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 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS ON UNIVERSITY	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 The standard Medicare/Medicaid recertification survey started on 02/05/24 and concluded 02/08/24.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, professional reference, and resident and staff interview, the facility failed to follow professional standards for 1 of 1 sampled resident (Resident #13) observed during blood glucose testing and insulin administration. Failure to clarify orders regarding the timing of blood glucose testing and administration of sliding scale insulin may result in inaccurate/inconsistent readings and insulin needs. Findings include: Review of a professional online reference "Diabetes Education Online - Sliding Scale Therapy" https://dtc.ucsf.edu/ Compiled 2007-2024, Diabetes Teaching Center at the University of California, San Francisco, stated, "The term 'sliding scale' refers to the progressive increase in the pre-meal or nighttime insulin dose, based on pre-defined blood glucose ranges. . . . short acting insulin (aspart, glulisine, lispro, Regular) before meals and at bedtime . . . The bolus insulin is based on the blood sugar	F 658	CORRECTIVE ACTION: The Director of Nursing or Designee called and obtained new orders on 2/6/2024 for resident # 13 on clarification on when to check blood sugar and administer insulin if the resident is non-compliant with seeing the nurse before mealtime. The Director of Nursing or Designee educated the facility staff member on 2/6/2024 regarding when to contact the provider for clarification and further orders before administering insulin. IDENTIFICATION OF OTHERS: The Director of Nursing or Designee conducted an audit on 2/6/2024 to validate that all residents are receiving blood glucose checks per provider's orders and sliding scale insulin correctly and are compliant with checks before	3/1/24

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

Electronically Signed | 02/21/2024

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F 658	Continued From page 1 level before the meal or at bedtime. . . ." Review of Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., New Jersey, page 62, stated, "Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. Clarification from any other source is unacceptable and regarded as a departure from competent nursing practice. . . ." Review of the facility policy titled "Insulin Administration" occurred on 02/06/24. This policy, revised September 2014, stated, ". . . The nurse shall notify the Director of Nursing Services and Attending Physician of any discrepancies, before giving the insulin. . . . Check blood glucose per physician order or facility protocol. . . ." Observation on 02/06/24 at 8:40 a.m. showed a staff nurse (#3) completed a blood glucose test on Resident #13. The test resulted in a blood glucose level of 237 milligrams per deciliter (mg/dL). The nurse administered six units of scheduled Humalog insulin (rapid acting) and an additional four units per sliding scale orders. When asked if the resident was going to eat breakfast, the resident replied, "I ate earlier this morning." Resident #13's orders failed to identify if staff should complete accuchecks and sliding scale insulin administration before or after meals.	F 658	meals. No concerns were identified. SYSTEMIC CHANGE: The Director of Nursing or Designee provided education to facility nurses on 2/6/2024 to call the provider if unable to obtain blood sugar before meals to determine if should still give sliding scale insulin and to clarify any orders that are questionable or appear to be incorrect. MONITORING: DON/designee will audit to ensure residents are receiving blood glucose checks and sliding scale insulin correctly and are compliant with checks before meals. Random audits will be completed on all residents receiving insulin, 3 times weekly x 2 weeks; then 2 times weekly for 1 month; then 1 time per month x 1 month. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed.	

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F 658	Continued From page 2 During an interview on 02/06/24 at 10:40 a.m., when asked about Resident #13's blood glucose test after breakfast, an administrative nurse (#1) agreed the after-meal testing for sliding scale insulin administration was against facility protocol. When asked, the facility did not provide a protocol. During an interview on the afternoon of 02/06/24, two administrative nurses (#1 and #2) identified a facility camera showed Resident #13 in the dining room at approximately 7:50 a.m. and left at approximately 8:07 a.m. Both nurses indicated the order for blood glucose levels did not specify before or after meals. The facility staff failed to clarify an order for the timing of blood glucose testing and sliding scale insulin administration.	F 658		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 758		3/1/24

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F 758	Continued From page 3 unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure each resident's medication regimen was free from unnecessary medications for 1 of 3 sampled residents (Resident #11) who received an as-needed (PRN) psychotropic medication.	F 758	CORRECTIVE ACTION: The Director of Nursing received an updated end date for Resident #11's PRN psychotropic medication on 2/7/2024.	

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F 758	Continued From page 4 Failure to ensure the provider indicates the duration for the PRN order when documenting the clinical justification for continued use of a PRN psychotropic medication may result in the resident receiving the medication for an excessive duration and/or experiencing adverse side effects related to its use. Findings include: Review of the policy titled "Medication Regimen Reviews" occurred on 02/08/24. This policy, revised May 2019, stated, ". . . An 'irregularity' refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. . . ." Review of Resident #11's medical record occurred on all days of survey. The physician's orders identified an active order for Ativan (an anti-anxiety medication), dated 09/27/23, which stated, "Ativan Oral Tablet 0.5 MG [milligrams] . . . Give 0.5 mg by mouth as needed for anxiety, severe agitation, and aggression. Up to 2x [times] per day." The facility failed to ensure the provider established a stop date when documenting the clinical justification for continued use of the PRN psychotropic medication. During an interview on 02/08/24 at 9:00 a.m., an administrative nurse (#1) confirmed the facility failed to obtain a new order for the extended use of Resident #11's PRN Ativan.	F 758	IDENTIFICATION OF OTHERS: The Director of Nursing or Designee conducted an audit of all residents on PRN psychotropics on 2/7/2024 to ensure that they all had stop dates. No concerns were identified. SYSTEMIC CHANGE: The DON or Designee provided nurses education on or before 2/20/2024 that all PRN psychotropic medications should be reassessed and renewed routinely. After an initial 14-day review, residents may have longer active orders but must have an end date to the order. Once the end date is reached, medication is to be reassessed, and determined if medication should be reordered. The Administrator or Designee provided education to the Social Services Director on 2/20/2024 regarding the tracking of PRN psychotropic medication orders for compliance. MONITORING: Social Services or Designee will audit to ensure all PRN psychotropic medication has an effective end date and or review date. Random audits will be completed on all residents receiving PRN psychotropic medications, 3 times weekly x 2 weeks; then 2 times weekly for 1 month; then 1 time per month x 1 month.	

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F 758	Continued From page 5	F 758	The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 10 residents (Resident #23 and #294) observed during medication administration. Three medication errors occurred during staff administration of 27 medications, resulting in an 11% error rate. Failure to properly administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of the facility policy titled "Administering Oral Medications" occurred on 02/06/24. This policy, revised October 2010, stated, ". . . Check the label on the medication and confirm the medication name and dose with the MAR [Medication Administration Record]. . . . Check the medication dose. Re-check to confirm the proper dose. . . ."	F 759	CORRECTIVE ACTION: Resident #23 – Patch was immediately removed on 2/6/2024. Resident #23 – The staff member was educated on 2/6/2024 regarding not removing the resident's medication as indicated. Resident #23 – The staff member was immediately educated on 2/6/2024 about not utilizing medications from another resident supply. Resident #294- The resident's medication orders were updated on 2/7/2024 for accuracy. Resident #294- The staff member was educated on 2/7/2024 regarding following the 10 rights of medication administration. IDENTIFICATION OF OTHERS: The Director of Nursing or Designee conducted an audit on 2/7/2024 to	3/1/24

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F 759	Continued From page 6 Review of Kozier & Erb's "Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., New Jersey, page 65, stated, "Make sure the correct medications are given in the correct dose, by the right route, at the scheduled time, and to the right client." During an interview the morning of 02/06/24, two administrative nurses (#1 and #2) agreed the policy for administering oral medications applied to any type of medication for staff to confirm the label, medication name, and dose with the MAR. - Observation on 02/06/24 at 9:45 a.m. showed a medication aide (MA) (#4) took one Lidocaine (pain medication) 4% patch from Resident #14's prescription box and applied to Resident #23. The MA stated Resident #23's patch reorder had not been delivered from the pharmacy, and when the order came the MA would replace the patch taken from Resident #14's prescription box. The MA entered Resident #23's room, removed the previous day's Lidocaine patch, and applied the new patch. The MA stated the old patch should have been removed the previous evening. Review of Resident #23's medical record on February 6-8, 2024 showed an order for a Lidocaine 4% patch every 12 hours; on at 8 a.m. and off at 8 p.m. Review of the MAR for February 2024 identified staff documented removal of the Lidocaine patch on 02/05/24 at 8 p.m. During an interview on the morning of 02/06/24 an administrative nurse (#2) agreed staff failed to remove Resident #23's previous day's Lidocaine patch and failed to contact the pharmacy to	F 759	confirm all MAR orders match current orders and pharmacy labels in the medication cart for all lidocaine patch orders. No concerns were identified. The Director of Nursing or Designee conducted an observation audit on 2/6/2024 to confirm all lidocaine patches from the previous night were removed. No issues were identified. The Director of Nursing or Designee conducted medication administration observations on or before 3/1/2024 to ensure compliance. SYSTEMIC CHANGES: The director of nursing or designee provided education to facility nurses and medication aides that, Lidocaine patches are to be timed, dated, and initialed when placed. Lidocaine patches are to be removed as ordered. Sharing of lidocaine patches and other medications is not permitted, if out of a medication must receive a hold order while waiting for the pharmacy to deliver. When the pharmacy changes a medication due to formulary it needs to be updated in the MAR immediately. The education was provided on or before 2/8/2024. MONITORING:	

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F 759	Continued From page 7 reorder the medication. The nurse identified both issues as medication errors. - Observation on 02/07/24 at 9:57 a.m. showed a staff nurse (#5) placed two Lidocaine 4% patches to Resident #294's lower back. Review of Resident #294's medical record on February 7-8, 2024 showed an order for Lidocaine 5% patch; two patches for 12 hours in A.M. Review of the pharmacy label (Lidocaine 4%) and the MAR order (Lidocaine 5%) with a staff nurse (#3) occurred on 02/07/24 at 11:23 a.m. The staff nurse agreed the MAR and pharmacy label failed to match and required a physician's order to clarify.	F 759	The Director of Nursing or Designee will audit to ensure Lidocaine patches are to be timed, dated, and initialed when placed, that Lidocaine patches are removed as ordered and that a hold order is obtained if needed. Random audits will be completed on all residents with Lidocaine patch orders, 3 times weekly x 2 weeks; then 2 times weekly for 1 month; then 1 time per month x 1 month. The Director of Nursing or Designee will conduct medication pass observations to ensure that no medications are borrowed between residents, Random audits will be completed 3 times weekly x 2 weeks; then 2 times weekly for 1 month; then 1 time per month x 1 month. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		3/1/24

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F 761	Continued From page 8 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure appropriate labeling of medications for 2 of 10 residents (Resident #13 and #37) observed during medication administration. Failure to ensure medication cards contain the correct administration information may result in medication errors and adverse drug effects. Findings include: - Observation on 02/06/24 at 8:40 a.m. showed a staff nurse (#3) prepared Resident #13's Humalog insulin pen for the scheduled six units and additional four units per sliding scale. The pen's label stated, "Inject 6 units subcutaneous three times a day with meals." The pen's label lacked instructions for sliding scale use. The nurse (#3) verified the resident's Humalog insulin pen was used for both scheduled and sliding scale administration.	F 761	CORRECTIVE ACTIONS: Resident #13 – Immediately placed, the “see MAR directions changed” sticker on the insulin pen on 2/6/2024. Resident #37- Immediately placed the AM medication label on the pharmacy medication card on 2/6/2024. The Director of Nursing or Designee provided education to all staff responsible for medication administration on 2/6/2024 related to not altering or writing on pharmacy labels and proper use of label stickers. IDENTIFICATIONS OF OTHERS: The Director of Nursing or Designee conducted cart audits on 2/6/2024 to ensure all insulin pens with sliding scale orders or differing orders from MAR have a refer to MAR sticker placed	

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F 761	Continued From page 9 During an interview on 02/06/24 at 1:00 p.m. an administrative nurse (#1) stated the pharmacy placed stickers on insulin pens indicating "Directions changed refer to chart." The nurse (#1) identified the sticker alerted nurses to read the medication administration record (MAR) for complete order instructions. The nurse confirmed Resident #13's insulin pen had no sticker applied. - Observation on 02/06/24 at 9:45 a.m. showed a medication aide (MA) (#4) administered rosuvastatin (cholesterol lowering medication) 40 milligrams (mg). The pharmacy label stated "at bedtime" and a handwritten "AM" (morning) noted in pink marker. When asked regarding the change, the MA stated the MAR identified to administer rosuvastatin in the morning, and the handwritten "AM" on the medication alerted staff of the order change. During an interview on 02/06/24 at 12:55 p.m. an administrative nurse (#1) stated nurses placed stickers on medication labels to note order changes in time of administration. The nurse confirmed the pharmacy does not send out new labels when there is a time change, and the next pharmacy delivery (every two weeks) will reflect the time change on the printed label. The nurse indicated the medication cart contained no "AM" stickers for nurses to place on medication labels. During an interview on 02/07/24 at 1:34 p.m., an administrative nurse (#1) stated the facility had no medication labeling policy, and educated nurses verbally regarding sticker labeling instructions.	F 761	appropriately. No issues or concerns were identified. The Director of Nursing or Designee conducted cart audits on 2/6/2024 of all medication cards to ensure that there was no writing on or alteration on pharmacy labels. No issues or concerns were identified. SYSTEMIC CHANGES: The Director of Nursing or Designee provided education to Nurses on 2/6/2024 for insulin pen labeling to ensure all insulin pens with sliding scale orders or differing orders from MAR have a refer to MAR sticker placed appropriately. The Director of Nursing or Designee provided education to all staff responsible for medication administration on 2/6/2024 related to not altering or writing on pharmacy labels and proper use of label stickers. MONITORING: The Director of Nursing or Designee will audit insulin pens to ensure appropriate stickers are placed for insulin pens with differing orders or sliding scale orders as appropriate. Random audits will be completed on all residents receiving insulin, 3 times weekly x 2 weeks; then 2 times weekly for 1 month; then 1 time per month x 1 month. The Director of Nursing or Designee will	

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F 761	Continued From page 10	F 761	audit medication cards to ensure no writing on or alteration of pharmacy labels. Random audits will be completed 3 times weekly x 2 weeks; then 2 times weekly for 1 month; then 1 time per month x 1 month. The results of the audits will be tracked and trended and presented to the Quality Assurance and Performance Improvement Committee Monthly to identify if any further action is needed.	