North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8054A	A. BUILDING: _____ B. WING _____	R-C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN	2143 6TH AVE W DICKINSON, ND 58601

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{B 000}	INITIAL COMMENTS For the on site revisit and complaint survey, started on 04/29/24 and completed on 04/30/24, the sample included eight residents and one closed record for review. Tier II citations included B0910, B0923, B0926, B1540, B1700, and B1800.	{B 000}		
{B 910}	33-03-24.1-09,1 GOVERNING BODY 1. The governing body is legally responsible for the quality of resident services; for resident health, safety, and security; and to ensure the overall operation of the facility is in compliance with all applicable federal, state, and local laws. This State Licensing Rule is not met as evidenced by: 1. Based on observation, policy review, and staff interview, the facility failed to comply with the North Dakota Administrative Code (NDAC), Chapter 33-43-01 "Nurse Aide Training, Competency Evaluation, and Registry," for 2 of 2 observations of insulin administration. Failure to ensure only qualified staff administered subcutaneous insulin and sliding scale insulin increases the risk for adverse consequences. Findings include: NDAC, Section 33-43-01-17 "Routes or Types of Medication Administration" states, "2. Medication assistant students and medication assistants may administer medications by the following routes to individuals or groups of individuals with stable,	{B 910}		

Health Repsonse and Licensure
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Taylor Clark
See attached document

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{B 910}	Continued From page 1	{B 910}		

predictable conditions according to the organization policy . . . 3. Medication assistants I and II may administer medications by the following routes only when specifically delegated by a licensed nurse for a specific client: . . . Subcutaneous . . ." Section 33-43-01-16 "Specific Delegation of Medication Administration" stated, ". . . 2. The individual on the department's nurse aide [registry] is taught by a licensed nurse for each specific client's medication administration which includes verbal and written instruction . . . 3. . . . is observed by a licensed nurse administering the medication to the specific client until competency is demonstrated. 4. . . . has been verified as competent by a licensed nurse . . ." "Section 33-43-01-19 "Medication interventions that may not be delegated" stated, "The medication assistant I or medication assistant II . . . may not perform the following acts even if delegated by a licensed nurse: 1. Conversion or calculation to medication dosage . . ."

Review of the facility policy titled "Insulin Pen Administration System" occurred on 04/30/24. This undated policy stated, "Policy . . . All Medication Aides providing insulin to residents will have first demonstrated competency with the licensed nurse providing direction and monitoring of the residents. . . . Sliding Scale Insulin will be administered by a licensed nurse."

Review of the facility policy titled "Medication Administration System" occurred on 04/30/24. This undated policy stated, ". . . Provision . . . i. When specifically delegated by a licensed nurse to a Medication Assistant II for a specific resident with a stable, predictable condition regularly scheduled medications may be given via the subcutaneous route after the licensed nurse has determined competency. . . ."

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{B 910}	Continued From page 2 Observation on 04/29/24 at 11:30 a.m. showed a medication assistant (MA) (#2) prepared and administered sliding scale insulin to a resident. Observation on 04/30/24 at 7:28 a.m. showed a MA (#3) administered Resident #4's Novolog and Levemer insulins subcutaneously in the resident's arms. Review of the "Medication Aide Skills Competency Verification" occurred on the afternoon of 04/29/24. This checklist failed to identify the MAs as competent to administer insulin. During an interview on the morning of 04/29/24, an administrative staff member (#1) stated she was not aware MAs could not administer sliding scale insulin. During an interview on the morning of 04/30/24, an administrative staff member (#1) stated she was unable to locate the training/competency for specific delegation of insulin administration for any of the MAs employed by the facility. 2. Based on review of the North Dakota Century Code (NDCC) Chapter (Ch.) 23-09.3 for Basic Care, review of a facility floor plan, and staff interview, this facility failed to appropriately utilize 2 of 59 rooms (Room #115 and #124) licensed for basic care. Failure to utilize rooms for the licensed designated level of care is a violation of North Dakota law. Findings include: Review of the NDCC Ch. 23-09.3 for Basic Care 23-09.3.1 Definitions, stated, "'Basic care facility'	{B 910}		

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{B 910}	Continued From page 3 means a residence . . . that provides room and board to five or more individuals . . . who, because of impaired capacity for independent living, require health, social, or personal care services, but do not require regular twenty-four-hour medical or nursing services and: . . . c. Is attached to a nursing home or assisted living facility and its staff are available to meet the needs of all residents and comply with state and federal regulations . . ." Review of information provided by facility staff occurred on 04/29/24. A floor plan of the facility identified rooms #115 and #124 licensed as basic care rooms. The facility identified rooms #115 and #124 are occupied by residents in assisted living, rather than basic care. An interview with an administrative staff member (#1) occurred on 04/29/24 at 4:15 p.m. This staff member confirmed the residents in rooms #115 and #124 were not receiving basic care services.	{B 910}		
{B 923}	33-03-24.1-09,2,c GOVERNING BODY c. Provisions for pharmacy and medication services developed in consultation with a registered pharmacist, including: (1) Assisting residents in obtaining individually prescribed medications from a pharmacist of the resident's choice. (2) Disposing of medications that are no longer used or are outdated, consistent with applicable federal and state laws. (3) Allowing the resident to be totally responsible for the resident's own medication upon resident	{B 923}		

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{B 923}	Continued From page 4 request and based on the assessment of the resident's capabilities with respect to this function by an appropriately licensed professional. This State Licensing Rule is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to assess and monitor the ability of residents to self-administer medications (SAM) for 3 of 4 sampled residents (Resident #5, #6, and #7). Failure to assess and monitor a resident's ability to SAM may result in unsafe medication administration and adverse drug effects. Findings include: Review of the facility policy titled "Self-Administration of Medication" occurred on 04/30/24. This undated policy, stated, ". . . 1. A Self Medication Assessment will be performed on each applicable resident to establish cognitive capacity and functional ability to self-administer medications. This assessment will be completed on admission, annually and with significant change . . . 4. If potential health hazards exist because of self-administration of medications, the resident and/or designee shall be counseled, and the results documented. A Negotiated Risk Agreement will be signed if indicated . . . 7. A written physician order stating medications may be self-administered or kept at bedside will be obtained. 8. A licensed nurse will review written instructions for taking medications initially, when changes are made and annually. . ." Upon request on the morning of 04/29/23, a facility staff member (#1) provided a list of	{B 923}		

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{B 923}	Continued From page 5 residents who self-administer medications, which included Residents #5, #6, and #7. - Review of Resident #5's medical record occurred on all days of survey. The physician's orders, dated 04/02/24, stated, "please allow patient to manage her own meds [medications] for the time being . . ." A letter from a physician with a behavioral health clinic, dated 04/10/24, stated, "[Resident #5] is under my care for mental health. It is my recommendation that she be allowed to manage her medications on her own. Noted that she does have a history of suicidal ideation, and at times with suicidal ideation and wanting to overdose on medication . . ." The record failed to contain a SAM assessment to determine Resident #5's ability, both physically and mentally, to be responsible for her own medications. - Review of Resident #6 and #7's medical records occurred on all days of survey. Both of these records failed to contain a SAM assessment and physician's orders indicating the residents are capable of being responsible for their medications. During interview on the morning of 04/30/24, an administrative staff member (#1) failed to provide a SAM assessment for Resident #5 and failed to provide a SAM assessment and physician's orders to self-administer medications for Resident #6 and #7.	{B 923}		
B 926	33-03-24.1-09,2,f GOVERNING BODY f. Reporting a significant medication error to officials in accordance with state law. A significant medication error by a medication assistant I or II	B 926		

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B 926	Continued From page 6 shall be reported to the department of health. This State Licensing Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to report a significant medication error for 1 of 4 sampled residents (Resident #4) and failed to develop protocols for reporting significant medication errors to the Department of Health and Human Services, Health Facilities Unit. Failure to report significant medication errors by a medication assistant I or II does not allow the state agency to stay informed of significant medication errors and investigate when necessary. Findings include: Upon request, the facility failed to provide a policy on significant medication errors. Review of Resident #4's medical record occurred on all days of survey. A nursing progress note on 02/02/24 at 9:15 p.m. stated, "Received call from MA [medication assistant] reporting she had accidentally given 18 units of Novolog [a rapid acting insulin] instead of 18 units of Levemir insulin [a long acting insulin]. Unable to contact [name] APN [advance practice nurse], so I spoke with Dr. [name] who gave me verbal orders to check blood sugar every 2 hoursx4 [sic]. I called MA and relayed the message. MA reports [resident name] does her own BG [blood glucose] checks with her Libra [a continuous glucose monitor] and she would pass the word to wake	B 926		

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B 926	Continued From page 7 her every two hours. . . ." During an interview on the morning of 04/30/24, an administrative staff member (#1) stated she was not aware the facility needed to report a significant medication error to the Department of Health and Human Services, Health Facilities Unit.	B 926		
{B1540}	33-03-24.1-15,4 PHARMACY/MED ADM SERVICES 4. All medications used by residents which are administered or supervised by staff must be: a. Properly recorded by staff at the time of administration. b. Kept and stored in original containers labeled consistently with state laws. c. Properly administered. This State Licensing Rule is not met as evidenced by: Based on observation, review of facility policy, and manufacturer's guidelines, the facility failed to ensure proper administration of insulin for 1 of 2 observations of insulin administration and proper labeling of insulin pens for 2 of 2 medication carts. Failure to properly administer insulin and label an insulin pen may result in an incorrect dose and adverse consequences for the residents. Findings include:	{B1540}		

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{B1540}	Continued From page 8 Review of the facility policy titled "Medication Administration System" occurred on 04/30/24. This undated policy stated, ". . . Procedure: . . . 3. Labeling . . . The label should contain the name of the pharmacy, resident's name . . . date . . . drug name and strength, dosage . . ." Review of the facility policy titled "Insulin Pen Administration System" occurred on 04/30/24. This undated policy stated, "Prepare your insulin pen . . . wipe the top of the pen with alcohol . . . Dial the appropriate amount of insulin into the pen . . . press the plunger in a gentle, steady motion until the insulin is all injected. Count to 10 to ensure appropriate administration. . . . ." The policy failed to address priming of the insulin pen. Manufacturer's instructions for the use of Humalog quik pen stated, ". . . If you do not prime before each injection you may get too much or to little insulin. Step 6. To prime your Pen [sic], turn the Dose Knob [sic] to select 2 units. Step 7. Hold your Pen with the Needle [sic] pointing up . . ." Observation on 04/29/24 at 11:30 a.m. showed a medication assistant (MA) (#2) prepared and administered insulin. The MA wiped the top of the pen with alcohol and then wiped it with a tissue, primed the pen holding it sideways and after injecting the insulin held the needle in the skin approximately 3 seconds. Observation of the medication carts on first and second floor on the morning of 04/29/24 showed two insulin pens without an open/discard date and one insulin pen without a label identifying the resident's name and directions for use of the pen.	{B1540}		

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{B1700}	Continued From page 9	{B1700}		
{B1700}	33-03-24.1-17 NURSING SERVICES 33-03-24.1-17. Nursing services. Nursing services must be available to meet the needs of the residents either by the facility directly or arranged by the facility through an appropriate individual or agency providing nursing services. This State Licensing Rule is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide nursing services to meet diabetic resident's needs for 1 of 7 sampled residents (Resident #4) with a continuous glucose monitor (CGM). Failure to change a CGM as ordered may result in negative health outcomes for the resident. Findings include: Upon request, the facility failed to provide a policy on a continuous glucose monitor. Review of Resident #4's medical record occurred on all days of survey. A physician's order dated 09/13/22, stated, "Resident uses a CGM [brand name]. Requires staff assist to change sensor every 14 days and as needed. . . ." Observation on 04/30/24 at 11:30 a.m. showed Resident #4 with a CGM sensor on her right arm. Review of Resident #4's treatment record from February 2024 - April 2024 showed staff changed the CGM once in three months. During an interview on the morning of 04/30/24,	{B1700}		

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{B1700}	Continued From page 10 an administrative staff member (#1) confirmed Resident #4's medical record lacked documentation staff changed the CGM every 14 days as ordered.	{B1700}		
{B1800}	33-03-24.1-18 DIETARY SERVICES 33-03-24.1-18. Dietary services. The facility must meet the dietary needs of the residents and provide dietary services in conformance with the North Dakota sanitary requirements for food establishments. Dietary services must include: This State Licensing Rule is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide dietary services to meet residents' needs and in conformance with the North Dakota sanitary requirements for food establishments in 1 of 1 kitchen/dining room. Failure to ensure staff serve food in a sanitary manner and test cleaning solutions before use may result in unsanitary conditions and/or foodborne illness. Findings include: Review of the "Food Service Sanitation" policy occurred on 04/30/24. This undated policy stated, ". . . Single- use gloves are used for one task, then discarded when damaged, soiled, or when interruptions occur in operation. . . ." Review of the product information label for Ecolab "Oasis 146 Multi-Quat [quaternary] Sanitizer" identified 150-400 parts per million (ppm) as the desired concentration.	{B1800}		

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{B1800}	Continued From page 11 Observation in the kitchen/dining room with a dietary staff member (#4) occurred on 04/29/24 at 9:15 a.m. Observation showed staff using a cloth from a red bucket to wipe down the tables. The staff member (#4) explained they use a disinfectant that is automatically dispensed and reported she does not check the solution using a test strip and she was unaware if the facility had any test strips. During an interview on 04/29/24 at 5:25 p.m. an administrative staff member (#1) stated kitchen staff found the strips to test the quat sanitizing solution. Observation on 04/29/24 at 5:30 p.m. showed a dietary staff (#6) using test strips labeled for fruit and vegetable disinfectant to test the quat solution used to sanitize surfaces. Observation of tray line occurred on 04/29/24 at 11:45 a.m. and showed a dietary staff member (#5) serving food with gloves on. The staff member opened the cooler door, obtained a bag of lettuce, touched the lettuce and placed it in a bowl, returned to the cooler and obtained tomatoes in her gloved hand, placed them into the bowl and reached into a container of shredded cheese and chopped meat and place it into the salad bowl. The staff member failed to change her gloves at any time during this observation. The facility failed to test the quat sanitizing solution before use and failed to change gloves before touching ready to eat food.	{B1800}		

Dickinson Evergreen Plan of Correction

All identified tags are in full compliance as of July 15, 2024.

B910 –

1. This tag affects 12 insulin dependent residents and has the potential to affect 24 residents who have been identified as diabetic as of the current resident roster.
Re-training and review of the Insulin Administration Policy will be completed by June 14, 2024 for all Med Aids by VP of Nursing. Re-Training and review of the Insulin Administration Policy was completed on May 23, 2024 for all Medication Aides by the facility DON. Competency checks of all Medication Aids were completed on May 23, 2024 by facility DON. Each competency check includes observation of administering insulin, as appropriate. Training and review of the sliding scale insulin protocol and procedure were reviewed and completed by May 23, 2024 by facility DON.

Continued compliance will be assured through New Employee Onboarding for new employees – policy review and competency verification to be completed by the RN in building within two weeks of start date; new medication aides will only pass insulin with another approved medication aide or licensed nurse until competency check is completed, documented, and filed. Additionally, annual competency checks will be completed for all active medication aides. All competency checks will be uploaded to our learning management system to ensure electronic copies are on file. This task will be completed by the HR Assistant, or delegate. Monthly audits of compliance will be completed by the Executive Director, or delegate, and documentation of these audits will be retained.
A random diabetic audit will be conducted weekly by VP of Nursing, RN (50% of census) to ensure medications and/or diabetic care needs are being observed and administered as ordered. After 4 weeks with no variance the audit will be done every other week. After 2 months with no variance the audit will be done monthly for 6 months.

2. Resident in 124 has not returned to the building and is awaiting placement in higher level of care. If he can return to the facility he will be placed in a proper room. Resident in room 115 will be consulted with family and moved by June 14th. For ongoing compliance to this rule, no incoming residents will be in residence in a licensed Basic Care room unless or until the specific resident is approved for Basic Care and paperwork has been received from the State of North Dakota that confirms the same.
This will be initially managed by the Sales Living Coordinator upon pre-admission processes and confirmed by the Executive Director and DON on the day of move in. This will be audited weekly by Executive Director, or delegate, and documentation of these audits will be retained.

B923 –

1. This tag has the potential to affect 9 residents that are on our current roster, and the potential to affect an unknown number of residents in the future, due to variance of individual needs.
RN identified all residents who self-administer medications and identified those who desire to self-administer medications. Regarding residents 5, 6, and 7, RN conducted a competency check for these residents and ensured there is a physician order for each resident who self-administers medications and this was retained for their file on May 28, 2024. Additionally, RN ensured care plan reflects self-care administration notation by that same date May 28, 2024. Re-education for caregivers and medication aides was held by VP of nursing on May 31, 2024.
Ongoing, self-administration of medication will be re-assessed by the RN quarterly and with significant change as part of the nursing assessment for 100% of residents affected for the term of self-

administration of medications. Executive Director will audit documentation completion and retention on a quarterly basis prior to the care plan conference, after the 90 day Nursing Assessment is completed.

B926 –
1. This tag has the potential to affect 100% of resident census.
Training and review of the Medication Administration Policy was reviewed with all Medication Aides on June 14, 2024 by Facility DON. This training includes the process for reporting medication errors to DON and/or ED upon incident. Further follow-up will be reported via an Incident Report within our system's database and any medication errors to be reported as defined and structured by this governing rule. Ongoing compliance will be overseen by RN in the building to ensure protocols are being followed and reported. New employees will review the Medication Administration policy during new employee orientation (Week 1 of onboarding). This will be completed by Licensed Nurse in the building. New employees will sign off via Relias, our learning management system to ensure electronic records of policy sign off are on file. Executive Director will review training compliance in the electronic database by the 5th of each month to ensure continued compliance.

B1540 –
1. This tag has the potential to affect 100% resident roster for those who have medications administered by Evergreen staff.
Medication administration practices were reviewed and documented by facility DON by May 23, 2024. Review of Insulin Pen administration, continuous glucose monitoring, and sliding scale insulin practice and procedure with all Med Aids.
On May 1, 2024, MA 2 received re-education of the insulin pen administration process and disciplinary processes were followed by DON.
Ongoing a Licensed Nurse in the building will audit the Medication administration practices for each med aid. Audit practices established for Medication Administration as outlined in B910 will apply for this tag as well.

B1700 –
1. This tag has the potential to affect 24 diabetic residents on the current roster.
Re-Training and review of Care of the Diabetic Resident Policy completed to Licensed Nurse by May 31, 2024.

A regularly scheduled date will be created and followed for the Continuous Glucose Monitoring sensors to be changed every 14 days, or as needed. These changes will be documented on the Electronic Health Record used by the Evergreen community. This was implemented immediately and continued ongoing. VP of Nursing is completing a weekly audit of compliance with documentation of diabetic cares and communicating this to the Executive Director.

Diabetic nail maintenance is provided by a Podiatrist or the Primary Care Provider, as allowable by the resident's insurance. The VP of Nursing is completing a weekly audit of compliance with documentation of diabetic foot cares and communicating this to the Executive Director or DON.

B1800 –
1. These tags have the potential to affect 100% of resident roster.

Culinary Services Manager reviewed sanitation processes and corrected by April 30, 2024. Re-education was provided by this person to all dietary staff before June 14, 2024 on sanitation practices, proper use of single use gloves and handwashing. All culinary employees also have been enrolled in our Food Handlers program to provided by our Dietician consulting company Dining RD and will be completed by July 15, 2024.
Acting Culinary Services Manager to inspect continued use of gloves at each meal service daily. Executive Director, or delegate will audit compliance weekly.

The proper sanitation strips were purchased on April 30th, 2024. All culinary staff have been educated on the correct use and system has been put into place to record sanitation levels which reflect changing the water at minimum twice daily after meal periods. The education was completed by Culinary Services Manager, and ongoing audits to be completed daily. Executive Director, or delegate will audit compliance weekly.