

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/27/2024	
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			F 000			
F 760 SS=G	An unannounced onsite investigation survey regarding a facility reported incident and a complaint was completed on August 27, 2024. During the investigation of the incident the facility was found noncompliant with regulatory requirements. Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility reported incident investigation, and staff interview, the facility failed to ensure residents remained free from significant medication errors for 1 of 1 closed record (Resident #1) receiving insulin. Failure to administer insulin according to a physician's order may have contributed to Resident #1's hospitalization. This citation is considered past noncompliance based on review of the corrective action the facility implemented immediately following the incident. Findings include: The surveyor determined a deficient practice existed on 08/16/24. The facility implemented corrective action on 08/19/24 and completed staff education and began audits on 08/19/24. The final facility reported incident, dated 08/19/24 stated, ". . . it was determined there was a transcription error on admission for the long-acting insulin dose. Instead of having an 8			F 760	Past noncompliance: no plan of correction required.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/13/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 760	Continued From page 1 PM scheduled long-acting insulin dose it was entered as an 8 AM dose. . . ." Review of Resident #1's medical record occurred on 08/27/24 and identified an admission date of 08/16/24. The physician's orders dated 08/16/24, stated, ". . . Toujeo: [long-acting insulin] 7 units every day in the evening. . . ." Review of Resident #1's August 2024 medication administration record showed Toujeo 7 units in the morning. A nursing progress note, dated 08/17/24 at 8:48 a.m., stated: "Resident blood sugar this morning was "HI" on our accucheck [sic] machine [device to check blood glucose] . . . PAtient [sic] given PRN [as needed] fiasp [rapid-acting insulin] as well as scheduled Fiasp. She came down to 475. At 0700 [7:00 a.m.] her vitals were 138/64 [blood pressure], 97.9 [temp], 121 [heart rate], 18 [pulse], 96% [oxygen saturation] RA [room air]. Resident now has a low-grade fever of 99.6 and she is vomiting brown bile. Resident's daughter, [name], called. She would like resident sent to ER [emergency room] as well as resident requests to be seen by MD [medical doctor]. . . . Dr [name] ordered to send to ER for evaluation. Review of Resident #1's hospital discharge notes from hospitalization on 08/17/24 - 08/19/24 identified a discharge diagnosis of diabetic ketoacidosis (a complication of diabetes in which acids build up in the blood), dehydration, and hyperglycemia (elevated blood sugar). During an interview on 08/27/24 at 2:00 p.m., an	F 760			

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F 760	Continued From page 2 administrative nurse (#1) confirmed staff failed to administer Resident #1's long-acting insulin on the evening of 08/16/24. Based on the following information, noncompliance at F760 is considered past noncompliance. The facility implemented the corrective actions to ensure the deficient practice does not recur by: * The facility conducted an investigation on 08/19/24 with interviews of staff that determined the cause of the incident. Nursing staff failed to administer long-acting insulin as ordered due to a transcription error. * Provided 1 to 1 education on transcribing orders after the incident and on 08/19/24 with all nursing staff on insulin administration, blood glucose monitoring, and notification of change policy. Those not in attendance received education prior to start of their shift. * Suspended the nurse involved until the investigation was completed. * Reviewed medical records of all residents receiving insulin to ensure insulin administered at the appropriate time. * Implemented a secondary observer of management staff to review all new admission orders. * On 08/19/24 began audits on new admission orders, insulin administration, blood glucose monitoring, physician notification, and documentation of blood glucose parameters.			F 760			