STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355052	A. BUILDING _____ B. WING _____	01/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON COUNTY HEALTH SYSTEM CARE CENTER	108 E NYHUS AVE MCVILLE, ND 58254

(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 standard Medicare/Medicaid recertification survey started on 01/21/14 and completed on 01/23/14, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 2 additional residents to verify specific concerns during the survey.	F 000		
F 281 SS=D	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 observation, record review, policy review, professional reference, resident interview, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 supplemental resident (Resident #11) observed with medication left unattended at the dining room table and for 1 of 1 supplemental resident (Resident #12) observed receiving pre-mixed MiraLax. Failure to stay with residents while administering medication, unless assessed as safe to do so, does not ensure residents ingest all their medications, and does not ensure the safety of other residents who may take the medication left at the table. Failure to administer medication immediately after preparation may result in medication errors or the loss of efficacy of the medication. Findings include: Berman and Snyder, "Kozier & Erb's	F 281	1. Resident #11 was not a candidate for self-administration of meds prior to the survey. Following the survey findings, the IDT reassessed to see if anything had changed. All agreed that #11 is not a candidate for self-administration. Administration of both Miralax and Metamucil was discussed with physician. The Miralax was increased to BID and Metamucil was discontinued. He does like to take his medications with his milk, later in the meal. Staff member who is passing medications will bring them to him toward the end of his meal, when he is ready to take them. Resident #12 is also not a candidate for self-administration of medications. Staff has been reminded of this. The policies for Self-administration of Medications and Miralax for a Crowd will be reviewed at a meeting for staff who pass medications. 2. All residents receiving laxatives have the potential to be affected. All residents	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bruce Donnerday — TITLE: CEO/Administrator — (X6) DATE: 2/19/14

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 281	Continued From page 1 Fundamentals of Nursing: Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, pages 870-871, states, ". . . Stay with the client until all medications have been swallowed. Rational: The nurse must see the client swallow the medication before the drug administration can be recorded. . . . A primary care provider's order or agency policy is required for medications left at the bedside. . . ." The Geriatric Medication Handbook, 7th ed., American Society of Consultant Pharmacists, page 148, states, "Medications should be prepared for the resident immediately before administration; medications should never be prepared in advance for multiple residents and left in unlabeled medicine cups for later use." Review of the facility policy titled "Medication Administration" occurred on 01/23/14. This policy, revised October 2006, stated, "Purpose: To assure accurate and accountable medication administration. . . . Procedure: . . . 2. Safety . . . F. Do not Pre-Dish medications. G. Do not leave medications with a CNA [certified nurse aide], family member or the resident. . . . 3. General Considerations . . . H. . . . Medications should not be given from an unlabeled bottle . . . J. Medications should be prepared for the resident immediately before administration. . . ." Review of the facility policy titled "Miralax for a Crowd" occurred on 01/23/14. This policy, dated 07/16/13, stated, "Purpose: When numerous residents receive Miralax during a medication pass . . . Mixing all of the doses at once can save time and effort. Procedure: . . . 2. Place the prescribed dose . . . from the resident's individually ordered container into a clean pitcher.	F 281	who are not capable of self-administering their own meds have the potential to be affected when medications are left to be taken independently. 3. Miralax is not saved for use at another medication pass. The pitchers used to mix the bulk Miralax have been marked 'Miralax only.' The policy for Miralax for a Crowd has been revised. It definitely states that the mixture can only be used for one medication pass, and then discarded. The assessment process was in place even prior to this incident, so nothing with that process was changed. All nurses who pass medications were made aware of or reminded that only those who have been assessed to safely do so can have their meds left to self-administer. The policies for Medication Administration, Self-Administration of Medications and Miralax for a Crowd were all reviewed and revised. These policies will all be reviewed on 2/26/14 at a meeting for all nurses who pass medications. 4. The DON will monitor using the QA – Medication Administration checklist. Monitoring will be completed weekly x 1 month, then monthly x 2 months and	

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F 281	Continued From page 2 3. Add 4-8 ounces of water to the pitcher for each dose. 4. Dispose of any unused Miralax in the pitcher once the medication pass is competed." - Review of Resident #11's medical record occurred on 01/22/14. Resident #11's Interdisciplinary Care Conference Note, dated 12/10/13, stated, "Self Administration of Medications: No [-] nurses dish [and] give . . ." The record did not include an assessment or physician order for self administration of medication (SAM). On 01/22/14 at 7:44 a.m., observation showed a Certified Medication Aide (CMA) (#2) dished up Resident #11's medications, which included aspirin, acetaminophen, the heart medications: amlodipine and losartan, the diuretic: Lasix, the supplements: multivitamin with mineral, potassium chloride, vitamin E, and calcium with vitamin D, and the laxatives: psyllium (Metamucil) and MiraLax. The CMA measured the dose of each laxative separately and placed the powder into two cups. The CMA (#2) failed to add liquid to either laxative. Observation showed Resident #11 eating breakfast at the dining room table. The CMA placed the medications by Resident #11's plate and stated, "He likes to mix his Metamucil and MiraLax in his milk." The CMA returned to the medication cart without observing whether Resident #11 took the medications. At 8:40 a.m., observation showed Resident #11 no longer at the table. The MiraLax powder remained in the cup by his plate, with another empty medication cup stacked inside it. The surveyor asked the CMA (#2) to view Resident #11's place setting. The CMA identified the	F 281	quarterly for the rest of 1 year. Any concerns identified will be immediately addressed by the DON with the staff member passing medications. A report of monitoring results will be submitted to the QA committee at their scheduled meetings.	02/26/14

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F 281	Continued From page 3 MiraLax and stated, "Oh, maybe he refused it today. I will ask him and offer it again." When asked how she knew Resident #11 could self administer medication, the CMA stated, "He usually is really good [at taking medication himself]." During an interview on 01/22/14 at 8:43 a.m., Resident #11 stated he thought he took all his medications. When questioned about the remaining MiraLax, the resident stated, "There is so many cups I might have mixed them up." At 9:42 a.m., a CMA (#2) told Resident #11 about the MiraLax powder left at the dining table, and asked, "You didn't want to refuse it did you?" The resident responded, "No, not really." Observation showed the CMA provided Resident #11 with MiraLax mixed with water to replace the dose the resident missed earlier. During an interview on 01/22/14 at 6:15 p.m., a nurse administrator (#3) stated if staff assessed a resident for SAM, medications may be left with the resident to take on his/her own. This nurse was unable to provide documentation of Resident #11's assessment for SAM. Failure to monitor and ensure a resident ingests all medications administered resulted in Resident #11 overlooking his MiraLax. The resident received the MiraLax two hours later, only after the CMA was informed of the missed dose. - On 01/21/14 at 5:20 p.m., observation showed a licensed nurse (#4) prepared medications for Resident #12. An unlabeled pitcher containing a clear liquid substance, which looked like water, sat on top of the medication cart. The nurse	F 281		

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F 281	Continued From page 4 stated the liquid was MiraLax and stated per policy, she mixed it at the beginning of the day shift to be used through the day for residents receiving MiraLax. The nurse (#4) filled a cup for Resident #12 with the MiraLax mixture. During an interview on 01/22/14 at 6:15 p.m., a nurse administrator (#3) stated the facility's intent regarding MiraLax was to mix all the residents' doses for the 8:00 a.m. medication pass, and mix more later if needed for the 6:00 p.m. medication pass. Failure to mix only the amount of MiraLax needed per medication pass and label the pitcher holding the MiraLax increases the risk of contamination and may result in medication errors.	F 281		
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 observation, record review, policy review, review of professional reference, and staff interview, the facility failed to ensure residents are free of any significant medication errors for 1 of 1 sampled resident (Resident #7) receiving liquid morphine sulfate (MS). Failure to administer the correct dose of morphine sulfate for the prescribed diagnosis may have resulted in Resident #7 being over medicated and at risk of fatal respiratory depression. Findings include:	F 333	1. The liquid Morphine Sulfate order for Resident #7 was clarified with her primary physician on 1/24/14 and the corrected order was written in the Medication Administration Record (MAR) immediately after it was received. The clarified order was also written on the order summary sheet in her chart. 2. All residents who have medication orders have the potential to be affected by orders that are incorrectly transcribed. 3. A system of checks has been devised so that all orders are double checked. Narcotic medications are triple checked. A new policy for Transcription of Medication Orders has been developed. Staff who are responsible for giving	

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F 333	Continued From page 5 Semla, Beizer, Higbee, "Geriatric Dosage Handbook," 12th Edition, 2007, Lexi-Comp, Inc., Ohio, page 1045, stated regarding the narcotic Morphine Sulfate, "Medication Safety Issues: . . . Use care when prescribing and/or administering morphine solutions. These products are available in different concentrations. Always prescribe dosage in mg [milligram]; not by volume (mL) [milliliter]. . . ." Exerts from the book "Symptom Control In Hospice & Palliative Care" by Peter Kaye, www.hospiceworld.org/book/dyspnea.htm, stated, "Dyspnea: Dyspnea means a distressing difficulty in breathing. . . . Management options: 1. Morphine reduces the inappropriate and excessive respiratory drive which is a feature of dyspnea. . . . A starting dose for treating dyspnea should be 2.5mg to 5mg of oral morphine every 4 hours. . . . Doses above 10mg to 20mg every 4 hours are unlikely to give further benefit. . . ." Review of the facility policy titled "Documentation Guidelines" occurred on 01/23/14. This policy, revised February 2009, stated, ". . . 23. Complete physician's orders include: Medication or treatment, dosage route of administration and frequency. PRN [as needed] orders must also include reason for the medication and frequency. When an order is transcribed onto the medication or treatment record, it must be transcribed exactly as the physician wrote it. If the order is incomplete or unclear, it should be clarified by contacting the physician and write the order again." Review of Resident #7's medical record occurred on 01/23/14. Diagnoses included shortness of	F 333	medications will be in-serviced regarding the policy on 2/26/14. 4. The DON will be responsible for monitoring order transcription using the QA – Transcription of Medication Orders. The monitoring will be completed for all orders received weekly x 4 weeks, monthly x 2 months and quarterly for the remainder of one year. Results of the monitoring will be submitted to the QA committee at their quarterly meetings.	02/26/14

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F 333	Continued From page 6 breath (SOB), chronic obstructive pulmonary disease (COPD), and oxygen use. Resident #7's annual Minimum Data Set (MDS), dated 01/01/14 and the quarterly MDS, dated 10/01/13, indicated severe cognitive impairment and shortness of breath or trouble breathing with exertion and when sitting at rest. A physician order, dated 09/11/13, stated, "Morphine sulfate 20mg/ [per] 5ml, 0.5ml - 1ml [2mg - 4mg] po [orally] or SL [sublingual - under the tongue] Q [every] 2 [hours] prn for labored breathing." Resident #7's Medication Administration Record (MAR) showed the following order and usage: * September 2013 - "Morphine Sulfate 20mg/1ml [5ml crossed out] give 0.5m [sic] - 1mg po or SL q [every] 2 [hours] prn for labored Breathing." Staff failed to transcribe the order exactly as written by the physician (the physician order indicated 2-4mg, but the transcribed order stated 0.5-1mg). - 09/11/13 at 7:45 p.m. - ".25" for "more restless - labored breathing," dose "SL 0.25ml = 5mg" Staff administered 1mg more than the physician ordered. - 09/11/13 at 8:15 p.m. - ".25" for "labored breathing," dose "SL 0.25ml = 5mg" Staff administered 1mg more than the physician ordered. - 09/11/13 at 11:00 p.m. - ".5" for "labored breathing," dose "0.5ml = 10mg" Staff administered more than twice the dose ordered. - 09/12/13 at 1:45 a.m. - ".5 ml" for "restless-labored breathing," dose "0.5ml = 10mg" Staff administered more than twice the dose ordered. The nurse's note stated, "Morphine 0.5mg repeated . . . ," which contradicts the MAR	F 333		

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F 333	Continued From page 7 dose of 10mg administered. - 09/16/13 at 4:40 a.m. - Staff failed to list the dose administered on the MAR or nurse's notes. - 09/16/13 at 9:30 a.m. - Staff failed to list the dose administered on the MAR or nurse's notes. - 09/16/13 at 2:00 p.m. - "0.5" Staff failed to clarify the dose administered as 0.5mg, which is how staff transcribed the order on the MAR, or 0.5ml (10mg), which is more than twice the dose ordered. Nurse' notes stated, 'Becoming agitated et [and] restless again now - given MS et [and] ativan for same." Staff administered the morphine without the symptom of labored breathing present. - 09/18/13 at 5:00 p.m. - Staff failed to list the dose administered on the MAR. Nurse's notes, dated September 17-18, 2013 stated, "Resident received MS 0.5ml = 10mg @ 1700 & 0445 (4:45 a.m.) for gen [general] disc [discomfort] & resident stating 'I hurt, I hurt' . . ." Staff administered more than twice the dose of morphine ordered by the physician and without the symptom of labored breathing present. * October 2013 - "Morphine Sulfate 20mg/1ml, .5ml-1ml po or SL q 2 [hours] for labored breathing." Staff again failed to transcribe the MS order exactly as the physician had written (MS 20mg/5ml, 0.5ml-1ml). - 10/25/13 at 1:00 a.m. - "yelling 'can't breath' where's my husband?" Staff administered Ativan, ordered prn for anxiety, instead of the MS, ordered for labored breathing, or DuoNeb nebulizer, ordered prn for shortness of breath. * November 2013 - "Morphine Sulfate 20mg/1ml [5ml crossed out] give .5mg - 1 mg po or SL q 2 [hours] for labored Breathing (10mg-20mg q 2 [hours]) prn." Staff transcribed contradicting	F 333		

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F 333	Continued From page 8 dosages, 0.5-1 mg and 10-20 mg, and failed to transcribe the order exactly as written by the physician. - 11/09/13 at 2:00 a.m. - "10mg" for "labored breathing" - 11/09/13 at 2:30 a.m. - "10mg" for "labored breathing" - 11/09/13 at 4:00 a.m. - "10mg" No further information on MAR - 11/09/13 at 7:00 a.m. - "10mg" for "labored breathing" - 11/09/13 at 9:00 a.m. - "10mg" for "labored resp. [respirations]" - 11/09/13 at 11:45 a.m. - "10mg" for "labored resp" Staff administered more than twice the dose ordered by the physician for the above six doses. * November 2013 (second page added for prn medication) - "Morphine Sulfate 20mg/ml. give 0.5ml - 1ml (o) [orally] or SL q 2 hrs [hours] for labored breathing prn (10-20mg)." Staff failed to transcribe the order exactly as written by the physician. - 11/09/13 at 7:30 p.m. - "10mg" for "labored resp" - 11/10/13 at 12 midnight - "10mg" for "labored resp" - 11/10/13 at 6:45 a.m. - "20mg" for "can't breath [sic], Resp 28" - 11/10/13 at 9:00 p.m. - "20mg" for "can't Breathe" - 11/11/13 at 2:30 a.m. - "20mg" for "can't Breath [sic]" - 11/14/13 at 9:30 p.m. - "20mg, leg pain, can't breathe et restless" - 11/15/13 at 2:00 a.m. - "20mg, can't breathe, restless" - 11/17/13 at 11:30 a.m. - "can't breathe (had neb	F 333		

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F 333	Continued From page 9 [nebulizer]) very agitated - MS 10mg given" Staff administered more than two to four times the dose ordered by the physician for the above eight doses. - 11/18/13 at 7:00 p.m. - "10mg" No further information on MAR. Nurse's note stated, "Res. [resident] has been wheeling up/down halls hollering et talking nonstop . . . ativan et MS given . . ." Staff administered more than twice the dose of morphine ordered by the physician and without the symptom of labored breathing present. *December 2013 - "MS 20mg/ml, 0.5-1.0 mg q. 2 h. [hours] prn for labored breathing" - 12/03/13 at 3:15 p.m. - "0.5" for "c/o [complaint of] pain all over, MS 0.5mg (SL)" - 12/09/13 at 11:15 a.m. - "c/o pain to R) [right] wrist, MS 0.5mg po" Staff again failed to transcribe the MS order exactly as the physician had written. Staff failed to follow the physician's order, administering less than four times the dose ordered and administered MS for pain when the order stated for labored breathing. Resident #7's medications included an order for Tylenol prn, which the resident received on multiple other occasions, with documented relief of her pain. * January 2014 - "MS 20mg/ml, 0.5-1.0 mg q. 2 h. prn for breathing" - 01/12/14 at 4:00 p.m. - "agitated/anxious, MS 0.5ml po" [10mg given] Staff again failed to transcribe the MS order exactly as the physician had written. Staff failed to follow the physician's order, when they administered MS for agitation/anxiety when the order stated for labored breathing.	F 333		

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F 333	Continued From page 10 During an interview on 01/23/14 at 12:15 p.m., an administrative nurse (#3) stated an order from the physician should be transcribed on to the MAR exactly as written, and the morphine prescribed for Resident #7 for labored breathing should only be used for that reason. Observation of Resident #7's morphine sulfate bottle, at this time, with the nurse (#3) showed the concentration as "100 mg per 5 ml (20 mg/ml)." The nurse could not explain why the MS bottle failed to match the physician's order of 20mg/5ml. Failure to administer the liquid MS per physician's order resulted in Resident #7 receiving multiple incorrect doses of MS (0.5mg - 20mg instead of 2mg - 4mg) and could result in fatal respiratory depression.	F 333		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on review of professional reference and record review, the consulting pharmacist failed to recognize and report a medication irregularity to the attending physician and director of nursing in	F 428	1. The liquid Morphine Sulfate order for Resident #7 was clarified and corrected 1/24/14. See F333. 2. All residents who have medication orders have the potential to be affected when orders are transcribed incorrectly. 3. The consultant pharmacist will be required to check physician orders that the resident has received during the past month. The drug regimen for each resident must be reviewed at least once monthly by a licensed pharmacist. This in combination with the QA – Transcription of Medication Orders that will be completed by the DON should detect any further transcription errors. NCHS has developed a new job description for the	

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F 428	Continued From page 11 conjunction with 4 of 4 medication regimen reviews (October 2013, November 2013, December 2013, and January 2014) for 1 of 1 sampled resident (Resident #7) receiving liquid morphine sulfate (MS). Failure to recognize and report irregularities may have resulted in the resident being over medicated and at risk of fatal respiratory depression. Findings include: Semla, Beizer, Higbee, "Geriatric Dosage Handbook," 12th Edition, 2007, Lexi-Comp, Inc., Ohio, page 1045, stated regarding the narcotic Morphine Sulfate, "Medication Safety Issues: . . . Use care when prescribing and/or administering morphine solutions. These products are available in different concentrations. Always prescribe dosage in mg [milligram]; not by volume (mL) [milliliter]. . . ." A physician order, dated 09/11/13, stated, "Morphine sulfate 20mg/5ml, 0.5ml - 1ml po [orally] or SL [sublingual - under the tongue] Q [every] 2 [hours] prn for labored breathing." The physician failed to prescribe the morphine dosage of 2mg - 4mg in milligrams. Resident #7's Medication Administration Record (MAR) showed the following: * September 2013 - "Morphine Sulfate 20mg/1ml [5ml crossed out] give 0.5m [sic] - 1 mg po or SL q [every] 2 [hours] prn for labored Breathing." 0.5-1mg is four times less than the dose of 2mg - 4mg ordered by the physician. * October 2013 - "Morphine Sulfate 20mg/1ml, .5ml-1ml po or SL q 2 [hours] for labored breathing." 0.5ml - 1ml (10mg - 20mg) is two to	F 428	consultant pharmacist. A new Drug Regimen Review policy has been written. These will be reviewed with the consultant pharmacist on 2/26/14. 4. A QA was developed that will check medication orders to see that they have been checked by the consultant pharmacist. This QA – Consultant Pharmacist Order Check will be completed by the DON weekly x 1 month, monthly x 2 months and then quarterly for the remainder of 1 year. Results communicated to the QA committee at their quarterly meetings.	02/26/14

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F 428	Continued From page 12 four times the dose ordered by the physician. * November 2013 - "Morphine Sulfate 20mg/1ml [5ml crossed out] give .5mg - 1 mg po or SL q 2 [hours] for labored Breathing (10mg-20mg . . .) prn." 0.5mg - 1mg is two to four times less than the dose ordered by the physician, and 10mg -20mg is two to four times more. * November 2013 (second page added for prn medication) - "Morphine Sulfate 20mg/ml. give 0.5ml - 1ml (o) [orally] or SL q 2 hrs [hours] for labored breathing prn (10-20mg)." 10mg - 20mg is two to four times more than the dose ordered by the physician. * December 2013 - "MS 20mg/ml, 0.5-1.0 mg q. 2 h. [hours] prn for labored breathing" 0.5mg - 1mg is two to four times less than the dose ordered by the physician. * January 2014 - "MS 20mg/ml, 0.5-1.0 mg q. 2 h. prn for breathing" 0.5mg - 1mg is two to four times less than the dose ordered by the physician. Staff failed to transcribe the MS order exactly (MS concentration and dosage) as the physician had written. Staff also failed to include the route of the MS upon transcription to the MAR in December and January. Resident #7's monthly pharmacist's medication review from October, 2013 through January, 2014 failed to indicate the pharmacist identified any discrepancies with the physician's order for MS, or the staff's transcription and use of the MS. See F333	F 428		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. In accordance with State and 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. 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, policy	F 431	~~1. The Gabapentin for Resident #5 was~~ sent to the pharmacy in Lakota where it was carded and labeled with the correct administration information. The progress note and correct order information were faxed to the VA on 2/3/14. The next Gabapentin supply we receive should have the correct administration information on the label. A clarified order for the Morphine Sulfate for Resident #7 was received on 1/24/14 from the resident's primary physician. 2. Since all residents could have a change in their medication orders at any time, they all have the potential to have labels on their medications that do not reflect the current physician order. 3. Nurses cannot affix new labels to medications and cannot alter what a label says. We have revised a current policy and have obtained labels that will be affixed to cards and bottles with incorrect labels due to an order change. The label is bright orange and states 'Directions Changed – Refer to Chart.' A resident's designated pharmacy will be informed of any order changes as soon as possible after an order change. This can be done on the same day with most pharmacies, but will have to wait until a	

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F 431	Continued From page 14 review, and staff interview, the facility failed to ensure a medication bottle bore an accurate label for 2 of 6 sampled residents (Resident #5 and #7). Failure to notify the resident's pharmacy when a medication label does not match the prescription and failure to obtain the correct medication or label increases the risk of error and has the potential for the resident to receive an incorrect dose of medication. Findings include: Review of the facility policy titled "Medication Administration" occurred on 01/23/14. This policy, revised October 2006, stated, "Purpose: To assure accurate and accountable medication administration. . . . Procedure: . . . 3. General Considerations . . . H. Medication directions on the pharmacy label should correlate with the medication directions on the MAR (Medication Administration Record). . . ." - On 01/21/14 at 5:40 p.m., observation showed a licensed nurse (#4) prepared medications for Resident #5. The nurse dished one tablet from a bottle labeled "Gabapentin 300 mg [milligrams]." The pharmacy-attached label on the bottle indicated the pharmacy filled the prescription on 01/07/14 and stated "give 2 tablets tid [three times daily]." When asked why the nurse only dished up one tablet, the nurse (#4) stated the physician decreased the dose recently. Review of Resident #5's medical record occurred on 01/21/14. A physician order, dated 10/16/13, stated, "Neurontin [gabapentin] 300 mg cap [capsule] 1 cap po [orally] tid." Resident #5's MAR reflected this order.	F 431	progress note is received if the pharmacy is the VA. The facility has put policies into place and has completed training to prevent further transcription errors. See F333 and F428. The policy and procedure entitled 'Tagging New Orders and Medication Cards' was revised. It will be included in the discussion that will be held at the meeting for staff who pass medications on 2/26/14. See also F333 and F428 POC. 4. This QA – New Medication Orders will be completed by the DON weekly x 1 month, monthly x 2 months and then quarterly for the remainder of 1 year. Results communicated to the QA committee at their quarterly meetings.	02/26/14

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F 431	Continued From page 15 During an interview on 01/23/14 at 7:45 a.m., an administrative nurse (#3) stated staff fax the progress note and order slip with medication changes to the resident's pharmacy whenever a physician changes a medication order. The nurse (#3) was unable to explain why the label on a recently filled bottle of gabapentin failed to match the order written over three months ago, and failed to provide evidence staff sent the change in Resident #5's gabapentin order to the pharmacy. - Review of Resident #7's medical record occurred on 01/23/14. A physician order, dated 09/11/13, stated, "Morphine sulfate 20mg/ [per] 5ml, 0.5ml - 1ml [2mg - 4mg] po or SL [sublingual - under the tongue] Q [every] 2 [hours] prn for labored breathing." Review of Resident #7's MARs from September, 2013 through January, 2014 showed the morphine order transcribed on the MARs did not match the physician's written order. See F333 and F428. On 01/23/14 at 12:15 p.m., observation with an administrative nurse (#3) of Resident #7's morphine sulfate bottle showed the concentration as "100 mg per 5 ml (20 mg/ml)." The nurse could not explain why the MS bottle failed to match the physician's order of 20mg/5ml.	F 431		
F 516 SS=B	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in	F 516	1. The occupational therapy evaluation for Resident #6 was secured at the nurses' station immediately after it was given to the DON by the maintenance man. Altru therapy staff secured the remaining resident information on 1/23/14.	

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F 516	Continued From page 16 accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure, and staff interview, the facility failed to safeguard clinical record information against loss, destruction, or unauthorized use regarding records stored in 1 of 1 rehabilitation areas on 3 of 3 days of survey (January 21-23, 2014). Failure to secure Resident #6's occupational therapy evaluation and an unlocked desk drawer containing approximately 50 resident evaluations containing protected health information (PHI) placed these records at risk of loss, destruction, or unauthorized use. Findings include: Review of the facility policy, "Documentation Guidelines," occurred on 01/23/14. This policy, revised February 2009, stated ". . . 12. Thinned records must be kept and stored in a locked room. . . . 31. Maintain confidentiality by never leaving a record open (when not attended) or in place where non-facility staff can see it. . . ." Observation in the rehabilitation services area during the facility environment tour, on 01/22/14 at approximately 3:00 p.m., identified Resident #6's occupational therapy evaluation "face up" on	F 516	2. All residents have the potential to be affected when the medical record is not kept secured. 3. A lock was applied to the desk in the therapy area so that any records there can be secured. A sign was affixed to the top of the desk reminding Altru and Care Center staff that resident information will not to be left on the desk top. The Manager of Outreach Therapy at Altru Health Systems in Grand Forks was informed of the breach made by her staff. She stated that she would speak with them. The current HIPPA policy has been reviewed and revised. On 2/25/14, all Care Center staff will attend a mandatory in-service to update them on that policy and their responsibility in maintaining confidentiality. Each Care Center employee must also complete a HIPPA lesson in Healthcare Academy annually. 4. The DON will be responsible for monitoring that no information is left in the unsecured area of the therapy room using the QA – Safeguarding the Medical Record. The QA will be completed daily x 1 week, weekly x 2 months and then quarterly for the remainder of 1 year.	

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F 516	Continued From page 17 the desk. This document included the resident's name, diagnosis, and other PHI. The desk also included a file of copies of approximately 50 resident evaluations in an unlocked desk drawer. These evaluations contained each resident's PHI. A maintenance management staff member (#1) reported the staff were gone for the day; removed Resident #6's evaluation from the desk; and, agreed it should have been secured. This staff member (#1) indicated he did not have a key to lock the desk drawer. The rehabilitation services area is located at the end of a resident care wing. The area includes the facility's resident beauty shop, has two open unlocked entrances, is across the hall from resident rooms, and an exit door is immediately adjacent to the area. Observation on all days of survey showed the doors open and the area unattended for extended periods of time. Observation on 01/23/14 at approximately 9:30 a.m. showed the file folder of resident evaluation copies remained in the unlocked desk drawer.	F 516	The results will be presented to the QA committee at their quarterly meetings.	02/26/14