STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8027	A. BUILDING _____ B. WING _____	04/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BORG PIONEER MEMORIAL HOME	61 BORG DR MOUNTAIN, ND 58262

(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) COMPLETE DATE
B 000	INITIAL COMMENTS For the unannounced licensure survey started on April 23, 2018 and completed on April 25, 2018, the sample included 10 residents for complete review and two closed records for review. In addition, the sample included three supplemental residents to verify specific concerns during the survey. Tier II citations included B0927, B1320, and B1540.	B 000		
B 927	33-03-24.1-09,2,g GOVERNING BODY g. Resident rights which comply with North Dakota Century Code chapter 50-10.2. This state licensing rule is not met as evidenced by: Based on observation, review of facility policy, review of the North Dakota Resident's Rights Guide, and staff interview, the facility failed to provide privacy during insulin adminstration for 2 of 2 sampled residents (Resident #5 and #15) who received insulin. Failure to ensure privacy during medical treatments is a violation of residents' rights. Findings include: The North Dakota Resident's Rights Guide, dated January 2016, page 10, stated, ". . . Personal & Privacy Rights . . . You have the right to privacy in medical treatment and personal care along with confidentiality of those records. . . ." Review of the facility policy titled "Insulin Adminstration - Syringe," occurred on 04/25/18.	B 927	Resident # 5 and #15, as well as all other residents who receive insulin, will be assured that privacy will will be provided when insulin administrated. Insulin administration policy reviewed. 4/26/18 No changes to policy In-service on resident right to privacy during medical treatments including insulin 4/26/18 administration to be completed by med techs. Administrator or DON will monitor that residents receiving insulin (including residents #5 and 15) to assure that privacy is provided during insulin administration. Monitoring will be completed weekly for 4 weeks Monthy x3 then quarterly for one year. If concerns are identified, immediate corrective action will be implemented.	

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

Tom Byron, Administrator 5-10-18

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B 927	Continued From page 1 This undated policy stated, ". . . Obtain insulin . . . Provide for resident privacy. . . ." Observation of medication administration occurred on 04/23/18 at 11:41 a.m. The certified medication assistant (CMA) (#1) administered insulin to Resident #15 (in the upper arm) at the dining room table with other residents present. At 11:48 a.m., the CMA (#1) administered insulin to Resident #5 (in the abdomen) at the dining room table with other residents present. During an interview on the afternoon of 04/24/18, a supervisory nurse (#2) identified the staff are taught to offer privacy to residents during insulin administration.	B 927		
B1320	33-03-24.1-13,2 RESIDENT RECORDS 2. Resident records must include: a. The resident's name, social security number, marital status, age, sex, previous address, religion, personal licensed health care practitioner, dentist, and designated representative or other responsible person. b. The licensed health care practitioner's orders and report of an examination of the resident's current health status. c. An admission note. d. A copy of an initial and current assessment and care plan. e. Documentation of resident observations by authorized staff.	B1320		

North Dakota Department of Health

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B1320	Continued From page 2 f. Documentation of death, including cause and disposition of the resident's personal effects, money, or valuables deposited with the facility. g. A quarterly progress note documenting the resident's current health condition, level of functioning, activity involvement, nutritional status, psychosocial interactions, and needs. h. Documentation of review of prescribed diets. i. Transfer forms that are completed, signed, and sent with the resident when transferred to another facility. j. A medication administration record documenting medication administration consistent with applicable state laws, rules, and practice acts. k. Documentation of an annual medication regimen review. l. A written report of any funds kept at a resident's request. Such record shall show deposits to and withdrawals from the fund. m. Documentation of a fire drill walk-through within five days of admission. n. All agreements or contracts entered into between the facility and the resident or legal representative. o. A discharge note.	B1320	For Resident # 4 and # 8 and all residents that are transferred to ER or sent to another facility will have documention in record that necessary medical information was provided to ensure appropriate care and treatment at the receiving facility. The current policy regarding transfer to hospital (ER) revised. See attached. (A) Appropriate staff will inserviced on documentation requirement. Currently only applicable to DON and Administrator,both aware. cont>	5-8-18

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B1320	Continued From page 3 This state licensing rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a complete medical record regarding transfer forms for 2 of 2 sampled residents (Resident #4 and #8) with transfers to the emergency room (ER). Failure to complete transfer forms with necessary medical information limits staff's ability to ensure appropriate care and treatment at the receiving facility. Findings include: Review of Resident #4 and #8's medical records identified the following transfers to the ER: *Resident #4: 03/02/18 *Resident #8: 02/09/18 and 02/24/18 The above records lacked evidence of transfer forms/information sent with residents upon their transfers to the ER. During an interview on the afternoon of 04/24/18, a supervisory nurse (#2) identified staff send medical information along with residents, but do not document that in the record.	B1320	DON or Administrator will monitor all records of residents that are transfered to ER or hospital to assure appropriate information has been provided and that this has been documented in the resident record. If concerns are identified, immediate corrective action will be implemented.	
B1540	33-03-24.1-15,4 PHARMACY/MED ADM SERVICES 4. All medications used by residents which are administered or supervised by staff must be: a. Properly recorded by staff at the time of administration. b. Kept and stored in original containers	B1540		

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B1540	Continued From page 4 labeled consistently with state laws. c. Properly administered. This state licensing rule is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure accurate labeling of medications for 1 of 7 residents (Resident #1) observed during medication administration. Failure to ensure medication labels match the physician's orders may result in medication errors. Findings include: Review of the facility policy titled "Borg Home Pharmacy Services" occurred on 04/25/18. This undated policy stated, ". . . The Borg Home will verify the receipt of the correct medications as ordered. Discrepancies and omissions are reported promptly to the pharmacy provider. . . ." Observation of Resident #1's medication pass occurred on 04/23/18. The label on the medication card identified clonazepam (an anti-seizure/anxiety medication) 0.5 milligram (mg) tablets, with the instructions "Take 1 and 1/2 tablets (1.5 mg) by mouth four times daily." The medication administration record (MAR) and physician's order both identified clonazepam 0.75 mg four times daily. Observation of the four medication cards (one each for morning, noon, afternoon, and bedtime passes) for clonazepam identified this discrepancy. During an interview on the afternoon of 04/24/18, a supervisory nurse (#2) stated the pharmacy	B1540	For Resident # 1 and all residents that receive medications, Borg Home will verify that pharmacy labels are accurate and match physician orders to prevent possible medication error. Pharmacy notified of label error 4/25/2018 and they placed new correct label on medication card for Resident #1 (Attach B) 4/26/18 All medications were double checked against MAR for accuracy and matched Dr orders 5/1/18 by DON Administrator or DON will monitor medication labels for resident #1 and a sampling of residents on medication exchange day and new orders to assure accuracy. Monitoring will be completed weekly x4 Monthly x3 then quarterly x 1 year If concerns are identified, immediate corrective action will be implemented.	