STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. BUILDING _____ B. WING _____	08/25/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	615 6TH ST SE STANLEY, ND 58784

(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 08/23/10 and completed on 08/25/10, the sample included 3 residents for complete review, 9 residents for focused review, and 2 closed records for review. The sample included 2 additional residents to verify specific concerns during the survey.	F332	1. All residents that had an order for potassium orally had their orders reviewed by their attending physician and order clarification done with the physician. The residents identified having potassium orders now have a physician's order on the MAR that is reflected on the OPUS cassette label with the potassium.	9/2/2010
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional references, and staff interview, the facility failed to ensure a medication error rate of 5% or less. Medication pass demonstrated a medication error rate of 6% involving 1 of 12 sampled residents (Resident #2) and 2 of 2 supplemental residents (Residents #15 and #16), creating the potential for unwarranted medication side effects and resident discomfort. Findings include: Lippincott, Williams, and Wilkins, "Nursing 2010 Drug Handbook", pages 1374-1375, stated, "potassium chloride . . . Look alike-sound alike: Potassium preparations aren't interchangeable; verify preparations before use and don't switch products . . ." Taylor, Lillis, and LeMone, "Fundamentals of Nursing", second edition, J.B. Lippincott		For resident #16, the physician was notified, order clarified and re-written to reflect the medication that resident was receiving. This was done on August 26, 2010. 2. Any resident within the facility has the potential to affected. A memo was also issued to the nursing staff on September 2, 2010 outlining the need for more vigilent practice of the 5 rights of medication administration and following MBH's policy. In addition, nursing staff will be educated at Nursing staff meeting on September 10, 2010 to follow the 5 rights of medication administration as well as Mountrail Bethel Home's policy and procedure on the Medication Stickers and first dose of medications.	8/26/2010 9/10/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mitch Lepp	administrator	9/8/10

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 332	Continued From page 1 Company, Philadelphia, 1993, pages 1192 and 1199, stated, "Common Types of Drug Preparations . . . Extended release [ER]: Preparation of a medication that allows for slow and continuous release over a predetermined period; may also be referred to as CR or CRT (controlled release), SR (sustained or slow release) . . . Checking the Medication Order: Agency policy specifies the manner in which the medication order is checked . . . The nurse is responsible for checking that the transcription of the medication order is correct by comparing it with the original order." - During observation of medication administration on 08/24/10 at 11:45 a.m., a licensed nurse (#3) administered to Resident #2 two tablets of Extra Strength Tylenol. Review of current physician's orders, the medication administration record (MAR), and the medication cartridge label identified Resident #2 is to receive "ES [Extra Strength] Tylenol 1 po [by mouth] q [every] 4 hrs [hours]. This error resulted in Resident #2 receiving twice the ordered dose of ES Tylenol. - During observation of medication administration on 08/24/10 at 11:54 a.m., a licensed nurse (#3) administered to Resident #15 one capsule of potassium chloride (KCL). Review of Resident #15's physician's order and MAR identified the resident is to receive KCL 20 millequivilents (meq) one by mouth every day. The KCL administered by a nursing staff member (#3) from the pharmacy cartridge read, "KCL 20 meq Extended Release [ER] 1 po q day". The cartridge contained KCL ER, not the prescribed potassium medication the physician ordered, resulting in a medication error.	F 332	3. As stated above, a nursing meeting will be held with nursing staff on September 10, 2010 to re-educate nursing staff on the 5 rights of medication administration as well as MBH's policy on medication stickers and first dose of medications. Education also done with Medical Staff at Pharmacy, Therapeutics and Dietitics Meeting on September 2, 2010, on the available forms of Potassium and how orders must be written.	9/10/2010
		F 332	QA, specifically, the QA assistant or designated nursing staff will monitor the physician orders, MAR's and OPUS medication cassettes twice a month for 2 months and then monthly for 6 months to ensure that physican orders, MAR's and OPUS cassettes match on 10 randomly selected orders.	9/27/2010

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F 332	Continued From page 2 An interview with an administrative nursing staff member (#1) occurred on 08/24/10 at 2:00 p.m. The staff member agreed the medications administered to Resident #2 and #15 were medication errors. - Observation of medication pass occurred on 08/24/10 at 12:12 p.m. A nursing staff member (#2) removed a tablet from a pharmacy cartridge labeled "Diltiazem 120 mg [milligrams] ER [extended release] once a day." The nurse gave the medication to Resident #16, which the resident took by mouth with a glass of milk. Review of Resident #16's current physician orders occurred shortly after the medication pass observation. The current orders stated, "Cardiazem Hcl [hydrochloride] [the brand name for Diltiazem] 120 mg (O) [orally] QD [once a day]." The physician's order did not indicate the use of an extended release form of the medication. An interview with an administrative nursing staff member (#1) occurred on 08/25/10 at 10:50 a.m. The staff member agreed the medication cartridge from the pharmacy did not match the current physician's orders and stated she would get the order clarified.	F 332		