| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 355059 | A. BUILDING _____ B. WING _____ | 11/02/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MISSOURI SLOPE LUTH CARE CTR | 2425 HILLVIEW AVE BISMARCK, ND 58501 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>For the standard Medicare/Medicaid recertification survey started on October 30, 2017 and completed on November 2, 2017, the sample included 5 residents for complete review, 22 residents for focused review, and 3 closed records for review. | F 000 | | |
| F 281 SS=D | SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br>CFR(s): 483.21(b)(3)(i)<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 10/06/16.<br><br>Based on observation, confidential resident interview, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure administration of insulin occurred within the recommended times for 2 of 6 observations of insulin (fast-acting) administration (Resident #9 and Resident #13) and 1 of 1 confidential resident interview (Resident A). Failure to provide appropriate nourishment within the specified time may result in low blood sugar levels (hypoglycemia).<br><br>Findings include:<br><br>"Nursing 2017 Drug Handbook," 37th edition, | F 281 | 1. What corrective action will be accomplished for those residents affected by the deficient practice?<br><br>Resident #9 and #13 have been started on the Rapid-Acting Insulin Administration and Nourishment Timing QAPI. This will assure staff is available at the time of rapid-acting insulin administration to provide nourishment within a timely manner. Nursing staff were re-educated at the nurses meeting on 11/14/17 on the importance of assuring nourishment within a timely manner after the administration of rapid-acting insulin.<br><br>2. How will the facility identify other residents having the potential to be | 12/7/17 |

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

Electronically Signed | 11/21/2017

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| F 281 | Continued From page 1<br>Wolters Kluwer, Philadelphia, page 790, stated regarding Rapid-Acting insulin,". . . give subcutaneous immediately (5 to 10 minutes) before a meal. . . ."<br><br>Review of the facility policy titled "Medication - Insulin" occurred on 11/01/17. This policy, dated 10/16, stated, "Administration of fast-acting/short-acting insulin. . . . residents go to dining room immediately after administration of fast-acting/short-acting insulin. If fast acting insulin has been given and the resident is not eating within 15 minutes, provide a snack for the resident. . . ."<br><br>- During the initial tour of the facility on 10/30/17 at 8:40 a.m., a resident (Resident A) stated "a nurse gave me my insulin before supper at 5:25 p.m., and I waited for half an hour to get help to the dining room. They finally came to my room at 5:55 p.m." When asked when this occurred, the resident stated, "within the last week."<br><br>- Review of Resident #13's medical record occurred on October 30 - November 1, 2017. Diagnoses included type 2 diabetes mellitus. A physician order dated 10/19/17 stated, "NovoLog insulin 5 units subcutaneous BID" (twice a day).<br><br>Observation of medication pass on 10/30/17 at 5:16 p.m. showed a nurse (#5) administered 5 units of NovoLog (fast-acting insulin) to Resident #13. The resident received his supper tray and beverages at 5:43 p.m. (27 minutes after the insulin administration).<br><br>- Record review of Resident #9's medical record occurred on October 30 - November 2, 2017. | F 281 | affected by the same deficient practice?<br><br>All residents that receive rapid-acting insulin have the potential to be affected.<br><br>3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur?<br><br>All residents receiving rapid acting insulin will be started on the Rapid-Acting Insulin Administration and Nourishment Timing QAPI. This will assure staff is available at the time of rapid-acting insulin administration to provide nourishment within a timely manner. Nursing staff were re-educated at the nurses meeting on 11/14/17 on the importance of assuring nourishment within a timely manner after the administration of rapid-acting insulin. Unit Directors will reinforce the importance of providing nourishment in a timely manner after rapid-acting insulin administration at nursing standups. CNAs will be re-educated by nursing staff that administer rapid-acting insulin at the time of administration on the importance of providing nourishment within a timely manner after the administration of rapid-acting insulin. This education will also be reinforced with CNAs at the CNA meeting scheduled on 12/06/17.<br><br>4. How will the facility monitor its performance to make sure that solutions are sustained? | |

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| F 281 | Continued From page 2<br>Medical diagnoses included type 2 diabetes mellitus.<br><br>Observation on 10/30/17 at 5:25 p.m. showed a nurse (#4) administered 16 units of Humalog insulin (fast-acting insulin) to Resident #9 before the evening meal. Observation showed the resident did not receive his/her evening meal until after 6:00 p.m. (35 minutes).<br><br>During an interview on 10/31/17 at 5:10 p.m., a nurse manager (#6) confirmed residents should be given a meal tray or snack within 15 minutes of injection of a fast-acting insulin per facility policy. | F 281 | A Rapid-Acting Insulin Administration and Nourishment Timing QAPI will be completed each time a resident receives rapid-acting insulin. Completed QAPI forms will be returned to the Vice President of Resident Services. The Vice President of Resident Services will monitor for compliance each time a form is returned. Results will be compiled on a weekly basis for 4 weeks (12/07/17, 12/14/17, 12/21/17, 12/28/17), then monthly for 3 months (01/31/18, 02/28/18, 03/31/18), and then quarterly (06/30/18, 09/30/18, 12/31/18) if compliance has been attained and sustained. | |
| F 327 SS=E | SUFFICIENT FLUID TO MAINTAIN HYDRATION<br>CFR(s): 483.25(g)(2)<br><br>(g) Assisted nutrition and hydration.<br>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>(2) Is offered sufficient fluid intake to maintain proper hydration and health.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy and staff interview, the facility staff failed to offer fluids to 5 of 11 sampled resident's (Resident #1, #6, #13, #14, and #15) dependent on staff for fluid intake. Failure to offer fluids during cares may result in dehydration, constipation and urinary tract infections. | F 327 | 1. What corrective action will be accomplished for those residents affected by the deficient practice?<br><br>Resident #1, #6, #13, #14, and #15 have had an every two hour task entered into POC. This task will prompt the CNAs to offer sufficient fluid intake to the residents. | 12/7/17 |

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| F 327 | Continued From page 3<br>Findings include:<br><br>Review of the facility policy titled "Basic CNA [Certified Nurse Assistant] Care Procedure" occurred on 11/01/17. This policy dated of 06/17 stated, " . . . Fluids are passed every shift except on West View. West View has a pitcher of water, and glasses available in the lounge and thickened water available in the kitchen. A. May offer fluids with cares. . . ."<br><br>- Review of Resident #13's medical record occurred on October 30 - November 1, 2017. Diagnoses included dementia with behavioral disturbance, UTI (urinary tract infection), sepsis, stage IV chronic kidney disease stage. The significant change Minimum Data Set (MDS), dated 10/24/17, identified severe cognitive impairment and extensive assistance of one for eating. The physicians orders, dated 10/19/17, identified honey thick liquids.<br><br>The current care plan stated, " . . . altered nutrition and potential for fluid volume deficit . . . offer adequate fluids daily . . . provide eating supervision cues and assistance as necessary . . ."<br><br>Observations identified the following:<br>* 10/30/17 at 3:17 p.m. - Two CNAs (#7 and #8) completed Resident #13's care and transferred him from bed to a wheelchair. Resident #13 asked for water, however, staff transported the resident out of his room to the lounge area and failed to provide the resident fluids, as requested.<br>* 10/31/17 at 11:05 am - Two CNAs (#8 and #9) completed Resident #13's care, transferred him from bed to a wheelchair and transported the | F 327 | An Offering Sufficient Fluids to Residents QAPI will be completed on these five residents to assure the deficient practice is corrected.<br><br>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>All residents dependent on staff offering sufficient fluids have the potential to be affected.<br><br>3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur?<br><br>All residents will have an every two hour task entered to prompt CNAs to offer sufficient fluid. Nursing staff were educated at the nurses meeting on 11/14/17 on the importance of assuring sufficient fluid intake. CNAs will be educated by Unit Directors at nursing standups on the importance of assuring sufficient fluid intake and the new two hour task that was created and added to each resident□s tasks. This education will also be reinforced with CNAs at the CNA meeting scheduled on 12/06/17.<br><br>4. How will the facility monitor its performance to make sure that solutions are sustained?<br><br>An Offering Sufficient Fluids to Residents QAPI will be completed to assure deficient practice is corrected and | |

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| F 327 | Continued From page 4<br>resident out of his room to the lounge area and failed to offer fluids.<br><br>- Review of Resident #14's medical record occurred on October 30 - November 1, 2017. Diagnoses included dementia with behavioral disturbance, insomnia, anxiety, UTI. The quarterly MDS, dated 10/03/17, identified severe cognitive impairment and extensive assistance of one for eating.<br><br>The current care plan stated, ". . . potential for constipation R/T (related to) history of constipation. . . . offer adequate fluids daily. . . provide eating supervision cues and assistance as necessary . . ."<br><br>Observations identified the following:<br>* 10/30/17 at 3:05 p.m. - Two CNAs (#7 and #8) assisted Resident #14 to her bathroom and assisted her on and off the toilet. Resident #14 returned to the lounge area and staff failed to offer fluids.<br>* 10/31/17 at 8:15 a.m. staff assisted Resident #14 with the breakfast meal. Observation showed the resident restless and accepted only a few bites of the meal, then left the table. At 10:03 a.m., two CNAs (#8 and #13) assisted Resident #14 to her bathroom. Staff directed Resident #14 back to the lounge area and failed to offer fluids.<br><br>- Review of Resident #15's medical record occurred on October 30 - November 1, 2017. Diagnosis included Alzheimers disease, constipation, and stage 3 chronic kidney disease. The quarterly MDS, dated 07/27/17, identified severe cognitive impairment. | F 327 | sustained. Completed QAPI forms will be returned to the Vice President of Resident Services. The Vice President of Resident Services will monitor for compliance and compile results on a weekly basis for 4 weeks (12/07/17, 12/14/17, 12/21/17, 12/28/17), then monthly for 3 months (01/31/18, 02/28/18, 03/31/18), and then quarterly (06/30/18, 09/30/18, 12/31/18) if compliance has been attained and sustained. | |

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| F 327 | Continued From page 5<br>The current care plan stated, ". . . encourage good nutrition and hydration . . . provide eating supervision cues and assistance as necessary . . ."<br><br>Observation on 10/30/17 at 3:32 p.m. showed a CNA (#8) assisted Resident #15 out of bed and to the bathroom for toileting. Staff directed Resident #15 to the lounge area and failed to offer fluids.<br><br>Resident's #13, #14, and #15 all reside on the West View unit, which is a locked dementia unit.<br><br>During an interview on 10/31/17 at 5:10 p.m., a nurse manager (#6) stated a water pitcher is located in the lounge area, and staff offer fluids throughout the day. Observation showed staff did not offer fluids before or after cares.<br><br>- Review of Resident #1's medical record occurred on October 30 - November 1, 2017. Diagnoses included Alzheimer's disease and constipation. The quarterly MDS, dated 10/24/17, identified severe cognitive impairment and extensive assistance of one for eating. The physicians orders, dated 10/25/17, identified nectar thick liquids and please encourage fluids.<br><br>The current care plan stated, " . . . altered nutrition and potential for fluid volume deficit . . . Offer adequate fluids daily . . . Offer meals in assisted dining room . . . provide eating supervision cues and assistance as necessary . . ."<br><br>Observations identified the following:<br>* 10/30/17 at 4:55 p.m. - Two CNAs (#19 and | F 327 | | |

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| F 327 | Continued From page 6<br>#20) transferred Resident #1 from the bed to the wheelchair and wheeled the resident to the dining room. Staff failed to offer the resident fluids during cares and Resident #1's meal tray did not arrive until after 5:50 p.m.<br>* 11/01/17 at 7:40 a.m. - Two CNA's (#21 and #22) completed Resident #1's morning cares, and transferred the resident from the bed to the wheelchair. Staff failed to offer the resident fluids during cares.<br><br>Review of Resident #6's medical record occurred on October 30 - November 1, 2017. Diagnoses included constipation and dementia. A quarterly MDS, dated 07/22/17, identified severely impaired cognition.<br><br>Resident #6's current care plan stated, ". . . Focus: [resident's name] has altered nutrition and potential for fluid volume deficit . . . Severe cognitive impairment . . . Need for increased supervision at meals . . . Interventions: . . . Offer adequate fluids daily . . ."<br><br>Observations identified the following:<br>*10/30/17 at 3:55 p.m., two CNAs (#14 and #15) transferred Resident #6 from the recliner into the wheelchair and to the bathroom for toileting. After providing cares, the CNAs transported the resident out of the room and to the day room. The CNAs failed to offer fluids to the resident.<br><br>*10/31/17 at 10:15 a.m., two CNAs (#16 and #17) transported Residents #6 to his room to provide cares. After providing cares, the CNAs transported the resident back to the day room. The CNAs failed to offer fluids to the resident. | F 327 | | |

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| F 327 | Continued From page 7<br>*10/31/17 at 3:26 p.m., two CNAs (#15 and #18) transferred Resident #6 from the recliner in the day room, into his wheelchair, and to his room to provide cares. After the CNAs provided cares, they transported the resident back to the day room. The CNAs failed to offer fluids to the resident. | F 327 | | |
| F 333 SS=D | RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br>CFR(s): 483.45(f)(2)<br><br>483.45(f) Medication Errors.<br><br>The facility must ensure that its-<br><br>(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to ensure 1 of 2 residents (Resident #9) with sliding scale insulin received the medication as ordered. Failure to administer the sliding scale insulin as ordered has the potential to result in high blood glucose levels.<br><br>Findings include:<br><br>Review of Resident #9's medical record occurred on all days of survey. Medical diagnoses include diabetes mellitus type 2. Medications include: Lantus insulin (long-acting insulin) 46 units once a day, Humalog insulin (fast-acting insulin) 14 units before meals, and a sliding scale for blood sugar levels above 150 milligrams per deciliter (mg/dL). | F 333 | 1. What corrective action will be accomplished for those residents affected by the deficient practice?<br><br>Resident #9 has had the Sliding Scale Insulin Administration Double Check QAPI initiated to assure the correct dose is administered.<br><br>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?<br><br>All residents receiving sliding scale insulin administration have the potential to be affected by the deficient practice.<br><br>3. What measures will be put into place or systematic changes made to ensure | 12/7/17 |

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| F 333 | Continued From page 8<br>- Observation on 10/31/17 at 9:15 a.m. showed a nurse (#3) prepared insulin for administration to Resident #9. The nurse had checked Resident #9's blood sugar prior to preparing the insulin. The Medication Administration Record (MAR) insulin sliding scale indicated 2 units of Humalog insulin for a blood sugar of 173 mg/dL, along with the a.m. Humalog insulin dose of 14 units (16 units total). The nurse (#3) withdrew 14 units of Humalog insulin from the vial into the syringe, set the syringe down, and began to prepare another medication for the resident. The surveyor asked the nurse to recheck the insulin dosage, and the nurse (#3) confirmed she withdrew 14 units and not 16 units. | F 333 | that the deficient practice will not recur?<br><br>All sliding scale insulin will be double checked prior to administration to assure correct dose is given. Nursing staff were educated at the nurses meeting on 11/14/17 on double checking sliding scale insulin dose before administration and the Sliding Scale Insulin Administration Double Check QAPI.<br><br>4. How will the facility monitor its performance to make sure that solutions are sustained?<br><br>A Sliding Scale Insulin Administration Double Check QAPI will be completed each time a resident receives sliding scale insulin. Completed QAPI forms will be returned to the Vice President of Resident Services. The Vice President of Resident Services will monitor for compliance each time a form is returned. Results will be compiled on a weekly basis for 4 weeks (12/07/17, 12/14/17, 12/21/17, 12/28/17), then monthly for 3 months (01/31/18, 02/28/18, 03/31/18), and then quarterly (06/30/18, 09/30/18, 12/31/18) if compliance has been attained and sustained. | |