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| **SOURIS VALLEY CARE CENTER** | **300 MAIN ST S VELVA, ND 58790** |

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| F 000 | INITIAL COMMENTS<br><br>The unannounced on-site complaint survey was completed on July 23, 2019. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph | F 580 | | 9/6/19 |

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

Electronically Signed | 08/21/2019

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| F 580 | Continued From page 1<br>(e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to notify the physician of a change in condition for 1 of 2 sampled resident records (Resident #3) reviewed with high blood glucose levels. Failure to update the physician on Resident #3's high blood glucose levels after initiating blood glucose monitoring did not allow the physician to make prompt decisions on treatment changes/options and is a violation of residents' rights.<br><br>Findings include:<br><br>On 07/23/19, when asked to provide a policy regarding blood glucose level parameters and when to notify the physician, an administrative staff member (#1) stated the facility did not have a specific policy for blood glucose levels/parameters.<br><br>Review of Resident #3's medical record occurred | F 580 | 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 participations, this response and plan of correction constitutes the facility□s allegation of compliance in accordance with section 7305 of the State Operations Manual<br><br>1. Resident #3 is no longer a resident at our facility effective 5/22/19<br>2. All residents with a medical diagnosis | |

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| F 580 | Continued From page 2<br>on 07/23/19 and identified her primary/principle diagnosis as diabetes mellitus type 2 with diabetic neuropathy, along with diagnoses of hypertension, and history of diabetic chronic kidney disease.<br><br>The physician's admission orders included Metformin 250 milligrams twice a day (an oral medication used to treat diabetes) and a carbohydrate controlled diet for Resident #3's diabetes. The physician did not order blood glucose monitoring on admission.<br><br>Review of lab results in Resident #3's medical record, dated 08/03/18 (prior to admission), identified a blood glucose level of 114 [Reference Range 70-105] and a Hemoglobin A1C (a blood test that provides information about average levels of blood glucose over the past 3 months) result of 6.7 [Reference Range of 4.0 - 6.0]. The Physician's Clinic Note (prior to admission), dated 08/06/18, stated, ". . . "Plan: Labs are reviewed with [Resident #3] today. . . . Her hemoglobin A1C is 6.7 percent indicating excellent of (sic) her diabetes with metformin alone. . . . I will plan to . . . see her back in 3 months with a CMP [comprehensive metabolic panel (blood test which includes blood glucose level)] . . . hemoglobin A1C, . . ."<br><br>Review of a podiatry clinic note, dated 10/31/18, stated, ". . . Assessment: . . . 2. Diabetes mellitus with peripheral neuropathy. 3. Peripheral arterial disease. Plan: . . I discussed the findings with her and her daughter. . . . She is to keep tight glycemic control on her blood sugars. . . ."<br><br>On 11/15/18, the physician wrote, ". . . PLAN: 1. | F 580 | of diabetes mellitus have the potential of being affected.<br>3. All Licensed Nurses will be re-educated on blood sugar management regarding high and low blood sugar readings as well as notification to the physician/family/residents.<br>4. DNS or designee will do a blood sugar audit daily for one week, weekly for three weeks, bi-weekly for one month, and monthly for four months. Quality Assurance committee will review and monitor blood sugar audits during monthly quality meeting. Quality Assurance committee will ensure compliance<br>5. Completion Date: 9/6/19 | |

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| F 580 | Continued From page 3<br>Will begin checking blood sugars 3 times weekly. . . ." The physician's orders stated, "Accu check three times a week. . . every Mon [Monday], Wed [Wednesday], Sat [Saturday] . . ."<br><br>Review of Resident #3's blood glucose level checks (starting on 11/17/18) showed the following:<br>Saturday 11/17/18 at 1:56 p.m. - 434 mg/dL (milligrams per deciliter)<br>Saturday 11/24/18 at 5:37 a.m. - 523 mg/dL<br>Sunday 11/25/18 at 5:36 a.m. - 380 mg/dL<br>Wednesday 11/28/19 at 5:10 a.m. - 401 mg/dL<br>Saturday 12/01/18 at 5:04 a.m. - 369 mg/dL<br>Monday 12/03/18 at 5:11 a.m. - 250 mg/dL<br>Wednesday 12/05/18 at 5:13 a.m. - 271 mg/dL<br>Saturday 12/08/18 at 5:51 a.m. - 484 mg/dL<br>Saturday 12/08/18 at 11:21 a.m. - 579 mg/dL<br>Saturday 12/08/18 at 5:48 p.m. - 437 mg/dL<br><br>A Care Conference note, dated 11/20/18, stated, ". . . We discussed her diabetic management. [Dietitian] did come in and review why not doing daily checks would be done. . . ."<br><br>A Care Conference note, dated 11/26/18, stated, ". . . We again discussed her blood sugar checks. She is now being checked three times a week. Family denied any further concerns and stated satisfaction with plans in place.<br><br>Nursing progress notes identified the following:<br>*11/29/18 at 4:28 p.m. "Fax sent to [name of provider] re: family wanted blood sugars to be done on resident, blood sugars have been running high. Copy of orders and blood sugars (sic) results sent with."<br>*11/30/18 at 3:30 p.m. "fax received from [name | F 580 | | |

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| F 580 | Continued From page 4<br>of provider]; new orders noted and observed."<br><br>Provider orders, dated 11/30/18, stated, "Repeat BMP (basic metabolic panel - a test which includes blood glucose levels) [and] A1C next wk [week]. Pending GFR [glomerual filtration rate (a test to measure how well the kidneys are filtering the blood) will adjust medication regimen RE: Metformin increase may be contraindicated w/ [with] low GFR"<br><br>Nursing progress notes identified the following:<br>*12/06/18 at 2:43 p.m. "[Name of provider] phones stated that resident blood sugar was critical on her labs and if we could recheck a blood sugar, blood sugar recheck here was 521 . . . resident is her usual self with no complaints, tires easily, rests often, this information was given to [provider], per [provider] all her labs were critical from blood draw on 12-5-18 and we will redraw them today. . . lab tech . . . here and drew blood without difficulty."<br>NOTE: (Laboratory results from blood drawn on 12/06/18 showed a Hemoglobin A1C of 13.8 [4.0 - 6.0] and glucose level of 541 [70 - 105].)<br>*12/07/18 at 6:29 p.m. - "[Name of provider] phones stating that resident needs to be put on insulin as resident hemoglobin a1c is 13.8, . . . spoke with [physician] making him aware of resident blood work . . . [name of physician] will phone [family member], . . . orders received for Levemir [type of insulin] 10 units b.i.d [twice a day] check blood sugars twice daily, fax an update of blood sugars to [provider]."<br>*12/08/18 at 11:22 a.m. "physician is aware that blood sugars are running high, resident was started on insulin, [family] aware." | F 580 | | |

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| F 580 | Continued From page 5<br>The facility failed to check Resident #3's blood glucose levels on Wednesday 11/19/18 and Saturday 11/22/18 as per provider order and failed to notify the provider of high blood glucose levels ranging from 380 to 523 until 11/29/18 (12 days after the initial blood glucose check). | F 580 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of facility investigation, review of personnel files, and policy/procedure review, the facility failed to ensure the resident received adequate supervision and assistance to prevent a fall with injury for 1 of 1 sampled resident (Resident #3) who experienced a fall from the facility van. Failure of the facility to ensure staff transporting Resident #3 provided the necessary supervision and assistance and completed the annual competency checklist resulted in Resident #3 experiencing a fall from the van, causing a hematoma to her right temple area and bruising on her right jaw and cheek.<br><br>Findings include:<br><br>Review of the facility policy, "Driver Requirements," occurred on 07/23/19. This | F 689 | 1. Staff member #2 will receive re-training on the Transporting Residents in Wheelchair Checklist and will continue to receive this training annually. Staff member #2 will also complete the Verification/Training Checklist annually.<br>2. All residents who are transported by facility to activities, appointments, or other outings have the potential to be affected by the same deficient practice.<br>3. All staff members who transport residents to and from facility will be retrained on the Wheelchair Checklist and Verification/Training Checklist on or before 9/6/19 and annually thereafter. All new drivers will have training completed prior to operation of facility vehicle.<br>4. Maintenance or designee will complete audits to ensure residents are | 9/6/19 |

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| F 689 | Continued From page 6<br>policy, revised May 2013, stated, "Purpose: To strive to provide high-quality and safe operation of owned/leased vehicles that are utilized for Society business. Policy: The operation of motor vehicles is secondary to our business. However with the operation of these vehicles comes the responsibility for the safety of the driver, passengers . . . All passengers must wear a seat belt. [last sentence printed in bold] . . . Driver Requirements: . . . 2. In addition to the requirements above, drivers operating . . .vehicles that contain wheelchair lifts, wheelchair securement systems and/or seat belt systems must complete the following: a. Prior to transporting residents or clients in the vehicle for the first time, the driver will be instructed on how to use the equipment and the vehicle in the proper manner. . . . c. Prior to a driver transporting residents in wheelchairs, a Transporting Residents in Wheelchairs Checklist . . . shall be satisfactorily completed. This checklist will ensure that the driver has a working knowledge of the wheelchair lift, wheelchair securement systems and accompanying seat belt systems. This checklist shall be completed prior to the initial trip and on an annual basis. . . ."<br><br>Review of Resident #3's medical record occurred on July 23, 2019. Nursing progress notes identified the following:<br>04/15/19 at 9:55 a.m. ". . . Called daughter to let her know that we received word that her mother had an incident while being transported to Dr. [doctor] visit this morning. . . . Resident was lowered to the ground until EMS [emergency medical system] arrived and transported resident to ER [emergency room]. . . ."<br>4/15/2019 10:30 a.m. ". . . Phone call received | F 689 | being secured into the facility vehicle. Audits will be completed weekly for one month, than monthly for 4 months, and every other month for 2 months. Quality Assurance committee will review audits during monthly quality meeting. Quality Assurance committee will ensure compliance.<br>5. Completion Date: 9/6/19 | |

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| F 689 | Continued From page 7 | F 689 | | |

from [daughter] re: [Resident #3's] fall. [Daughter] was at the ER with [resident]. . . . She then told me that they were doing a CAT [computed tomography] scan since she hit her head. [Daughter] also reported that [resident] was c/o [complains of] leg pain. They are going to be sending her to X-ray for the leg."
4/15/2019 1:30 p.m. "Received nurse to nurse [report] from ER. Resident has hematoma to right temple and some bruising to right jaw and cheek . . ."

Review of the emergency room record documentation for Resident #3, dated 04/15/19, stated, "Patient will grimace with movement of the hip. . . . Acute fall, acute forehead contusion, acute nonspecific right leg pain/hip pain. . . ."
X-rays of Resident #3's pelvis and hip showed no evidence of hip fracture or dislocation and the CT of the head showed no acute intracranial findings.

After return to the Souris Valley Care center on 04/15/19, facility staff performed neurological checks on the resident. Nursing progress notes identified the following:
4/15/2019 "Resident returned from ER . . . resident ate some of her lunch and was glad to be back. Resident was enjoying book club in activity room and talking during activity. . . . bruising to right, neuro check done within normal limits, resident states a little sore pain level at this time a 1 . . . "
4/16/19 "Resident up per usual with no complaints, denies hurting anywhere 'why do you ask me' alert and oriented to self . . ."
4/17/2019 ". . . phoned [daughter] to update re: incident review. . . . updated [daughter] that

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| F 689 | Continued From page 8<br>[Resident #3's] wheelchair rolled toward the side door of the van and her wheelchair wheel fell off the van step causing [the resident] and the wheelchair to fall into the side of the vehicle next to the van. [Resident #3] stayed in the wheelchair during this incident. [Resident #3] and the wheelchair were then lowered by [staff member #2] and the witness in the parking lot. [Resident #3] was then lowered to the ground as she was starting to slide out of the chair. . . We informed [daughter] that [staff member #2] has been educated to not remove safety restraints and/or wheelchair brakes until she is ready to move the resident and wheelchair onto vehicle lift. . . ."<br>4/17/19 ". . . alert and oriented to self, needs cuing to time and place, able to voice needs, . . . bruise remains to right side of the forehead and right jaw line, v/s [vital signs] and neuros within normal limits. . . "<br>4/19/19 ". . . writer completed a skin assessment on resident. Writer noted faded bruising to right side of forehead and cheek. No injury noted anywhere else on resident. Resident denied any pain."<br>5/02/19 ". . . [daughter] was questioning why her mom's face is still swollen, when looking at her right side of her face, continues to have a very slight bruise noted to mid cheek on the right, upon feeling the cheek, can feel a quarter size firm lump under the skin, informed the dtr [daughter] that is a hematoma and can take anywhere from one to 6 months to totally dissolve . . . "<br><br>Physician's Progress Notes, dated 4/24/19, stated, ". . . She was out of the building last week . . . for an appointment . . . and slipped from the van. She bumped her head. . . . She had some | F 689 | | |

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| F 689 | Continued From page 9 | F 689 | | |

bruising and abrasion above the eyebrow. No loss of consciousness was reported. She has had no problems since the incident. She essentially has returned to normal with no signs of any bruising or abrasion left at this point. . . ."

Review of the facility's investigation of the incident on 04/15/19 identified the following:
*The staff member (#2) parked the van in the parking lot and walked to the back of the van through the aisle [in the van] and unhooked the seat belt and straps from the wheelchair and unlocked the brakes. The staff member (#2) then opened the side door of the van to go around to open the back end with the lift. During this time, Resident #3's wheelchair had "moved up somehow" and "tilted out of the van." The wheelchair was slanted leaning up on the car to [the driver's] right side, the resident's head and shoulder was touching the car and her glasses were crooked. The staff member (#2) lowered resident to the ground to ensure safety of the resident until EMS arrived and noticed the resident had a bruise on the right side of her head.
*The facility interviewed a witness to the incident via phone call. The witness stated he was parked in front of the van in the parking lot and saw the incident happen. He stated that he saw the resident either roll forward or wheel forward in the van and the wheel caught the edge of the step and leaned out of the van hitting the car beside. Resident hit her head and right side against the car. He stated that the whole parking lot is at a slant or angle.

The staff member (#2) unhooked the seat belt and and straps, unlocked the wheelchair brakes

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| F 689 | Continued From page 10<br>and failed to close the side door after exiting the van to go open the back door.<br><br>Review of the staff member's (#2) personnel file identified the staff member had completed an initial "Verification/Training Checklist" in December of 2017. After the above incident, the staff member (#2) completed the "Transporting Residents in Wheelchairs Checklist" on 4/22/19. The facility provided no initial "Transporting Residents in Wheelchairs Checklist for the staff member (#2), nor an annual competency verification in 2018 for staff member (#2). After the incident, the facility completed annual competency verifications for all drivers on 04/16/19.<br><br>The facility failed to do the following:<br>* Ensure Resident #3 received the care and services necessary to attain the highest degree of safety possible while being transported via the facility van<br>* Ensure staff completed the initial and annual "Transporting Residents in Wheelchair Checklist"<br>* Perform Quality Assurance monitoring of staff providing van transport to ensure this type of incident did not occur again | F 689 | | |