STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355024	A. BUILDING _____ B. WING _____	C 02/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	1315 S UNIVERSITY DR FARGO, ND 58103

(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 unannounced complaint survey conducted February 24-26, 2015, the sample included four sampled residents and two records of residents discharged from the facility for complete review.	F 000	Fargo Plan of Correction for Complaint Survey on February 26th, 2105 The statements on this plan of correction are not admittances to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited have been or will be corrected by dates indicated.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on information received from the complainant, record review, review of professional reference, and staff interview, the facility failed to provide the necessary care and services to manage constipation for 2 of 6 sampled residents (Resident #1 and #6). Failure to implement timely and effective interventions to manage constipation resulted in unrelieved constipation for Resident #1 and #6. Findings include: Information submitted by the complainant identified the facility failed to effectively manage constipation, which resulted in a fecal impaction and perforated colon. "Nursing 2015 Drug Handbook," 35th edition,	F 309		

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

Stellevue | Admin | 3-23-15

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 309	Continued From page 1 Wolters Kluwer, Philadelphia, pages 704-705, stated the following, "... hydrocodone bitartrate-acetaminophen [a narcotic pain reliever] ..., ADVERSE REACTIONS ... constipation ..." Page 604-605 stated, "... ferrous fumarate [iron supplement] ... ADVERSE REACTIONS ... constipation ..." - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included constipation, osteoarthritis, anemia, and dementia. Current medications included hydrocodone-acetaminophen (Norco) 10-350 mg two tablets every 6 hours for pain (initiated 10/03/14), iron gluconate 325 mg three times per day for anemia (initiated 12/26/14), and Doc-Q-Lace (i.e. Colace, a stool softener) 100 mg twice per day as needed (prn) (changed from scheduled to prn on 09/16/14). The current care plan stated, "... Bowel Elimination Alteration; Constipation related to: Medications Date initiated: 09/15/14 ... Goal ... Will have bowel movement at least q [every] 3 days ... Interventions ... Administer medications per physician order & observe effectiveness ... Record BM [bowel movement] and report abnormalities. ..." Resident #6's medical record identified no scheduled medications or dietary interventions for constipation. Review of Resident #6's bowel records and prn medication administration records (MARs) identified the following: *October 2014: - A BM on 10/02/14 and none until 10/06/14 (four days later), no interventions attempted	F 309	F309: ManorCare Fargo strives to provide necessary care and services to attain and maintain the highest practicable well-being in accordance with the comprehensive assessment and plan of care. Patient #1's care plan and medication administration record have been reviewed and updated as necessary. Patient # 6 is no longer a patient at ManorCare of Fargo. Residents with a diagnosis of constipation are affected by this practice. Licensed nursing staff members will be re-educated on interventions for treatment of constipation, which was completed on 3/25/15. DCD and ADNS reviewed all Care Plans of current residents to ensure appropriate interventions in place for all residents with diagnosis of constipation. L.Staff was also educated on documenting the intervention and outcome for residents with constipation, completed on 3/25/15. CNAs educated on correct documentation of bowel movements and charting them accurately, completed on 3/25/15.	

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F 309	Continued From page 2 - A BM on 10/18/14 and none until 10/25/14 (six days later), no interventions attempted - A BM on 10/27/14 and none until 11/01/14 (five days later), no interventions attempted - A BM on 11/01/14 and none until 11/05/14 (four days later), no interventions attempted - A BM on 11/11/14 and none until 11/16/14 (five days later), no interventions attempted - A BM on 11/24/14 and none until 11/28/14 (four days later), Colace administered on 11/25/14 and 11/26/14. The MAR showed nursing staff failed to document a response after administration of the prn Colace, and no other interventions were attempted. - A BM on 12/09/14 and 12/12/14. The MAR showed the administration of prn Colace on 12/10/14 with no response documented by staff. - A BM on 12/18/14 and 12/21/14. The MAR showed the administration of prn Colace on 12/20/14, 12/21/14, and 12/22/14 without a response documented by staff - A BM on 12/24/14 and none until 12/29/14 (four days later). The MAR identified the administration of prn Colace on 12/26/14 and 12/27/14 without a response documented by staff - The last recorded BM was a small BM on 12/29/14 Nurses' notes identified the following: *09/18/14 at 4:13 p.m.: "... Colace changed to PRN due to does not wish to take unless has not had any BM's ... is now PRN and she will let us know when she does not have a BM. ..." *12/26/14 at 4:22 p.m.: "... Nutrition/Weight ... She states she continues to not be a breakfast person. ... She states she has been having times of constipation which she is at risk for due to the pain medication & feels that at times this maybe effecting her appetite. This writer did offer	F 309	F309: Continued from page two We will audit this daily x 8 weeks, Q month x 4, and quarterly x 2. NP's educated on ordering PRN laxative and Dulcolax supp PRN for those residents triggering day 2 and 3 without a BM, completed on 3/2/15. ADNS or designee will monitor point of care alerts for residents who have not had a recorded bowel movement in three days and validate unit nurse has provided appropriate clinical follow up and documentation. Reports will be forwarded to the QAPI committee monthly times three and quarterly times two for further recommendations and actions based on findings. Quality Assurance initiated on 3/17/15, and will be ongoing as per center routine. ADNS or designee responsible for compliance by 3/30/15.	

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F 309	Continued From page 3 prunes/prune jc [juice] & she stated she would try prune jc at breakfast. This writer did encourage fruits & vegetables as well as this writer offered raisin bran which she is going to have more frequently at breakfast. This writer also did encourage water & she stated that she is not drinking much water. This writer provided education on my [sic] water was important, including constipation & infections . . . She stated she would try to drink more water. . . ." *01/01/15 at 1:40 a.m.: ". . . patient voiced no concern during evening shift, up to the dinning [sic] room and resting in bed without difficulty at HS [bed time]. However, while writer was giving report to oncoming nurse, CNA [certified nursing assistant] reported client is c/o [complaining of] cramps and being nauseated. . . . Both nurses attended to pt [patient] needs and stated has had no BM in two days and needed something to help with BM/induce vomiting because she had 360 cc [cubic centimeters] of prune juice during the day and did not help promote BM. Fleet enema ordered administered but No result in one hour and patient started being anxious, wanting staff to stay with her. one CNA stayed with the client but soon came to report that client c/o SOB [shortness of breath], and chills. . . . Vitals: BP [blood pressure] 170/101, T. [temperature] 99.6, O2 [oxygen saturations] 84%, RA [room air], P [pulse] 127, R [respirations] 24, diminished lung sounds but denies pain at this time. Pt. put on O2 via nc [nasal cannula] at 2L [liters] but O2 sats [saturations] remains at 82%, increased to 5L, O2 sats stayed at 86%. On call MD [medical doctor] updated of change in condition patient send [sic] to Sanford ER [emergency room] by ambulance for eval. [evaluation] . . . " *01/01/15 at 3:15 a.m.: ". . . Called to Sanford er and herd [sic] from nursing staff resident was still	F 309		

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F 309	Continued From page 4 at ER but would for sure be admitted and stated that resident was coughing up blood at er. . . ." "01/12/15 at 10:59 a.m.: ". . . pt has been on a ventilator at hospital and has been trying to come off of it for 8 days now. She has been unable to for more than 10 minutes at a time and tonight she will come off for good. . . ." Resident #6's discharge summary, dated 01/19/15, stated, ". . . Scheduled for knee repair surgery - pre-op [preoperatively] Hgb [hemoglobin] [decreased] - postponed. [decreased] O2 sats, [increased] pale/clammy - transfer to ER for eval. Rupture of colon - admitted on vent [ventilator] - patient discharged . . ." During an interview on the morning of 02/26/15, a managerial nursing staff member (#1) stated the facility did not have a policy/protocol for constipation management or monitoring bowel movements. The staff member also identified the facility does not use standing orders. Failure to implement a timely and effective bowel management program (including dietary interventions) resulted in multiple episodes of constipation and an admission to the hospital for a ruptured colon. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included constipation and dementia. The physician's orders, dated December 15-16, 2014, identified the following medications for constipation: * Lactulose 30 milliliters (ml) daily	F 309		

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F 309	Continued From page 5 * Docusate/Senna 50 mg-8.6 mg daily * Bisacodyl Suppository 10 mg prn The current care plan stated, ". . . Bowel Elimination Alteration; Constipation related to: Medications Date initiated: 12/24/14 . . . Goal . . . Will have bowel movement at least q 3 days . . . Interventions . . . Administer medications per physician order & observe effectiveness . . . Record S&S [signs and symptoms] constipation such as abdominal cramping, diarrhea . . . no BM for 3 days . . ." Resident #1's medical record identified no dietary interventions for constipation. Review of Resident #1's bowel records, dated January 1 - February 25, 2015, identified the following: * No BM from January 1-4, 2015 (four days) * No BM from February 8-14, 2015 (seven days) * A small BM on February 15th and 16th * No BM on February 17th or 18th * A small BM on February 19th * A small, medium, and large BM on February 20th * No BM on February 21st or 22nd * A large BM on February 23rd * Two small BMs on February 24th The progress notes identified Resident #1 experienced "continued nausea and emesis" on February 23rd and 24th, and an xray was ordered. The physician's orders, dated February 23-24, 2015, identified the following medications for constipation: * Bisacodyl 10 mg suppository prn * Miralax 17 grams twice per day * 150 ml dose of Magnesium Oxide due to a	F 309		

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F 309	Continued From page 6 "large [amount of] feces present throughout [the] colon per resident xray [taken 02/24/15], exists" During an interview on the afternoon of 02/25/15, an administrative (#2) and a managerial nursing staff member (#1) confirmed staff failed to administer prn medications for constipation and/or dietary interventions to Resident #1 between January 1-4 and February 8-14, 2015. Failure to implement a timely and effective bowel management program (including dietary interventions) resulted in repeated episodes of constipation and the need for xrays to diagnose the "large [amount of] feces present throughout [Resident #1's] colon."	F 309		
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 information provided by the complainant, record review, review of professional literature, review of facility policy, and staff interview, the facility failed to follow current standards for medication administration for 1 of 1 resident discharged (Resident #2). Failure to administer insulin using safe administration practices resulted in a significant medication error which resulted in Resident #2 experiencing low blood sugars and requiring two doses of Glucagon. Findings include:	F 333	F333: ManorCare Fargo strives to maintain the right of the residents to be free from significant medication errors. Resident # 2 is no longer a patient at ManorCare of Fargo. Residents residing in this facility have the potential to be affected by this practice.	

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F 333	Continued From page 7 Berman, Snyder, Kozier, and Erb, "Fundamentals of Nursing Concepts, Process, and Practice", 9th Edition, Copyright 2012 by Pearson Education, Inc., Upper Saddle River New Jersey, page 860-864, stated, "... Before administering a medication, identify the client correctly using the appropriate means of identification ... Errors can and do occur, usually because one client gets a drug intended for another. ... The Joint Commission's National Patient Safety ..., goal requires a nurse to use a least two client identifiers whenever administering medications. Neither identifier can be the client's room number or physical location. ... Acceptable identifiers may be the person's name, assigned identification number, telephone number, photograph, or other person-specific identifier. ..." Review of the facility policy titled "Medication Management Guidelines" occurred on 02/26/15. This policy, revised 08/11/06, stated "... RIGHT PATIENT: Confirm the identity of each individual patient ... Be sure every patient has an identification band. Maintain a current photo of each patient in the Medication Administration Record (MAR); never use just room number or location as an identifier. Check the visual identified prior to medication administration ... Call the patient by name prior to medication administration. ..." Information provided to the State agency indicated facility staff failed to ensure Resident #2 received only his medications per physician order. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses	F 333	F333: Continued The nurse that made the medication error was a traveling nurse and no longer works in this facility. Immediate education provided to the travel staff involved, and immediately started education with Manorcare L. Staff regarding the 6 rights of medication administration. Ad Hoc QA meeting on 2/2/15 regarding the medication error and reviewed education completed during 1/29/15-2/2/15. Nurse supervisors were reeducated regarding identifying patients during medication pass by calling name, identifying photograph in the medication administration record and by checking name bands if applicable, and this was completed 2/13/15, with one nurse educated on 2/24/15, due to vacation. Regular QA meeting on 2/24/15 also included the medication error that occurred and completed education for L.Staff. ADNS or designee will conduct random audits weekly times six and monthly times three of medication passes with nurse supervisors.	

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F 333	Continued From page 8 included diabetes. The physician's orders, dated 02/11/15, identified the following: * Humalog 10 units three times daily with meals and per sliding scale *Levemir 48 units every morning - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included bone and prostate cancer, weakness, and non-insulin dependent diabetes. An incident report, dated 01/29/15 at 10:01 p.m., identified, "... [Nurse] gave pt 48 units lantus [insulin]. The 48 units of lantus was his roommates. ... [Resident #2] does not get any lantus at night, blood sugar low at 64. Pt. is refusing any BS [blood sugar] checks or food or anything to drink. Pt hitting out. ... physician notified ..." Following record review, it was unclear which type of insulin Resident #2 actually received as Resident #1's physician's orders identified he received humalog and levemir, versus lantus. The progress notes identified the following: * 01/29/15 at 11:12 p.m., "Order rec'd [received] from [physician] 1.) Cont. [continue] hourly blood sugar checks 2.) Glucagon 1 mg [milligram] IM [intramuscular] every hour as needed for blood sugar less than 70 mg/dl [milligrams per deciliter]. ..." * 01/30/15 at 10:08 a.m., "Pt [patient] blood sugar checked every hour, see MAR. ... Administered glucagon x 2 at 1 a[.m.] and at 5:20 a[.m.] ..." Following record review, it was unclear why staff waited to administer glucagon at 1:00 a.m., after establishing Resident #1 had a blood sugar of 64	F 333	F333: Continued from page 8 Audits will be forwarded to the QAPI committee for further recommendations and actions based on findings. Quality Assurance initiated on 1/29/15, and will be ongoing as per center routine. ADNS or designee responsible for compliance by 3/30/15.	

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F 333	Continued From page 9 at 10:01 p.m. During an interview on the afternoon of 02/26/15, an administrative (#2) and a managerial nursing staff member (#1) confirmed the traveling nurse administered Resident #1's a.m. dose of insulin to Resident #2. They were unable to explain what steps the nurse took to identify the resident prior to administering the insulin. It was also unclear why, per their report, Resident #2 received Resident #1's a.m. dose of insulin at 10:01 p.m. Failure to administer medications using safe administration practices resulted in Resident #2 experiencing low blood sugars and requiring two doses of Glucagon.	F 333		
F9999	FINAL OBSERVATIONS Based on record review the complaint concerns regarding call light accessibility, falls, feeding assistance, grooming, hydration, palatability of food, physician's orders, Rehabilitation services, and toileting were unsubstantiated.	F9999		