1-13-11

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

PRINTED: 01/12/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355058	A. BUILDING _____ B. WING _____ JAN 13 2011	C 12/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HOME INC	1100 E BOULEVARD AVE BISMARCK, ND 58501

(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 For the complaint survey started on November 30, 2010 and completed on December 1, 2010 the sample included 8 residents for focused review, and 1 closed record for review. The sample included 3 additional residents to verify specific concerns during the survey.	F 000	1-13-10 Per TC c Sandy Fixler Don, this POC replaces the one Rec'd 12-29-10 and the completion date for all tags is 1-27-11 K Sadler (w)	
F 281 SS=G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to meet professional standards of quality for 1 of 1 resident (Resident #9) selected for closed record review. Failure to follow professionally accepted standards of practice regarding medication administration resulted in Resident #9 receiving an excessive dose of a potentially lethal medication (morphine sulfate) and an admission to the emergency department (ED). Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 8th Edition, dated 2008, page 842, states, ". . . The nurse should always question the primary care provider about any order that is ambiguous, unusual (e.g., an abnormally high dosage of a medication), or contraindicated . . ." Page 846 states, ". . . Nurses who administer medications are responsible for their own actions. . . . Be knowledgeable about the medications you administer. You need to	F 281	F281 Baptist Home will comply with the Professional Standards of Care, including a specific focus on standards for medication administration. Resident #9 has been discharged. The nurses involved in the medication transcription, processing orders and medication pass were counseled on medication processing and medication pass upon further investigation and additional education; presently are being audited daily by nurse manager in the above areas for compliance until 100% accuracy of all transcriptions for 1 month, (zero tolerance for error). Random audits will be completed weekly for 1 month and monthly for 3 months. Reports will be presented	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bridget Kemble	Administrator	1/13/2011

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 281	Continued From page 1 know why the client is receiving the medication. Look up the necessary information if you are not familiar with the medication. . . ." Lippincott, Williams, and Wilkins, "Nursing 2011 Drug Handbook", pages 760-761, states, ". . . morphine sulfate [i.e. MS Contin] . . . INDICATIONS AND DOSAGES . . . Severe pain . . . For extended-release tablet, give 15 or 30 mg [milligrams] PO [by mouth] every 8 to 12 hours. . . . ADVERSE REACTIONS . . . CNS [central nervous system]: . . . dizziness, sedation, seizures . . . Respiratory: apnea, respiratory arrest, respiratory depression . . . CAUTIONS . . . Use with caution in elderly or debilitated patients . . . Overdose S&S [signs and symptoms] . . . CNS depression, respiratory depression, hypotension . . . NURSING CONSIDERATIONS . . . Monitor circulatory, respiratory, bladder, and bowel functions carefully. Drug may cause respiratory depression, hypotension, . . . altered level of consciousness regardless of the route. If respirations drop below 12 breaths/minute, withhold dose and notify prescriber." Review of Resident #9's medical record occurred on 12/01/10. Diagnoses included chronic pain and hypertension. A notification to the resident's provider, dated 09/25/10, identified a request from facility staff for scheduled pain medication for Resident #9. A health care provider order, dated 09/27/10, identified a new order for MS Contin sustained release tablet 60 mg po bid (twice a day). Licensed nurses administered the first dose of MS Contin at or around 8:00 p.m. on 09/28/10, and a second dose of MS Contin at or around 8:00 a.m. on 09/29/10. Review of Nurses' Notes revealed the following:	F 281	at the Quality Assurance Committee meeting. All The medications will be checked for all nurses with the Lippincott, Williams, and Wilkins Nursing 2011 Drug Handbook, to assure that dosage and strength are within the accepted parameters. The facility's consultant pharmacist, (Mayo Pharmacy), will be notified per his request to review all medication orders for appropriate medication and dosage. Mayo Pharmacy utilizes Data Stat Pharmacy Management Systems which provides pharmaceutical information such as dosage parameters, contraindications etc. Nursing administration will sign monitor sheet, stating the medication order was reviewed and appropriate medication will be administered to facility resident. Consultant Pharmacist Dan Mayo presented a pharmacy in service entitled "Review of Narcotic Drugs and Doses" on December 14th 2010. Any order that exceeds these parameters will be verified by prescribing physician/NP/PA, prior to processing order. Licensed staff is being mandated per T.C. w Deb Larson/ Sandy Fuchs/ DON 1/19/11 9 am PA Lawson	

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F 281	Continued From page 2 *09/29/10 at 1:31 p.m.: . . . fax sent to [physician name] that resident does not want to take the MS Contin that was ordered because he said it makes him feel light headed and he can't think right . . ." *09/29/10 at 5:00 p.m.: ". . . telephone call from [physician name] to DC [discontinue] MScontin [sic]. . . ." *09/29/10 at 6:09 p.m.: ". . . Resident not 'feeling like himself'. . . . Assessed, resident in recliner and declined to come to dining room for supper . . ." (No evidence of vital signs recorded during this time frame.) *09/30/10 at 12:24 p.m.: ". . . Wet respirations 7 at rest, decreased Level of Consciousness, does not make eye contact unless specifically requested, speech garbled. Uncontrolled left sided twitching. Call to [physician name] with orders to send to ER [emergency room]. . . ." Vital signs at this time included a respiratory rate of 7 breaths per minute and a blood pressure of 97/60 mmHg (millimeters of mercury, a measurement of pressure), a decreased reading for this resident. *09/30/10 at 1:25 p.m.: Vital signs included a respiratory rate of 7 breaths per minute and a blood pressure of 96/60 mmHg. *09/30/10 at 4:32 p.m.: ". . . Resident returned from ER . . . resident remains confused, paranoid . . ." *10/01/10 at 2:20 a.m.: Vital signs included a respiratory rate of 6 breaths per minute. *10/01/10 at 5:08 a.m.: ". . . resident has been sleeping all night. . . . respirations 6-8 at beginning of shift, resps [respirations] are now 10-12 most of the time. . . ." Documentation indicated emergency department staff evaluated Resident #9 for decreased respiratory status, decreased level of	F 281	to refer to Nursing 2011 Handbook for further compliance. Additional inservices are scheduled for processing, administering all medications as well as standard and routine dosage on 1-25-2011. Also included will be the definition of a medication error relative to...Preparation, Administration of drugs or biological which is not in accordance with physician orders; manufacturer's specification, or accepted professional standards and principals. Corporate Quality Assurance nurse will present the inservice on 1-25-2011 the role of the nurse in regards to assessment of pain, and pain management within the parameters of the Nurse Practice Act, set forth by the North Dakota Board of Nursing. Procedures of medication administration should be reviewed as set forth by "The Fundamentals of Nursing" Potter and Perry Seventh Edition, Published by Mosby. per T.C. with Deb Larson/ Sandy Fischer Dord 1/18/11 9 am RDuran	

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F 281	Continued From page 3 consciousness, and left sided twitching. Vital signs obtained in the ED included a blood pressure of 97/60 mmHg and a respiratory rate of 7 breaths per minute. The ED physician documented a diagnosis of "Iatrogenic [induced inadvertently] OD [overdose]". A discharge plan signed by the ED physician stated, ". . . You have been evaluated and/or treated for: Morphine Overdose. Reduce MS Contin to 15 mg twice per day. . . ." During an interview on 12/01/10 at 4:05 p.m., an administrative nurse (#1) stated she expected nurses to review new medication orders and "look it [the medication] up if it's unfamiliar." She agreed the dose of morphine sulfate ordered and administered was an excessive dose. The administrative nurse stated it is "a part of nursing practice" to question unclear medication orders. Failure of facility staff to ensure the dose of morphine sulfate ordered was appropriate before administration of the medication resulted in Resident #9 receiving two excessive doses of morphine sulfate and experiencing severe respiratory depression, which then resulted in an admission to the emergency department.	F 281	All new orders received by nursing personal will be reviewed by nurse administration, daily for 1 month, weekly for 1 month and randomly for 3 months. Monthly nurses meetings for the months of Jan, Feb, and March will have a presentation by pharmacy regarding topics related to the role of the nurse and medication administration.	1-27-11 KF
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	F329 Resident's drug regimen must be free from unnecessary drugs. Resident #9 had been discharged.	

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F 329	Continued From page 4 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to ensure a drug regimen free from unnecessary medications for 1 of 1 resident (Resident #9) selected for closed record review. The administration of an excessive dose of a potentially lethal medication (morphine sulfate) resulted in Resident #9's admission to the emergency department (ED). Findings include: The Centers for Medicare and Medicaid Services, State Operations Manual, gives the following definition for "excessive dose": ". . . the total amount of any medication (including duplicate therapy) given at one time or over a period of time that is greater than the amount recommended by the manufacturer's label, package insert, current standards of practice for a resident's age and	F 329	Baptist Home requires licensed staff to monitor the effectiveness, side effects for pain medications, and psycho-pharmacologic medications as well as resident being free from unnecessary drugs. **F329 Unnecessary Drug Inservice for Licensed Staff** ~~February 8, 2011~~ January 25, 2011; to be presented by consulting pharmacist. Mayo Pharmacists will review ALL medication physician/NP/PA orders to ensure the pharmaceutical guidelines prior to processing, Nurse Manager will audit **(INITIAL ORDERS ONCE REVIEWED)** daily for **30** days for **ZERO** tolerance then proceed to random weekly audits for **1** month and monthly for **3** months. Consultant Pharmacists will maintain **MONTHLY** reviews and periodic consulting. Mayo Pharmacy is located in the Baptist Home facility, and a Pharmacist is in house Monday thru Saturday for consultation and advice they are available 24hrs a day 7 days a week per phone. A Mayo Pharmacy Pharmacist makes daily rounds to each TC. with per Deb Larson/ Sandy Fischer, DON 1/19/11 9 am PJ Larson	

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F 329	Continued From page 5 condition, or clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals . . ." Lippincott, Williams, and Wilkins, "Nursing 2011 Drug Handbook", pages 760-761, states, ". . . morphine sulfate [i.e. MS Contin] . . . INDICATIONS AND DOSAGES . . . Severe pain . . . For extended-release tablet, give 15 or 30 mg [milligrams] PO [by mouth] every 8 to 12 hours. . . . ADVERSE REACTIONS . . . CNS [central nervous system]: . . . dizziness, sedation, seizures . . . Respiratory: apnea, respiratory arrest, respiratory depression . . . CAUTIONS . . . Use with caution in elderly or debilitated patients . . . Overdose S&S [signs and symptoms] . . . CNS depression, respiratory depression, hypotension . . . NURSING CONSIDERATIONS . . . Monitor circulatory, respiratory, bladder, and bowel functions carefully. . . ." Review of Resident #9's medical record occurred on 12/01/10. Diagnoses included chronic pain and hypertension. A notification to the resident's provider, dated 09/25/10, identified a request from facility staff for scheduled pain medication for Resident #9. A health care provider order, dated 09/27/10, identified a new order for MS Contin extended release tablets 60 mg po bid (twice a day). Licensed nurses administered the first dose of MS Contin at approximately 8:00 p.m. on 09/28/10, and a second dose of MS Contin at approximately 8:00 a.m. on 09/29/10. Review of Nurses' Notes revealed the following: *09/29/10 at 1:31 p.m.: . . . fax sent to [physician name] that resident does not want to take the MS Contin that was ordered because he said it makes him feel light headed and he can't think	F 329	nursing unit Monday through Saturday. Mayo Pharmacy will conduct monthly in services at regular scheduled meetings for the months of Jan, Feb, and March regarding topics related to the role of the nurse, medication administration and duplication of medications. Additional medication audits will be conducted by the Elim Corporate Quality Assurance Nurse and reports to the Quality Assurance Committee. The Director of Nursing is responsible for compliance. 1-27-11	

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F 329	Continued From page 6 right . . ." *09/29/10 at 5:00 p.m.: ". . . telephone call from [physician name] to DC [discontinue] MScontin [sic]. . . ." *09/29/10 at 6:09 p.m.: ". . . Resident not 'feeling like himself'. . . . Assessed, resident in recliner and declined to come to dining room for supper . . ." (No evidence of vital signs recorded during this time frame.) *09/30/10 at 12:24 p.m.: ". . . Wet respirations 7 at rest, decreased Level of Consciousness, does not make eye contact unless specifically requested, speech garbled. Uncontrolled left sided twitching. Call to [physician name] with orders to send to ER [emergency room]. . . ." Vital signs at this time included a respiratory rate of 7 breaths per minute and a blood pressure of 97/60 mmHg (millimeters of mercury, a measurement of pressure), a decreased reading for this resident. *09/30/10 at 1:25 p.m.: Vital signs included a respiratory rate of 7 breaths per minute and a blood pressure of 96/60 mmHg. *09/30/10 at 4:32 p.m.: ". . . Resident returned from ER . . . resident remains confused, paranoid . . ." *10/01/10 at 2:20 a.m.: Vital signs included a respiratory rate of 6 breaths per minute. *10/01/10 at 5:08 a.m.: ". . . resident has been sleeping all night. . . . respirations 6-8 at beginning of shift, resps [respirations] are now 10-12 most of the time. . . ." Documentation indicated emergency department staff evaluated Resident #9 for decreased respiratory status, decreased level of consciousness, and left sided twitching. Vital signs obtained in the ED included a blood pressure of 97/60 mmHg and a respiratory rate of 7 breaths per minute. The ED physician	F 329		

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F 329	Continued From page 7 documented a diagnosis of "Iatrogenic [induced inadvertently] OD [overdose]". A discharge plan signed by the ED physician stated, ". . . You have been evaluated and/or treated for: Morphine Overdose. Reduce MS Contin to 15 mg twice per day. . . ." During an interview on 12/01/10 at 4:05 p.m., an administrative nurse (#1) stated she expected nurses to review all new orders and look up medications with which they are unfamiliar. She agreed the dose of morphine sulfate ordered and administered was an excessive dose. Failure of facility staff to ensure the dose of morphine sulfate ordered by the provider was appropriate before administration of the medication resulted in Resident #9 receiving two excessive doses of morphine sulfate and experiencing severe respiratory depression, which then resulted in an admission to the emergency department.	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425	F-425 Mayo Pharmacy is our primary vendor as well as our consulting pharmacy. A free standing Mayo Pharmacy is located on the first floor of the Baptist Home, and a pharmacists is at the facility Monday through Saturday. Daily rounds, by a licensed pharmacist, is completed twice daily, mid morning and evening to each unit. The pharmacist's role includes	

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F 425	Continued From page 8 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to provide pharmaceutical services to meet the needs of 1 of 1 resident (Resident #9) selected for closed record review. Failure to identify and address an excessive dose of a potentially lethal medication (morphine sulfate) before dispensing the medication resulted in Resident #9 receiving two inappropriate doses of morphine sulfate and experiencing severe respiratory depression, which then resulted in an admission to the emergency department (ED). Findings include: Lippincott, Williams, and Wilkins, "Nursing 2011 Drug Handbook", pages 760-761, states, ". . . morphine sulfate [i.e. MS Contin] . . . INDICATIONS AND DOSAGES . . . Severe pain . . . For extended-release tablet, give 15 or 30 mg [milligrams] PO [by mouth] every 8 to 12 hours. . . . " The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of pharmaceutical services procedures which include: *Verification or clarification of an order to facilitate accurate acquisition of a medication when	F 425	monthly resident medication reviews, in service and consultation. Mayo Pharmacy will be notified during processing of all orders received at the facility, since outside vendors are utilized by some residents. Mayo Pharmacy utilized Data Stat Pharmacy Management System, which provides pharmaceutical information such as dosages parameters, contraindications, etc. Pharmacists will notify licensed nursing staff if any alerts are shown, or they themselves question a dosage of a medication. Pharmacy may and will request verification or clarification of an order to facilitate acquisition of a medication when necessary. Staff are being educated and monitored for appropriate dosage dispensing of all medications and observation of side effects to provide the necessary care and services to maintain appropriate plan of care. Consulting pharmacist will monitor medication regimen to achieve same goal. Pm T.C. with Deb Larson/ Sandy Fischer, DON on 1/18/11 at 9 am PDuncan January 25, 2011 by Pharmacy - by the pharmacist by Data Stat Pm T.C. with Deb Larson/ Sandy Fischer, DON on 1/10/11 at 9 am. PDuncan	

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F 425	Continued From page 9 necessary (e.g., clarification when the resident has allergies to, or there are contraindications to the medication being ordered) *Assuring that the correct medication is administered in the correct dose, in accordance with manufacturer's specifications and with standards of practice, to the correct person via the correct route in the correct dosage form and at the correct time Review of Resident #9's medical record occurred on 12/01/10. Diagnoses included chronic pain and hypertension. A notification to the resident's provider, dated 09/25/10, identified facility staff requested a scheduled pain medication for Resident #9. A health care provider order, dated 09/27/10, identified a new order for MS Contin extended release tablets 60 mg po bid (twice a day). A hand written notification on the document indicated facility staff faxed the order to the pharmacy on 09/27/10. Licensed nurses administered the first dose of MS Contin at or around 8:00 p.m. on 09/28/10 and a second dose at or around 8:00 a.m. on 09/29/10. Refer to F329. During an interview on 12/01/10 at 4:05 p.m., an administrative nurse (#1) stated the pharmacy "did not question" the dose, and facility staff did not receive any type of notification from the pharmacy regarding the large dose of morphine sulfate. She agreed the dose of morphine sulfate ordered and administered was an excessive dose. The facility failed to obtain the services of a pharmacy that assured the accurate dispensing and administration of MS Contin to meet the	F 425	Mayo Pharmacy will conduct monthly in services at regular scheduled meetings for the months of January, February and March. Nurse Managers will audit **(INITIAL ORDERS ONCE REVIEWED)** daily for **30** days for **ZERO** tolerance than proceed to random weekly audits for 1 month and monthly for 3 months. Additional medication audits will be conducted by Elim Corporate Quality Assurance Nurse and reports to Quality Assurance Committee. Director of Nursing is responsible for compliance. 1-27-11 HH	

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F 425	Continued From page 10 needs of Resident #9.	F 425		