STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	620 14TH AVE NE DEVILS LAKE, ND 58301

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 04/17/23 and concluded 04/20/23.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and	F 583		5/22/23

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

Electronically Signed | 05/12/2023

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F 583	Continued From page 1 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to provide confidentiality of electronic medication administration records (eMAR) for 2 of 3 medication carts (Front and New Wing). Failure to close or lock the eMAR may result in unauthorized viewing of confidential resident records by other residents, unlicensed staff, and visitors. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 234, stated, ". . . ensure the privacy and confidentiality of client information stored in computers. . . . Do not leave client information displayed on the monitor where others may see it. . . ." Observations on 04/18/23 from 11:25 a.m. until 12:07 p.m. showed staff left the medication carts unattended with the residents' eMARs visible on three separate occasions. During an interview on 04/18/23 at 5:00 p.m., an administrative nurse (#1) confirmed she expected nursing staff to close or lock the computer screen when they leave medication carts unattended.	F 583	1. The facility is unable to determine which residents eMAR may have been left unattended and visible. The staff members responsible for medication administration on 04-18-2023 have received individual education on Confidentiality of Resident Records & Information / Access to Records. 2. The facility has identified that all residents have the potential to affected by this practice. 3. Confidentiality of Resident Records & Information/Access to Records policy was reviewed and is appropriate. Education on this policy and the requirement that all electronic medication administration records on med carts will be closed and locked while unattended will be provided to all staff responsible for medication administration. This education will be completed on 05/15/2023. 4. The Director of Nursing or Designee will audit to ensure that all residents eMARS are secured and locked out while unattended. The Director of Nursing or Designee will audit 10 medication cart eMARs weekly for one month, then 10 medication carts eMARs monthly for three months and 10 medication carts eMARS audits will be completed quarterly for one year. If concerns are identified, immediate	

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F 583	Continued From page 2	F 583	corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. 5.Compliance will occur on or before 05-22-2023.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		5/22/23

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F 609	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to identify and report to the State Survey Agency (SSA) a incident of serious bodily injury for 1of 3 sampled residents (Resident #65) who experienced injury. Failure to identify and report an event that resulted in serious bodily injury does not comply with regulations established to protect residents. Findings include: Review of facility policy titled "Vulnerable Adult - North Dakota" occurred on 04/20/23. This policy, dated May 2022, stated, ". . . POLICY: It is the policy of Eventide that all staff, residents, and families are required to report suspected abuse or neglect of vulnerable adults. The DON [director of nursing] or designee shall be responsible for maintaining a log of any suspected and/or actual cases of abuse or neglect. . . . Once discovered, report to the North Dakota Department of Health occurs as follow: All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are to be reported: Immediately but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. Immediately but not later than 24 hours if the cause of the allegation do not involve abuse and do not result in serious bodily injury. . . ." Review of Resident #65's medical record occurred on 04/18/23. The medical record included the following progress notes:	F 609	1. Facility submitted an initial & final incident report to the State Survey Agency on 5/9/2023 for resident # 65. 2. Facility has identified that all residents who have a fall with a serious bodily injury have the potential to be affected by this practice. 3. The Vulnerable Adult of North Dakota policy and procedure was reviewed and is appropriate. All leadership team members who submit vulnerable adult reports have been educated on reporting requirements on 05-16-23. This will include education regarding resident falls with serious bodily injury and the reporting timelines. Nurses are now required to place a call to the on-call nursing leader for all resident falls. The on-call nursing leader is required to assess the severity of the fall. If they determine the fall resulted in serious bodily injury they will notify facility administrator and file a vulnerable adult report with the state agency within the required reporting timelines. 4. The Executive Director or designee will audit to ensure that all falls with serious bodily injury are reported to the State Agency and Administrator with in the reporting time frame requirements. All falls with serious bodily injury will be audited for 3 months, then 4 per month for 6 months and then 2 per month for 3 months to ensure reporting requirements	

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F 609	Continued From page 4 * 03/07/23 11:42 p.m. "Time of fall: 2205 [10:05 p.m.] Description of event: writer arrived for shift and was informed that res [resident] had just fell. [Staff name], informed writer that res was found lying on floor on left side just outside of the bathroom. Bathroom door was open partially. Res states she was trying to go to bathroom, but don't know what happened to cause fall. she also states she don't [sic] what she hid [sic] her head but she knew that she hit. res was assessed and noted to have lump the size of baseball on left side of head. res reported feeling nauseous immediately after fall. . . . writer called oncall manager, then provider. . . . Was the fall witnessed?: no . . . Did the resident hit their head?: res has lump on left side of head about size of baseball . . . Action Plan/Intervention: after assessment, vital signs, and neuro assessment, writer spoke with [doctor's name] who ordered she be sent to ER [emergency room] for further assessment. res sent to ER by ambulance at 2241 [10:41 p.m.] . . ." * 3/8/2023 at 6:39 a.m. "Order(s) received: Admit to CHI St Alexis. Indication/Diagnosis: hematoma left side of head, concussion, . . ." Review of SSA records lacked evidence the facility reported Resident #65's unwitnessed fall that resulted in injury and transfer to the hospital. During an interview on 04/18/23 at 6:06 p.m., when asked about the facility's reporting process, an administrative nurse (#1) stated the facility felt the fall had not involved a major injury, and no SSA report was needed. Refer to F689	F 609	are met. If concerns are identified, immediate corrective action will be implemented. The results of the audit will be reported to the QA committee for further review and recommendation. 5. Compliance will occur on or before 05-22-2023.	

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F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs,	F 623		5/22/23

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F 623	Continued From page 6 under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623		

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F 623	Continued From page 7 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the resident's representative and/or the State Long Term Care (LTC) Ombudsman a written notice of transfer for 1 of 6 sampled residents (Resident #65) with a recent hospital transfer. Failure to provide a written copy of the transfer notice does not allow the resident and/or their representative to make an informed decision regarding their rights or inform the Ombudsman of the transfer. Findings include: Review of Resident #65's medical record occurred on 04/18/23 and identified a hospital transfer on from 03/07/23. The residents' medical record lacked evidence of a transfer notice given to the residents' representative, and/or the ombudsman.	F 623	1. Facility provided transfer/discharge form for resident #65□s representative and ombudsman on 05-11-2023. 2. The facility has identified that all residents who have a discharge to a hospital have the potential to be affected by this practice. 3. Notice of Discharge and Transfer policy and procedure was reviewed and is appropriate. The Social Service Director and Nurses will receive education on the notice and transfer policy on 5/15/2023 to ensure notice is properly given to resident and or legal representative and the Ombudsman. 4. The Director of Nursing or designee will	

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F 623	Continued From page 8 During an interview on 04/18/23 at 3:29 p.m., an administrative staff member (#8) verified the facility did not provide a transfer notice to Resident #65's representative and/or to the ombudsman.	F 623	audit all transfer/discharges to the hospital for 3 months, then 4 per month for 6 months and then 2 per month for 3 months. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. 5. Compliance will occur on or before 05-22-2023.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 2 sampled residents (Resident #55) who experienced a significant change in status. Failure to determine the need for and complete a SCSA in response to a resident's decline limited the facility's ability	F 637	1. Facility established significant change was opened on 3/20/2023 for resident #55. 2. The facility has identified that all residents who experience a significant change in health status have the potential to affected by this practice.	5/22/23

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F 637	Continued From page 9 to accurately assess the resident's status, and identity and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.15), dated October 2019, page 2-22 stated, ". . . A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without staff intervention . . . 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . ." and page 2-25 stated, "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . This may include two changes within a particular domain (e.g., [for example] two areas of ADL [Activities of Daily Living] decline or improvement mobility, transfers, walking in corridor and toileting." Review of Resident #55's medical record occurred on all days of survey. A Minimum Data Set, dated 03/06/23, identified the resident required supervision with walking in the room, walking in the corridor, locomotion on the unit, locomotion off the unit, and transfers and limited assistance with bathing. The medical record identified Resident #55 had a fall on 03/17/23 that resulted in a right fibula (leg) fracture. Review of Certified Nurse Aide (CNA) activities of daily living flow sheets from 03/20/23 to 04/17/23 identified Resident #55 required extensive to total dependence with bathing and transfers, and extensive assistance with walking in the room	F 637	3. Track Changes from Chapter 2 RAI for Nursing Homes was reviewed. The MDS staff and the nursing IDT staff will review this education on 05-15-2023. Nursing IDT will discuss all significant changes during the Change of Condition meeting which occurs Monday - Friday. Monday's change in condition review will include the weekend 72-hour review. As a result of these meetings, the nursing IDT will ensure that all residents who experience a significant change in health status will have a significant change in status assessment completed. The IDT staff will be responsible to notify the MDS Coordinator of any significant change in conditions if not present during change in condition meetings. 4. The Director of Nursing or Designee will audit to ensure to ensure any resident who experiences and significant change in health status has a significant change status assessment completed. The audits will be completed as 10 audits a week x 1 month, 10 audits monthly x 3 months and 10 audits quarterly for 1 year. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. 5. Compliance will occur on or before 05-22-2023.	

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F 637	Continued From page 10 and corridor, and with locomotion on and off the unit. Observations showed: * 04/17/23 at 1:57 p.m. two CNAs (#6 and #7) provided physical assistance while they transferred Resident #55 from the wheelchair to the toilet. * 04/18/23 at 8:03 a.m. a CNA (#6) provided physical assistance when she transferred Resident #55 from the wheelchair to the bathroom using the sit to stand mechanical lift. The record lacked evidence the staff identified and/or completed a SCSA following Resident #55's decline in activities of daily living. During an interview on 04/19/23 at 2:30 p.m., a staff member (#5) confirmed the facility staff failed to complete a significant change in status assessment for Resident #55.	F 637		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		5/22/23

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F 686	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care and services to promote healing of pressure ulcers for 1 of 3 sampled residents with a pressure ulcer (Resident #31). Failure to compleete dressing changes as ordered may result in worsening of pressure ulcers. Findings include: Review of Resident #31's medical record occurred on all days of survey. Physician orders stated, "4/5/23 Unstageable ulcer to coccyx: cleanse with saline and apply dry gauze dressing 3x [three times] a day and prn [as needed] if soiled/wet. . . . for wound care . . ." Review of Resident #31's treatment administration record (TAR) showed staff failed to complete the 6:00 a.m. dressing change to the coccyx on April 6, 8, 9, 12, 13, 14, 16, and 17 (8 of 14 days reviewed). During an interview on 04/20/23 at 8:00 a.m., an administrative staff member (#1) agreed the record lacked documentation for completion of the 6:00 a.m. dressing changes on the dates reviewed.	F 686	1. Facility has changed resident #31's dressing treatment time from 6AM to 8AM on 4/22/2023. Since then, resident has had treatment documented as completed by charge nurse. Education was provided to staff on 05-12-23 who failed to provide documentation of dressing change treatment. 2. All resident who require pressure ulcer treatment have the potential to be affected by this practice. 3. The wound dressing change policy was reviewed and is appropriate. Nurses will receive education on this policy on 05-15-2023. Nurse's will be required to properly document all resident treatments in resident's electronic health records. As a process change, the facility will no longer schedule wound / dressing treatments at nursing change of shift hours to ensure proper shift responsibility of treatments. 4. The Director of Nursing or Designee will audit to ensure residents requiring wound treatments have accurate and proper documentation recorded in residents electronic medical record. The audits will be completed 10 times a week x 1 month, 10 times monthly x 3 months and 10 times quarterly for 1 year. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the	

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	355069	A. BUILDING _____ B. WING _____	04/20/2023

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F 686	Continued From page 12	F 686	QA committee for further review and recommendation. 5. Compliance will occur on or before 05-22-2023.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)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 necessary to prevent accidents for 1 of 1 supplemental resident (Resident #65) identified with a fall and 1 of 3 sampled residents (Resident #55) transferred with a sit to stand mechanical lift. Failure to provide adequate assistance as careplanned for toileting and transfers may have resulted in a fall with injury for Resident #65 and placed all residents requiring assistance at risk for falls and/or injuries. Findings include: Review of the facility policy titled "Falls - Resident" occurred on 04/20/23. This policy, dated March 2022, stated, ". . . PURPOSE: . . . To prevent falls, reduce injury, assess the resident, and ultimately improve the quality of life	F 689	Part 1. 1. Resident #65 is now being assisted with toileting needs according to individualized care plan. 2. Facility has identified residents that have a toileting care plan have the potential to be affected. 3. The care plan policy was reviewed and is appropriate. Education on this policy and the requirements to follow and document toileting activities will be provided to all nurses and certified nursing assistants on 05-15-2023. 4. The Director of Nursing or designee will complete audits ensure certified nursing assistants are following toileting care	5/22/23

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F 689	Continued From page 13 of our residents. All residents will be assessed for fall risk upon admission . . ." - Review of Resident #65's medical record occurred on 04/18/23 and included a history of falling. The admission care plan, dated 03/07/23 stated, ". . . TOILETING: Need extensive assist of 1 staff member. . . . Offer toileting every 2 hours. . . . ACTUAL FALL related to mobility deficit . . . Has poor safety awareness. . . . THOUGHT PROCESS: Resident is alert and oriented to person, sometimes place or general time of day. Has short and long term memory deficits. May have declining cognition. Scores for severe cognitive impairment . . ." The medical record included the following progress note: * 03/07/2023 at (11:42 p.m.) - "Time of fall: 2205 [10:05 p.m.] Description of event: writer arrived for shift and was informed that res [resident] had just fell. [Staff name], informed writer that res was found lying on floor on left side just outside of the bathroom. Bathroom door was open partially. Res states she was trying to go to bathroom, but don't know what happened to cause fall. she also states she don't [sic] what she hid [sic] her head but she knew that she hit. res was assessed and noted to have lump the size of baseball on left side of head. res reported feeling nauseous immediately after fall. . . . ordered she be sent to ER [emergency room] for further assessment. res sent to ER by ambulance at 2241 [10:41 p.m.]. . . ." Review of the certified nurse aide (CNA) task flow sheets, dated 03/07/23, showed staff failed to document toileting assistance for Resident #65	F 689	plans and documentation is complete. Audits will be completed as 10 audits a week x 1 month, 10 audits monthly x 3 months and 10 audits quarterly for 1 year. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. 5. Compliance will occur on or before 05-22-2023. Part 2. 1. Resident #55 is now being transferred according to care plan. 2. Facility has identified that all residents being transferred with a mechanical lift have the potential to affected. 3.The care plan policy and procedure was reviewed and is appropriate. Education on this policy and the requirements to follow residents transfer methods on individualized care plans will be provided to all nurses and certified nursing assistants on 05-15-2023. 4. The Director of Nursing or designee will complete to ensure nursing staff providing residents transfers using mechanical lifts are following residents transfer care plan. The facility will complete 10 transfer audits a week x 1 month, 10 audits monthly x 3 months and 10 audits quarterly for 1 year. If concerns are	

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F 689	Continued From page 14 from 1:48 p.m. to 10:05 p.m. (the time of the resident's fall and transfer to the hospital). During an interview on 04/20/23 at 10:58 a.m., an administrative nurse (#14) agreed the medical record lacked evidence staff had assisted Resident #65 with toileting on 03/07/23. Failure to assist Resident #65 with toileting as care planned may have resulted in the resident's fall with injury and transfer to the hospital. - Review of Resident #55's medical record occurred on all days of survey and included a previous fall with fracture. The current care plan stated, ". . . Pal [sit to stand mechanical lift] assist of 2 for all transfers . . ." Observation on 04/18/23 at 1:57 p.m. showed one CNA (#6) transferred Resident #55 from the wheelchair to the bathroom with a sit to stand lift. During an interview on 04/18/23 at 10:56 a.m., a therapy staff member (#13) confirmed the resident still required the assistance of two staff with all sit to stand lift transfers. During an interview on 04/20/23 at 10:09 a.m., an administrative nurse (#1) confirmed staff are expected to follow the resident's care plan.	F 689	identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. 5. Compliance date will occur on or before 05-22-2023.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759		5/22/23

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F 759	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and professional interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 8 residents (Resident #28 and #61) observed during medication administration. Two medication errors occurred during staff administration of 27 medications, resulting in a 7% error rate. Failure to properly administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of the facility policy titled "Medication, Documentation on the eMAR [electronic medication administration record] occurred on 04/18/23. This policy, revised May 2021, stated, ". . . Staff will administer the medication according to the instructions on the eMAR . . ." Review of the facility policy titled "Insulin - Subcutaneous" occurred on 04/18/23. This policy, revised May 2022, stated, ". . . Insulin will be administered as ordered. . . . Insulin Pen . . . Pull off the inner needle shield . . . Prime the insulin pen . . . With the pen pointing upward . . . Select the prescribed insulin dose by turning the knob . . . " Observation during medication pass on 04/18/23 showed the following: * At 8:39 a.m., a nurse (#9) administered Nateglinide 120 milligram (mg) to Resident #61 after completing breakfast. The physician's order	F 759	Part 1. 1. A Medication error report was completed for the medication which was administered at wrong time. Resident #61 is now receiving medication prior to meals per physician's order. Nurse #9 has received education on 05-11-2023 that medication needs to be administered before meals. 2. The facility has identified that all residents who have an order to administer medications prior to meals have the potential to be affected by this practice. 3. The facility Medication, Documentation on the eMAR policy and procedure has been reviewed and is appropriate. Nurses and CMA's received education on medication administration according to provider orders on 5-15-2023. As a process change, the facility has placed note under special instructions that Nateglinide must be given prior to meals 1-30 minutes per Wolter Kluwer Nursing 2023 Drug Handbook. 4. The Director of Nursing or designee will audit to ensure medications are administered per physician's order. The facility will complete 10 audits a week x 1 month, 10 audits monthly x 3 months and 10 audits quarterly for 1 year. If concerns are identified, immediate corrective action will be implemented. The results of the	

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F 759	Continued From page 16 identified to administer this medication before meals. * At 11:38 a.m., a nurse (#2) read Resident #28's physician's order in the eMAR and determined the resident was to receive eight units of Lispro insulin. The nurse (#2) attached a needle to Resident #28's Lispro insulin pen, dialed the dose to two units, held the pen horizontally and pushed the button to expel the air (prime the pen) without removing the inner needle cap. The nurse (#2) then realized there were only three units left in the pen, administered the three units, and stated "I will give him the extra five units after he is done eating." At 12:07 p.m., the nurse (#2) had still not administered the additional five units of Lispro to Resident #28 (29 minutes later). During a phone interview on 04/18/23 at 4:21 p.m., a pharmacist (#10) confirmed the efficacy of the Nateglinide could be affected if taken after meals. The pharmacist (#10) stated staff should administer the total dose of the Lispro insulin at the same time.	F 759	audits will be reported to the QA committee for further review and recommendation. 5. Compliance will occur on or before 05-22-2023. Part 2. 1. A medication error report was completed for incorrect insulin dose. Resident #28's insulin is now being administered per physician orders. Nurse #2 received education on insulin preparation and administration on 5/11/2023. 2. Facility has identified that all residents who have an insulin pen order have the potential to affected by this practice. 3. The facility has reviewed the Medication, Documentation on the eMAR & Insulin-subcutaneous policy and procedure and it is appropriate. Nurses will receive education on insulin preparation and administration on 5-15-2023. As a process change, current and future nurses will undergo insulin administration skills validation to ensure competencies for this practice. 4. The Director of Nursing or designee will complete audits ensure insulin dosage and priming of insulin pen are completed per Physician orders and according to policy and procedure. The facility will complete 10 audits a week x 1 month, 10	

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F 759	Continued From page 17	F 759	audits monthly x 3 months and 10 audits quarterly for 1 year. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. 5. Compliance will occur on or before 05-22-2023.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		5/22/23

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F 761	Continued From page 18 by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure accurate labeling of medications for 2 of 5 residents (Resident #10 and #23) observed for insulin administration. Failure to correctly label medications to match the current physician orders increased the risk of residents receiving an inaccurate dose of insulin and placed the residents at risk for an adverse reaction (a blood sugar too high or too low). Findings include: Information found at https://www.nccmerp.org/recommendations-enhance-accuracy-administration-medications, revised 05/01/15, stated, ". . . Healthcare professionals only administer medications that are properly labeled, and labels should be read during the following . . . When reaching for or preparing the medication; Immediately before administering the medication . . ." - Review of Resident #10's medical record occurred on all days of survey and identified an order for Novolog insulin 12 units three times a day. Observation on 04/18/23 at 11:38 a.m., showed a nurse (#2) reviewed Resident #10's Novolog insulin order entered in the electronic medication administration record (eMAR), removed the insulin vial from its box, and drew up 12 units of the Novolog. The patient label on the insulin box identified to administer Novolog insulin 10 units three times a day. When asked about the discrepancy between the label and the	F 761	1. Resident #10 and Resident #23 now have accurate labeling of their insulin. 2. Facility has identified that all residents who are insulin dependent have the potential to affected by this practice. 3. Medication Administration Information policy reviewed and appropriate. Education will be provided to nurses on 5-15-2023 that with a change in insulin orders it is expected that a (Directions change, refer to chart) sticker is placed when labels dont match MAR. 4. The Director of Nursing or designee will audit to ensure that insulin dependent resident are completing audits that insulin medication labels are labeled correctly. Audits will be completed 10 audits per week x 1 month, 10 audits monthly for three months and then 10 audits will be completed quarterly for one year with additional audits as recommended by the QA committee. If there are any concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. 5. Corrective action would be compliance of 5-22-2023.	

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F 761	Continued From page 19	F 761		

physician's order, the nurse (#2) stated, "There have been changes to insulin orders. We must not have asked for new labels [from the pharmacy]." The nurse confirmed the order as 12 units and administered the Novolog to Resident #10.

- Review of Resident #23's medical record occurred on 04/19/23 and identified an order for Humalog insulin inject per sliding scale three times a day: 100-399 administer 8 units, 400-449 administer 10 units.

Observation on 04/18/23 at 11:35 a.m., showed a nurse (#11) obtained Resident #23's blood sugar reading of 378. The nurse proceeded to check the Humalog insulin order entered in the eMAR, removed the insulin vial from its box, and drew up 8 units of the Humalog. The resident label on the insulin box identified to administer insulin 10 units in the morning, 7 units at 1100 (11:00 a.m.) and 1700 (5:00 p.m.). When asked about the discrepancy between the label and the physician's order, the nurse (#11) stated, "The label on the insulin box and vial is an old order when [doctors name] was her doctor." The nurse confirmed the order as 8 units and administered the Humalog to Resident #23.

Observation on 04/19/23 at 08:52 a.m., showed a nurse (#12) reviewed Resident #23's Humalog insulin order entered into the eMAR. The resident label on the insulin box identified to administer insulin 10 units in the morning, 7 units at 1100 and 1700. When asked about the discrepancy between the label and the physician's order, the nurse (#12) stated, "That order was changed."

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F 761	Continued From page 20 During an interview on 04/18/23 at 5:00 p.m., an administrative nurse (#1) stated she expected the nurse to call pharmacy for new labels when new insulin orders come in.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		5/22/23

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F 880	Continued From page 21 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, professional reference, review of facility policy, and staff interview, the	F 880	Part 1.	

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F 880	Continued From page 22 facility failed to follow infection control practices for 1 of 4 sampled residents (Resident #270) observed during wound care and 1 of 5 supplemental residents (Resident #26) observed during insulin administration. Failure to practice appropriate infection control during wound care and medication administration has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: Review of facility policy titled "Dressing Changes/Bandages" occurred on 04/19/23. This policy, revised March 2022, stated, ". . . Policy: all dressing changes will be completed in a clean and/or sterile technique as appropriate for wound care. Purpose: To avoid cross-contamination of wounds. . . . Procedure: . . . Perform hand hygiene, don [apply] gloves, remove old dressing and place in plastic bag. . . . remove gloves and perform hand hygiene, don gloves, clean wound as appropriate with saline or prescribed solution, . . . remove soiled gloves and perform hand hygiene, don gloves, apply loose woven gauze, apply additional layers as needed, apply thicker woven pad, if need, remove soiled gloves and perform hand hygiene . . ." WOUND CARE - Observation on 04/18/23 at 8:57 a.m. showed a staff nurse (#3) performed wound care and dressing changes to multiple sites on Resident #270. The nurse (#3) performed hand hygiene, donned gloves, removed the stockinette and gauze stretch wrap from the wound on the resident's right lower extremity. After discarding the outer dressings, the nurse removed the ABD	F 880	1. Resident # 270 is now receiving proper wound care and dressing changes according to the dressing change / bandages policy and procedure. Nurse #3 was provided education on dressing change/bandages policy and procedure on 5/11/2023. 2. Facility has identified that all residents who have a dressing change have the potential to be affected by this practice. 3. The facility has reviewed the policy dressing changes/bandages and it is appropriate. Education will be provided to nurses on wound dressing changes/bandages on 5-15-2023. As a process change, current and future nurses will undergo dressing /bandages skills validation to ensure competencies for this practice. 4. The Director of Nursing or designee will audit to ensure that hand hygiene, gloves are changed between clean and dirty procedures and cleaning barriers. Audits will be completed 10 audits per week x 1 month, 10 audits monthly for three months and then 10 audits will be completed quarterly for one year with additional audits as recommended by the QA committee. If there are any concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. BUILDING _____ B. WING _____	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 23 pad (heavy gauze pad used to absorb discharges from draining wounds) which was soiled with an approximate 3-centimeter ring of yellow/brown drainage and laid it on the bed. The nurse, without changing gloves, obtained a vial of sterile saline from the overbed table, opened the saline, and applied it to the gauze packing in the wound then removed the gauze. The nurse dried the wound bed with another piece of gauze. Using a sterile cotton tipped applicator, the nurse packed the wound with a new gauze pad, taped a new ABD in place, wrapped the extremity with new gauze stretch wrap and re-applied the stockinette. The nurse (#3) failed to change her gloves or complete hand hygiene between dirty and clean procedures. Wearing the same soiled gloves, the nurse (#3) removed the stretch gauze wrap on Resident #270's left ankle/foot and discarded it, removed her gloves, performed hand hygiene, and donned new gloves. The nurse removed the soiled ABD from the left ankle/foot and placed it on the bed underneath the foot. The nurse poured Dakin's (a solution used to cleanse wounds) on the anterior (top of foot) wound and dried the wound with a clean piece of gauze. Using the same piece of gauze, the nurse poured Dakin's solution on the posterior (back of foot) wound and dried the wound. The nurse applied betadine (a topical antiseptic) to both wounds, discarded the soiled ABD that was used as the barrier on the bed, applied a clean ABD, and wrapped the foot/ankle with stretch wrap gauze. The nurse failed to place a clean barrier on the bed, wash hands and apply new gloves when moving sites, removing soiled dressings, and	F 880	5. Compliance will occur on or before 05-22-2023. Part 2. 1. Resident #26 is now receiving insulin according to the insulin-subcutaneous policy. Nurse #3 was provided education on 5/11/2023 on aseptic technique for insulin administration. 2. Facility has identified all residents who are insulin dependent diabetics have the potential to be affected by this practice. 3. The facility reviewed the Insulin-subcutaneous policy and it is appropriate. As a process change, current and future nurses will undergo insulin administration skills validation to ensure competencies for this practice. 4. The Director of Nursing or designee will audit to ensure that aseptic technique is carried throughout insulin administrations. Audits will be completed 10 audits per week x 1 month, 10 audits monthly for three months and then 10 audits will be completed quarterly for one year with additional audits as recommended by the QA committee. If there are any concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation.	

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F 880	Continued From page 24 applying clean dressings. During an interview on 04/20/23 at 8:00 a.m., an administrative nurse (#1) agreed the nurse should follow the dressing change policy. MEDICATION ADMINISTRATION Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., Massachusetts, page 854 stated, ". . . Prepare the medication vial for drug withdrawal. . . . Remove the protective cap or clean the rubber cap of a previously opened vial with an antiseptic wipe by rubbing in a circular motion. Rationale: -The antiseptic cleans the cap and reduces the number of microorganisms. . . ." - Observation on 04/18/23 at 11:35 a.m., showed a nurse (#3) prepared an insulin injection for Resident #26 using an open vial of Novolog. Without cleansing the rubber stopper, the nurse inserted the syringe into the vial, injected the required units of air, and filled the syringe with 4 units of insulin. The nurse failed to use aseptic technique for insulin preparation.	F 880	5. Compliance will occur on or before 05-22-2023.	