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	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Souris Valley Care Center	300 Main St S Velva, ND 58790

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31725 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 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 admitted [DATE]. 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. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's hospital discharge notes from hospitalization on [DATE] - 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 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.