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 11/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH CONTINUING CARE CENTER OFF COLLINS	201 14TH STREET NW 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 For the unannounced complaint survey conducted on November 17-18, 2014, the sample included four residents for complete review. The concerns regarding facility staff failing to ensure Resident #1 received only her medications per physician order was substantiated.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual.	
F 333 SS=G	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 professional standards for medication administration for 1 of 1 sampled resident (Resident #1). Failure to administer medications using safe administration practices resulted in a significant medication error which required Resident #1 to be hospitalized. Findings include: 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	F 333	**F-333: Resident's free of significant medication errors** Resident #1 and all other residents of this facility have the potential to be affected by a medication pass that does not follow P & P or adhere to regulatory guidelines. Because of this, the following action has been taken to ensure that residents are correctly identified using two methods prior to medication administration: The Medication Administration P & P was revised to include the requirement to identify the resident by using two methods of identification if the resident is unknown to the staff person.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mindy Mason	Administrator	12/12/14

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 333	Continued From page 1 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 "Principles of Medication Administration" occurred on 11/18/14. This policy, revised 09/29/14, stated ". . . Identify the resident prior to administering the medication by checking the picture in the MAR, call the resident by name, or verify with other care center personnel. . . ." The facility policy failed to reflect at least two client identifiers should be used prior to administering medications. Information provided to the State agency indicated facility staff failed to ensure Resident #1 received only her medications per physician order. Review of Resident #1's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 10/04/14, identified severely impaired cognition and extensive assistance required for Activities of Daily Living (ADLs). The Progress Notes identified the following: * 09/28/14 at 6:00 p.m., "Resident given another resident's medications on top of her own scheduled medications. [Physician] . . . notified with instructions to monitor vitals hourly x 6 hours and to monitor mental status closely." * 09/28/14 at 6:15 p.m., "Resident's initial BP	F 333	Thereafter, and in any situation of continuing one-on-one care where the nurse "knows" the individual, one of the identifiers can be direct facial recognition. Individual education was completed with the nurse involved immediately following the error occurrence. The DON met with this nurse on 9-28-14 to review the Medication Administration P & P and establish the importance of positive identification using two methods of identification prior to med administration. Education will be repeated with the nurse involved on 12-16-14 & will include a review of the revised Medication Administration P & P. Education will emphasis the importance of proper identification using two methods of identification when the resident is unknown to the staff prior to med administration Education will be completed with all CMA's and nursing staff on 12-17-14 and will include a review of the revised Medication Administration P & P along with resident identification requirements. QI monitoring will begin following education on 12-17-14. Monitoring will be completed by the QI Coordinator and/or his designee using the QI Worksheet titled "Medication	

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F 333	Continued From page 2 [blood pressure] 81/48 [120/80 systolic/diastolic blood pressure is considered within normal limits] with a HR [heart rate] of 65. Resident brought to her room and laid down with her feet elevated. Staff at bedside to feed resident and monitor BP every 10 minutes." * 09/28/14 at 6:50 p.m., "Resident's BP 70/40 [hypotension: systolic reading consistently between 85 and 110 mm/Hg (manometric unit of pressure)] with a HR of 49 [60 to 100 beats per minute is considered within normal limits]. [Physician] . . . notified of BP drop and order received [sic] to send her to [local Hospital Emergency Room (ER)] to be evaluated and treated. . . . Resident left facility at 7:10 p.m. with EMS [Emergency Medical Services] crew. Report called to [ER]. Awaiting update on resident's condition." The hospital history and physical, dated 09/28/14, identified, ". . . accidental administration of medications . . . woman residing in SNF [skilled nursing facility] who was mistakenly given another patient's medications along with her own. She received an extra dose of Norco [a pain medication] along with metoprolol [an anti-anginal medication] and lisinopril [a medication for hypertension] and sinemet [a medication for Parkinson's disease] and tegretol [a seizure medication]. Patient was lethargic and hypotensive thus prompting ER visit. . . ." The progress noted, dated 09/29/14 at 2:27 p.m., identified, "Resident returned from hospital . . . ." The medication safety report, dated 09/29/14, identified, ". . . Administering error . . . wrong patient . . . in the dining room . . . Resident sitting in wrong spot, also nonverbal. . . . An error	F 333	Administration LTC". All staff members whose work responsibilities include passing medications will be observed prior to 12-21-14 and will include the nurse involved. Beginning the week of 12-22-14 monitoring of 5 staff per week will be completed weekly X4 and monthly X3 to insure that compliance is achieved and maintained. Results of the QI monitoring will be reviewed at the monthly QI meetings and then at the Quarterly CQI Meeting with the Medical Director in attendance. Further monitoring will be determined by the results reviewed at these meetings. DATE CERTAIN: 12-21-14	

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F 333	Continued From page 3	F 333		

occurred that resulted in the need for treatment or intervention and caused temporary patient harm. . . . Vital signs monitoring initiated . . . Referred to provider . . . ER . . . Hospitalization . . ." The report further indicated the nurse received education on the "facility's policy, the rights of medication administration, and alternative identifiers."

During an interview on 11/17/14 at 5:00 p.m., an administrative nurse (#1) reported facility staff use the dining room assigned-seating chart, the photos on the MAR [medication administration record], and verbal confirmation to identify residents prior to administering medications. The nurse [who never met either Resident #1 or the new admit] dished the new resident's medications, reviewed the updated seating chart, went to the table identified on the chart, addressed Resident #1 by the new resident's name, and gave her [the new resident's] medications. The nurse felt Resident #1 "looked similar to the person on the MAR," and wasn't surprised when Resident #1 was non-responsive as she had been told the new resident "wasn't very verbal."

The nurse used the resident's physical location as an identifier, addressed the resident by name even though she had previous knowledge the resident "wasn't very verbal," and administered the medications even though the resident "looked similar to the person on the screen." Failure to administer medications using safe administration practices resulted in Resident #1 requiring hospitalization.