STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355128	A. BUILDING _____ B. WING _____	C 05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSOURI SLOPE	4916 N WASHINGTON ST BISMARCK, ND 58503

(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 An unannounced onsite complaint survey was completed on May 11, 2022. The sample included eight (8) sampled residents for focused review.	F 000		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, review of facility policy, and staff interview, the facility failed to follow professional standards for medication administration for 1 of 1 resident (Resident #3) who required hospitalization as a result of a significant medication error. Failure of staff to administer medications using professional standards and facility practice resulted in a significant medication error which required an avoidable hospitalization for Resident #3. This citation is considered past non-compliance based on review of the corrective action the facility implemented immediately following the incident. Findings include: Information provided by the complainant indicated nursing staff administered the wrong medications to a resident. Review of the facility policy titled "Medication Errors" occurred on 05/11/22. This policy, revised September 2021, stated, ". . . It is the policy of [Facility Name] to provide protections for the	F 760	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 06/10/2022

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 760	Continued From page 1	F 760		

health, welfare and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. . . . 3. [Facility Name] will consider factors indicating errors in medication administration as A. Not being given in accordance with providers orders, examples include . . . incorrect medication. . . ."

Review of the facility policy titled "Medication Administration" occurred on 05/11/22. This policy, revised April 2022, stated, ". . . 6. Proper steps for identification of medication and identification of resident should be carried out each time medications are administered. Medications should not be pre-dished for future medication passes. . . ."

Review of Resident #3's medical record occurred on 05/11/22. Diagnoses included congestive heart failure, atrial fibrillation, and hypertensive heart disease.

Nursing progress notes identified the following:
* 04/13/22 at 10:51 p.m., "Resident was administered incorrect medications. Phone call placed to [Provider Name], on call NP [nurse practitioner]. . . . directed to call poison control. Poison control directed to send to ER [emergency room] immediately. 911 called for transfer to [Hospital Name]. VS [vital signs] obtained, stable at this time. Resident AOX3 [alert oriented times three], baseline at this time. Updated [Provider Name] on transfer. Updated [power of attorney] via phone of incident and transfer, verbal okay to hold bed and transfer. Medications administered not ordered for resident: clozapine [anti-psychotic medication]

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F 760	Continued From page 2	F 760		

400 mg [milligram], depakote [anti-seizure medication] 1000 mg, seroquel [anti-psychotic medication] 600 mg. . . . Stable at discharge from facility. Report given to ER nurse at [Hospital Name]."
* 04/14/22 at 10:33 p.m., "[Name] from [Hospital Name] called. EKG's [electrocardiogram shows electric signals in the heart] done throughout the night resident is stable and is projected to return tomorrow."
* 04/15/22 at 12:25 p.m., "Spoke with [POA Name] this a.m. re: the incident on the 13th. Answered questions she had about the incident and discussed [Resident #3's] current condition. . . ."

Review of Resident #3's hospital history and physical (H&P) occurred on 05/11/22. This H&P, dated 04/13/22, stated, ". . . presented to the ER of our facility today after accidental ingestion of another patient's medications. Patient was given another patient's medications including 400 mg of clozapine, 1 g [gram] of Depakote and 600 mg of Seroquel. Patient was also given his nighttime medications including melatonin [supplement for sleep], mirtazapine [antidepressant], Zoloft [antidepressant], potassium chloride [potassium supplement] and trazodone [antidepressant]. Patient seen and examined in the ER. Patient very somnolent [drowsy]. Responds to verbal command however immediately goes back to sleep therefore no history could be obtained. In the ER patient's blood pressure was 108/59, respiratory rate 20, pulse 87, temperature 98 and O2 [oxygen] saturation 92% on room air. Labs were significant for potassium of 3.4 and BUN [blood urea nitrogen showing kidney function 7-20 normal range] of 24. EKG showing a normal

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sinus rhythm with nonspecific intraventricular conduction delay . . . Poison control was contacted and was advised to monitor the patient for 6 hours. Patient was given potassium chloride 20 mEq [milliequivalent] IV [intravenous] x1 and magnesium sulfate 1 g IV x1 in the ER. Patient admitted for observation. . . ."

Hospital Physician progress notes identified the following:
* 04/14/22 at 3:51 a.m., ". . . Poison control called to follow-up with patients [sic] EKG. QRS was noted to be greater than 130 ms so they recommended 1 amp [ampoule] of bicarb [sodium bicarbonate used to shorten QRS interval] to be given and repeat EKG to be obtained. . . . Poison control recommended repeating EKG at 6 AM . . ."
* 04/15/22 at 11:00 a.m., ". . . Starting to wake up but still somnolent; tolerated CLD [clear liquid diet] . . . "
* 04/16/22 at 10:30 a.m., ". . . Improved alertness, mumbling . . ."

A physician discharge summary, dated 04/19/22 at 11:03 a.m., stated, ". . . was admitted . . . due to acute encephalopathy in the setting of accidental polypharmacy. . . . Condition on discharge stable. . . ."

Review of the facility incident investigation report, dated 04/20/22 stated, "MAII [medication aide two] pre-dished medications for Resident #3 and another resident. Accidentally gave the other resident's medications to Resident #3. . . . MAII received corrective action with re-education on proper medication administration. . . . Seven shift monitoring log will be completed to ensure

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F 760	Continued From page 4 re-education was understood. . . . " During an interview on 05/11/22 at 2:45 p.m., an administrative nurse (#2) agreed the MAII failed to follow facility policy by pre-dishing medications and not performing the five rights of medication administration prior to administering medications to Resident #3. Based on the following information, non-compliance at F760 is considered past non-compliance. The facility implemented the corrective action for the resident affected by the deficient by: * Educated the staff member involved in the error on 04/14/22 at 10:00 a.m. * Educated all staff who administer medications to residents on 04/15/22. * Extended the orientation period for travel medication aides from four hours to eight hours. * Updated the facility policy titled "Medication Administration." * Began audits of medication administration on 04/18/22. The survey team determined deficient practice existed on 04/13/22. The facility implemented corrective action on 04/14/22, provided staff education on 04/15/22, and audited medication administration beginning on 04/18/22 through 05/28/22.	F 760		