STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355066	A. BUILDING _____ B. WING _____	C 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WISHEK LIVING CENTER	**400 S 4TH ST WISHEK, ND 58495**

(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 03/11/24 and concluded 03/13/24.	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 professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 resident (Resident #13) observed for insulin pen preparation. Failure to properly prepare insulin pens may result in the resident receiving an inaccurate dose of insulin. Findings include: Review of a professional online reference "Insulin Lispro single-patient-use pen" https://pi.lilly.com/insulin-lispro-kwikpen-us-ifu.pdf , occurred on 03/13/24. These instructions, dated July 2023, stated, "Pull off the outer needle shield . . . to prime your pen, turn the dose knob to select 2 units. Hold your pen with the needle pointing up [vertically]. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and "0" is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat	F 658	1. Corrective Action: Regarding all residents affected in this deficient practice; the protocol for proper insulin preparation has been reviewed with the nurse found to be completing the deficient practice as well as the rest of the nurses and MA-II staff. 2. Identification of Others: All residents receiving insulin have the potential to be affected by this deficient practice. 3. System Changes: We will continue to follow our current protocol of priming insulin pens in a vertical position. Education is provided to nurses and MA-II staff to ensure all current staff are aware of this protocol. We will also add this to our travel staff orientation check list for new nurses or MA-II's that will be working with us. 4. Monitoring: Director of nurse, QA nurse, or designee will observe a total of 4 nurses or MA-II's during medication pass for proper priming of insulin pens weekly x4, monthly x2, and quarterly x3. If	4/11/24

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

Electronically Signed | 04/02/2024

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F 658	Continued From page 1 priming steps . . ." Observation on 03/12/24 at 5:01 p.m. showed a nurse (#2) prepared Resident #13's insulin pen for administration. The nurse cleansed the tip of the pen with an alcohol swab, attached a needle and without removing the needle cap, dialed the insulin pen dose knob to 26 units (ordered stated 24 units), held the pen horizontally and expelled 2 units. The nurse (#2) failed to remove the needle cover, prime to 2 units only, and hold the device vertically to prime the pen. During an interview on 03/13/24 at 12:54 p.m., an administrative nurse (#1) stated, "She expected nursing staff to prime the insulin pens properly."	F 658	irregularities are noted, further education will be provided to that staff immediately. Results will be reviewed quarterly by the QA committee. QA monitoring will begin 4/15/24. 5. Corrective action will be complete and in place on 4/11/24.	
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, review of facility policy, and staff interview the facility failed to provide care and services for 1 of 1 closed record (Resident #43) reviewed with a change in health status and transfer to the emergency room (ER). Failure to assess and monitor the resident's changing condition resulted in a worsening of symptoms	F 684	1. Corrective Actions: Regarding all residents affected in this deficient practice; the resident that was affected by this deficient practice is no longer a resident of this facility and the nurse who was noted to complete this deficient practice is no longer an employee of this facility.	4/11/24

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F 684	Continued From page 2 and delay in emergency care. Findings include: Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 189, stated, ". . . the nurse is still responsible for identifying and responding to data that indicate real or potential medical problems. . . . and preventing development of the potential complication." Review of the facility policy titled "Notification of Changes" occurred on 03/13/24. This policy, dated November 2023, stated, "Policy: The purpose of this policy is to assure the resident, provider and or family member . . . is immediately informed . . . when there is a change requiring notification. . . . 2. Significant change in the resident's physical, mental, and psychosocial condition such as a deterioration in health . . . This may include: clinical complications. . . ." Review of Resident #43's medical record occurred on all days of survey. Diagnoses included dementia with other behavioral disturbances and adult failure to thrive. An admission Minimum Data Set (MDS), dated 12/28/23, identified substantial/maximal assist with activities of daily living (ADLs) such as eating, oral cares, hygiene, bathing, and dressing. Review of Resident #43's Emergency department (ED) physician's report, dated 02/28/24, stated, "HPI [history of present illness]: . . . CNA [certified nurse aide] told nursing staff the [sic] when she	F 684	2. Identification of Others: Due to this nurse no longer being employed here the immediate risk for other residents is low, however, all residents could potentially be affected by this deficient practice. 3. System Changes: Education was provided by DON on 3/20/24 to review the change of status policy and review the importance of completing assessments. Nurses will also participate in a training about change of status assessments between 4/4/24 and 4/10/24. Education will be completed by 4/11/24. 4. Monitoring: Director of Nursing, QA nurse, or designee will observe a nurse completing an assessment weekly x4, monthly x2, and quarterly x3. If irregularities are noted, further education will be provided to the nurse immediately. Results will be reviewed quarterly by the QA committee. QA monitoring will begin 4/15/24. 5. Corrective action will be complete and in place by 4/11/24.	

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F 684	Continued From page 3 checked the blood pressure it was 60s/40s [60s systolic over 40s diastolic] and pulse was 111 [beats per minute] . . . When seen in the ER there was . . . food particulate in the mouth . . . there was also a potassium pill in his mouth . . . Physical exam . . . Neurologic: No purposeful movement, Heart sounds: irregular, but appropriate, Lungs: clear sounds, Oropharynx: full of food particulate and pills. After it was cleaned out the mucosa was dry. . . . Assessment and Plan: Dehydration, Acute renal failure, and altered mental status . . . Plan: admit to inpatient." Resident #43's nursing notes showed the following: * 02/26/23 8:25 p.m. ". . . BP [blood pressure] 75/55 . . . noted to have difficult time with holding up his head . . . took medication with much attempts . . . writer did hold head up to take medication then resident would allow his head to drop down in front of him . . ." * 02/26/23 8:40 p.m. "BP 67/49 . . . lethargic . . . call to residents [sic] family . . . will call for ambulance . . ." Review of the facility's investigation and video evidence showed the nurse (#3) entered Resident $43's room at 6:44 p.m. with medication then stepped out to crush medications and re-entered at 6:49 p.m. At 7:45 p.m., the nurse (#3) entered the resident's room for the last time. At 9:12 p.m., video evidence showed the ambulance crew tranported the resident out of the facility. Review of facility investigation, dated 02/24/24, identified the following:	F 684		

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F 684	Continued From page 4 * Family Nurse Practitioner (FNP) (#6) called administrative staff member (#1) with ". . . grave concerns about [nurse #3 name] and her lack of assessment . . . he is upset that not only did she [nurse #3] not do a manual blood pressure before calling him, but that she [nurse #3] didn't even do the basic ABC's [airway, breathing, circulation] of assessments because his [Resident #43] airway was likely partially obstructed by all of the food that was pocketed in his mouth. . . ." * CNA (#4) stated, ". . . [nurse #3] told me to go ahead and lay him [Resident #43] down in bed as she [sic] was just hanging his head and not eating. . . . while in the lift . . . he went unresponsive . . . [nurse #3] said she [CNA #4] should lay [Resident #43] down and get his vitals . . . vitals were reported to name [nurse #3] . . . she [CNA #4] was not feeling comfortable with the situation and urged [nurse #3] 1 or 2 times to get him out of here . . . she felt the ambulance needed to be called as he did not look good. . . ." * Administrative staff member (#1) stated, ". . . [nurse #3] did not complete an assessment and relied completely on the reported vital signs from the CNAs. . . ." The facility's nursing staff failed to monitor Resident #43's declining condition to prevent the development of additional complications. During an interview on 03/13/24 at 12:54 p.m., an administrative staff member (#1) stated, "She expected nursing staff to complete a full assessment and verify the vital signs themselves."	F 684		