STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER POINTE, A PROSPERA COMMUNITY	**3500 21ST ST SE MANDAN, ND 58554**

(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 An unannounced onsite complaint survey, was completed on 04/17/18. The sample included nine (9) sampled residents and four (4) records for focused review.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) 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, and staff interview, the facility failed to ensure residents remained free of significant medication errors for 1 of 1 sampled resident (Resident #6) with a significant medication error. Failure of staff to administer medications ordered may negatively impact a resident's quality of life. Findings include: Information provided by the complainant indicated nursing staff failed to administer physician ordered medications. Review of Resident #6's medical record occurred on 04/17/18. Diagnoses included hypothyroidism, Alzheimer's disease, and depression. A physician order, dated, 02/16/18, stated, ". . . Levothyroxine Sodium Tablet 50 MCG [micrograms] Give 50 mcg by mouth one time a day . . ." Review of Resident #6's February and March 2018 electronic medication administration record (eMAR) identified the levothyroxine as "U SA	F 760	It is the intent of this facility to remain in compliance with F-760 and be free of any significant med errors. The Levothyroxine order for Resident #6 was corrected on 3/30/18 when the error was identified. Correction was confirmed on 4-18-18 to ensure that the medication order was corrected in the Electronic Medical Record (EMR) and appears in the Electronic Medication Administration Record (EMAR) to be administered by facility staff. A report in PCC was run on 4-20-18 to identify all other residents who have medications entered to be self-administered to ensure these medication orders were entered correctly. 3 Residents were identified as self-administering medications. To ensure medication orders for self-administration are entered correctly the following has/will be completed: 1. Reeducation was done with nursing and CMA staff on 4-18-18 regarding the importance of accurate order entry,	5/22/18

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

Electronically Signed | 04/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355106	A. BUILDING _____ B. WING _____	C 04/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER POINTE, A PROSPERA COMMUNITY	**3500 21ST ST SE MANDAN, ND 58554**

(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 760	Continued From page 1 [unknown self-administered]" from 02/17/18 through 03/30/18. Nursing staff started administering the levothyroxine on 03/31/18, 42 days after the order was written. Review of an incident form, dated 03/30/218, stated, ". . . Found that resident had not been receiving Levothyroxine medication since admission. When looking at order it was selected as self administration vs [versus] clinician administer. Order was up dated to clinician to administer. . . ." The form identified the facility notified the physician and Resident #6 experienced no negative outcomes. During an interview on the afternoon of 02/17/18, an administrative nurse (#1) stated the nursing staff failed to enter the correct administration type during order entry and the nurse (#1) could not explain why the error remained unnoticed for 42 days.	F 760	specifically medications to be self-administered. 2. Continued reeducation with nursing and CMA staff regarding medication errors and order entry will be held on 5-18 -18 at the schedule nursing staff meeting. This will include review of the Medication Order Verification QI Worksheet. 3. A PCC report to identify all residents whom have medications that are coded for self-administration will be run weekly X4 and then monthly X2. The order entry of the medications coded for self –administration including Resident #6 will be reviewed for accuracy. QI monitoring will begin the week of 4/23/18 using the Medication Order Verification QI Worksheet and the self-administration report. Order entries for self-administration will be monitored weekly X 4, then monthly X 2. Results of the QI monitoring will be reviewed as part of the monthly facility QAPI meetings and the results summarized for the quarterly QAPI meeting with the Medical Director in Attendance. The need for further monitoring will be determined based upon these results.	