STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355077	A. BUILDING _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

(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 07/29/2019 and concluded on 08/01/2019.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		9/5/19

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

Electronically Signed | 08/22/2019

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F 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, the facility failed to ensure the resident's right to request, refuse, and/or discontinue treatment for 3 of 31 sampled residents (Resident #35, #65, and #137) reviewed for advance directives. Failure to ensure all methods of communication and/or documentation of code status for each resident accurately reflected the resident's wishes has the potential to limit his/her access to life-sustaining services or result in unwanted treatment. Findings include: Review of facility policy titled "Advance Directives" occurred on 07/30/19. This policy, revised February 2018, stated, ". . . PURPOSE: 1. To allow residents the choice of making health care decisions and of their right to execute Advanced Directives. . . . PROCEDURE: . . . 3. On admission each resident and/or representative will be asked to make a decision for a code level directive for cardiopulmonary resuscitation . . . 4. Sheyenne Care Center will request upon admission a copy of each resident's advance directive that will be placed in his/her medical record. . . . 8. Documentation in the medical record will me [sic] made if a resident	F 578	F 578 Request/Refuse/discontinue Treatment; formulate Advanced Directive 1. As of 8/16/19 Resident #35, #65 and #137, their paper chart, electronic records and room door reflect current Code Status. 2. Facility has identified that all residents with in the facility have the potential to be affected by this practice. 3. Education will be provided to Social workers and Nurse Managers in regards to Advanced Directives. The facility has implemented a systemic change. Upon admission Social workers will make copy of Advanced Directives and place original in Dr.□s folder to be signed and give copy to Nurse Managers. Nurse Managers will then update paper chart, electronic chart and room door. Quarterly chart audit form will be updated to reflect code status. 4. An audit tool has been developed to ensure that code status has been updated timely and accurately. Audit tool will be completed by Director of Nursing or designee weekly for one month, 1 X a week for two months, and then quarterly for one year.	

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F 578	Continued From page 2 has any type of advanced directives. Medical records will be updated to reflect any change of status as to the existence and content of an advance directive if any changes occur. . . ." Observation during the initial tour on 07/29/19 showed a green sticker on some name plates outside the resident's doors beside their names. When asked, a certified nursing assistant (CNA) (#8) stated, "The green stickers mean they [the residents] want CPR [cardiopulmonary resuscitation in the event of a cardiac arrest]. If there isn't a sticker, they don't want CPR." Observation on 07/29/19, in the 3rd floor nurses' station, showed either a green sticker or a red sticker labeled with a 1 or a 2 on the cover of the resident's paper charts. When asked, an unidentified staff member stated, "The red sticker with a 2 means No Code [do not resuscitate (DNR) in the event of a cardiac arrest] and the green sticker with a 1 means Code [wants CPR]." - Review of Resident #35's medical record occurred on all days of survey. The paper medical record showed a signed document, dated 05/13/19, indicating DNR and a green sticker labeled 2 on the cover of the chart. A physician's order, dated 05/13/19, stated, "CODE 2 - DNR." The resident's electronic record profile page failed to identify a code status. All other residents reviewed had a code status listed on their profile page. - Review of Resident #65's medical record occurred on all days of survey. The paper medical record showed a signed document, dated 07/11/18, indicating the resident wished to	F 578	a. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 5. Compliance will occur on or before September 5th, 2019.	

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F 578	Continued From page 3 receive CPR and green sticker labeled 1 on the cover of the chart. A physician's order, dated 11/21/18, stated, "Code 1--CPR." The name plate outside Resident #65's room lacked a green sticker. - Review of Resident #137's medical record occurred on all days of survey. The paper medical chart showed a signed document, dated 12/28/18, indicating the resident wished to receive CPR and a green sticker labeled 1 on the cover of the chart. A physician's order, dated 12/31/18, stated, "Code 1--CPR." The name plate outside Resident #137's room lacked a green sticker. During an interview on 07/31/19 at 10:21 a.m., a CNA (#9) stated the CNAs at this facility are certified in CPR and if a resident went into cardiac arrest she would "Look for a green sticker on the door which means CPR." During an interview on 7/31/19 at 4:17 p.m., an administrative nurse (#5) confirmed there were inconsistencies between the paper/electronic medical records and the sticker system used and "those [inconsistencies] could be a problem."	F 578		
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,	F 583		9/5/19

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F 583	Continued From page 4 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 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to promote privacy and confidentiality of the medication administration records for 1 of 3 days of survey. Failure to promote resident privacy may result in viewing of resident records by other residents, visitors, or unlicensed staff. Findings include: Observation on 07/30/19 at 8:17 a.m. showed a	F 583	F 583 Personal Privacy/Confidentiality of records 1. On 7/31/19 all Nurses and CMAs located on second floor were reeducated on HIPPA and Confidentiality of Personal information and importance of locking EMAR when leaving the med cart unattended. 2. The facility has identified that all residents in the facility have the potential to be affected by this practice.	

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F 583	Continued From page 5 medication cart unattended on the 200 floor hallway with the medication administration record (MAR) open to resident information. Observation on 07/30/19 at 8:47 a.m. showed a medication cart unattended outside of the dining room on the 200 floor with the MAR open to resident information. During an interview on 08/01/19 at 11:15 a.m., an administrative nurse (#5) confirmed she would expect staff to lock all computer screens at all times when not attended. The facility failed to promote privacy and confidentiality of the resident's MAR when unattended by staff.	F 583	3. As of 8/28/19 all staff will be educated on HIPPA and Personal Privacy and Confidentiality 4. An audit tool has been developed to ensure resident□s personal privacy and confidentiality of records is secure. Audit tool will be completed by Social Worker or designee 4 X week for one month, 2 X a week for two months, 1 X week for 3 months and then quarterly for one year. This goes for all audits developed for resident and family concerns. a. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 5. Compliance will occur on or before September 5th, 2019.	
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 and staff interview, the	F 637	F 637 Comprehensive Assessment After	9/5/19

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F 637	Continued From page 6 facility failed to complete a significant change in status assessment (SCSA) for 1 of 1 sampled resident (Resident #111) 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 to accurately assess the resident's status and identify and implement appropriate interventions. Findings include: Review of Resident #111's medical record occurred on all days of the survey. Resident #111's quarterly Minimum Data Set (MDS), dated 03/21/19, identified extensive assistance with walking in room and corridor, no depression, and one fall with minor injury. Resident #111's quarterly MDS, dated 06/21/19, identified walking in room and corridor did not occur, mild depression, two falls, one with major injury. A progress note, dated 04/03/19 at 10:26 a.m., stated, " . . . Uses walker and ambulates short distances in room, wheelchair for mobility for longer distances. . . ." A progress note, dated 05/02/19, identified Resident #111 had a fall at the facility that resulted in a right clavicle fracture. A progress note dated 06/27/19 at 12:04 p.m., stated, " . . . Uses wheelchair for mobility. . . ." During an interview on 07/29/19 at 2:46 p.m., Resident #111 stated, "I'm a little disgusted that I	F 637	Significant Change 1. As of 8/16/19 a Significant change has been opened for resident #111. 2. Facility has identified that all residents in the facility triggering for significant changes have the potential to be affected by this practice. 3. Facility has implemented a systemic change. An Interdisciplinary Team meeting will be implemented 2 x week. In this meeting the team will review: Current triggered MDS for significant changes, progress notes, and communications from therapies, social services, dietary, activities and direct care staff. The team will also review current MDS schedules and upcoming MDS schedules to identify potential significant changes. 4. An audit tool has been developed to ensure that resident status is being evaluated for significant changes. Audit tool will be completed by Director of Nursing or designee 2 X week for one month, 1 X a week for two months, and then quarterly for one year. a. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 5. Compliance will occur on or before September 5th, 2019.	

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F 637	Continued From page 7 am no longer able to walk and I was walking when I came here." During an interview on the afternoon of 07/30/19, an administrative nurse (#7) confirmed a significant change in status should have been completed for Resident #111. During an interview on 07/31/19 at 9:34 a.m., a physical therapist (#6) stated Resident #111's decline in ambulation was due to her rapid progression of Parkinson's Disease. The facility failed to complete a significant change in status assessment in response to Resident #111's decline in functional and mood status.	F 637		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review	F 644		9/5/19

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F 644	Continued From page 8 upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, review of facility policy, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures For Long Term Care Services, the facility failed to complete a status change assessment for 2 of 6 sampled residents (Resident #35 and #93) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with residents' needs. Findings include: Review of the facility policy titled "Resident Assessment with PASRR Screening" occurred on 08/01/19. This policy, revised on November 2018, stated, ". . . 1. All individuals will have a PASRR screening submitted prior to admission. a. Sheyenne Care Center will admit individuals with a mental disorder or intellectual disability who is approved for admission via the PASRR Screening. 2. Upon admission a Tracking Change Request Form will be submitted. 3. Exceptions to the preadmission screening program include those individuals who are readmitted directly from the hospital. 4. Recommendations, such as any specialized services, from a PASRR level II determination and/or PASRR evaluation report will be incorporated into the resident's care planning and transitions of care. 5. Any level II resident who experiences a significant change in status related to their level II diagnosis will be referred for	F 644	F 644 Coordination of PASRR and Assessments 1. As of 8/5/19 a Level 1 was completed on resident #93 and as of 8/13/19 a Level 2 was completed for resident #93. As of 8/9/19 a Level 1 was done on resident #35 and no level 2 was required due to Primary diagnosis of Dementia. 2. The facility identified that any residents newly diagnosed with mental illness or intellectual disability could potentially be affected by this practice. 3. Facility has implemented a systemic change. An Interdisciplinary Team meeting will be implemented 2 x week. Unit secretaries will develop an appointment tracking log that will be given to Clinical Support Nurse to review appointments and new orders. From that log, the clinical Support Nurse will then obtain progress notes from all appointments. Clinical Support Nurse will review progress notes for new diagnosis and new orders. Clinical Support Nurse will then enter new diagnosis into Point Click Care. Clinical Support Nurse will then notify appropriate IDT members of new diagnosis. Clinical Support Nurse will then give progress notes from appointments to Unit Secretaries to upload into resident□s chart in Point click Care. IDT members will then evaluate diagnosis for justification for screening. If screening is needed Social Services will complete screening within 13 days of	

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F 644	Continued From page 9 additional resident review. 6. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred to for a PASRR Screening. . . ." The North Dakota PASARR Provider Manual, pages 7 and 13, stated, ". . . If the Level I Screen indicates that the applicant does have indicators for MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]), a Level of Care Form must be completed and forwarded to Ascend (regardless of the individual's method of payment). If the individual with MI, ID, and/or RC meets criteria for nursing facility level of care, s/he will be referred for a Level II PASARR evaluation, which then must be completed prior to the individual's admission to a nursing facility.. . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." - Review of Resident #35's medical record occurred on all days of survey. The record showed a Level I PASARR completed on 05/16/16 stated, ". . . No MI, MR [mental retardation], RC. A Level II not required at this time unless a significant change occurs and suggests the presence of MI, MR, DD	F 644	diagnosis, upload it into Point Click Care and update Care Plan. Also included in Interdisciplinary Team meetings the team will be discussing and reviewing Psychotropic medications and GDRs. 4. An audit tool has been developed to ensure that resident status is being evaluated for screenings needed related to new diagnosis of mental illness or intellectual disability. Audit tool will be completed by Director of Nursing or designee 2 X week for one month, 1 X a week for two months, and then quarterly for one year. a. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 5. Compliance will occur on or before September 5th, 2019.	

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F 644	Continued From page 10	F 644		

[developmental disability] that is not dementia. . . " The facility added a diagnosis of Obsessive Compulsive Disorder and Unspecified Psychosis on 04/24/17. The record lacked evidence of an updated Level I screen/change in status assessment with these added diagnoses.

During an interview on 07/31/19 at 5:18 p.m., two administrative staff (#11 and #12) agreed that a status change in assessment should have been completed when the diagnoses were added.

- Review of Resident #93's medical record occurred on all days of survey. A Level I PASARR, dated 07/07/10, completed while a patient at another facility, identified the diagnoses of schizophrenia and borderline intellectual mental disorder and stated, ". . . meets PASARR criteria for major mental illness. Will be referred for Level II evaluation for further review. . . ."

After the resident admitted to the facility, the following diagnoses were added:
* 09/20/13 - diagnosis of other specified mental disorders due to known physiological condition
* 10/01/15 - diagnosis of major depressive disorder; schizophrenia added as the primary diagnosis
* 01/25/18 - diagnosis of unspecified mental disorder due to known physiological condition
* A diagnosis of SAD (seasonal affective disorder) depression included in multiple psychiatric progress notes since admission, but not added to the diagnosis list

Resident #93's medical record lacked evidence of a Level II evaluation completed as stated in the 07/07/10 Level I screen. The record also lacked

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F 644	Continued From page 11 evidence the facility completed an updated Level I screening/change in status assessment with the added diagnoses. During an interview on 07/31/19 at 5:18 p.m., two administrative staff (#11 and #12) stated there have been different staff working over the years and they were not sure if completion of the necessary paperwork occurred.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		9/5/19

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	355077	A. BUILDING _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CARE CENTER	979 CENTRAL AVE N VALLEY CITY, ND 58072

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F 656	Continued From page 12 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to develop a comprehensive care plan for 1 of 31 sampled residents (Resident #31). Failure to develop a care plan that included the care and services to be provided to the resident may negatively impact the resident's quality of life. Findings include: Observation on 07/29/19 at 3:39 p.m. showed two certified nurse aides (CNAs) (#1 and #2) assisted Resident #31 to the bathroom. Resident #31 walked independently with the CNAs guiding him. One CNA (#1) reported Resident #31 required assistance of two because he was completely blind. Observation on 07/30/19 at 10:12 a.m. showed two CNAs (#1 and #2) assisted Resident #31 out of bed and walked with him to the shower room. Resident #31 walked independently with the	F 656	F 656 Develop/Implement Comprehensive Care Plan 1. As of 7/31/19 Resident #31 Care Plan has been updated to reflect current status and care required 2. Facility has identified that all residents have the potential to be affected by this practice. 3. Facility has implemented a systemic change. An Interdisciplinary Team meeting will be implemented 2 x week. The team will review Care Plans and update current status and care required. 4. An audit tool has been developed to ensure that resident current status is reflected in the care plan. Audit tool will be completed by Director of Nursing or designee 2 X week for one month, 1 X a week for two months, and then quarterly for one year. a. A summary of completed audits will	

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F 656	Continued From page 13 CNAs guiding him. Resident #31 became unsteady when he turned from his room into the hall and again when he turned from the hall into the shower room. Review of Resident #31's record occurred on all days of the survey. An annual Minimum Data Set (MDS), dated 04/26/19, showed the resident has highly impaired vision. Resident #31's current care plan failed to address his impaired vision or the assistance he required related to his impaired vision. During an interview on 08/01/19 at 10:40 a.m., an administrative nurse (#3) confirmed staff failed to address Resident #31's vision impairment in his care plan.	F 656	be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 5. Compliance will occur on or before September 5th, 2019.	
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 and staff interview, the facility failed to maintain safe water temperatures at handwashing sinks in resident bathrooms in 1 of 5 resident care areas. Failure to ensure safe water temperatures may result in injuries/burns to residents and staff. Finding include:	F 689	1. On 7/30/2019 Envir. Serv. Coordinator adjusted the hot water temp in 3109, 3110, 3112, and 3114 to appropriate temperature and monitored hot water temp throughout the day to ensure hot water temperature is in appropriate temperature range. 2. All residents are at risk with hand	8/24/19

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F 689	Continued From page 14 Upon request, the facility failed to provide a policy regarding water temperatures. Observation on 07/30/19 at 5:08 p.m. to approximately 5:20 p.m. showed the following water temperatures at handwashing sinks in resident bathrooms on the 3rd floor: * Room 3109 - 162.8 degrees F * Room 3110 - 162.5 degrees F * Room 3112 - 149.1 degrees F * Room 3114 - 165.9 degrees F On 07/30/19 at 5:26 p.m., after informing an administrative staff member (#13) of the hot water temperatures, the staff member immediately informed an environmental service staff member (#14) to turn down the temperature of the hot water. During an interview on 08/01/19 at 9:38 a.m., the administrative staff member (#13) agreed the hot water temperature could potentially harm residents and staff.	F 689	washing sinks in resident bathrooms have the potential to be affected. 3. the Envir. Serv. Coordinator/QA educator will in-service staff on hot water temp policy on resident rooms and will Q.A. hot water temp at residents hand-washing sinks. 4. QA will be completed by the Envir. Serv. department weekly for one month, monthly for 3 months and then quarterly there after. 5. 8/24/2019	
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; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 3 of 9 residents (Resident #32, #93,	F 759	F 759 Free of Medications Error rate are not 5 percent or greater. Part I	9/5/19

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F 759	Continued From page 15 and #139) observed during medication pass. Three medication errors occurred during staff administration of 35 medications, resulting in an 8% error rate. Failure to ensure medications are administered correctly may alter their therapeutic effect and/or result in adverse side effects. Findings include: Review of facility policy titled "Medication Administration Record" occurred on 7/30/19. This policy, revised November 2018, stated, ". . . 5. Document when a medication is refused or omitted for any reason in PCC [Point Click Care - electronic medical record]. 6. Documentation is to be done immediately in PCC following the administration of medication. . . ." Review of facility policy titled "Use of Insulin Pens" occurred on 07/30/19. This policy, revised November 2017, stated, ". . . It is the policy of this facility that insulin pens are considered to be single use items. . . . 2. A new needle will be applied for each injection. . . . 4. Nurse must prime each single use needle with 2 units of insulin before dialing ordered units and administering." - Review of Resident # 93's medical record occurred on 07/31/19 and identified a physician's order for MiraLAX (laxative) 17 grams daily. Observation of medication pass occurred on 07/31/19 at 9:17 a.m. Resident #93 refused to take the scheduled MiraLAX when offered by nurse (#4). After the nurse completed the resident's medication pass, the nurse left the room and documented all of the resident's	F 759	1. Residents #32 and #139 are now receiving their insulin correctly via insulin pen. Verbal education was provided immediately on 7/31/19 by Nurse Manager to Staff Nurse in regards to insulin administration and proper priming of insulin pen. 2. Facility has identified that all residents that receive insulin via insulin have the potential to be affected by this practice. 3. All licensed nursing staff that are responsible for administering insulin will be educated on the proper procedure and policy of insulin administration. 4. An audit tool has been developed to assure that all insulin administrations are being performed correctly according to the use of insulin pen. These audits will be performed by Director of Nursing or designee 4 times a week for one month, 2 x week for 2 months and 1 x week for 3 months and then quarterly. a. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 5. Compliance will occur on or before September 5th, 2019 Part II 1. Resident #93 MAR reflects the correct documentation of refusal for the medication Miralax that was scheduled for the AM dose. 2. Facility has identified that all residents that receive medication have the potential to be affected by this practice.	

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F 759	Continued From page 16 medications as given in the eMAR (electronic medication administration record). The nurse failed to accurately document Resident #93's refusal of the MiraLAX. - Review of Resident #32's medical record occurred on 07/31/19 and identified a physician's order for Lantus insulin 80 units. Observation of medication pass occurred on 07/31/19 at 10:45 a.m. A licensed nurse (#4) dialed the first Lantus pen to 58 units (the remainder of insulin left in this pen), dialed the second pen (a new pen) to 22 units, and administered the insulins to Resident #32. The nurse failed to prime both insulin pens. - Review of Resident #139's medical record occurred on 07/31/19 and identified a physician's order for Tresiba insulin pen 22 units. Observation of medication pass occurred on 07/31/19 at 10:52 a.m. A licensed nurse (#4) dialed Resident #139's Tresiba pen to 22 units and administered the insulin to Resident #139. The nurse failed to prime the insulin pen. During an interview on the morning of 07/31/19, an administrative nurse (#5) confirmed staff are to document "refused" in the eMAR when residents refuse a medication and stated she expected staff to prime insulin pens prior to dialing the prescribed dose and administering the insulin.	F 759	3. All staff that are responsible for administering medication will be educated on the policy and procedure of proper medication administration and documentation regarding medication taken and refusals of medication. 4. An audit tool has been developed to assure that all medication administration and documentation of medication taken or refused is followed correctly. These audits will be performed by Director of Nursing or designee 4 times a week for one month, 2 x week for 2 months and 1 x week for 3 months and then quarterly. a. A summary of completed audits will be provided monthly to the quality assurance committee to ensure compliance is achieved and sustained. 5. Compliance will occur on or before September 5th, 2019.	