STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355051	A. BUILDING _____ B. WING _____	06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTON PRAIRIE VILLAGE	950 DAKOTA AVE HATTON, ND 58240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 06/03/19 and concluded on 06/06/19.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and manufacturer's guidelines, the facility failed to follow professional standards of practice for 2 of 7 residents (Resident #7 and #26) observed during medication pass. Failure to properly store medications and refer to the Medication Administration Record (MAR) (Resident #7) and ensure staff offered food within the recommended time frame after administration of rapid-acting insulin (Resident #26) may result in medication errors and low blood sugar. Findings include: Review of the facility policy titled "Medication Administration" occurred on 06/06/19. This undated policy stated, " . . . Identify and compare medication supply with Medication Administration Record . . . Observe the Six Rights of Medication Administration: Right patient, Right medication, Right dosage, Right time, Right route, right documentation . . ." Review of the facility policy titled "Injection	F 658	F658 - Failure to properly store medications and refer to MAR: 1. For Resident #7 eye drops medication will be transported to resident on medication delivery tray and prior to administering the eye drops medication, the medication will be checked against MAR observing the 6 rights of medication administration. 2. All residents receiving eye drop medications have the potential to be affected by these deficient practices. 3. The current policy and procedures on proper storage, transportation and administration of medications to residents are correct. DON will conduct an in-service/refresher course for nurses and medication aides on the proper storage, transportation and administration of eye drop medications,including the 6 rights of medication administration.	7/11/19

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

Electronically Signed | 06/19/2019

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F 658	Continued From page 1 (Subcutaneous)" occurred on 06/06/19. This undated policy stated, " . . . Please follow these recommendations when administering insulin: NovoLog 5 -10 minutes before a meal. . . ." Patient package insert information for Humalog KwikPen insulin, found at www.humalog.com., stated, ". . . Humalog starts acting fast, so inject it up to 15 minutes before or right after you eat a meal . . . Humalog may cause serious side effects, including low blood sugar [hypoglycemia] . . . ." - Observation of medication pass occurred on 06/04/19 at 3:57 p.m. A licensed nurse (#1) retrieved Resident #7's eye drops from her uniform pocket, located the Resident in his room and administered the eye drops. The nurse stored Resident #7 and another resident's eye drops in her uniform pocket and failed to check Resident #7's MAR before administering the eye drops. - Observation on 06/04/19 at 4:58 p.m., showed a licensed nurse (#1) administered six units of Humalog insulin to Resident #26. Observation showed Resident #26 received his meal tray at 5:18 p.m., 24 minutes after receiving a fast-acting insulin.	F 658	4. DON will audit the proper storage, transportation and administration of eye drops medication, including the 6 rights of medication administration, weekly for 3 months and monthly for 3 months. Results will be reported by the DON to the QAPI Committee at each scheduled meeting. QAPI Committee will timely review all audit reports. If issues are identified, immediate corrective action will be implemented by the DON. F658 - Failure to administer fast-acting insulin within 15 minutes before a meal: 1. For Resident #26 fast-acting insulin (Humalog) will be administered within 15 minutes before Resident's meal, in accordance with manufacturer's recommendations. 2. All residents receiving fast-acting insulin have the potential to be affected by the deficient practice. 3. The current policy and procedures on insulin administration are correct. DON will conduct an in-service/refresher course for nurses on the proper administration of insulin, following manufacturer's recommendations or physician's orders. 4. DON will audit the proper administration of insulin weekly for 3 months and monthly for 3 months. Results will be reported by the DON to	

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F 658	Continued From page 2	F 658	the QAPI Committee at each scheduled meeting. QAPI Committee will timely review all audit reports. If issues are identified, immediate corrective action will be implemented by the DON.	