STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	C 01/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	**300 MAIN ST S VELVA, ND 58790**

(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 An unannounced onsite complaint survey was completed on January 2, 2019.	F 000		
F 689 SS=G	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 information provided by the complainant, record review, and staff interview, the facility failed to provide adequate supervision necessary to prevent accidents for 2 of 2 sampled residents (Resident #1 and #2) who sustained a burn. Failure to monitor the temperature of the baseboard heat register and position residents' beds away from the heat register resulted in Resident #1 receiving a first and second degree burn. Findings include: Information provided by the complainant indicated a resident fell from her bed and obtained a significant burn from a heat register. - Review of Resident #2's medical record occurred on 01/02/19. Diagnosis included history of falls and Alzheimer's disease. Resident #2's progress note dated, 12/23/19 at	F 689	Preparation and execution of this response and plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purpose of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. F0689 1)Resident #2 bed was moved away from baseboard heat. Family came up and helped with room	2/6/19

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

Electronically Signed | 01/18/2019

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F 689	Continued From page 1 3:35 a.m., stated, "Resident yelling. Found between bed and wall. Lying on right side, legs caught under bed and left hand on register holding torso off of floor. Wedged between bed and wall. Register hot to touch." An investigation form completed on 12/23/18 stated, " . . . Time Occurred 03:35 [3:35] a.m. . . . Minimal Injury . . . bed in low position, attempted self transfer out of bed. . . . Describe corrective actions taken . . . register heat lowered . . . Resident Injuries . . . Abrasion [right] lateral knee, Burn [left] hand, Skin discoloration red [right] hip, forearm, knee . . ." During an interview on 01/02/19 at 2:22 p.m., an administrative staff member (#1) stated staff moved Resident #2's bed away from the heat register to ensure the resident's safety from further burns and initiated one hour checks at night. The facility failed to ensure corrective actions occurred for all residents after Resident #2 received a burn from touching a hot heat register. - Review of Resident #1's medical record occurred on 01/02/19. Diagnosis included history of falling and dementia with behavioral disturbance. The current care plan stated, "The resident is at risk for falls . . . slid out of bed on 07/05/18 and 12/12/18. Found on floor by bed 12/26/18 . . . Resident requires assist of 2 staff and a total lift . . . " Resident #1's progress note dated 12/26/18 at 1:35 a.m., stated, "Resident found lying on floor between bed and wall. Right buttock, hip against heat register. . . . Noted redness with large	F 689	rearrangement, family was given an option to move resident to different room in bed 1 position or to re arrange resident room, Family wanted resident head of bed to be up against wall with base board heat and night stand next too bed. Facility made those changes on 12/24/18. Resident #2 was also put on hourly rounds while in bed. Resident #1 was moved to different room and placed in a bed one position. Resident #1 is no longer here. 2)All residents have the potential of being affected. 3)All residents room bed 2 position have been reassessed to ensure bed is not close to baseboard heater. Resident bed was moved away from wall and nightstand has been put in between resident bed and base board heat to ensure proper spacing. If resident preferred a different bed placement, center documented in progress note that arrangement. On 1/3/19 center held a mandatory all staff in service to address safety concerns over baseboard heat. All staff were educated on what the proper placement of bed 2 and nightstand position. We addressed resident overall safety with the baseboard heater. Education was provided regarding proper procedure on heat adjustment in resident rooms. Center is placing safety cover over control knob of base board heater.	

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F 689	Continued From page 2 blisters to right buttock, hip. Skin intact measuring 12 cm [centimeters] x 27 cm. . . . Administrator, DNS [direct nursing services], son notified. . . . NP [nurse practitioner] notified with orders received to leave blister intact until it opens. . . ." Resident #1's progress are as follows: *12/26/18 at 3:00 a.m.: "Noted blisters to right buttock to weep . . . noted to be shaking. Stated feels cold. BP [blood pressure] 70s/40s. . . ." *12/26/18 at 3:53 a.m.: "son notified, updated on current condition. Agreed to transfer to ER [emergency room] for evaluation. . . ." *12/26/18 at 11:18 a.m.: "Room rearranged and bed was moved away from the heater." *12/26/18 at 7:00 p.m.: "RN [registered nurse] from [hospital name] phones stating resident is receiving Silvadene dressing changes two times daily, pain control with Tylenol and is [sic] observation, should return on 12/27/18 to facility." *12/27/18 at 3:43 p.m.: "resident returns from hospital . . . transferred to bed with assist of four. . . . color is very pale with little duskiness noted . . . dressing intact to left lower leg and right buttock . . ." *12/28/18 at 9:53 a.m.: "resident moved to room [number] to be closer to the nurses station . . . Nursing order for q [every] 1 hour safety checks . . . Resident's bed has been placed in new room so it is not near the heater. . . ." *12/31/18 at 11:59 a.m.: "Resident is somewhat lethargic. Her skin is cool to touch and grey in appearance. Resident has had very little food intake and very little output. Has been getting the MS [morphine sulfate] [pain medication] for pain and helps when resident keeps it in her mouth. . . . O2 [oxygen] is at 70% [percent]. 2 liters of O2	F 689	The Center has also purchased heavier blankets to be put on residents beds per resident choice. Maintenance has received an infrared thermometer for setting the temperatures of the base board heater. 4. Two audits have been implemented. 1) Nursing staff or designee are checking bed placement daily for two months, then weekly for two months, and monthly for 2 months to ensure proper spacing between bed and base board heater. 2)Charge Nurse or designee are recording baseboard heat temperature using the infrared thermometer. Any temperature over 110 degrees coming from a base board heater are to notify maintenance per phone call and maintenance will make adjustment. Charge nurse will be responsible for resident safety until heater is adjusted. Charge Nurse or designee is responsible for all 25 rooms to be audited daily for two months, weekly for 2 months, and monthly for 2 months. If audits support monitoring longer, Quality Committee will make recommendation for system change. Room audits are reviewed Monday through Friday during Quality meetings, if there is pattern noted with the audit the Quality assurance team review the audit to makes sure we are sustaining the quality of the heaters. System change with Quality Assurance program: The Center is holding a quality meeting Monday through Friday reviewing	

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F 689	Continued From page 3 placed on resident a this time. Doctor notified. . . ." *12/31/18 at 1:13 p.m.: "Resident has been sent to the ER in [hospital name] for evaluation, due to possible dehydration. . . ." An investigation form completed on 12/26/18 at 1:35 a.m., stated, " . . . Immediate Action Taken: . . . Cool compress applied to right hip, buttock area. . . . Resident's bed moved away from register and register adjusted to low setting. . . . Injuries Observed at Time of Incident: Burn to Right Buttock and Burn to Right trochanter (hip). . . ." A hospital note dated 12/26/18 at 5:26 a.m., stated, "History of Present Illness: . . . She sustained a large area of 1st and 2nd degree partial thickness burn to her right buttock with some blistering . . ." During an interview the afternoon of 01/02/19, a facility certified nursing assistant (CNA) (#3) stated she entered Resident #1's room on 12/26/18 at 1:30 a.m. to assist when she heard the resident had fallen. The CNA stated she observed resident #1's buttocks up against the heater vent and identified the vent was hot to touch. The CNA (#3) stated she immediately turned down the temperature on the vent without using a plastic dial. The CNA verified the base board heaters in the residents' rooms can be adjusted without using the plastic dial, and that she has adjusted other residents' base board heaters without using the plastic dial. During an interview on the afternoon of 01/02/19 two administrative staff members (#1 and #2)	F 689	audits, work order review, incident review and concerns. Monday through Friday the center is also having a stand up meeting with all staff to ensure communication within all departments. Quality coordinator or designee is responsible for compliance with audits. Quality Assurance committee will reviews monthly to make recommendation to sustain compliance. 5. Compliance date will be 2/6/19	

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F 689	Continued From page 4 stated staff implemented the following interventions to ensure residents safety : * All residents' beds were positioned away from the heat registers * Monitoring the temperatures of the heat registers * Hourly checks on Resident #1 after hospital return on 12/28/18	F 689		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of the State Agency (SA) facility file, facility Quality Assurance (QA) program, review of facility policy, survey findings, and staff interview, the facility failed to ensure the quality assurance program monitored and addressed areas identified, and failed to complete audits/monitoring for quality deficiencies	F 865	F0865 1&2. All residents have the potential of being affected by this practice. 3.All prior audits from last survey have been restated.	2/6/19

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F 865	Continued From page 5 identified during the previous standard survey completed 05/09/18. Findings include: Review of the facility policy, titled "Quality Assurance and Performance Improvement (QAPI)", occurred on 01/02/19. This policy, revised 03/18, stated, ". . . is ongoing and comprehensive to address all care and services . . . is data driven, capable of showing measurable improvement and focuses on safety, choice, outcomes, quality of care and quality of life . . . Uses the best available information to define and measure goals, Will document QAPI principles, processes and goals in a written QAPI plan. . . . The QAPI program uses data to identify and prioritize problems and process improvement opportunities and takes action to address areas in need of improvement. . . . have a system in place to monitor performance indicator including adverse events . . . will perform a regular review of applicable performance data, and compare findings to set benchmarks and targets to determine areas in need of improvement . . . assign, document and monitor completion of all performance improvement efforts . . . Monitoring regulatory survey preparations, outcomes and plans of correction. Ensuring action is taken to address identified areas in need of improvement. Implementing a process to evaluate completed improvement initiatives to ensure effectiveness and sustainability . . ." Review of the facility's file prior to the on site investigation, revealed the following deficiencies cited during the previous standard survey, completed 05/09/18.	F 865	F558:Admission, Activities or designee are responsible for call light audits. Call light audits will be completed daily for 2 weeks, then twice a week for 6 months. F641: MDS Coordinator or designee will conduct the Non Pharmacological interventions audit. The audit will be completed weekly for 4 weeks , and then monthly for 6 months. F658: HIM or designee will conduct the Physician orders reviewed audit daily for 2 weeks and then monthly for 6 months. F689:Mainentance, Staff Development,DNS or designee are responsible for Wheelchairs, Hot beverage spills, and transfers audits weekly for 1 month, and then monthly for 5 months. Nursing department staff were assigned new gait belts to assist with transfers. F693: Staff Development or designee will conduct the Feeding tubes audits. Audits will be done monthly for 6 months. We have had a system change with Quality. The center is holding a quality meeting Monday through Friday reviewing audits, work order review, incident review and concerns. Monday through Friday the center is also having a stand up meeting with all staff to ensure communication within all departments. 4.Quality coordinator or designee is responsible for monitoring and bringing audits to monthly quality meeting to ensure compliance. Quality committee will review monthly and make recommendation to ensure measures are sustainable.	

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F 865	Continued From page 6 * F 558 - Reasonable Accommodations: Audit every two weeks for six months. * F 641 - Accuracy of Assessments: Audit monthly for six months. * F 658 - Services Provided Meet Professional Standards: Audit monthly for six months. * F 689 - Free of Accident Hazards/Supervision/Devices: Audit monthly for five months. * F 693 - Tube Feeding Management/Restore Eating Skills: Audit monthly for six months. Review of the facility's Quality Assurance (QA) audits for 2018 and 2019 revealed the following: * F 558 last completed audit 07/06/18 * F 641 last completed audit 07/06/18 * F 658 last completed audit 06/13/18 * F 689 last completed audit 07/05/18 * F 693 last completed audit 07/09/18 The facility failed to complete audits as indicated in the plan of correction for the survey completed on 05/09/18. The facility failed to follow the POC by continueing with the QA plan as written.	F 865		