North Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8034	A. BUILDING: _____ B. WING _____	07/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITA	1515 2ND AVE W WILLISTON, ND 58801

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B 000	INITIAL COMMENTS The unannounced licensure survey completed 07/14/15, included a complete review of 6 current residents and 1 closed record. The survey identified no Tier I findings and two Tier II deficiencies.	B 000		
B1540	33-03-24.1-15,4 PHARMACY/MED ADM SERVICES 4. All medications used by residents which are administered or supervised by staff must be: a. Properly recorded by staff at the time of administration. b. Kept and stored in original containers labeled consistently with state laws. c. Properly administered. This state licensing rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure appropriate administration of medications for 2 of 2 residents (Resident #5, and #6) and 1 of 1 closed record (Resident #7) who received medications administered by unlicensed personnel on an as needed (PRN) basis without appropriate assessment by a licensed nurse. Failure to ensure unlicensed nursing personnel did not administer medications inconsistent with their defined scope of practice, and lack licensed nurse assessment of the resident's need for, and response to PRN medication, placed Resident #5, #6, and #7 at risk of receiving inappropriate or unnecessary medication.	B1540	**B1540** 1. Resident #5 physician was notified and order received for Tylenol to be administered for fever or pain. Resident #6 eMAR was adjusted to include number of tablets administered for the PRN (as needed) medication. The Licensed Nursing staff and Certified Medication Aides were re-educated for the need to document the conversation with the Licensed Nurse and required assessment prior to and after administration of PRN (as needed) medication. Resident #7 is no longer in the facility. 2. All Residents have the potential to be affected. 3. The Licensed Nursing Staff and Certified Medication Aides were re-educated by the Nurse Manager on the need for the Licensed Nurse to be notified when a PRN (as needed) medication is requested or identified, and the assessment by the Licensed Nurse prior to and	

Health Resources Section

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kat Stuner — TITLE: Administrator — (X6) DATE: 8-3-15

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B1540	Continued From page 1 Findings include: Chapter 33-43-01 Nurse Aide Training, Competency Evaluation, and Registry, Sections 33-43-01-18 Pro Re Nata [PRN] Medications, and Section 33-43-01-19 Medication Interventions That May Not Be Delegated, require: "33-43-01-18 - 1. The decision to administer pro re nata medications cannot be delegated in situations where an onsite assessment of the client is required prior to administration. 2. Some situations allow the administration of pro re nata medications without directly involving the licensed nurse prior to administration. a. The decision regarding whether an onsite assessment is required is at the discretion of the licensed nurse. b. Written parameters specific to an individual client's care must be written by the licensed nurse for use by the medication assistant when an onsite assessment is not required prior to administration of a medication. The written parameters: (1) Supplement the physician's pro re nata order; and (2) Provide the medication assistant with guidelines that are specific regarding the pro re nata medication. 33-43-01-19 - The medication assistant I or II, . . .may not perform the following acts even if delegated by a licensed nurse: 1. Conversion or calculation to medication dosage; 2. Assessment of client need for or response to medications; and 3. Nursing judgment regarding the administration of pro re nata medications." Review of the medical records for Resident #5, #6, and #7 occurred on July 13-14, 2015, and identified medication assistants administered PRN (as needed) medications to the residents without evidence a licensed nurse had determined an onsite assessment was not required, and had established written parameters for the administration of the medication prior to	B1540	after administration of PRN (as needed) medication. Policy and Procedure for PRN (as needed) medication administration by a Certified Medication Aide has been developed. Nursing staff (Licensed and Certified Medication Aides) will be educated on Policy and Procedure August 5th and 6th, 2015. 4. August 7, 2015. 5. The Nurse Manager (or designee) will monitor weekly x 4 weeks, then monthly x 2 months, then quarterly thereafter. The results will be reported to the QA committee by the DON (or designee) monthly for three months, then quarterly.	

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B1540	Continued From page 2 and following administration of the medication as follows: - Resident #5's prescribed medications included, "Tylenol 325 mg [milligrams] 2 tabs [tablets] by mouth for fever PRN." The medication administration record showed a medication assistant administered Tylenol PRN "for pain" to the resident seventy-two times in May 2015 and fifteen times from June 1-6, 2015. Following each PRN medication administration the record included a notation by a medication assistant indicating "PRN administration was: Effective." On 06/10/15, nurses' notes included the following entry, "Writer [a registered nurse] spoke with resident and [name of physician] related to Tylenol use. Resident states she does not have pain and that she does not want her Tylenol to be scheduled that she was only requesting it often because she thought she was supposed to. Resident states that her sister is the one that wanted her to take Tylenol. Resident voices that she has not taken any Tylenol on the last few days and that she does not feel the need to. Will notify staff if she wishes to have it scheduled at a later date." The record lacked evidence a licensed nurse had determined Resident #5 did not require an onsite assessment prior to administration of the Tylenol, and had not established written parameters for staff to use prior to administration of Tylenol (ordered for fever) to Resident #5. Lack of adequate licensed nurse assessment, monitoring and oversight of PRN administration to Resident #5 by unlicensed nursing staff resulted in Resident #5 being administered a medication "for pain" without physician orders, and receive the medication repeatedly and unnecessarily for an	B1540		

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B1540	Continued From page 3 extended period of time without adequate indication of its use. - Resident #6's MARs showed the resident had prescribed orders for: (1) "Antacid (Alum & Mag [magnesium] Hydrox-Simethicone) Suspension 200 - 200-20 mg/5ml [milliliters] for upset stomach. Antacid of choice as needed for stomach distress PRN " (2) "Benefiber 1 tsp [teaspoon] in 8 oz. [ounces] of noncarbonated beverage bid [twice daily] PRN for diarrhea." (3) Imodium 2 mg tab - 1-2 tabs up to four times a day PRN for diarrhea." The record showed medication assistants administered the following to Resident #6: * 05/08/15, 05/15/15, 05/16/15, and 05/24/15, Imodium administered. Dose (1 or 2 tablets) administered not indicated. * 05/16/15, at 8:24 p.m. a medication assistant administered the Antacid, Benefiber, and Imodium simultaneously. The record indicated, at 8:25 p.m. on 05/16/15, one minute after administration, the same medication assistant documented for each of the three PRN medications, "PRN Administration was: Effective." Resident #6's record included an order for: "Tramadol HCL 50 mg 1-2 tablets q 6 hrs. [every 6 hours] for pain in joint, multiple sites PRN." The MAR showed medication assistants administered Tramadol fourteen times in May 2015. The MAR lacked evidence of the dose (1 or 2 tablets) administered. Resident #6's record lacked evidence a licensed nurse had determined an onsite assessment was not needed for any of the above referenced PRN medications, and lacked evidence a licensed nurse had provided written parameters for the administration of the above prescribed PRN	B1540		

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B1540	Continued From page 4	B1540		

medications, including the administration of multiple medications for the same complaints/reason, administration of Tramadol and side effects/monitoring required following administration, etc.

- The medical record for Resident #7 included physician orders for the following PRN medications: (1) "Advil PM 200-38 mg - 2 tablets PRN to promote sleep [discontinued 12/06/15]. Take at bedtime PRN for insomnia." (2) "Tylenol 325 mg - 1 tablet every 4 hours as needed for pain." (3) "Tylenol with Codeine 300-30 mg. - give 1 tablet by mouth every 6 hours as needed for pain " (4) "Benadryl 12.5 - 25 as needed, take at bedtime for insomnia" [ordered 12/07/15].

Resident #7's MARS showed the following:
* A medication assistant administered the Tylenol with Codeine to Resident #7 on twenty-two occasions from November 7-30, 2015, and fifteen times from December 01-12, 2015.
* A medication assistant administered both the Advil for insomnia and the Tylenol with Codeine at the same time on six occasions in November, two times in December; and the Benadryl and Tylenol with Codeine two times in December.

Resident #7's record lacked evidence a licensed nurse had determined an onsite assessment was not needed for any of the above referenced PRN medications; lacked evidence a licensed nurse had provided written parameters for the administration of the above prescribed PRN medications, including the administration of multiple medications for the same complaints/reason; administration of Tylenol with Codeine and side effects/monitoring required following administration; and the use of both medications to promote sleep and medication for

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B1540	Continued From page 5 pain simultaneously without means to determine whether one would be effective for both pain and sleep, and parameters for administering medication to promote sleep. During an interview with an administrative staff member (#1) on the afternoon of 07/14/15, the staff member concurred a licensed nurse had not been involved in the assessment of Resident #5, #6, and #7, prior to, or following, the administration of the above referenced PRN medications, nor, did a licensed nurse develop written parameters specific to the individual resident's care for use by the medication assistant when an onsite assessment is not required prior to administration of a medication.	B1540		
B2000	33-03-24.1-20 HOUSEKEEPING/LAUNDRY SERVICES 33-03-24.1-20. Housekeeping and laundry services. The facility shall maintain the interior and exterior of the facility In a safe, clean, and orderly manner and provide sanitary laundry services, including personal laundry services, for residents. This state licensing rule is not met as evidenced by: Based on observation, the facility failed to maintain a clean and safe environment during 2 of 2 observations. Failure to store hazardous chemicals in a manner inaccessible to the residents and/or visitors, and failure to maintain a clean/sanitary kitchenette for use by residents and visitors, placed residents and/or visitors at risk for avoidable harm.	B2000	**B2000** 1. Chemicals were locked in cabinet. Open container of cookies were removed. Oven and stove top were cleaned. 2. All Residents have the potential to be affected. 3. All Nursing Staff have been re-educated by the Nurse Manager, at All Staff Meeting held on July 15, 2015, and will be re-educated at Nursing Meetings on August 5th & 6th, 2015 that chemicals are to be locked up, food is to be placed in containers after being opened, and daily check is to be	

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B2000	Continued From page 6 Findings include: - A tour of the facility on the morning of 07/13/15, identified a spray bottle of tub cleaner in an unlocked cupboard in the unlocked bathing area. - A tour of the lounge/kitchenette area, on the afternoon of 07/14/15, identified the following: * An open gallon of concentrated pot/pan cleaner in the unlocked cupboard below the sink. The bottle of concentrate included instructions for diluting prior to use and also warnings regarding the need to keep away from children. * Two open boxes of cookies in a cupboard in the kitchenette with contents of the open boxes exposed to the air/environment and susceptible to insects/excessive humidity, etc. * The oven and stove top/burners in the kitchenette had a large accumulation of dried/burned on food/spillage. Observation, on July 13-14, 2015, identified large groups of family and residents preparing food and congregating for lunch in the lounge/kitchenette area. During an interview on the afternoon of 07/14/15 with two administrative/management staff (#1 and #2), the staff members could not specifically identify who had responsibility for maintaining the cleanliness and safety of the lounge/kitchenette area. The staff members indicated the area is frequently reserved and used by families/visitors because of the availability of the kitchenette.	B2000	completed to assure that oven and stove top/burner are clean. 4. August 7th, 2015. 5. The Nurse Manager (or designee) will monitor to assure chemicals are secure, open food is placed in containers, and that oven and stove top/burner are clean on a daily basis. The results will be reported to the QA committee by the DON (or designee) monthly for three months, then quarterly.	