STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355054	A. BUILDING _____ B. WING _____ JAN 3 2011	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST HEALTHCARE SERVS	802 2ND ST NW BOWMAN, ND 58623

(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 standard Medicare/Medicaid recertification survey started on December 6, 2010 and completed on December 9, 2010, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure the safe administration of medications for 2 of 13 sampled residents (Resident #2 and #13) who received medication prescribed for other residents. Failure to administer medications to the correct resident has the potential for residents to experience adverse drug events which may negatively impact their health. Findings include: Review of the facility policy entitled "Standards for Safe Medication Administration" occurred on 12/09/10. This policy, revised February 2010, stated, ". . . Policy . . . 8. Only one resident's medication is to be prepared at a time. . . . 9. The resident's identity is checked before drugs are administered to the resident. . . ."	F 333	1. Physician was notified at the time of the medication errors. Residents were monitored. The Nurse responsible was counseled and educated on both occasions. Nurse responsible for the medication errors was observed passing medications per policy and according to the 5 Rights of Medication Pass. 2. CMA's and Nurses were observed passing medications per policy and according to the 5 Rights of Medication Pass. (See attachments A) 3. The following policies were revised: Administering Medications, Standards for Safe Medication Administration (See attachments B and C) Education for CMA's and Nurses regarding Standards for Safe Medication Administration was provided. A video was also presented entitled "Preventing Medication Errors in Long Term Care". (See attachment D)	2/7/10 12/9/10 12/30/10 12/13/10 12/28/10 12/29/10 12/30/10 12/15/10 12/28/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Becky Hansen — TITLE: Administrator — (X6) DATE: 12/30/10

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355054	A. BUILDING ______ B. WING ______	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST HEALTHCARE SERVS	802 2ND ST NW BOWMAN, ND 58623

(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 333	Continued From page 1 Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 8th Edition, dated 2008, page 850, stated, ". . . Ten "Rights" of Medication Administration . . . Right Medication . . . The medication given was the medication ordered . . . Right Client . . . Medication is given to the intended client . . ." - Review of Resident #2's medical record occurred on all days of survey. A nurses' note dated 02/07/10 stated the following: ". . . Gave meds [medications] to wrong resident. He received ASA [aspirin] 81 mg [milligrams], omeprazole [a medication for gastroesophageal reflux disease] 20 mg, remeron [an antidepressant] 30 mg, [and] buspar [an anxiolytic] 15 mg. NOD [nurse on duty] called [hospital name]. They had [physician name] (on call) return my call . . ." The facility provided a form titled "Medication Safety Reporting Form," used to report medication errors and completed by the nurse on 02/07/10. A question on the form asked the writer to describe the error. The nurse wrote, ". . . I had 2 med cups delivering [sic] to dining room, I went 1st to the closest resident. She was refusing her supper [and] absolutely refused her meds. Then I went to [Resident #2's name] [and] picked up the other resident's cup [and] gave it to him. . . ." Another question on the form asked the writer to describe what factors contributed to the error. The nurse responded, "Weather [and] speed. I was in a hurry attempting to finish ASAP to beat the weather [and] was slightly annoyed at the 1st resident for refusing. Typically, I throw a refused med away rt [right] away, but I did not walk to the garbage . . ."	F 333	Nurses and CMA's are now allowed to take the medication cart into the dining room. Medication Safety Reporting Form was revised. DON/QA responsible for monitoring - 4. Quarterly, 5 CMA's/Nurses will be observed passing 10 medications each. All medication errors will be investigated. CMA/Nurse responsible for a medication error will be educated and/or observed performing a medication pass depending on the medication error.	12/10/10 12/27/10 Per telephone call with Sandy W[illegible], DON 1/4/11 @ 9:30 [illegible] ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355054	A. BUILDING _____ B. WING _____	12/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST HEALTHCARE SERVS	802 2ND ST NW BOWMAN, ND 58623

(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 333	Continued From page 2 - Review of Resident #13's medical record occurred on December 08-09, 2010. A nurses' note dated 08/01/10 stated the following, ". . . T.O. [telephone order] per [provider's name]: 1) 'Do Nothing' R/T [related to] med error. . . . [provider] reviewed that [Resident #13's name] was not on coumadin nor had allergies to meds passed in regards to above order. . . ." The facility provided a form titled "Medication Safety Reporting Form," used to report medication errors and completed by the nurse on 08/01/10. A question on the form asked for the drug involved with the error. The nurse wrote, "Coumadin [a blood thinner] 5 mg PO [by mouth] Keflex [an antibiotic] 500 mg PO." Another question on the form asked the writer to describe the error, to which the nurse responded, "Gave [Resident #13's name] another resident's meds by mistake; discovered around 1730 [5:30 p.m.]. When preparing to load the other resident's meds, found her doses were already gone. Then dble [double] checked [Resident #13's name] cassettes [and] her meds for 5:00 p.m. doses were still in cassettes." When describing on the form the factors that contributed to the error, the nurse responded, "Many interruptions all thru [sic] med pass . . . Also, names on med cups sml [small] print. Will label my own in future or ask CMA [certified medication aide] to write lrg [larger]. . . ." In an interview on the morning of 12/10/10, a supervisory nursing staff member (#4) confirmed the above incidents were medication errors and the same nurse committed both errors.	F 333		