Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: North Dakota Veterans Home

Facility Location: 1600 Veterans Drive, Lisbon, ND 58504

Onsite / Virtual: Onsite

Dates of Survey: 5/19/22 – 5/20/22

Nursing Home / Domiciliary/ Adult Day Health Care: DOM

Survey Type: Annual

Total VA Recognized Beds: 98

Census on First Day of Survey: 58

Regulation #	Statement of Deficiencies
	Initial Comments: A VA Annual Survey was conducted from May 19, 2002, to May 20, 2022, at the North Dakota Veterans Home Domiciliary. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§51.180(e)(2) Pharmacy Storage of drugs and biologicals. (2) The facility management 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. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected - Many	Based on observation and staff interview, the facility failed to provide separately locked compartments that were permanently affixed, for the storage of controlled drugs. This was true for three (3) of three (3) medication carts used daily in the facility's Domiciliary, with orders for controlled substances to include three (3) residents of random opportunity, Resident #36, Resident #37, and Resident #38. The absence of permanently affixed, separately locked storage compartments on the medication carts increased the potential for diversion by making the storage of those substances on the carts less secure. The findings include: 1. [LOCATION]

	In the Wellness Center for [LOCATION] beginning on 5/20/22, at 10:56 a.m., the medication cart serving residents on [LOCATION] and the medication room, ("Pill Box"), inside the Wellness Center were audited for storage of medications and biologicals in the company of Licensed Nurse A. During the audit of this medication cart, it was noted that all controlled substances were stored in a drawer in the middle of the cart, which was not separately locked from the other drawers. At 11:00 a.m., after completion of the medication storage audit, Licensed Nurse A opened the Wellness Center for residents on [LOCATION] to come up and receive their medications. The first resident to enter the Wellness Center was Resident #36, who received a total of four (4) medications, one (1) of which was Hydrocodone, a Schedule II controlled drug, and Gabapentin. These two (2) medications were pulled from the middle drawer of the medication cart. An interview with Licensed Nurse A revealed that there was a separately locked compartment permanently affixed in the bottom drawer of the medication cart. When asked, Licensed Nurse A reported that there were no medications stored in that compartment. 2. [LOCATION] In the Wellness Center for [LOCATION] beginning at 11:30 a.m., on 5/20/22, one (1) of two (2) medication carts serving residents on that unit was audited for storage of medications and biologicals in the presence of Licensed Nurse B and Certified Nurse Aide A. During the audit of this medication cart, it was noted that all controlled substances were stored in a drawer in the middle of the cart, which was not separately locked from the other drawers. An interview with Licensed Nurse B revealed that there was a separately locked compartment permanently affixed in the bottom drawer of the medication cart. When asked, Licensed Nurse B reported that there were no medications stored in that compartment. Licensed Nurse B and Certified Nurse Aide A, who was responsible for their own medication cart, pushed their carts into the common areas of their respectively assigned households – [LOCATION] for Licensed Nurse B and [LOCATION] for Certified Nurse Aide A. During observation of medication administration in the common area of [LOCATION] at 11:50 a.m., on 5/20/22, Licensed Nurse B was noted to prepare three (3) medications to administer to Resident #37, to include Gabapentin and Tramadol, two (2) Schedule II controlled drugs. These two (2) medications were pulled from the middle drawer of the medication cart. During observation of medication administration in the common area of [LOCATION] at 12:05 p.m., on 5/20/22, Certified Nurse Aide A was noted to prepare three (3) medications to administer

	to Resident #38, to include Gabapentin and Tramadol. These two (2) medications were pulled from the middle drawer of the medication cart, which was not a separately locked, permanently affixed compartment. During an interview with Administrative Nurse A, who has supervisory responsibility over both [LOCATION] and [LOCATION], while in the Wellness Center for [LOCATION] beginning at 2:34 p.m., on 5/20/22, Administrative Nurse A acknowledged that, prior to the onset of the COVID-19 pandemic, medications were stored in, and dispensed from, the medication room, (Pill Box), located in the Wellness Centers on [LOCATION] and [LOCATION], and that these medication carts were not in use. Once the campus was affected by the COVID-19 pandemic, the medication carts were retrieved from storage and put back into use. The locks to the carts themselves had to be replaced, as the keys to them had been lost. The keys to the separately locked, permanently affixed compartment in the bottom drawers of each of these carts were also lost. Those locks could not be replaced, and the compartments were now too small to hold the large volume of medications that required such secure storage. According to Administrative Nurse A, in 2019, the State of North Dakota passed legislation that designated Gabapentin a controlled substance, requiring it to be securely stored as a drug subject to abuse.