STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE DEVILS LAKE CARE CENTER	**302 7TH AVE NE DEVILS LAKE, ND 58301**

(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 and complaint survey started on 09/28/20 and concluded 09/30/20.	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 record review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 1 of 1 closed resident record (Resident #45) who experienced a serious injury. Failure to carry out physician's orders and complete neurological exams per facility policy following Resident #45's fall with head injury may result in adverse health effects. Findings include: PHYSICIAN'S ORDERS Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, stated, ". . . Carrying Out a Physician's Orders . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out . . . Documentation . . . Insufficient or inaccurate assessments and documentation can hinder	F 658	Part 1 1. Resident #45 expired on 04/22/2020 2. The facility has identified that all residents requiring a Physician follow-up appointment have the potential to be affected by this practice. 3. Unit secretary will receive all communications for physician follow-up appointments. She will add them to electronic facility wide calendar. She will keep interdisciplinary team (IDT) up to date during morning standup meetings. All Licensed Nursing staff and facility secretary will receive education on the process 10/21/2020. 4. An audit tool has been developed to monitor Physician ordered follow-up appointments for residents. The audit tool will be completed by the	11/13/20

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

Electronically Signed | 10/21/2020

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F 658	Continued From page 1 proper diagnosis and treatment and result in injury to the client. . . ." Review of Resident #45's medical record occurred on all days of survey and included diagnoses of quadriplegia, traumatic brain injury, and left proximal humerus (bone in the upper arm) fracture. An orthopedic progress note, dated 03/06/20, identified to follow-up in 4 weeks with shoulder x-ray. The medical record lacked evidence of a follow-up appointment for Resident #45. During an interview on 09/30/20 at 2:20 p.m. an administrative nurse (#1) confirmed the facility failed to schedule a follow-up appointment with shoulder x-ray for Resident #45. NEUROLOGICAL STATUS Review of the facility policy titled "Falls - Resident" occurred on 09/30/20. This policy, revised September 2019, stated, ". . . if the resident has hit their head vital signs and neuro [neurological] checks will be completed as follows: initial assessment, every 15 minutes' x 4, every 30 minutes' x 2, every hour x 2, and then every 8 hours x 9. . . . Documentation: Complete neuro checks and document using the Neuro Check Flow Sheet Assessment in [electronic medical record]. . . ." Review of the nurses' progress notes showed the following: *04/19/20 at 6:35 a.m. ". . . Resident fell to the floor during transfer using a Hoyer lift . . ." *04/19/20 at 8:03 a.m. ". . . writer explained that	F 658	Director of Nursing or designee 4X week for 1 month, 2X a week for two months, 1X week for 3 months and then quarterly for a year. 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 11/13/2020. Part 2 1. Resident #45 expired on 04/22/2020 2. The facility has identified all residents who require neurological checks after an unwitnessed fall or when the resident falls and hits their head have the potential to be affected by this practice. 3. Anytime resident requires neurological check, the nurses will use a written flowsheet that follows our policy and procedure. They will document the findings from the flowsheet to the electronic record. The nurse will turn flowsheet into resident care manager for review. All Licensed Nursing staff will receive education on the process, policy and procedure regarding Falls-Resident on 10/21/2020. 4. An audit tool has been developed to monitor neurological checks. The audit	

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F 658	Continued From page 2 [the resident] was being transferred from bed to w/c [wheelchair] and one of the jacket straps came unhooked while [the resident] was hooked up to machine. writer told her that [the resident] did hit his head and [the resident] does have a bump on the left side of his head, [the resident] also c/o [complains of] pain in left hip. [Facility Provider] was informed of incident, res [resident] complaints of pain and injury to head so a CT [computerized tomography] scan was ordered. writer stated that res was on his way to hospital now. . . . writer also told her that [the resident] will be monitored closely and will be doing neuro assessments for next 72 hours. [Family member] verbalized understanding and requested that as soon as [we] have more information to please call back and update." *04/19/20 at 9:45 a.m. "writer spoke with [Facility Provider] regarding res CT scan results. she states that res does not have any broken bones, but does have a bleed in brain. . . . she states staff need to monitor res closely and to continue neuro assessments per facility policy. she also states if res has a change in status or concerns arise to notify her immediately." Staff completed neuro check flow sheets per policy except for 04/19/20 at 6:35 p.m., and 04/21/20 at 10:35 a.m. and 6:35 p.m. During an interview on 09/30/20 at 2:20 p.m., an administrative nurse (#1) agreed staff failed to complete the neuro checks per policy.	F 658	tool will be completed by the Director of Nursing or designee 4X a week for 1 month, 2X a week for two months, 1X a week 3 months and then quarterly for a year. In the event no residents have been receiving neurological checks the auditor will audit licensed nursing staff competency on policy and procedure. 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 11/13/2020.	
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 -	F 689		

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F 689	Continued From page 3 §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 record review, review of facility policy, and staff interview, the facility failed to provide appropriate and sufficient supervision to prevent accidents for 1 of 1 closed resident record (Resident #45) who required total assistance with transfers. Failure to safely utilize an electronic lift with a sling resulted in a fall with serious injury for Resident #45, and placed all residents requiring this type of transfer at risk for accidents and/or injury. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident. Findings include: Review of the facility policy titled "Hoyer Lifts - EZ Way" occurred on 09/30/20. This policy, revised September 2020, stated, "1. Choose the style of the sling to be used: The divided leg sling is the most common and should be used with residents who have 2 full legs. . . . 7. Two staff members must be present when operating the Hoyer lift. One person's job is to handle the lift and the other person's job is to assist the resident while the transfer is occurring. . . . 8. Transfer from bed to chair: . . . Attach the straps on the sling to the lift ensuring that the strap is 'nesting' in the bottom of the hook. Begin lifting the resident using the 'up' button. Once there is slight tension	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 4 on the straps check to make sure that all four loops are still nested in the bottom of the hooks. . . ." Review of Resident #45's medical record occurred on all days of survey. The current care plan stated, ". . . TRANSFER: I use the total lift, total assist of 2 staff full body sling. . . ." The progress notes identified the following: *04/19/20 at 6:35 a.m., ". . . Resident fell to the floor during transfer using a Hoyer lift about 2 feet from the ground. . . ." *04/19/20 at 7:33 a.m., "[Facility Provider] has been notified at 06:45 [a.m.]. DON [Director of Nursing] and Nurse Manager has [sic] been notified." *04/19/20 at 7:34 a.m., "Resident has cold pack applied to the left parietal [side of skull] area as per PMD [primary medical doctor] order and PRN [as needed] Hydrocodone [pain medication] given." *04/19/20 at 8:03 a.m., "writer spoke with [family member name], and informed her of fall. writer explained that [resident] was being transferred from bed to w/c [wheelchair] and one of the jacket straps came unhooked while [resident] was hooked up to machine. writer told her that [resident] did hit his head and [resident] does have a bump on the left side of his head, he also c/o [complained of] pain in left hip. [Facility Provider] was informed of incident, res [resident] complaints of pain and injury to head so a CT [computed tomography] scan was ordered. writer stated that res was on his way to hospital now. . . . writer also told her that he will be monitored closely and will be doing neuro [neurological] assessments for next 72 hours. . . ."	F 689		

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F 689	Continued From page 5 *04/19/20 at 9:45 a.m., "writer spoke with [Facility Provider] regarding res CT scan results. she states that res does not have any broken bones, but does have a bleed in brain. . . . she states staff need to monitor res closely and to continue neuro assessments per facility policy. she also states if res has a change in status or concerns arise to notify her immediately." *4/20/20 at 10:35 a.m., "Resident is on follow up fall monitoring with neuro checks. Neuro checks performed and found pupil response to be a 3 but sluggish. Strength to extremities unable to accurately measure due to contortion. Vitals obtained and found that resident is tachycardic with a pulse of 102. All other vitals WNL [within normal limits] for resident at this time. Resident did express pain through grunting when asked, PRN Morphine [pain medication] given at the time. We will continue to monitor further and report any changes or concerns." *04/20/20 at 4:15 p.m., "Writer into residents room. Resident not responding to verbal stimuli. Resident will follow residents [sic] finger from side to side. Temp noted to be 100.4. Cool wash cloth placed on residents forehead and PRN tylenol suppository given, . . . Respirations noted to be at 22, PRN morphine sulfate given,. . . Resident did respond to tylenol suppository by grunting." *04/20/20 at 10:38 p.m., "Call to [Provider Name] and updated on [family member name] decision for code level 2." *04/21/20 at 5:29 a.m., "Resident is unresponsive, he has a gurgling breathing, PRN Atropine [medication given for increased secretions] given and it's relieving the symptoms. He is in respiratory distress and in pain. PRN Morphine is administered. . . ."	F 689		

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F 689	Continued From page 6 *04/21/20 at 3:35 p.m., "Resident is unresponsive at this time. Seizure activity noted during the day today. PRN Lorazepam was administer IM [intramuscular] after seizure activity. PRN was effective for seizure. PRN Morphine administered today for noted pain and respiratory distress. . . ." *04/22/20 at 3:11 p.m., "Resident continues to be unresponsive at this time. Seizure activity noted in later morning. Resident was noted to have a seizure every 30-40 mins [minutes] ranging from 25 secs [seconds] to 45-50 sec. PRN Lorazepam was administer IM after noted seizure activity. PRN was ineffective at this time for seizures. PRN Morphine administered today for noted pain and respiratory distress. . . ." *04/22/20 at 10:43 p.m.,"res [resident] had no pulse, respirations or BP [blood pressure]. . . .RN [registered nurse] left message with [Facility Provider] regarding death. . . ." During an interview on 09/30/20 at 12:20 p.m., an administrative nurse (#1) stated the facility implemented corrective action and follow up after the fall. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented the corrective action for the resident affected by the deficient practice by: *Completing an investigation with interviews of staff who assisted with the transfer on 04/19/20. *Determining the investigation showed staff failed to follow EZ-Way Hoyer lift policy and resulted in a resident's fall with serious injury. *Inspecting the EZ-Way Hoyer lift and sling involved immediately following the incident and finding the equipment to be in good working	F 689		

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F 689	Continued From page 7 condition. *Providing 1 on 1 education (video) immediately after the incident with involved staff regarding proper use of EZ-Way Hoyer lift and sling with return demonstration to the DON. The facility addressed measures put in place and implemented systemic changes to ensure the deficient practice does not recur by: *Providing education to all nursing staff on proper EZ-Way Hoyer lift transfers from 04/20/20 - 04/23/20. *Auditing EZ-Way Hoyer lift transfers starting on 04/22/20. The facility completed audits monthly for 3 months and continued at random. The survey team determined a deficient practice existed on 04/19/20. The facility implemented corrective action on 04/19/20 and completed nursing education on 04/23/20.	F 689		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		11/13/20

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F 761	Continued From page 8 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: SECURE MEDICATION STORAGE 1. Based on observation and staff interview, the facility failed to store all medications in a secure manner on 2 of 3 days of survey (09/28/20 and 09/30/20). Failure to store all medications in a secure manner may result in unauthorized access to medications and/or medication errors. Findings include: Observations during the survey showed the following: * 09/28/20 at 03:35 p.m., a bottle of acetaminophen 325 milligram (mg) tablets left unattended on top of the medication cart located in the hallway outside the West nurses' station and out of the staff nurse's (#3) direct sight * 09/28/20 at 5:10 p.m., a medication cart located in the hallway outside the North nurses' station left unlocked and out of the staff nurse's (#2) direct sight * 09/30/20 at 7:54 a.m., a medication cup, containing 4 different medications, left unattended on top of the medication cart located in the hallway outside the West nurses' station	F 761	Part 1 1. Facility determined no residents were affected from the identified incidents. 2.The facility has identified that all residents have the potential to affected by this practice. 3.Nurses/Medication Assistants will ensure that all medications are placed in cart and locked prior to walking away from cart. All Licensed Nursing staff & Medication Assistants will receive education on 10/21/2020 regarding secure medication storage. 4. An audit tool has been developed to monitor secure medication storage. The audit tool will be completed by the Director of Nursing or designee 4X a week for 1 month, 2X a week for two months, 1X a week 3 months and then quarterly for a year.	

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F 761	Continued From page 9 where residents passed to and from breakfast. A licensed staff nurse (#4) returned to the cart approximately 5 minutes later, retrieved the medication cup, and walked down the hall During an interview on 09/30/20 at 04:00 p.m. an administrative nurse (#1) stated she expected medications secured at all times. LABELING OF INSULIN 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure accurate labeling and disposal of insulin for 3 of 3 residents (Resident #4, #15, and #27) observed during medication pass. Failure to correctly label and dispose of insulin may increase the risk of residents receiving an inaccurate dose of insulin and/or reduced medication efficacy. Findings include: Review of the facility policy titled "Medication Administration Information" occurred on 09/30/20. This policy, revised October 2019, stated, ". . . Multi-dose vials must be labeled with the date opened and expiration date. . . ." - Observation on 09/28/20 at 5:17 p.m. showed a staff nurse (#2) draw up 16 units of Novolog insulin from an open multi-dose vial to administer to Resident #15. The vial had a hand written date of 09/26/20 on it. The staff nurse (#2) confirmed it was the opened date and the vial lacked an expiration date. - Observation on 09/28/20 at 5:28 p.m. showed a	F 761	5.Compliance will occur on or before 11/13/2020. Part 2 1. Residents #4, #15 and# 27 had labels on insulin that did not match current physician orders. Labels on current insulin and additional supply were replaced by Pharmacist on 10/2/20. Insulin was noted to be missing an expiration date. Expired insulin was pulled from the cart. Resident who received expired insulin had no known adverse effects. Expiration dates have been added to all open vials. 2. The facility has identified all residents receiving insulin have the potential to be affected by this practice. 3. When a nurse receives a new insulin order, they will enter order into TAR. Current vial and stock supply will be taken to pharmacy for new label directions to be placed on supply. All opened insulin vials will have an open and an expiration date noted. All Licensed Nursing staff will receive education on 10/21/2020 regarding labeling of insulin. 4. An audit tool has been developed to monitor accurate labeling and disposal of insulin. The audit tool will be completed by the Director of Nursing or designee 4X	

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F 761	Continued From page 10 staff nurse (#2) prepare to administer a three times a day (TID) scheduled Humalog insulin to Resident #4. The staff nurse (#2) discovered the vial opened for longer than 28 days. The Humalog vial had an opened date of 08/28/20 and an expiration date written on the box of 09/26/20. The staff nurse (#4) agreed the staff utilized the vial of Humalog insulin for two to three days past the expiration date. - Observation on 09/28/20 at 5:28 p.m. showed the label on Resident #4's Humalog insulin box identified Humalog insulin 5 units (TID). A staff nurse (#2) administered Humalog 8 units before supper. During the observation, the staff nurse (#2) agreed the label did not match the current physician's order. Review of Resident #4's physician orders showed the physician changed the Humalog insulin dosage from 5 units to 8 units on 08/12/20, 48 days prior to the 09/28/20 observation. - Observation on 09/29/20 at 9:35 a.m. showed the label on Resident #27's Novolog insulin box identified Novolog 8 units before breakfast, and 6 units before lunch and supper. The multi-dose Novolog vial had an opened date of 08/31/20, with no expiration date noted on the vial. A staff nurse (#4) administered Novolog 8 units before breakfast. During observation, the staff nurse (#4) agreed the label did not match the current physicians order and the multi-dose vial lacked an expiration date. Review of Resident #27's physician orders showed the physician changed the Novolog	F 761	a week for 1 month, 2X a week for two months, 1X a week 3 months and then quarterly for a year. 5. Compliance will occur on or before 11/13/2020.	

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F 761	Continued From page 11 insulin dosage from Novolog 8 units before breakfast, and 6 units before lunch and supper, to Novolog 8 units before breakfast and lunch, and 6 units before supper on 08/15/20, 46 days prior to the 09/29/20 observation.	F 761		