STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	C 02/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING CENTER OF GARRISON	609 4TH AVE NE GARRISON, ND 58540

(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 complaint investigation completed on February 24, 2015, the sample included seven (7) residents for complete review.	F 000	This plan of correction is this facility's allegation of compliance with applicable regulatory requirements.	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to follow facility policy and professional standards of care regarding physicians' orders, administration of medications, and/or disposing of and checking for placement of fentanyl patches for 4 of 7 sampled residents (Resident #2, #4, #5, and #6) reviewed. Failure to follow physicians' orders and professional standards of care resulted in medication errors and placed Residents #2, #4, and #5 at risk for adverse medication reactions. Failure to dispose of fentanyl patches per facility policy for Residents #4, #5, and #6 may result in misuse and drug diversion. Findings include: Review of the facility policy titled "MEDICATION ADMINISTRATION" occurred on 02/24/15. This undated policy stated, "OBJECTIVE: To administer medications in a safe and accurate manner that will ensure the 5 rights of patient identification for administration. PROCEDURE: . . . 4. Properly identify ordered medications for each neighbor [resident], check label for proper	F 281	F 281 SS = E PROFESSIONAL STANDARDS Fentanyl Patch 1) Fentanyl patches were checked on Residents #4, #5, and #6 to ensure proper placement. 2) All neighbors would potentially be affected who have an order for a Fentanyl patch. Fentanyl patches were checked on all residents to ensure proper placement. 3) Policy was revised that we will not wake neighbors at night to check placement of their Fentanyl patch. Education was completed at a nurses meeting on 3/5/15 and Certified Medication Assistants were educated by DON 1:1 on checking appropriate placement of fentanyl patches, policy of two staff witnessing destruction of patch and proper documentation on the MAR. 4) Audits to be completed by DON and/or designee on appropriate placement of patch, proper procedure for destruction and documentation on the MAR 5x/wk x 1 month, then 3x/wk x 1 month, then 1x/wk quarterly thereafter x 1 year. 5) Date certain is 3/31/15.	3/31/15

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

administrator — 3/24/15

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 281	Continued From page 1 medication, dose, frequency and route. . . . 7. Sign med [medication] out on MAR [medication administration record] at time of dispensing medication. 8. Any refused medication needs to be disposed of properly, initials circled on MAR and reason documented. . . ." Review of the facility policy titled "Destruction of Used Fentanyl Patches" occurred on 02/24/15. This policy, dated May 2013, stated, "PURPOSE: To avoid potential abuse, misuse and diversion of controlled substances and/or to minimize accidental exposure risk. PROCEDURE: 1) The CMA [certified medication aid] or Licensed nurse will remove used Fentanyl patch from the neighbor. 2) CMA or Licensed nurse will . . . flush it down the toilet with a witness present. 3) Staff present at the time of destruction (flushing) shall include a CMA and Licensed nurse OR 2 Licensed nurses. 4) Both witnesses will co-sign the neighbor's MAR that the patch was removed and flushed per policy." - Review of Resident #4's medical record occurred on 02/24/15. Diagnoses included chronic back pain. Medications included a fentanyl patch every 72 hours and to check patch placement every shift. Review of the October and December 2014 narcotic administration count sheet identified Resident #4 received a fentanyl patch on 10/27/14 and again on 10/29/14, one day earlier than prescribed. On 12/25/14, a CMA removed Resident #4's fentanyl patch from locked storage, and the MAR identified placement of the patch. The MAR also identified placement of another fentanyl patch on 12/26/14.	F 281	F 281 SS = E PROFESSIONAL STANDARDS Med Errors 1) Resident #2, #4 and #5 did not have any adverse effects from the medication errors. 2) All residents who receive medications have the potential to be affected. Medication error reports for all residents were reviewed to ensure no adverse reactions due to not receiving appropriate medications. 3) Nurses and Certified Medication Assistants were educated 1:1 by DON on Med Administration policy. All MARS are being checked for proper documentation. All Certified Medication Assistants and Nurses will be required to demonstrate competency on all areas of medication administration (oral, eye drops, inhalers etc). 4) Audits to be completed by DON and/or designee to ensure correct medication administration policy is followed by both CMA's and Nurses and that the MAR's are being documented on correctly 5x/wk x 1 month, then 3x/wk x 1 month, then 1x/wk quarterly thereafter x 1 year. 5) Date certain is 3/31/15.	3/31/15

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F 281	Continued From page 2 Further review of Resident #4's MARs from October 2014 to February 22, 2015 showed the nurse/CMA failed to: *Check placement of the fentanyl patch on 26 occasions *Ensure two staff members witnessed the destruction of the fentanyl patch on six occasions - Review of Resident #5's medical record occurred on 02/24/15. Diagnoses included chronic pain. Medications included a fentanyl patch every 72 hours and to check patch placement every shift. Review of the "Med Error Summary" report identified Resident #5 received a fentanyl patch on 10/29/14, one day earlier than prescribed. The October MAR showed the CMA documented an administration date of 10/30/14 (the correct prescribed date) and not the date he/she actually administered the patch. Further review of Resident #5's MARs from October 2014 to February 22, 2015 showed the nurse/CMA failed to: *Check placement of the fentanyl patch on seven occasions *Ensure two staff members witnessed the destruction of the fentanyl patch on six occasions - Review of Resident #6's medical record occurred on 02/24/15. Diagnoses included joint pain. Medications included a fentanyl patch every 72 hours and to check patch placement every shift. Review of Resident #6's MARs from October 2014 to February 22, 2015 showed the nurse/CMA failed to:	F 281		

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F 281	Continued From page 3 *Check placement of the fentanyl patch on 12 occasions *Ensure two staff members witnessed the destruction of the fentanyl patch on five occasions During an interview on 02/24/15 at 3:20 p.m., an administrative nurse (#1) stated she expected destruction of fentanyl patches witnessed by two staff members and expected staff to check placement of fentanyl patches on residents every shift. - Review of Resident #2's medical record occurred on February 24, 2015. Diagnoses included congestive heart failure (CHF), depression, anxiety, osteoarthrosis, chronic airway obstruction, peripheral neuropathy, atrial fibrillation, chronic kidney disease, and hypertension (HTN). Quarterly Minimum Data Sets (MDS), dated 06/19/14 and 09/19/14, identified intact cognition. Review of a "Med Error Summary" report stated, "10/31/14 [Resident #2] Dose omitted-Supper meds dished and left in cart." Review of Resident #2's October 2014 MAR identified supper medications included amiodarone 200 mg (CHF), carvedilol 12.5 mg (blood pressure), Zoloft 50 mg (anti-depressant), and hydralazine 10 mg (HTN). The MAR showed staff had initialed those medications as administered at supper. During an interview on 02/24/15 at 4:00 p.m. a nurse manager (#1) verified the medication error occurred because Resident #2 failed to receive his supper medications on 10/31/14. She	F 281		

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F 281	Continued From page 4 indicated staff probably dished up the supper medications, signed off the medications on the MAR, failed to administer the medications for some reason, placed the cup containing the medications back into the med cart where staff found them later, and disposed of them. Staff further failed to circle the initials on the MAR and document a reason why the resident failed to receive the medications. Failure of staff to follow physicians' orders and facility policy resulted in multiple medication errors, placed all residents at risk for medication errors and adverse medication reactions, and may result in misuse and drug diversion.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the safety of 1 of 4 sampled residents (Resident #2 following a medication error. (See F333) Failure to ensure and maintain resident safety by providing adequate supervision, implementing timely/effective interventions, and monitoring/re-evaluating interventions may have contributed to Resident #2's recurrent falls (eight	F 323	F 323 SS= D FREE OF ACCIDENT HAZARDS 1) Resident #2 has expired. 2) All neighbors have the potential to be affected that receive medications and are therefore, at risk for medication errors and any adverse effects of that error, i.e. falls, lethargy etc. 3) Policy revised that upon identification of a significant medication error, the nurse will make a thorough assessment, notify the MD, management staff and family, and implement frequent monitoring at an appropriate interval to prevent additional adverse reactions, i.e. falls. Education was completed at nurses meeting on 3/5/15 regarding this procedure.	

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F 323	Continued From page 5 times within ten days) with injuries (skin tears and a bruised shoulder) and pain which required medical interventions. Findings include: Review of the facility's policy titled "Identifying and Managing Medication Errors and Adverse Consequences" occurred on 02/24/15. This undated policy stated, ". . . In the event of a clinically significant adverse medication consequence, nursing staff shall implement and follow any related Physician orders, and shall monitor closely and document the resident's condition and response to any corrective interventions for at least the next 24 hours or as otherwise directed. . . ." Review of the facility's policy titled "Falls Investigation Policy" occurred on 02/24/15. This undated policy stated, "Purpose: Falls investigations will be conducted to establish the reason behind neighbor's [resident's] falls and establish interventions to proactively prevent further falls . . . Procedure . . . Charge nurse and line staff will implement immediate intervention r/t [related to] circumstances of fall . . . IDT [interdisciplinary team] will review new falls and intervention recommendations weekly. IDT will add interventions to care plan and trend fall data. . . ." Review of Resident #2's medical record occurred on February 24, 2015. Diagnoses included congestive heart failure (CHF), chronic airway obstruction, atrial fibrillation, chronic kidney disease, and hypertension. Quarterly Minimum Data Sets (MDS), dated 06/19/14 and 09/19/14, identified intact cognition and extensive assist of	F 323	4) Medication errors will be reviewed by DON to ensure procedure has been followed appropriately and timely monitoring/interventions were implemented 3x/month x 3 months, then 1x/month x3 months, then 1x quarterly thereafter x 6 months. 5) Date Certain 3/31/15.	3/31/15

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F 323	Continued From page 6 one for bed mobility, transferring, and toileting. The 06/19/14 MDS identified one fall with injury in the previous three months. The 09/19/14 MDS identified two or more falls with no injury, and two or more falls with injury, in the previous three months. Review of Resident #2's events and progress notes identified the following: * 09/05/14 at 5:32 p.m. - "Event: Medication error. Resident given another resident's medications." Received physician's order to "give supper medications, hold beta-blocker [carvedilol], and accucheck q [every] 4 hrs [hours] until with in normal range and then dc [discontinue]." * 09/05/14 at 6:11 p.m. - Unwitnessed fall in room. Three skin tears to the right foot area. Staff assessment stated, "[Resident] lethargic/drowsy, upper and lower extremities weak, pupils sluggish, slurred speech, restless, and complains of dizziness . . . Intervention: monitor every 1-2 hours." * 09/06/14 at 8:23 p.m. - "Event: Unwitnessed fall in room with no injuries . . . [Resident] confused and restless . . . Intervention: Changed to low bed." * 09/07/14 at 2:44 a.m. - Progress note: ". . . found on floor attempting to toilet self. self alarm sounded . . . was then found on the floor in the restroom in his room . . . changed socks to no skid socks et [and] whiched [sic] out bed to low rise bed . . . redirected on the importance of using call light . . . falls happen [sic] with in an hour of each other. . . ." Staff failed to implement the low bed after the 09/06/14 fall. * 09/07/14 at 7:00 p.m. - "Event: Unwitnessed fall in room with no injuries." * 09/07/14 at 11:49 p.m. - Progress note: ". . . had fall on 9-7-14. 4th fall since med era [sic] . . .	F 323		

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F 323	Continued From page 7 electric low bed unplugged to prevent neighbor from raising it when attempting to stand. educated on the importance of calling staff for assistance. will continue to monitor." * 09/08/14 at 5:57 p.m. - "Event: Unwitnessed fall in room . . . self transfer from w/c [wheelchair] to bed . . . no injuries . . . [Resident] dizzy. . . ." * 09/09/14 at 1:15 a.m. - "Event: Unwitnessed fall from low bed . . . Skin tear to left elbow . . . Mild pain . . . [Resident] confused." * 09/09/14 at 6:20 a.m. - "Event: Unwitnessed fall in room out of low bed . . . Skin tear to right arm. . . ." * 09/10/14 at 1:00 a.m. - Progress note: "while in shower . . . bruises found on the left shoulder et [and] scaoula [sic] (3) et right shoulder (2). bruising dark in color et possinble [sic] R/T [related to] falls. . . ." * 09/10/14 at 11:46 a.m. - Progress note: "[resident] stated his left shoulder was hurting so was given tylenol 650mg [milligrams] . . . at 9:30am [a.m.]. . . ." * 09/10/14 at 10:29 p.m. - Progress note: ". . . c/o [complaints of] pain to left shoulder. administered PRN [as needed] tylenol. . . ." * 09/11/14 at 10:17 a.m. - Progress note: "[Resident] has complaints of left shoulder pain. Is medicated with PRN tylelnol [sic] . . . usually . . . pulley exercises. He does refuse this am, and . . . program on hold until . . . PT [physical therapy] can evaluate . . . going for an x ray. . . ." * 09/11/14 at 12:32 p.m. - Progress note: ". . . back from . . . X ray, it is not broke . . . immobolizer [sic], and have a PT consult. . . ." * 09/12/14 at 9:59 a.m. - Progress note: ". . . complains of discomfort to the right shoulder . . . medicated with PRN tylenol. . . ." * 09/13/14 at 11:08 - Progress note: ". . . generalized discomfort. Imbolizer [sic] to (L) arm	F 323		

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F 323	Continued From page 8 in place as per orders." * 09/13/14 at 11:07 p.m. - Progress note: ". . . continues to have bruising noted . . . requested and received Tylenol earlier in evening. . . ." * 09/15/14 at 11:34 p.m. - "Event: Unwitnessed fall in room . . . No apparent injuries. . . ." During an interview on 02/24/15 at 2:20 p.m., 3:30 p.m. and 4:00 p.m. a nurse manager, (#1) verified staff administered several incorrect medications to Resident #2 on 09/05/14. The nurse (#1) indicated after the medication error nursing staff failed to document specific, timely interventions implemented to closely monitor for adverse effects and to prevent further falls or injuries. The facility failed to ensure staff followed facility policies and procedures to closely monitor Resident #2's condition after the medication error for the first twenty-four hours. Staff documentation showed a fall occurred approximately forty-five minutes after the medication error and failed to show immediate interventions implemented during that time to ensure Resident #2's safety. The facility failed to implement/evaluate interventions in a timely manner to prevent further falls and injuries.	F 323		
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, facility policy review,	F 333	F 333 SS = D FREE OF MED ERRORS 1) Resident #2 has expired. 2) All neighbors who receive medications have the potential to be affected and are therefore, at risk for medication errors.	

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F 333	Continued From page 9 and staff interview, the facility failed to ensure residents were free of significant medication errors for 1 of 7 sampled residents (Resident #2) who received multiple incorrect medications. Failure of nursing staff to verify Resident #2's identity before administering medications belonging to another resident resulted in Resident #2 experiencing adverse health consequences. Failure to follow physician's orders and closely monitor Resident #2 may have contributed to the increased number of falls with injuries. (Refer to F323). Findings include: Review of the facility's policy titled "Identifying and Managing Medication Errors and Adverse Consequences" occurred on 02/24/15. This undated policy stated, ". . . The staff and practitioner shall try to prevent medication errors and adverse medication consequences, and shall strive to identify and manage them appropriately when they occur . . . In the event of a clinically significant adverse medication consequence, nursing staff shall implement and follow any related Physician orders, and shall monitor closely and document the resident's condition and response to any corrective interventions for at least the next 24 hours or as otherwise directed. . . ." Review of the facility's policy titled "MEDICATION ADMINISTRATION" occurred on 02/24/15. This undated policy stated, "OBJECTIVE: To administer medications in a safe and accurate manner that will ensure the 5 rights of patient identification for administration . . . PROCEDURE: . . . 2. Neighbor's [resident's] identification is to be verified prior to	F 333	3) Staffing responsibilities were revised so that CMA's will only be assigned to passing medications and CNA's will only be assigned to doing cares for the residents on their shift. Nurses and Certified Medication Assistants were educated on revised staffing assignments at report on 3/5/15 and 3/6/15 by DON and/or designee. Communication was provided every shift thereafter by the charge nurses on the new system until all staff was notified. Staff was also reeducated 1:1 by the DON on the medication administration policy which includes following the 5 Rights (Right person, right medication, right dose, right time and right route) and to check their MAR against their label 3x for each medication. 4) Audits to be completed by DON and/or designee to ensure correct medication administration policy is followed by both CMA's and Nurses and that the MAR's are being documented on correctly 5x/wk x 1 month, then 3x/wk x 1 month, then 1x/wk quarterly thereafter x 1 year. 5) Date Certain 3/31/15.	3/31/15

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F 333	Continued From page 10 administration of meds. Photographs are on MARs [medication administration record] . . . 4. Properly identify ordered medications for each neighbor, check label for proper medication, dose, frequency and route . . . 7. Sign med [medication] out on MAR at time of dispensing medication. . . ." Review of Resident #2's medical record occurred on February 24, 2015. Diagnoses included congestive heart failure (CHF), chronic airway obstruction, atrial fibrillation, chronic kidney disease, and hypertension (HTN). Quarterly Minimum Data Sets (MDS), dated 06/19/14 and 09/19/14, identified intact cognition. Review of a "Med Error Summary" report and Resident #3's "Physician's Order Summary" identified nursing staff failed to verify the resident's identity and administered the following incorrect medications to Resident #2 on 09/05/14 at 5:32 p.m.: Xanax .25 milligrams (mg) (anti-anxiety), Crestor 5 mg (cholesterol), Metoprolol 12.5 mg (cardiac beta-blocker), Glucophage 500 mg (diabetes), Remeron 30 mg (anti-depressant), and Seroquel 50 mg (anti-psychotic). Progress notes, dated 09/05/14 at 5:32 p.m., stated, "Neighbor was given wrong medication . . . physician notified . . . we are to hld [sic] the carvedilol, and [resident] can take the rest of his meds. We will be doing accu checks Q [every] 4 hours until b/s [blood sugar] stabilize." A physician's order, dated 09/05/14, stated, "accucheck q [every] 4 hrs [hours] until with in normal range and then dc [discontinue] . . . Start Time 06:00 PM. . . ."	F 333		

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BENEDICTINE LIVING CENTER OF GARRISON	609 4TH AVE NE GARRISON, ND 58540

(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 11 Review of Resident #2's blood sugar monitoring showed nursing staff failed to begin accuchecks until sixteen hours later. All results included: * 09/06/14 at 10:00 a.m. - 188 milligrams/deciliter (mg/dl) * 09/07/14 at 2:44 a.m. - 183 mg/dl * 09/07/14 at 11:49 p.m. - 173 mg/dl Review of Resident #2's September 2014 MAR identified after the medication error, staff failed to initial the MAR to verify and follow the physician's order to administer the rest of Resident #2's scheduled medications except carvedilol, on 09/05/14. Medications not initialed included Ciloxan eye drops at supper and bedtime, amiodarone 200 mg (CHF) at supper, gabapentin 100 mg (osteoarthroisis) at supper, Lasix 20 mg (CHF) at supper, hydralazine 10 mg (HTN) at supper, Zoloft 50 mg (depression) at supper, Ativan 1 mg at bedtime, and Flomax 0.4 mg at bedtime. Review of Resident #2's events and progress notes identified multiple falls following the medication error with the first fall occurring approximately forty-five minutes after the error. A progress note, dated 10/03/14, stated, "IDT [Interdisciplinary Team] . . . decided that we would continue to monitor [Resident] as his falls previously had been acquainted with the medication error." (Refer to F323) During an interview on 02/24/15 at 4:00 p.m. a nurse manager, (#1) verified a certified medication aide (CMA) (#2) failed to identify the right resident and administered several incorrect medications to Resident #2 on 09/05/14. The nurse manager (#1) indicated the charge nurse	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355064	A. BUILDING _____ B. WING _____	C 02/24/2015

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F 333	Continued From page 12 educated the CMA at that time to slow down and follow the five rights of medication administration. The nurse (#1) verified staff failed to follow physician's orders to check blood sugars every four hours and to initial the MAR to verify Resident #2 received the rest of his medications. Failure of nursing staff to administer medications in a safe manner resulted in Resident #2 receiving several incorrect medications. Failure to follow physician's orders, monitor for adverse reactions, and promptly implement interventions increased the risk for falls and injuries.	F 333		