting her medication rounds. Nurse #3 was not observed returning to Resident #96's room before leaving from his shift or after insulin was provided. Nurse #1 was not observed to enter Resident #96's room after the report was received or prior to the breakfast meal being provided.

During an interview on 03/18/15 7:49 AM NA #3 stated that breakfast trays normally arrive on the 200 hall at 8 AM.

During an observation on 03/18/15 at 7:57 AM the breakfast meal tray cart arrived to the 200 hall.

During an observation on 03/18/15 at 8:04 AM Resident #96 was served her breakfast meal tray.

During an interview on 03/19/15 12:35 PM the Director of Nursing (DON) confirmed nurses were permitted to give medications 1 hour before and 1 hour after they were due to be given. She explained finger stick blood sugars and insulin administration was a part of the routine

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medication pass. She stated if a resident had a blood sugar scheduled for 6:30 AM the nurses could check it as early as 5:30 AM and then would give the insulin. She then stated if a resident had blood sugar done at 5:30 AM and was given fast acting insulin but the resident didn't eat till 8:00 AM or after that was too early for the insulin to be given. She stated it was her expectation for the nurses to keep an eye on the resident and make sure they received something to eat when fast acting insulin was given or should give fast acting insulin at meal times.

#2. Resident #155 was admitted to the facility on 02/26/15 with diagnoses which included diabetes, diabetic retinopathy, and cranial & carotid artery vascular disease, peripheral vascular disease.

The most recent Minimum Data Set (MDS dated 02/26/15 indicated Resident #155 was cognitively intact for daily decision making skills. The MDS further indicated Resident #155 required assistance with activities of daily living (ADLs) which included eating. The MDS coded Resident #155 for receiving insulin injections daily.

A review of monthly physician orders 03/01/15 through 03/31/15 indicated the following medications in part:
Fasting Blood sugar (FSBS) before meals and at night at 6:30 AM, & 11:30 AM
Novolog (fast acting insulin) sliding scale insulin (SSI) subcutaneous (SQ) before meals at 6:30 AM for ranges 100-150=6 units, 1511-200=8 units, 201-250=10 units, 251-300=12 units, >300=14 units. No SSI at night.
Levemir (long acting insulin) insulin SQ 22 units at night
Mechanical soft carbohydrate controlled diet

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A review of monthly Medication Administration Records (MAR) dated 03/01/15 through 03/31/15 indicated the following medications in part:
FSBS at 6:30 AM
Novolog SSI insulin give 6 units SQ for FSBS of 140 at 6:30 AM

A review of the care plans indicated a problem for Hypo (low blood sugar)/hyperglycemia (high blood sugar) related to diabetes dated 01/29/15. The goals indicated blood sugar ranges would remain stable through next review as ordered by the physician. The interventions included in part observing for signs and symptoms of high or low blood sugar, finger stick blood sugars as ordered, SSI insulin and medications as ordered, and notify the physician as indicated.

Review of a document titled Insulin Formulations indicated Novolog insulin was rapid acting insulin with onset of action starting within 15 minutes and peak action between ½ hour to 1.5 hours.

Review of DRUG HANDBOOK "NURSING 2014 DRUG HANDBOOK " by Lippincott, Williams & Wilkins revealed in part for Novolog insulin administration instructions: give Novolog insulin 5 to 10 minutes before start of the meals because of its rapid onset of action and short duration of action to prevent hypoglycemia.

Review of the dietary meal provision schedule revealed breakfast was to be served at 7:55 AM on the 200 hall where Resident #155 resided.

Review of the facility census record dated 03/30/15 indicated Resident # 155 resided in room 217.

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F 309	Continued From page 14 During an interview on 03/18/15 at 6:05 AM Nurse #3 was making his morning rounds of checking Blood sugars and providing AM Insulin to Residents on the 200 hall. Nurse #3 stated he had already completed doing blood sugars and SSI for Resident #155 between 5:30 AM and 6:00 am. Nurse #3 further stated he normally started his morning rounds at 5:30 AM and it takes 2 hours to complete these rounds. Nurse #3 revealed he then finishes off his shift by doing documentation and giving report to the oncoming day shift nurse. Nurse #3 was not observed returning to Resident #155 after insulin was provided. Nurse #3 confirmed Resident #155's blood sugar was 140 and was given 6 units SSI. During observations on 03/18/15 from 6:10 AM to 7:57 AM Resident #155 was in her chair in her room on the 200 hall. Nurse aides (NA) were observed going to residents' rooms to check and change residents but there were no nurses observed going into resident #155's room during that time period. During an observation on 03/18/15 at 7:45 AM Nurse #1 received report from Nurse #3. After the report was exchanged Nurse #3 was observed making nurses documentation at the nurse station and Nurse #1 was observed starting her medication rounds. Nurse #3 was not observed returning to Resident #155's room before leaving from his shift or after insulin was provided. Nurse #1 was not observed to enter Resident #155's room after the report was received or prior to the breakfast meal being provided. During an interview on 03/18/15 7:49 AM NA #3 stated that breakfast trays normally arrive on the	F 309		

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200 hall at 8 AM.

During an observation on 03/18/15 at 7:57 AM the breakfast meal tray cart arrived to the 200 hall.

During an observation on 03/18/15 at 8:03 AM Resident #155 was served her breakfast meal tray.

During an interview on 03/19/15 12:35 PM the Director of Nursing (DON) confirmed nurses were permitted to give medications 1 hour before and 1 hour after they were due to be given. She explained finger stick blood sugars and insulin administration was a part of the routine medication pass. She stated if a resident had a blood sugar scheduled for 6:30 AM the nurses could check it as early as 5:30 AM and then would give the insulin. She then stated if a resident had blood sugar done at 5:30 AM and was given fast acting insulin but the resident didn't eat till 8:00 AM or after that was too early for the insulin to be given. She stated it was her expectation for the nurses to keep an eye on the resident and make sure they received something to eat when fast acting insulin was given or should give fast acting insulin at meal times.

#3. Resident #27 was admitted to the facility on 06/08/15 with diagnoses which included Alzheimer's disease, dementia, type 2 diabetes and a stroke.

A review of the most recent quarterly Minimum Data Set (MDS) dated 01/09/15 indicated Resident #27 had short term and long term memory problems as was moderately impaired in cognition for daily decision making. The MDS also indicated Resident #27 required extensive

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assistance with activities of daily living which included eating.

A review of monthly physician's orders dated 03/01/15 through 03/31/15 indicated the following medications in part:
Novolin R (fast acting) insulin 12 units subcutaneously (SQ) daily at 4:30 PM. Hold for blood sugar less than 120.
Novolin R insulin 12 units SQ every morning. Hold for blood sugar less than 120.
Levemir (long acting) insulin 38 units SQ every morning.
Finger stick blood sugars twice a day at 6:30 AM and 4:30 PM.
Mechanical soft carbohydrate controlled diet.

A review of monthly Medication Administration Records dated 03/01/15 through 03/31/15 indicated the following medications in part:
Novolin R insulin 12 units SQ at 6:30 AM
Levemir 38 units SQ daily at 6:30 AM
Novolin R insulin 12 units SQ daily at 4:30 PM

A review of a care plan indicated a problem statement for hypoglycemia (low blood sugar)/hyperglycemia (high blood sugar) related to diabetes with a revised date of 01/09/15. The goals indicated blood sugar ranges would remain stable through next review and the approaches indicated in part to observe for signs and symptoms of hypoglycemia/hyperglycemia and give medications as ordered.

During an observation on 03/18/15 at 6:15 AM Resident #27 was in bed in his room in the Alzheimer's Care Unit. Nurse aides were going to each resident room to check and change residents but there were no nurses observed

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giving medications to residents in the Alzheimer's Care Unit.

During an interview on 03/18/15 at 7:29 AM Nurse #5 who worked the 11:00 PM to 7:00 AM shift and was assigned to care for Resident #27 explained nurses could give medications an hour before or after they were due to be given. He stated he usually gave Resident #27 his morning insulin between 5:45 AM and 6:00 AM. He confirmed Resident #27's blood sugar was 141 that morning and gave him Levemir insulin and Novolin R insulin at 6:00 AM because he was running behind with his medication pass. Nurse #5 confirmed Resident #27 had not been served a snack or breakfast and he had not reassessed the resident's blood sugar since he last checked it.

During an observation on 03/18/15 at 8:21 AM Resident #27 was seated in a wheelchair in the dining room in the locked Alzheimer's Care Unit and a breakfast tray was placed in front of him and began to eat breakfast.

During an interview on 03/18/15 at 10:05 AM the Director of Nursing confirmed nurses were permitted to give medications 1 hour before and 1 hour after they were due to be given. She explained finger stick blood sugars and insulin administration was a part of the routine medication pass. She stated if a resident had a blood sugar scheduled for 6:30 AM the nurses could check it as early as 5:30 AM and then would give the insulin. She further stated if a resident had a blood sugar checked at 5:30 AM and was given fast acting insulin but didn't eat until 8:00 AM or later then that was too early for the insulin to be given. She stated it was her

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F 309	Continued From page 18 expectation for the nurses to keep an eye on the resident and make sure they received something to eat when fast acting insulin was given or should wait to give fast acting insulin at meal times. During an interview on 03/20/15 at 11:15 AM with Nurse #6 who worked the 7:00 AM to 3:00 PM shift and was assigned to Resident #27's care confirmed she did not recheck or assess the residents blood sugar after she started her shift at 7:00 AM or before he ate breakfast earlier that morning.	F 309		
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 observations and staff interviews the facility failed to clean a metal utensil rack and hooks that contained serving utensils directly over a food preparation table. During an observation in the kitchen on 03/19/15 at 11:20 AM while food for lunch was being prepared a food preparation table with a metal rack above it was observed in front of the stove	F 371	F371 1. Corrective action was accomplished for the alleged deficient practice by the Dietary Manager cleaning the metal utensil rack and hooks on 3-20-15. 2. All residents have the potential to be affected by this alleged deficient practice. The Dietary Manager and Regional Dietary Manager cleaned all metal racks	4/17/15

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F 371	Continued From page 19 and next to the tray line. The metal rack above the food preparation table contained a rectangular bar at the top that had 4 hooks with serving utensils hanging from them and there was another metal bar below it with 6 hooks that had serving utensils hanging from them. A build-up of brownish residue and grayish fuzzy matter was observed hanging from each of the hooks that held the serving utensils. During observations of food preparation at 11:30 AM an open container of butter was on top of the food preparation table directly under the metal racks with the hooks and serving utensils. At 12:12 PM the cook placed 2 metal pans that contained mashed potatoes on top of the food preparation table and stirred them directly under the utensil rack. At 12:26 PM dietary aide #1 was making cheese sandwiches on the food preparation table under the utensil rack. At 12:39 PM dietary aide #1 removed a metal tray of meatballs from the stove and placed it on the food preparation table directly under utensil rack. At 12:40 PM dietary aide #1 opened a can of tomato soup and the hooks and utensils shook back and forth when food was stirred or the table was bumped. At 12:44 PM the Dietary Manager removed a large serving spoon from a hook on the utensil rack and stirred food in a pot directly under the utensil rack on the food preparation table. During an interview on 03/19/15 at 3:58 PM the Dietary Manager confirmed the food preparation table was where meals were prepared for breakfast, lunch and dinner. She stated she was not sure when the hooks or utensil rack had been cleaned and acknowledged they were not clean. She further stated it was her expectation for the	F 371	and hooks near food preparation areas in the kitchen on 3-20-15. 3. The Dietary Manager will re-educate all dietary staff on the procedures, frequency and documentation of cleaning specifically around food preparation areas by 4-16-15. The Dietary Manager will review the cleaning documentation log and visually validate cleaning of the metal utensil rack and hooks two times per week for six weeks, then weekly for six weeks. Opportunities will be corrected as identified. 4. Measures to ensure that corrections are achieved & sustained include: The results of these interviews will be submitted to the QAPI Committee by the DON or designee for review by IDT members each month. The QAPI committee will evaluate the effectiveness and amend as needed. Date of compliance is 4/17/15.	

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F 371	Continued From page 20 hooks and utensil rack to be cleaned routinely.	F 371		