North Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8058	A. BUILDING: _____ B. WING _____	12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD BISMARCK SENIOR LIVING, LLC	3406 DOMINION ST BISMARCK, ND 58503

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B 000	INITIAL COMMENTS For the unannounced licensure survey started on December 28, 2015 and completed on December 29, 2015, the sample included 10 residents for complete review and 2 closed records for review. In addition, the sample included 3 supplemental residents to verify specific concerns during the survey. Tier II citations included B921, B923, B1040, B1050, B1220, B1230, B1320e, B1520 and B1540.	B 000		
B 921	33-03-24.1-09,1,a GOVERNING BODY a. All services provided by the facility to meet the needs of the residents, including admission, transfer, discharge, discharge planning, and referral services. This state licensing rule is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to consult the appropriate licensed health care practitioner (HCP) at the time of admission to the basic care facility for 2 of 10 sampled residents (Resident #1 and #5). Failure to notify and receive orders from the HCP does not provide for a continuance of care when the resident moves to a different level of care and this has the potential to negatively affect the resident. Findings include: Kozier and Erb, "Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed.,	B 921		

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B 921	Continued From page 1 Pearson Education, Inc., New Jersey, page 860, stated, "Medication Reconciliation: Another safety issue that affects the nurse is to ensure that clients receive the appropriate medications and dosages as they move or transition through a facility (e.g. on admission, during transfer, and at discharge). . . creating the most accurate list possible of all medications a patient is taking . . . and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications . . ." - Review of Resident #1's record occurred December 28-29, 2015. The record identified an admission date in October 2014 and HCP orders to admit to the secured basic memory care unit of the facility. In December 2014, the resident moved to the assisted living unit within the building and in May 2015 moved to the basic care unit (not memory care). Resident #1's current record contained information from the secured basic memory care stay, the assisted living stay, and basic care stay. Both levels of care (basic and assisted living) have different rules for licensing. The record lacked communication and/or updated orders from the HCP reflecting Resident #1's change in level of care with each transfer. During an interview on 12/29/15 at 9:30 a.m., a staff nurse (#3) stated, "I have been told when they [residents] move from assisted living to basic care there should be a new chart." - Review of Resident #5's record occurred on December 28-29, 2015. The record identified an admission date in March 2013 with orders for admission to assisted living. In April 2015, the resident moved to the basic care unit within the	B 921	B921 – It is our current protocol that a new chart including new physician orders will be initiated every time a resident moves between Assisted Living, Basic care and Memory care. Review and education was provided to nursing staff on the current policy of admission and transfer on January 13, 2016 Admission orders for Resident #1 were obtained and filed in the chart on 12/30/2015. Resident #5 has been discharged and the chart has been closed. All current basic care charts will be reviewed by the Clinical Services Director or designee for admission orders by 2/12/2016. QA/audit plan going forward: All move in and transfers will be monitored for admission orders for the next three months by the Clinical Service Director or designee. 2-12-16	

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B 921	Continued From page 2 building. The record lacked communication and/or updated orders from the HCP reflecting Resident #5's change in level of care. During an interview on 12/29/15 at 4:00 p.m., a staff nurse (#4) stated she could not find orders for Resident #5 when she moved into basic care.	B 921		
B 923	33-03-24.1-09,2,c GOVERNING BODY c. Provisions for pharmacy and medication services developed in consultation with a registered pharmacist, including: (1) Assisting residents in obtaining individually prescribed medications from a pharmacist of the resident's choice. (2) Disposing of medications that are no longer used or are outdated, consistent with applicable federal and state laws. (3) Allowing the resident to be totally responsible for the resident's own medication upon resident request and based on the assessment of the resident's capabilities with respect to this function by an appropriately licensed professional. This state licensing rule is not met as evidenced by: Based on record review, review of facility policy/procedure, and staff interview, the facility failed to conduct an assessment to ensure the capability of 2 of 10 sampled residents (Resident #2 and #3) to safely self-administer medications. Failure to complete an assessment for the ability	B 923		

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B 923	Continued From page 3 to self administer medications placed Resident #2 and #3 at risk for receiving the incorrect medication or dose. Findings include: Review of the section titled "Section 2 - Self-Administration of Medication" in the facility's policy manual occurred on 12/29/15. This policy, dated April 2015, stated, ". . . To ensure that residents can safely administer their medications, a Licensed Nurse will conduct a Self-Administration of Medications Evaluation with each resident to determine the individual's ability to safely administer any prescribed medications. . . ." - Review of Resident #2's record occurred on December 28-29, 2015. Review of the resident's current medication administration record (MAR) showed the medication "Gas Relief Ext [extra] Str [strength] 125 mg [milligrams] take 1 capsule by mouth twice daily after breakfast and at bedtime - ok to self administer". Resident #2's current care plan, stated, ". . . Medications: . . .[box checked] Medication Admin [administration] pills . . . insulin in med [medication] fridge admins own & [and] checks BS's [blood sugars] . . . " A Self-Administration Medication (SAM) assessment, dated 07/22/15, showed facility staff assessed the resident for the use of an insulin pen, however, lacked an assessment for administration of an oral medication. During an interview on 12/29/15 at 11:15 a.m., a staff nurse (#3) stated, "they had an order for SAM for the Gas X, but only assessed for the	B 923	B923 – All residents that self-administer medications will have a self-administration assessment for each medication and have this reviewed on a quarterly basis. Nursing staff was educated on the medication self-administration process on 12/30/2015 and repeated again on 1/18/16. Resident #2 SAM was completed on 1/18/16. All of the current self- administering residents will have their chart reviewed for the presents of a medication assessment by 2/12/16. Going forward, the QA process will be for the Clinical Services Director or designee to monitor 10 charts each quarter for the next year for compliance. 2-12-16	

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B 923	Continued From page 4 insulin." - Review of Resident #3's record occurred on December 28-29, 2015. Review of an annual nursing assessment, dated 12/09/15, stated ". . . Able to self-administer medications? No. Requires staff to administer medications? Yes . . ." The current care plan identified the resident did not self administer medications. Resident #3's current MAR listed the following medications to self administer: * Liquitears (eye drops) 1.4% place one drop in the right eye 4 times daily * Senna S (a laxative) 8.6-50 mg take 2 tablets by mouth at bedtime **self * Systane nighttime Oint [ointment] Apply 1/4 inch to right eye lid at bedtime During an interview in the morning of 12/29/15, a staff nurse (#3) reported staff failed to complete a SAM assessment for Resident #3.	B 923		
B1040	33-03-24.1-10,4 FIRE SAFETY 4. Written records of fire drills must be maintained. These records must include dates, times, duration, names of staff and residents participating and those absent and why, and a brief description of the drill including the escape path used and evidence of simulation of a call to the fire department. This state licensing rule is not met as evidenced by: Based on facility policy review and fire drill record review, the facility failed to maintain a complete written record of the fire drills conducted for 8 of	B1040		

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B1040	Continued From page 5 11 months (March, April, June, July, August, September, October and November 2015) reviewed. Failure to include a brief description of the fire drill, including the escape path used, and evidence of simulation of a call to the fire department does not allow the facility to assess and monitor the effectiveness of the drills and make changes as necessary. Findings include: Review of the section "Fire Safety" in the facility's policy/procedure manual, dated April 2015, stated, ". . . B. Fire Drill Guidelines . . . 4. Written records of fire drills will be maintained and will include the dates, times, duration, names of staff and residents participating in the drill. The report will also include the names of those absent and the reason for the absence. A brief description of the drill including the escape path used and evidence of simulation of a call to the fire department will be included as part of the written record . . ." Review of the facility fire drill reports, dated January 2015 - November 2015, occurred on 12/29/15. The facility failed to include a brief description of the fire drill on eight fire drill reports, including the escape path used on four fire drill reports. The facility failed to include evidence staff simulated a call to the fire department during the drill on 11/30/15.	B1040	B1040 –The environmental services director was educated on the requirement on 12/30/2016. Our forms already contain space for this. The fire drill conducted on 12/31/2016 contained the description of the escape path and the call to the fire department was simulated. All drills will be entered into the TELS system and monitored on a monthly basis. For quality monitoring, all drills will be reviewed by the Executive Director on monthly basis and forwarded to the Safety committee for the next year. 2-12-16	
B1050	33-03-24.1-10,5 FIRE SAFETY 5. Each resident shall receive an individual fire drill walk-through within five days of admission.	B1050		

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B1050	Continued From page 6	B1050		

This state licensing rule is not met as evidenced by:
Based on record review, facility policy review, and staff interview, the facility failed to conduct an individual fire drill walk-through within five days of admission for 2 of 10 sampled residents (Resident #1 and #2). Failure to provide each resident with orientation to fire drill procedures/protocols placed both residents and staff at risk for harm in the event of an actual fire.

Findings include:

Review of the section "Fire Safety" in the facility's policy/procedure manual, dated April 2015, stated, ". . . B. Fire Drill Guidelines, The following guidelines will be used at the facility to ensure steps are taken to protect residents and staff in the event of an emergency . . . 5. Each resident will receive an individual fire drill walk-thru [sic] within five days of admission . . ."

- Review of Resident #1's record occurred on December 28-29, 2015. The record showed a "Fire Drill Walk-Through Information" form, dated 12/02/14, when Resident #1 moved into the assisted living unit within the building. The record lacked documentation of a fire drill walk through when the resident moved into the basic care unit within the building in May 2015.

During an interview on the afternoon of 12/28/15, an administrative nurse (#2) stated they should have done a five day walk-through when Resident #1 moved into basic care.

- Review of Resident #2's record occurred on December 28-29, 2015. The record showed an admission date of 01/09/15 and the five day

B1050 – All residents will have a fire drill walk through with-in five days of admission and on every change in room with in Basic care and Memory care as per policy.

Education completed with the Resident Family Relations and with nursing staff 1/13/2016.

Utilization of the admission checklist for nursing and resident family relations will be started 1/15/2016. This will be checked off and filed in the chart as the quick reference

An updated fire drill walk-through was completed on all basic care residents on 1/15/2016.

Going forward, the QA process will be for the Clinical Services Director or designee to monitor 10 charts each quarter for the next year for compliance.

2-12-16

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B1050	Continued From page 7 walk-through date as 01/21/15, 13 days after admission.	B1050		
B1220	33-03-24.1-12,2 RESIDENT ASSESSMENTS/CARE PLANS 2. The assessment must be completed in writing by an appropriately licensed professional. The assessment must include: a. A review of health, psychosocial, functional, nutritional, and activity status. b. Personal care and other needs. c. Health needs. d. The capability of self-preservation. e. Specific social and activity interests. This state licensing rule is not met as evidenced by: Based on observation, record review, review of facility policy/procedure, review of professional reference, and staff interview, the facility failed to thoroughly assess the health status and safety risks for 2 of 10 sampled residents (Resident #3 and #6). Failure to perform routine and comprehensive skin assessments may contribute to a delay in treatment and a longer healing time (Resident #3 and #6). Failure to evaluate the safe use of side rails and consider side rails as a potential entrapment and safety hazard (Resident #3) may result in injury. Findings include:	B1220		

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B1220	Continued From page 8 Review of the section titled "Assessments and Care Plans" located in the facility policy/procedure manual, dated April 2015, stated, ". . . An assessment of each resident will be conducted to identify the individual needs of the resident, any changes in condition, additional services needed, and to ensure the resident's needs are being met . . ." Bergstrom, Bennett, Carlson, et al. "Pressure Ulcer Treatment, Clinical Practice Guideline. Quick Reference Guide for Clinicians, No. 15," Rockville, MD: US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, 1994, pages 2-4 states, "Assessment: Assessment is the starting point in preparing to treat or manage an individual with a pressure ulcer. . . . Adequate assessment is also essential for communication among caregivers. . . . Assessing the Pressure Ulcer: Initial Assessment. Assess the pressure ulcer(s) initially for location, stage, size (length, width, and depth), sinus tracts, undermining, tunneling, exudate, necrotic tissue, and the presence or absence of granulation tissue and epithelialization. . . . Reassessment: Reassess pressure ulcers at least weekly . . ." The Hospital Bed Safety Workgroup publication titled, "A Guide to Bed Safety - Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts," revised April 2010, stated, ". . . Potential risks of bed rails may include: Strangling, suffocating, bodily injury or death when patients or part of their body are caught between rails or between the bed rails and mattress. More serious injuries from falls when patients climb over rails. Skin bruising, cuts, and scrapes . . . When bed rails are used, perform an	B1220	B1220 – Nursing staff will be educated on the assessments/documentation needed in the chart in regards to any assistive devices that could be considered as a restraint. Education was completed on 12/30/2015 and again on 1/18/16. This will be completed annually thereafter. All residents that have a device such as a hospital bed or a bed cane will have a chart audit by the Clinical Services Director or designee. Resident #3 was discharged. Nursing staff was educated on 1/18/2016 on the documentation process for skin assessments. Resident #3 was discharged. Resident #6 has an update care plan and nurses notes reflecting the status of the wound. As a part of our QA program, All skin breakdowns and use of bed canes or side rails will be tracked monthly and those charts will be reviewed at by the Clinical Services Director or designee on a monthly basis for the next year. 2-17-16	

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B1220	Continued From page 9	B1220		

on-going assessment of the patient's physical and mental status; closely monitor high-risk patients. . . . Reassess the need for using bed rails on a frequent, regular basis."

Information requested at the beginning of the survey included "names of residents with current pressure sores and/or open areas." The facility identified Resident #3 with an area to the "buttock" and Resident #6 with an area to the "Rt [right] great toe."

- Review of Resident #6's record occurred on December 28-29, 2015 and identified a diagnosis of diabetes. A nurse's note, dated 11/18/15, identified an aide reported a skin concern to the nurse on call. The note stated, ". . . [Name of Resident #6] had an ulcer on her right big toe and a little one on the same toe but lower . . ." The record lacked documentation a nurse completed an initial and subsequent assessments of the resident's toes.

The record identified Resident #6's family member took the resident to the clinic on 11/18/15 and received orders for an antibiotic. Additional clinic appointments on 11/20/15 and 12/04/15 resulted in orders for wet-to-dry dressing changes.

The resident's treatment administration record (TAR) identified the dressing change orders to the resident's right great toe, but failed to show evidence a licensed nurse assessed Resident #6's toe ulcers.

- Review of Resident #3's record occurred on December 28-29, 2015 and identified a diagnosis of a pressure ulcer.

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B1220	Continued From page 10 An "Order Information Sheet," dated 08/26/15, stated, ". . . Apply bacitracin ointment to pressure ulcers to buttock once daily and cover with dry dressing for today and patient scheduled to see [wound specialist] . . . 8/27/15 . . . " A fax dated 08/31/15, from the facility to Resident #3's physician stated, ". . . having a lot of incontinence, concerned with skin breakdown, may we have an order for Calmoseptine-aloe vista to buttock BID [twice a day] for prevention. Please advise. . . . Healthcare Provider Response: OK for Calmoseptine as above. . . ." Review of Resident #3's annual assessment, dated 12/09/15, identified "healing pressure wound - open area to buttock." The current care plan lacked a plan of care and/or treatment for the area. The resident's medication administration record (MAR) identified Calmoseptine ointment and aloe vesta to the affected area twice daily, but failed to show evidence a licensed nurse provided an ongoing assessment of Resident #3's pressure ulcer. - Observation of Resident #3's room on 12/29/15 at 2:10 p.m. showed a hospital bed with a side rail on the side next to the wall. The side rail was in a raised position and was located in the middle section of the bed. Review of Resident #3's current care plan stated, ". . . Has 'Hosp' [hospital] bed in room. Side rail X [times] 1 per Resident & [and] Family . . . " The medical record lacked an assessment or documentation in the record regarding the use of a side rail. During an interview on 12/29/15 at 2:30 p.m., an	B1220		

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B1220	Continued From page 11 administrative nurse (#1) reported staff should have assessed the side rail, and the facility does have physical and occupational therapies to assess the needs of residents.	B1220		
B1230	33-03-24.1-12,3 RESIDENT ASSESSMENTS/CARE PLANS 3. A care plan, based on the assessment and input from the resident or person with legal status to act on behalf of the resident, must be developed within twenty-one days of the admission date and consistently implemented in response to individual resident needs and strengths. This state licensing rule is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to review and revise the care plans for 3 of 10 sampled residents (Resident #3, #6, and #9). Failure to develop a care plan based on assessment of Resident #3 and #6's skin breakdown and failure to review Resident #9's care plan on a quarterly basis does not provide an accurate reflection of the residents' current status. Findings include: Review of the section titled "Assessments and Care Plans" in the facility's policy/procedure manual, dated April 2015, stated, ". . . Interdisciplinary Plan of Care . . . The care plan will be: a) Individualized b) Designed to address needs, strengths, and preferences of the resident . . . e) Include the necessary information for staff to provide care for the resident. f) Updated at least quarterly to reflect the current status of the	B1230		

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B1230	Continued From page 12 resident . . . The care plan will be based on the resident assessment and input from the resident or person with legal status to act on behalf of the resident . . ." - Review of Resident #6's record occurred on December 28-29, 2015 and identified diagnoses of diabetes. A nurse's note, dated 11/18/15, identified a pressure ulcer on Resident's #6's right great toe. Physician orders on 11/20/15 and 12/04/15 identified wet-to-dry dressing changes to the pressure ulcer on the resident's toe. The resident's current care plan failed to identify the pressure ulcer. During an interview on 12/29/15 at 10:00 a.m., an administrative nurse (#1) stated the care plan should reflect the skin breakdown to Resident #6's right toe. - Review of Resident #9's record occurred on December 28-29, 2015 and identified a diagnosis of dementia. The resident's care plan identified the facility last reviewed the care plan on 07/02/15 (almost 6 months prior). The facility failed to review, and if applicable, revise the resident's care plan on a quarterly basis. - Review of Resident #3's record occurred on December 28-29, 2015. The annual assessment, dated 12/09/15, identified "healing pressure wound - open area to buttock." The resident's current medication administration record (MAR) identified Calmoseptine ointment and aloe vesta to the affected area twice daily. The current care plan, dated 12/14/15, lacked a plan of care and/or treatment for the pressure ulcer.	B1230	B1230 –Education will be provided to the nursing staff on care planning and the quarterly review process on 1/18/2016. The care plans will reflect the resident assessment. Resident #6 and #9 care plans were updated on 1/15/2016 and reviewed by the nursing staff. Going forward, the QA process will be to monitor 10 charts each quarter for the next year for compliance. This will be completed by the Clinical Services Director or designee. 2-12-16	

North Dakota Department of Health

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	8058	A. BUILDING: _____ B. WING _____	12/29/2015

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B1320	Continued From page 13	B1320		
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. 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.	B1320		

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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.

This state licensing rule is not met as evidenced by:
Based on record review and staff interview, the facility failed to maintain records which included documented observations for 1 of 6 sampled residents (Resident #9) and 1 of 2 closed records (Resident #11) identified with a fall. Failure to document observations in the medical record does not allow the record to accurately reflect the resident's status, does not allow for adequate assessments, and may prevent the resident from receiving the care to meet his or her needs.

Findings include:

- Review of Resident #9's record occurred on

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B1320	Continued From page 15 December 28-29, 2015. Information requested at the beginning of the survey included "names of residents who have experienced fall(s) within the last 4 months." The facility identified Resident #9 fell on 12/10/15. Resident #9's record lacked evidence of the fall occurring on 12/10/15, including a follow-up assessment. During an interview on 12/29/15 at 11:15 a.m., an administrative nurse (#1) stated she recalled faxing Resident #9's medical provider after the fall, but confirmed the resident's record lacked additional information regarding the details of the fall. - Review of Resident #11's closed record occurred on December 28-29, 2015. Information requested at the beginning of the survey included "names of residents who have experienced fall(s) within the last 4 months." The facility identified Resident #11 fell on 11/30/15. Resident #11's nursing progress notes lacked evidence of the fall occurring on 11/30/15, including a follow-up assessment. The progress notes identified the most recent entry by a licensed nurse occurred on 07/06/15. Upon request for further information regarding Resident #11's fall on 11/30/15, an administrative nurse (#1) provided a fax sent to the resident's medical provider, dated 11/30/15. This fax identified the facility sent the resident to the Emergency Room via ambulance and stated, "Entire [left] side of body as well as head involved - reading newspaper, 'tripped over my own feet'	B1320	B1320 – Nursing will document all relevant resident observations in the chart, including falls, hospitalizations, and other changes of condition. Education was be completed for all the nursing staff on the assessment and care planning process for this on 1/18/2016. Resident #9 has had a review of her care plan and service level, this was completed 1/18/2016. Going forward, the QA process will be to monitor 10 charts each quarter for the next year for compliance. This will be completed by the Clinical Services Director or designee. 2-17-16	

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B1320	Continued From page 16 and fell - unable to get to feet, [decreased] LOC [level of consciousness] we did not move her."	B1320		
B1520	33-03-24.1-15,2 PHARMACY/MED ADM SERVICES 2. The facility shall provide a secure area for medication storage consistent with chapter 61-03-02. a. A specific system must be identified for the accountability of keys issued for locked drug storage areas. b. Residents who are responsible for their own medication administration must be provided a secure storage place for their medications. This state licensing rule is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 09/07/12. Based on observation, review of facility policy/procedure, staff interview, and review of the North Dakota Administrative Code (NDAC), Chapter 61-03-02 "Consulting Pharmacist Regulations for Long-Term Care Facilities (Skilled, Intermediate, and Basic Care)," the facility failed to ensure controlled medications in 1 of 1 memory care unit were stored in accordance with acceptable professional standards of practice. Failure to secure controlled medications may result in unauthorized access to these	B1520		

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B1520	Continued From page 17 medications. Findings include: NDAC, Section 61-03-02-03 "Consulting Pharmacist Regulations: Physical requirements of provider pharmacy licensed on premises or other pharmacy" states, ". . . 4. Storage . . . (2) A container or compartment which is capable of securing controlled substances with a lock or other safeguard system shall be permanently attached to storage carts or medication rooms [double locked]. . . . " Review of the section titled "Clinical Services Pharmacy and Medication Administration" in the facility's policy manual occurred on 12/29/15. This policy, dated April 2015, stated, ". . . Edgewood Vista will take the steps necessary to ensure optimal safe handling, storage and administration of medications for all residents . . . e) Controlled substances will be kept in a double-locked area . . . " On 12/29/15 at 4:30 p.m., observation of the facility's medication storage area in the memory care unit occurred with an administrative nurse (#2). Observation showed a locked cabinet, the staff member (#2) opened the cabinet door and the box inside contained a key in the lock. The observation showed the box contained controlled narcotic medications. When asked about the system regarding double locking narcotics, an administrative nurse (#2) confirmed this is not a double locked system.	B1520	B1520 Narcotic keys will be located on the CMA staff key chains, CMA staff and Nursing were educated in double locking the medication on 1/8/2016. This will be audited at random intervals by the Clinical Services Director or designee as part of the ongoing practice. 2-12-16	
B1540	33-03-24.1-15,4 PHARMACY/MED ADM SERVICES	B1540		

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B1540	Continued From page 18 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 labeled consistently with state laws. c. Properly administered. This state licensing rule is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEY COMPLETED ON 09/07/12. Based on observation, record review, review of North Dakota Administrative Code (NDAC), and policy/procedure review, the facility failed to ensure staff properly documented the medication administered to 2 of 10 sampled residents (Resident #6 and #7). Failure to document the reason an "as needed" (PRN) medication was administered and the resident's response or outcome to the medication has the potential for residents to receive unnecessary or inappropriate medication and does not allow for the evaluation of the effectiveness of treatment. Findings include: NDAC 33-43-01-18. Pro re nata (PRN) medications stated, "1. The decision to administer pro re nata medications cannot be delegated in situations where an onsite assessment of the client is required prior to administration. 2. Some situations allow the administering of pro re nata	B1540	B1540 Staff will be educated on the follow-up after the administration of an as needed medication. This was be completed by 1/13/ 2016. Implementation of an electronic medical record will be completed by 2/12/2016 which will require follow-ups to all PRN medications. As a quality monitor, PRN follow up documentation reports from the electronic record will be audited by the Clinical Service Director or designee weekly for the next quarter. 2-17-16	

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B1540	Continued From page 19	B1540		

medications without directly involving the licensed nurse prior to each administration. a. The decision regarding whether an onsite assessment is required is at the discretion of the licensed nurse. b. Written parameters specific to an individual client's care must be written by the licensed nurse for use by the medication assistant when an onsite assessment is not required prior to administration of a medication. The written parameters: . . . (2) Provide the medication assistant with guidelines that are specific regarding the pro re nata medication."

Review of the Section titled "Section 8 - Pharmacy and Medication Administration" in the facility's policy manual occurred on 12/29/15. This policy, revised April 2015, stated, ". . . A. Medication Administration . . . h) Each resident who has medications administered by the facility will have a Medication Administration Record which includes: . . . PRN medication information will include the date, time, route, reason the medication is given, and response (side effects) to the drug. Any unexpected reactions observed are reported to the nurse . . . The response to PRN medication is to be recorded on the back of Medication Administration Record . . ."

Observation of medication pass on December 28, 2015 identified certified medication assistants (CMAs) administering medications to the residents.

Review of the sampled residents' September 2015 - December 2015 medication administration records (MAR) occurred on all days of survey and identified the following PRN medications and times staff failed to identify the reason for administering the medication and/or the response to the medication:

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B1540	Continued From page 20 - Resident #6 - physician orders for PRN Lorazepam (used for anxiety) and Acetaminophen (used for pain or fever) *September - no response of PRN Lorazepam on seven occasions and PRN Acetaminophen on one occasion *October - no reason for administering PRN Lorazepam on three occasions and the response of the medication on four occasions *November - no response of PRN Lorazepam or the response on one occasion - Resident #7 - physician orders for PRN Lorazepam (used for anxiety) and PRN Hydrocodone/Acetaminophen and Tramadol (both used for pain) *September - no response of PRN Lorazepam on three occasions *November - no reason for administering PRN Lorazepam or the response on one occasion *November - no response of PRN Tramadol on six occasions	B1540		