STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355091	A. BUILDING _____ B. WING _____ JAN 28 2011	01/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLEY MEDICAL CENTER NURSING HOME	612 CENTER AVE N ASHLEY, ND 58413

(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 01/03/11 and completed on 01/05/11, the sample included 2 residents for complete review, 8 residents for focused review, and 1 closed record for review. The sample included 4 additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Darlene Hoyt RN CRRN		1-27-11

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 156	Continued From page 1 at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter	F 156		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 156	Continued From page 2 related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 01/21/10 AND 01/07/09. Based on record review and staff interview, the facility failed to provide required notices to 2 of 2 supplemental residents (Resident #12 and #13) whose Medicare coverage ended. Failure to provide denial notices to residents is an infringement of the residents' rights. Findings include:	F 156	It is the policy of the Ashley Medical Center to notify residents or legal representatives of non-coverage of Medicare benefits and to provide the opportunity to request a demand bill and/or appeal the decision of non-coverage. AMC will provide required notices to residents whose Medicare coverage has ended. The facility will send a denial notice (including the right to request a demand bill) to the resident or their representative. The Licensed Social Worker (LSW) will notify the resident or legal representative of non-coverage by Medicare and their right to request a demand bill. The LSW and Social Service Designee (SSDD) will complete Medicare denial letters for resident # 12 and # 13 by 02-09-11 LSW (HB) 2-8-11 SSD will be in serviced on proper procedures for demand bills and/or Medicare denial letters by 02-09-11 via webcast titled Liability Notices & Beneficiary A... originally air date 6/14/2004 A QA study will be documented monthly x 3 and quarterly x 3 to ensure that proper procedures are followed regarding Medicare denial letters. Responsible Party: ~~LSW~~ Administrator (HB) 2-8-11 02-09-11 (HB) 2-8-11	

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F 156	Continued From page 3 Review of Resident #12 and #13's Medicare billing records occurred on the afternoon of 01/04/11. The records identified Resident #12's Medicare part A coverage ended on 12/01/10, and Resident #13's coverage ended on 10/02/10. Both of the situations required the facility to send a denial notice (including the right to request a demand bill) to the resident or their representative; however, review of the billing records identified the facility failed to issue these denial notices. In an interview on the morning of 01/05/11, a licensed staff member (#4) confirmed that no residents or their representatives received denial notices.	F 156	F164 It is the policy of the Ashley Medical Center to provide the right to personal privacy. Staff will examine and treat residents in a manner that maintains the privacy of the resident's bodies. A. The nurses and certified medication aide (CMA) were in serviced on the need to provide privacy for residents during lift transfers and when receiving eye drops on 1-25-11. 1. All patient rooms were checked for sufficient privacy curtains. Where privacy curtains were needed, they were added and hung. 2. The nurses and CMA were instructed that when administering eye drops in the resident rooms, the treatment needed to be done in a private manner. The privacy curtains need to be pulled; and/or the treatments need to be done in an unoccupied room, and out of public view. B. The CNA's were in serviced on 1-26-11 regarding providing privacy to the resident while the roommate is in the room. For toileting- If the resident is needed to be taken out of bed by a Hoyer or a medi stand lift, the privacy curtains must be pulled completely around the resident and the resident's wheelchair is to be out of public view.	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		

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F 164	Continued From page 4 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to provide privacy for 3 of 6 sampled residents (Resident #5, #6, and #7) observed during lift transfers and 2 supplemental residents (Resident #14 and #15) receiving eye drops. Failure to provide care and administer medications in a manner that promotes privacy is an infringement on the residents' rights. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards regarding resident privacy which state facility staff must examine and treat residents in a manner that maintains the privacy of their bodies. A resident must be granted privacy when going to the bathroom and in other activities of personal hygiene. Staff should pull privacy curtains, close doors, or otherwise remove residents from public view during the provision of personal care and services. - Observation of medication pass occurred on the morning of 01/04/11. A certified medication aide (CMA) (#10) administered eye drops to Resident #14 in the hallway near the dining room.	F 164	When a resident is taken to the toilet, the bathroom door must be closed. Before transporting resident to the bathroom, examine the resident to be sure that the men's pants are pulled up, the ladies' dresses are pulled down, and/or lap robes are put over the residents laps or so that no portion of the incontinent brief is showing. A QA will be done weekly x 1 month and monthly x 2, and quarterly x 1 year on providing private care and administering medications in a manner that promotes privacy for the resident. Responsible Parties: ~~RN's, LPN's, CNA's, CMA's, RA,~~ and DON. SU 2-7-11 SU SU SU SU 2-7-11 2-7-11 2-7-11 CMA #10 and Resident # 14: Refer to response A, 1-2.	02-09-11

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F 164	Continued From page 5 Observation showed another resident watching as Resident #14 received her eye drops. The CMA (#10) also administered eye drops to Resident #15 in her room while her roommate watched. - Observation of personal cares with Resident #7 occurred on 01/04/11 at 1:12 p.m. Two certified nursing assistants (CNAs) (#2 and #9) assisted Resident #7 (who had a roommate) from her bed to the toilet using a sit-to-stand mechanical lift. During the observation, the privacy curtain dividing the two sides of the room remained open, as did the bathroom door. Resident #7's roommate watched the entire transfer to the bathroom from her side of the room. - Observation on 01/03/11 at 4:45 p.m. identified two CNAs (#2 and #3) assisted Resident #5 out of bed using a Hoyer lift. Observation showed Resident #5's roommate seated in her wheelchair near the window. The CNAs pulled the privacy curtain between residents' beds and placed Resident #5's wheelchair near the foot of her bed. The privacy curtain extended only to the foot of the bed, allowing Resident #5's roommate to view the wheelchair from her position directly across the room. The facility identified both Resident #5 and her roommate as interviewable. Observation showed Resident #5 wore a dress. When the CNAs (#2 and #3) positioned Resident #5 in the lift sling, her dress rode up, exposing her upper legs and portions of her incontinent brief. As the CNAs transferred Resident #5 to her chair, the resident stated, "Pull down my dress." After seating Resident #5 in her chair, a CNA (#3)	F 164	CMA # 10 and Resident's # 14 and #15. Refer to response A, 1-2. CNA's #2 and #9; Resident #7: Refer to response B, 1. CNA's #2 and #3 , Resident #5: Refer to response B, 1. CNA's #2 and #3, Resident #5: Refer to response B, 1.	

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F 164	Continued From page 6 pulled down her dress and placed a lap robe covering the resident's lower body. Observation showed the resident's roommate looking directly at Resident #5 as the CNA pulled down the dress and covered the resident's legs. - Observation on 01/04/11 at 12:55 p.m. identified two CNAs (#5 and #6) assisted Resident #6 out of bed using a Hoyer lift. Observation showed Resident #6's roommate seated in her wheelchair near the window with her eyes closed. The CNAs pulled the privacy curtain between the residents' beds and placed Resident #6's wheelchair near the foot of her bed. The privacy curtain extended only to the foot of the bed, leaving the wheelchair in the direct line of vision of the roommate. Observation showed Resident #6 wore a dress. When the CNAs (#5 and #6) positioned Resident #6 in the lift sling, the dress rode up. exposing her upper legs and portions of her incontinent brief. The CNAs transferred Resident #6 from her bed to the wheelchair using the lift. During the transfer, the resident's roommate remained seated directly across the room from Resident #6's wheelchair, allowing her to view the transfer. When interviewed on the morning of 01/05/11, an administrative nurse (#1) stated the facility has educated staff to provide privacy during residents' cares and agreed staff should have provided privacy in the above situations.	F 164	CNA's #5 and #6; Resident #6: Refer to response B,1. CNA's #5 and#6; Resident #6: Refer to response B,1.	02-09-11
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of	F 167		

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F 167	Continued From page 7 correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the most recent Life Safety survey results were available for examination by residents for 3 of 3 days (January 3-5, 2011) of survey. Findings include: Observation on January 3-5, 2011, showed the results of the Health survey, conducted 01/21/10, in a folder in a display case in the hallway. The facility staff failed to post the results of the previous Life Safety survey, conducted on 11/09/09. During interview on 01/05/11 at 10:40 a.m., the administrative nursing staff member (#1) agreed the facility failed to post the Life Safety survey results.	F 167	It is the policy of the Ashley Medical Center that all residents will have the right to examine the results of the most recent survey of the facility, conducted by Federal or State surveyors, and any plan of correction in effect, with respect to the facility. The 11-09-09 and the 12-21-11 will be posted by 02-09-11 SSD will be instructed on what the facility must make available for examination, and that the facility must post in a place readily accessible to resident and post a notice of the survey's availability. A QA will be completed monthly x3 and quarterly x 3 to ensure that all results of the most recent State survey results, along with the Life Safety Code surveys are posted in a place readily accessible to residents. Responsible Party: LSW	02-09-11
F 205 SS=C	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any,	F 205		

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F 205	Continued From page 8 during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a bed-hold notice upon transfer to the hospital for 1 of 2 sampled residents (Resident #1) and 1 closed record (Resident #11). Failure to provide notice of the duration of the facility's bed-hold policy does not allow residents or their legal representatives to make informed choices regarding their readmission rights. Findings include: - Review of Resident #11's medical record occurred on 01/05/11. Resident #11 was transferred to the hospital on 06/09/10 and 06/24/10. The record lacked evidence facility staff provided Resident #11 or her legal representative written notice of the bed-hold policy upon transfers to the hospital. On the afternoon of 01/05/11, an administrative nurse (#1) confirmed Resident #11's record lacked bed-hold notices for the two transfers to the hospital.	F 205	It is the policy of the Ashley Medical Center to provide written information to the resident, family member, or legal representative, that specifies the duration of the bed hold policy. The nurses were in serviced on 1-25-11 discussing the importance of providing notice of the duration of the facility's bed hold policy to allow residents or their legal representative to make informed choices regarding their readmission rights. A QA will be done monthly x 3, and then quarterly x 1 year on the providing of the bed hold policy to the resident or their legal representative when being transferred, etc. Responsible Parties: MDS Coordinator, DON Resident #11: Resident Bed Hold policies will be sent to the legal representatives for the transfers to the hospital. Refer to above response. 01-27-11	02-09-11

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F 205	Continued From page 9 - Resident #1's medical record, reviewed January 3-5, 2011, identified the facility transferred the resident to the hospital on 09/22/10. Resident #1 returned to the facility on 09/24/10. The record lacked evidence facility staff provided Resident #1 or her legal representative with written notice of the bed-hold policy. When interviewed on 01/05/11 at 3:00 p.m., an administrative staff member (#7) stated she could not locate a bed-hold notice for Resident #1.	F 205	Resident# 1: Resident Bed Hold Policies will be sent to the legal representative for the transfers to the hospital. Refer to the above response. 01-27-11	02-09-11
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEYS COMPLETED ON 01/21/10 AND 01/07/09. Based on record review, review of facility policy, resident interview, and staff interview, the facility failed to provide medically-related social services for 1 of 1 sampled resident (Resident #4) with unresolved grief issues. Failure to address the needs of Resident #4 and develop and implement interventions related to these needs may be detrimental to the resident's psychological and mental well-being and may negatively affect her overall level of functioning. Findings include:	F 250	It is the policy of the Ashley Medical Center to provide medically-related social services to attain, or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Resident # 4was assessed by the LSW to determine if she required additional bereavement services. See attachment F 250. (1)	

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F 250	Continued From page 10 Review of the facility document titled "Social Worker Job Description" occurred on 01/05/11. This document, revised 08/30/05, stated, ". . . Duties and Responsibilities: . . . 6. To develop a social assessment care plan, which identifies medically related social, emotional, problems and needs with realistic goals and specific actions to be taken. . . . 15. To provide individual and group help for families and clients at times of adjustment, crisis, or particular need. . . ." Review of Resident #4's medical record occurred on all days of survey. The facility admitted Resident #4 in February 2010. Resident #4's current Minimum Data Set (MDS), dated 11/22/10, indicated the resident was cognitively intact and had felt down, depressed, and/or hopeless nearly every day. Review of Social Service Progress Notes revealed visits occurred with Resident #4 on 02/25/10, 04/20/10, 05/25/10, 08/24/10, and 11/23/10. The progress notes stated the following: * 02/25/10: ". . . This resident is unhappy being here. She states she is used to being alone. . . ." * 08/24/10: ". . . Resident continues to adjust to SNF [skilled nursing facility] placement. . . . Has ongoing grief for lost husband. . . ." * 11/23/10: ". . . Resident continues to have ongoing unresolved grief over her [sic] loss of her husband approx. [approximately] two years ago. . . ." * Progress notes fail to identify other social services visits related to Resident #4's grieving issues or interventions attempted prior to initiation of the bereavement care plan in November 2010.	F 250	LSW and/or SSD will complete one to ones weekly to ensure all bereavement needs are being met. A form will be utilized during the morning report to note any residents with bereavement issues. See attachment F 250. (2) Care Plans will be reviewed monthly to ensure accuracy. PHQ-9 will be completed quarterly and if a resident score is above a 9, a form will be given to the physician to determine how they would like to proceed. Behavioral meetings will be held monthly to ensure that all resident's needs are being addressed and bereavement resident's concerns will be reviewed at these meetings. See Attachment F 250. (3) ~~SSD will be in-serviced on proper bereavement protocols by the LSW.~~ CHG 2-8-11 LSW & SSD will complete bereavement education via online CEU, "Grief, Bereavement, and coping with Loss" A QA will be completed monthly x 3 and quarter x 3 on bereavement care plans, bereavement one to ones, as relating to needs addressed in morning report. Responsible Parties: ~~LSW and SSD~~ Administrator	02-09-11

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	355091	A. BUILDING _____ B. WING _____	01/05/2011

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F 250	Continued From page 11 Review of Resident #4's care plan identified the following problem, dated 11/22/10 (nine months after her admission to the facility): ". . . Patient continues to struggle with ongoing grief over loss of husband. . . ." with the following interventions: "1. Allow [Resident name] to express feelings. 2. Pastor visits regularly. 3. Family calls regularly. 4. [Resident name] has company frequently. . . ." The care plan failed to identify further interventions specific to social services. During the initial tour of the facility, which occurred on the morning of 01/03/11, Resident #4 expressed sadness over the death of her husband, who passed away almost two years before. Resident #4 stated, "It's hard; I still miss him," and became teary-eyed. An interview occurred with Resident #4 on the morning of 01/04/11. Resident #4 again expressed sadness related to her husband's death and stated, "I can't get over the loss of my husband. We did everything together. He took care of me when I couldn't see or hear anymore." Resident #4 again became teary-eyed. She stated her children (who live out of state) call regularly, and her nephew visits occasionally. Resident #4 stated she "sometimes" receives visits from social services, and her pastor visits "when he can." An interview with a licensed social worker (#4) occurred on 01/05/11 at 10:15 a.m. She stated she visits Resident #4 to ask her how things are going and to give the resident her mail. She was unable to identify visits with Resident #4 specifically addressing her grieving issues. The licensed social worker stated she did not complete an assessment prior to initiating	F 250		

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F 250	Continued From page 12 Resident #4's care plan and had not discussed any type of referrals with Resident #4. She also stated "I can add more interventions" to Resident #4's care plan. Failure to adequately assess Resident #4's psychosocial needs, develop appropriate and timely interventions related to these needs, and to perform sufficient follow-up resulted in Resident #4 continuing to experience unresolved grief which may have negatively affected her overall well-being.	F 250		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to complete a comprehensive assessment for 2 of 2 sampled residents (Resident #1 and #9) who experienced a significant change in their physical and/or mental	F 274	It is the policy of the Ashley Medical Center to address significant changes and complete Significant Change assessments in accordance with the Long Term Care RAI User's Manual. "Document the initial identification of a significant change in terms of the resident's clinical status in the progress notes. ...If the condition does not return to baseline, the assessment should be completed as soon as needed to provide appropriate care to the resident, but in no case later than 14 days after the determination was made that a significant change occurred...A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-	

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F 274	Continued From page 13 condition requiring interdisciplinary review. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 2.0, December 2002, Revised July 2008, page 2-7 through 2-9 stated, "Document the initial identification of a significant change in terms of the resident's clinical status in the progress notes. . . . If the condition does not return to baseline, the assessment should be completed as soon as needed to provide appropriate care to the resident, but in no case later than 14 days after the determination was made that a significant change occurred. . . . A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self limiting.' 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. . . . Decline in two or more of the following: Emergence of sad or anxious mood pattern as a problem that is not easily altered. . . . Any decline in an ADL (Activities of Daily Living) physical functioning area where a resident is newly coded as 3, 4, or 8 (Extensive assistance, Total dependency, Activity did not occur) . . ." The CMS Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0, May 2010, revised September 2010, page 2-20 through 2-23 stated, "Significant Change in Status Assessment (SCSA) . . . A SCSA is appropriate when: There is a determination that a significant change (either improvement or	F 274	related clinical interventions, is not 'self limiting.' 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan... Decline in two or more of the following: Emergence of sad or anxious mood pattern as a problem that is not easily altered...Any decline in an ADL (Activities of Daily Living) physical functioning where a resident is newly coded as 3, 4, or 8 (Extensive assist, Total dependency, Activity did not occur)..." The MDS Coordinator will review Significant Change Criteria with the Interdisciplinary Team. Inservice will be completed on or before 2-3-11. Responsible Party: MDS Coordinator A QA study will be conducted monthly x 3 then quarterly x 3. Will randomly select 3 residents to review their cares and conditions to determine whether a resident meets the significant change guidelines for either improvement or decline. Completion of first QA study by 2-9-11. Responsible Party: D ON	2-9-11 2-9-11

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F 274	Continued From page 14 decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks. . . . Decline in two or more of the following: . . . Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency . . . Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment . . ." - Review of Resident #1's medical record occurred on January 03-05, 2011. Resident #1's diagnoses included anxiety, panic disorder, separation anxiety, and congestive heart failure. A quarterly Minimum Data Set (MDS) 2.0, dated 05/31/10, identified the resident had no indicators of depression, anxiety, or sad mood during the assessment period. The MDS also identified Resident #1 required supervision with bed mobility and transfers, and limited assistance with walking in the room and corridor and with locomotion on and off the unit. Review of nurse's notes identified Resident #1 displayed anxious behaviors during the months of June through August 2010. A quarterly MDS 2.0, dated 08/29/10, identified changes in the resident's physical and mental status. The resident displayed the following indicators on depression, anxiety, or sad mood up to five days a week, not easily altered: repetitive verbalizations, persistent anger with self or others, expressions of what appear to be	F 274	CNA and Nursing Staff will be inserviced on identifying aspects of significant change that will assist the MDS coordinator and interdisciplinary team in identifying significant changes. Inservice to be completed on 1-25-11 and 1-26-11 with further inservice as needed by 2-9-11. Responsible Party: MDS Coordinator, DON. See Attachments F 274 (1) and (2) A QA study will be conducted monthly x 3 then quarterly x 3. Will randomly select 3 residents to review their cares and conditions to determine whether a resident meets the significant change guidelines for either improvement or decline. Completion of first QA study by 2-9-11. Responsible Party: DON	2-9-11 2-9-11

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F 274	Continued From page 15 unrealistic fears, repetitive health complaints, repetitive anxious complaints/concerns, insomnia/change in usual sleep pattern, crying, tearfulness, and repetitive physical movements. The MDS also identified a decline in Resident #1's ADL status, requiring extensive assistance with bed mobility, transfers, walking in the room and corridor, locomotion on and off the unit, and toilet use. The record lacked evidence staff considered completing a comprehensive assessment (SCSA) with the resident's decline in mood and ADL status. A quarterly MDS 3.0, dated 11/29/10, identified the resident showed the following mood symptoms on 2-6 days of the past two weeks, feeling or appearing down, depressed or hopeless, trouble falling or staying asleep, indicating that she feels bad about self, trouble concentrating on things, and had felt tired with little energy 12-14 days of the last two weeks. The MDS also indicated Resident #1 continued to require extensive assistance with bed mobility, transfers, walking in the room and corridor, toilet use, as well as personal hygiene. The record again lacked evidence staff considered completing a SCSA for Resident #1. Observation of cares for Resident #1 on January 03-04, 2010 identified the resident required assistance of one to two staff members for transfers, toilet use; and personal hygiene. When interviewed on 01/05/11 at 10:20 a.m. an administrative nurse stated she considered Resident #1's mood changes to be a result of a short term illness, so did not consider doing a SCSA. She further stated she thought two or more changes within just the ADL area did not	F 274	A "Change Noted" form was developed and CNA and Nursing staff instructed on its correct completion. This form will assist the MDS Coordinator and Interdisciplinary Team in identifying possible need for a significant change assessment. Inservice to be completed on 1-25-11 and 1-26-11 with further inservice as needed by 2-9-11. Responsible Party: MDS Coordinator, DON. See Attachments F 274 (3) A QA study will be conducted to monitor that any "Change Noted" forms were appropriately addressed. Completion of first QA study by 2-9-11. Responsible Party: DON A Significant Change MDS was completed for Resident #1 on 1-21-11. See Attachment F 274 (4)	2-9-11 2-9-11 2-9-11

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F 274	Continued From page 16 require a SCSA. - Review of Resident #9's medical record occurred January 4-5, 2011. The record included an annual MDS completed 04/05/10 and a quarterly review completed 07/05/10. Review of the resident's 04/05/10 annual and 07/05/10 quarterly MDS 2.0 assessments indicated the resident experienced the following declines in ADL [activities of daily living]: * 04/05/10 - The resident required limited assistance with walking in his room/corridor and with personal hygiene. * 07/05/10 - The resident required extensive assistance with walking in his room/corridor and with personal hygiene. The record lacked evidence staff considered completing a comprehensive assessment with the resident's decline in ADL status. Observations made on 01/05/11 revealed the following: * At 9:45 a.m., A CNA (#9) transported Resident #9 into the hallway for his restorative therapy session. Staff attempted to assist him down the hallway using a platform walker. Due to fatigue, the resident was returned to his room. * At 10:10 a.m., Two CNAs (#11 and #12) transferred Resident #9 into the bathroom using a stand lift and provided pericares.	F 274	A Significant Change MDS was completed for Resident #9 on 1-21-11. See Attachment F274 (5)	2-9-11
F 281 SS=E	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:	F 281		

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F 281	Continued From page 17 Based on observation, facility policy review; review of professional reference, and staff interview, the facility failed to follow currently accepted professional standards of practice during 2 of 3 observations (the mornings of January 3-4, 2011) of oral medication administration involving 5 residents. Failure to administer medications as they are dispensed (and not "pre-dished") increases the risk of medication errors which may result in adverse drug events for residents. Findings include: The Geriatric Medication Handbook, 7th ed., American Society of Consultant Pharmacists, page 148 stated, "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- Oral Meds [medications]" occurred on January 5, 2010. This policy, revised March 2005, stated, ". . . 4. Administer meds to each resident as they are dispensed. . . ." Observation of a medication pass occurred on the afternoon of 01/03/11. Observation showed a metal tray with several residents' medications dispensed in unlabeled plastic cups located in the drawer of the medication cart. Facility staff wrote the resident's name, drug name, and dose on little cards which they placed behind the plastic cups. The tray contained three residents' oral medications, two residents' eye drops, and one resident's ointment. During the observation, the nurse (#14) wheeled the medication cart down	F 281	The Ashley Medical Center will demonstrate professional standards of practice with the dispensing of oral medications. The nurses and the CMA were in serviced on 1-25-11 reviewing: 1. Facility policy medication administration for oral medications. 2. The risk of medication errors with unlabeled plastic cups with the medication cards placed behind the plastic medication cups. 3. The medication cart will be used for all medication passes. For small medication passes, the medication cards will be set on an empty, small medication tray placed on the medication cart. This will be the nurses' guide to prevent medication errors. A QA will be done weekly x 1 month and then monthly x 2, and then quarterly x 1 year on the passing of oral medications. Responsible parties: ~~RN's~~ SH 2-7-11, ~~LPN's~~ SH 2-7-11 and DON.	02-09-11

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F 281	Continued From page 18 the hall, removed medications from the tray, and administered them to different residents. Observation of a medication pass on the morning of 01/04/11 showed the same tray and cards mentioned above in the drawer of the medication cart with four residents' oral medications (in unlabeled plastic cups) and four residents' eye drops located on the tray. During the observation, the certified medication aide (CMA) (#10) removed medications from the tray and administered them to different residents. In an interview on the afternoon of 01/05/10, an administrative nurse (#1) stated, "They [the staff] shouldn't be doing that [referring to pre-dishing medications]." She confirmed that pre-dishing medications could result in a medication error.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/21/10 Based on record review, facility policy review, and staff interview, the facility failed to provide assistive devices (gait belts) necessary to prevent accidents for 1 of 1 sampled resident (Resident	F 323	It is the policy of the Ashley Medical Center that the facility must ensure that residents remain as free of accidental hazards as possible, and that each resident receives adequate supervision and assistive devices to prevent accidents. The CNA's were in serviced on this deficiency on 2-1-11 by Physical Therapy, reviewing the Gait Belt policy: Reviewed were; 1. The importance of using the gait belt for resident's safety. 2. The gait belt is to be used: - When transferring a resident, unless using a Hoyer Lift.	

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F 323	Continued From page 19 #7) who experienced a fall with a fracture. Failure to utilize a gait belt with a staff assisted transfer resulted in Resident #7 falling and sustaining a fracture to her toe. Findings include: Review of the facility policy titled "Gait Belt Policy for Ashley Medical Center" occurred on 01/05/11. This policy, dated June 2010, stated; ". . . It is the policy of the Ashley Medical Center to at all times ensure safety. . . . In that effect gait belts may be used at any time but especially in these situations: 1. When transferring a resident unless using a Hoyer Lift . . ." Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dizziness and macular degeneration. Resident #7's nurses' notes contained the following entries: * 08/16/10 at 8:45 p.m.: "CNA [certified nursing assistant] requests help, another CNA attempting to assist pt. [patient] from bed to W/C [wheelchair], pt. fell on top of CNA, pt. rolled off CNA and CNA assisted to W/C, pt. taken to ER [emergency room] [with] backboard and cart for exam. . . ." * 08/17/10 at 7:30 a.m.: ". . . c/o [complains of] pain [left] foot/ankle, back of lower [left] leg. [increased] pain [with] motion et [and] touch. Noted bruising on top of foot near toes. . . ." * 08/17/10 at 9:30 a.m.: ". . . Orders for x-ray [left] foot. . . ." * 08/17/10 at 4:45 p.m.: ". . . [Physician name] informed nurse that x-ray shows fx [fracture] 5th metatarsal [toe bone] Lt. [left] foot. . . ." The facility provided a copy of the "Incident Report" dated 08/16/10. The "Summary of Injury"	F 323	3. Each CNA will wear a gait belt while on duty. 4. An additional gait belt will be placed in the dining room. 5. This PT in-service will be videoed for use for general in servicing and for orientation for future new hires. A QA will be done monthly x 3, quarterly x 1 yr. Responsible Parties: ~~Charge nurses~~, ~~CNA's~~, ~~PT~~, DON. SH - 2-7-11 2-7-11 SH 2-7-11 SH	02-09-11

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F 323	Continued From page 20 section of the report stated, ". . . CNA [CNA name] attempted to assist pt. [with] transfer from bed to W/C, apparently pt. lost balance. [CNA name] tried to hold her, put her leg behind her to prevent pt. from falling; both fell, pt. falling on top of [CNA name] . . ." The report also contained a section titled, "Safety Device Used," which included a checklist of devices such as gait belts, TAB alarms, stand-assist lifts, etc. This section was blank (indicating staff did not use a safety device). An update to Resident #7's care plan, dated 08/30/10, stated, ". . . Mechanical stand lift for transfers- [Resident name] having difficulty bearing weight . . ." In an interview on the morning of 01/05/11, an administrative nurse (#1) stated that although Resident #7 did transfer herself independently prior to her fall, she would expect staff to use a gait belt with any assisted transfers, especially with the resident's history of chronic dizziness.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	355091	A. BUILDING _____ B. WING _____	01/05/2011

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ASHLEY MEDICAL CENTER NURSING HOME	612 CENTER AVE N ASHLEY, ND 58413

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F 329	Continued From page 21 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to ensure each resident's drug regimen remained free of unnecessary medications for 1 of 5 sampled residents (Resident #8) receiving an antipsychotic medication. Failure to ensure adequate indications for use and to attempt a gradual dose reduction could result in the resident receiving unnecessary medications, experiencing adverse consequences, and failing to achieve their highest level of well-being. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the standards of practice regarding indications for use of antipsychotic medication and Gradual Dose Reduction (GDR). An evaluation process is important when making initial medication selections and when deciding whether to modify or discontinue a current medication intervention. Evaluation should include an appropriately detailed evaluation of mental, physical, and psychosocial functional status including pertinent psychiatric symptoms and diagnoses. Tapering may be indicated when the	F 329	It is the policy of the Ashley Medical Center that each resident's drug regimie will be free from unnecessary drugs. 1. The nurses will be in serviced on 1-25-11 regarding the need for supporting diagnosis for the use of the antipsychotic drug therapy. 2. The nurses will contact the psychiatrist for a diagnosis. 3. The Pharmacist Consultant will be notified 2-9-11, during her next visit, informing her of the facility deficiency of the resident needing a gradual dose reduction, with behavioral interventions, unless clinically contraindicated in an effort to discontinue the drug. AIMS (Abnormal Involuntary Movement Scale) screening will need to be done q 6 months on those receiving an antipsychotic. A QA will be done monthly x 3 and then quarterly x 1 year to ensure that the resident's drug regime is free from unnecessary drugs. Responsible parties: ~~Psychiatrist, charge nurses, pharmacist consultant,~~ DON SW 2-7-11 SW 2-7-11 SW 2-7-11	02-09-11

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F 329	Continued From page 22 resident's clinical condition has stabilized or the underlying causes of the original target symptoms have resolved. Often the only way to know whether the dose remains appropriate is to reduce the dose and monitor the resident closely for improvement, stabilization, or decline. For antipsychotic medication, within the first year the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. A GDR may be clinically contraindicated if the physician has documented the clinical rationale for why an attempted dose reduction would be likely to impair the resident's function or increase distressed behavior. The Nursing 2011 Drug Handbook, Lippincott, Williams, and Wilkins, Wolters Kluwer, Philadelphia, pp. 675-677 identified indications for use of Seroquel include schizophrenia, short-term treatment of acute manic episodes and depression associated with bipolar disorder. The handbook further states, ". . . NURSING CONSIDERATIONS . . . Alert: Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV [cardiovascular] disease or infection. . . ." - Resident #6's medical record, reviewed January 04-05, 2011, identified diagnoses including depression and mild dementia. The record identified physicians orders, dated 10/16/09, for a psychiatric consult and for Seroquel (an antipsychotic) 12.5 milligrams (mg) every morning and 37.5 mg at bedtime, and Celexa (an antidepressant) 10 mg at bedtime. Psychiatrist's progress notes, dated 11/02/09,	F 329		

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F 329	Continued From page 23 stated, ". . . According to staff, the patient had been admitted back in June of 2009 and initially during that time the patient had some issues with behaviors in which she had been physically and verbally abusive and had not been cooperative with cares and activities. They noted that eventually things seem to have gotten better but then between now and June the patient had her leg amputated and again soon after that, she had similar behaviors. According to staff she had been physically aggressive again and again refusing cares and not wanting to do things when asked. According to them, usually the behaviors arise when the staff is asking her to do things that she does not want to do, but other than that, she normally is somewhat cooperative. . . . at this time there was no concern for any manic or psychotic symptoms and no concern that the patient was suicidal or homicidal. . . . She is on Seroquel and Celexa at this time and I feel that increasing the Celexa would help minimize the depression and in doing so, the patient should be more cooperative. . . . increase Celexa to 20 mg p.o. [orally] q [every] h.s. [bedtime]. . . ." Psychiatrist's notes, dated 11/30/09 and 06/01/10, failed to identify an adequate indication for the use of the Seroquel or the clinical rational for not attempting a GDR. A "Monthly Drug Regimen Review" note, dated 10/29/10, stated "no changes - [check] psych [psychiatric] eval [evaluation] in Nov [November]." A psychiatrist's note, dated 12/02/10, stated, "Depressive disorder, not otherwise specified. The patient is doing well and continues to do well so at this point we will have her continue on all her current psychiatric medication . . ." The note	F 329	Resident # 6: 1. The psychiatrist has been contacted to update the diagnosis for a supporting diagnosis for the medication Seroquel, an antipsychotic. 2. Resident will continue to have follow up psychiatric telemeds with the psychiatrist to evaluate her behavior and to attempt medication dose reduction and/or to address if reductions is clinically contraindicated. 3. The Pharmacist Consultant will follow up on the medication, if the medication is to be continued. 4. AIMS Screening will be done by the DON every 6 months, while the resident is on the antipsychotic medication.	

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F 329	Continued From page 24 failed to identify the clinical rational for not attempting a GDR. Review of social services notes for the past year identified the following: *03/24/10: "Resident has had a couple of days being sad, crying and resisted cares. She usually is doing quite well . . . She can be rather sharp with some staff if she is asked more than once if she would like to do something, saying, 'I was just asked NO.' . . ." *06/23/10: ". . . has improved behaviorally since last reporting period. Does have times when she gets upset when repeatly [sic] asked to go to activities but does well otherwise. . . ." *06/28/10: "Care Plan today . . . Resident does have some occasional behavior problems depending on her pain, how she is approached and her mood. . . ." *9/22/10: "Resident remains about the same. Has diagnosis of depressive disorder . . ." Review of Resident #6's nurse's notes for the January through December 2010 identified episodes of yelling, resisting cares, and/or attempts to hit at staff once in March, five times in April, and once in December. The record failed to identify staff considered requesting a dose reduction for the Seroquel when Resident #6's behaviors decreased in frequency. When interviewed on 01/05/11 at 10:30 a.m., an administrative nurse (#1) agreed depression was not an appropriate diagnosis for the use of Seroquel. When asked for additional information regarding the clinical rational for the failure to attempt a dose reduction, the nurse provided no further information.	F 329		

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F 329	Continued From page 25 Failing to attempt GDR for Resident #8's Seroquel placed the resident at risk for side effects and adverse consequences from the medication.	F 329	F356 It is the policy of the Ashley Medical Center to post the total number and the actual hours worked, by licensed and unlicensed staff directly responsible for resident care for each shift.	
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 356	The posted nurses staffing information will be posted daily and be available for the public visitors and residents for a 24 hr period. 1. The nurses will be in serviced on 1-25-11, addressing that each charge nurse will be responsible to post the total number of staff and actual hours worked by the licensed and unlicensed staff, directly responsible for resident care, at the beginning of each shift. 2. The nurses will be educated as to how to properly complete the posting. 3. Direct Care Staff are RN's, LPN's, CNA's, and CMA. A QA will be done weekly x 1 month, monthly x 2, and quarterly x 1 year on the accurate posting of the total number and the actual hours worked, by licensed and unlicensed staff directly responsible for the resident care for each shift. Responsible Parties: ~~Charge Nurses,~~ DON SW 2-7-11 Exhibit 356: See attached.	02-09-11

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F 356	Continued From page 26 by: Based on observation and staff interview, the facility failed to post the total number and the actual hours worked, by licensed and unlicensed staff directly responsible for resident care, for each shift on 2 of 3 days of survey (January 4-5, 2011). Findings include: Observation on January 4-5, 2011 identified staffing data (number and actual hours worked by licensed and unlicensed staff directly responsible for resident care) located on a clip-board to the right of the nurses station. Facility staff failed to update the board with the staffing data at the beginning of every shift. During interview on 01/05/11 at 10:40 a.m., the administrative nursing staff member (#1) stated, "The staffing coordinator or charge nurse is responsible" for updating the data every day. She agreed the facility failed to maintain the required posting of staff.	F 356		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520		

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F 520	Continued From page 27 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of North Dakota Department of Health (ND DoH), Division of Health Facilities provider files, and staff interview, the facility failed to ensure a physician actively participated as a member for the Quality Assurance Committee for 4 of 4 quarters in 2010 and failed to sustain compliance with federal requirements as evidenced by repeat citations at F156, F250, and F323. Failure to have a physician participate in quality assurance activities deprives the committee of the unique contribution a physician provides for analysis of quality issues. Failure to sustain compliance with identified issues could impact the quality of life for all residents of the facility. Findings include: - During the entrance conference held on the morning of 01/03/11, when asked about physician participation on the Quality Assurance Committee, an administrative staff member (#7) stated the nurse practitioner attends meetings as	F 520	It is the policy of the Ashley Medical Center that the quality assessment and assurance committee will consist of the director of nursing, a physician designated by the facility and at least 3 other members of the facility's staff. A physician will be a part of the Facility wide QA Committee. Te committee will meet quarterly. If the physician is unable to attend physically, a conference call will be made to his clinic to allow the physician to attend via a conference call. A check list will be used to do a QA on checking the physician attendance at the Facility wide QA meeting. See attachment F 520. Arrangements were made with the Ashley Clinic for conference calling with the physician on 01-07-11. A QA study will be done following each quarterly meeting to see if the physician attended personally or via phone for one year. Responsible Party: QA Coordinator See attachment F 520 (1)	02-09-11

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F 520	Continued From page 28 a representative of the medical staff and the physician reviews the minutes at medical staff meetings. When interviewed, on 01/05/11 at 9:45 a.m., regarding quality assurance, a quality assurance committee member (#13) confirmed the physician does not attend meetings, but reads the minutes. On the afternoon of 01/05/11, the staff member (#13) stated the physician attended no Quality Assurance Meetings in 2010. - The facility's ND DoH, Division of Health Facilities provider file, reviewed in preparation for the survey, identified F156 regarding Notice of Rights (Medicare Billing) concerns cited in 2009 and 2010. The team has identified current concerns with this requirement. Refer to F156. Review of the file also identified F250 Social Services cited in 2009 and 2010. The team also identified current concerns with social services. Refer to F250. Review of the file further identified F323 Accidents and Supervision cited in 2010. The team identified current concerns with prevention of accidents. Refer to F323. The facility's Quality Assurance Committee has failed to adequately address the concerns and ensure sustained compliance with the federal requirements regarding Notice of Rights (Medicare Billing), Social Services, and Accidents and Supervision.	F 520	At the Quarterly QA meetings, the Quality Assurance Committee will address the concerns and seek to ensure sustained compliance with the federal requirements regarding Notice of Rights (Medicare Billing), Social Services, and Accidents and Supervision. DON, LSW, MDS Coordinator and QA Coordinator were instructed on 01-27-11 that these areas need to be addressed prior to the QA meetings and then deficiencies F 156, F 250 and F323 will be discussed at the QA quarterly meetings, as well. A QA will be done on F 156, F 250 and F323 that they were presented and discussed by the QA committee. Responsible Party: Adm./Or assigned designee See attachment F 520 (2)	02-09-11