North Dakota Department of Health

RECEIVED
Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8103A	A. BUILDING: _____ B. WING _____	08/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD FARGO SENIOR LIVING	4420 37TH AVE S FARGO, ND 58104

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B 000	INITIAL COMMENTS For the announced licensure survey, started on August 27, 2018 and completed on August 29, 2018, the sample included 10 residents for complete review and 2 closed records for review. In addition, the sample included 4 supplemental residents to verify specific concerns during the survey. Tier II citations included B0930, B0950, B1320, B1400, and B1830.	B 000		
B 930	33-03-24.1-09.2.j Governing Body Reporting a significant medication error to officials in accordance with state law. A significant medication error by a medication assistant 1 or 11 shall be reported to the department of health. This ELEMENT is not met as evidenced by: Based on review of facility policy and staff interview, the facility failed to develop protocols for reporting significant medications errors to the department of health. Findings include: Review of the facility protocol titled "Pharmacy and Medication Administration" occurred on 08/29/18. The protocol, dated December 2016, failed to include reporting significant medication errors to the department of health. During an interview on the morning of 08/29/18, a supervisory nurse (#1) stated the facility reports medication errors to their corporate office, but not to the health department.	B 930		

Health Resources Section
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karla Benson, TITLE: Assistant Executive Director, (X6) DATE: 10/4/18

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B 950	Continued From page 1	B 950		
B 950	33-03-24.1-09,5 GOVERNING BODY 5. The governing body shall ensure sufficient trained and competent staff are employed to meet the residents' needs. Staff must be in the facility, awake and prepared to assist residents twenty-four hours a day. This state licensing rule is not met as evidenced by: Based on record review and review of the North Dakota Century Code (NDCC), the facility failed to ensure sufficiently trained and competent staff were available to meet the residents' needs for 1 of 1 sampled resident (Resident #4) who received as needed (PRN) Ativan (an anti-anxiety medication). Failure to determine whether a nursing assessment is needed prior to the administration of a PRN medication and properly delegate the administration to certified medication assistants (CMAs) may result in residents receiving unnecessary medications. Findings include: The North Dakota Century Code Chapter 33-43-01-18, Pro re nata (PRN) medications states: "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 administration of pro re nata 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	B 950		

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B 950	Continued From page 2 licensed nurse for use by the medication assistant when an onsite assessment is not required prior to administration of a medication. The written parameters: (1) Supplement the physician's pro re nata order; and (2) Provide the medication assistant with guidelines that are specific regarding the pro re nata medication." The North Dakota Century Code Chapter 33-43-01-19, Medication interventions that may not be delegated states: "The medication assistant I or medication assistant II, or other individual listed on the department's nurse aide registry, may not perform the following acts even if delegated by a licensed nurse: 1. Conversion or calculation of medication dosage. 2. Assessment of client need for or response to medications; and 3. Nursing judgment regarding the administration of pro re nata medications." - Review of Resident #4's medical record occurred on 08/28/18. Current orders included Ativan 0.25 milligrams (mg) every four hours PRN. Record review identified Resident #4 received PRN Ativan five times in June 2018. Resident #4's medical record lacked evidence of individualized parameters for PRN Ativan use or a nursing assessment prior to administration.	B 950		
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.	B1320		

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B1320	Continued From page 3 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. 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.	B1320		

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B1320	Continued From page 4 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, facility policy review, and staff interview, the facility failed to ensure evidence of a fire drill walk through within five days of admission for 2 of 2 sampled residents (Resident #6 and #8) admitted within the last six months. Findings include: Review of the facility protocol titled "Resident Records - Content of Resident Record" occurred on 08/29/18. This protocol, dated December 2016, stated, ". . . All resident records will include: . . . Documentation of a fire drill walk-through within five (5) days of admission . . ." Review of Resident #6 and #8's medical record occurred on 08/28/18. Both records lacked documentation of a fire drill walk-through within five days of admission. During an interview on the morning of 08/29/18, a staff member (#2) identified she had not been providing fire drill walk-throughs after admission.	B1320		

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B1400	33-03-24.1-14 PERSONAL CARE SERVICES 33-03-24.1-14. Personal care services. The facility shall provide personal care services to assist the residents to attain and maintain their highest level of functioning consistent with the resident assessments and care plans. These services must include assistance with: 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 provide personal care services consistent with the assessment and care plan for 1 of 1 sampled resident (Resident #3) observed during a transfer. Failure to use a gait belt with staff assisted transfers may result in falls and/or injuries to residents. Findings include: Review of the facility policy titled "Gait Belt" occurred on 08/29/18. This policy, dated March 2015, stated, ". . . Gait belts shall be used to aid in transferring and ambulation of all residents on fall precautions. . . ." Review of Resident #3's medical record occurred on 08/28/18. The resident's current care plan identified assist of one for transfers and mobility, fall risk, and a right knee brace applied daily. Observation on 08/28/18 at 9:30 a.m. showed a certified nursing assistant (CNA) (#4) assisted Resident #3 out of bed by lifting her under the arms. The resident ambulated to the bathroom with a walker and CNA assist. Upon completion of toileting, the CNA assisted Resident #3 with dressing but failed to apply her knee brace. The	B1400		

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B1400	Continued From page 6 CNA then assisted the resident to ambulate with her walker down the hallway to the dining room. During ambulation, the resident complained of pain and her right knee buckled. The CNA failed to use a gait belt during this observation. Observation on 08/28/18 at 1:38 p.m. showed a CNA (#4) assisted Resident #3 to stand from the couch by lifting under her arm and walked with her down the hallway to the bathroom. The resident's knee brace was on her lower leg/ankle area. The CNA stated, "We should fix your knee brace." During ambulation back to the living room area, the resident's knee again buckled and she complained of pain. The CNA assisted the resident to sit on the couch, but failed to adjust the knee brace and failed to use a gait belt during this observation. During an interview on 08/29/18 at 11:06 a.m., a supervisory nurse (#5) stated staff should use gait belts when residents are one assist.	B1400		
B1830	33-03-24.1-18,3 DIETARY SERVICES 3. Snacks between meals and in the evening. These snacks must be listed on the daily menu. Vending machines may not be the only source of snacks. This state licensing rule is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to offer morning snacks and list them on the daily menus on 3 of 3 days of survey (August 27-29, 2018). Findings include:	B1830		