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 _____	01/08/2015

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 01/05/15 and completed on 01/08/15, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 9 additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=B	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.	F 156	F156 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 within the appropriate timeframes.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Admin/CEO	2/17/2015

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 The facility must inform each resident before, or 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 inform each resident of the	F 156	F 156 Continued The LSW or SSD will notify the resident or legal representative of non-coverage by Medicare and their right to request a demand bill upon admission to SNF or upon notification that the resident is no longer requiring a skilled service to meet criteria for coverage by Medicare and 2 days prior to coverage ending. LSW will notify the resident or legal representative of failure to provide the notice of non-coverage of Medicare in a timely manner which is an infringement of resident rights. Medicare Denial Checklist to be completed for each resident upon notification that coverage will be ending. Checklist to be kept with original notices upon completion. (See attachment F 156)	

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F 156	Continued From page 2 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: Based on review of Medicare billing records, Centers for Medicare and Medicaid Services guidelines, and staff interview, the facility failed to provide Medicare notices in a timely manner for 1 of 5 residents (Resident #12) reviewed. Failure to provide the Notice of Medicare Provider Non-Coverage at least two days in advance of the service termination prevents the resident from requesting an expedited review of the decision to terminate the services and is a violation of the resident's rights. Findings include: The Centers for Medicare and Medicaid Services (CMS) outlined standards of practice regarding information Medicare beneficiaries of their rights related to billing. The facility must issue the Notice of Medicare Provider Non-coverage (CMS form 10123, also call an Expedited Appeal Notice or a Generic Notice) when there is a termination of all Medicare Part A Services for coverage reasons. This notice informs the beneficiary of his/her rights to an expedited review of Medicare	F 156	F 156 Continued QA study will be done monthly x3, quarterly x3 to ensure proper procedure is followed in regards to Medicare denial letters. Responsible party: LSW	2/12/2015

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F 156	Continued From page 3 benefit termination by the Quality Improvement Organization (QIO). These notices need to be provided to the resident or representative in writing and in a language the resident understands. The SNF (Skilled Nursing Facility) Provider is required to notify the beneficiary of the decision to terminate covered services (Generic Notice, CMS 10123) no later than 2 days before the proposed end of the services. Review of the Notice of Medicare Provider Non-Coverage forms the facility provided to residents/representatives occurred on 01/08/15 at 10:30 a.m. and identified: *Resident #12's Medicare A services ended on 09/20/14. The resident's representative dated the form as received and understood on 09/19/14, one day after the required delivery date. During an interview on 01/08/15 at 11:30 a.m., a social services staff member (#15) stated the Notice of Medicare Provider Non-coverage or the Generic Notice should be completed two days prior to termination.	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the accurate assessment of 1 of 4	F 176	F176 1. Resident #1 and Resident #13 have been reevaluated by the IDG and found to not be safe to self-administer their medication at mealtime.	

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F 176	Continued From page 4 sampled residents (Resident #1) and 1 supplemental resident (#13) to safely self administer medication (SAM). Failure to consider a resident unsafe to SAM, especially residents with confusion and dementia, has the potential for medication errors to occur. Findings include: Review of the facility policy titled "Self Administration of Medications" occurred on 01/08/15. This policy, dated March 2008, stated, "Policy: Residents who desire to self-administer medications are permitted to do so if members of the facility's Interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility. Procedures: . . . B. If the resident desires to self-administer medications, an assessment is conducted by a licensed nurse to review the resident's cognitive, physical and visual ability to carry out this responsibility. . . . E. . . . Nursing may leave oral medications at bedside or table unattended for resident to take as directed. F. DON [Director of Nursing]/Pharmacist to evaluate annually for resident's continued ability to self administer medications. . . ." - Observation throughout the day on 01/06/15 showed Resident #1 resistive to care, and verbally and physically aggressive with staff. Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's dementia and unspecified psychosis. The current care plan stated, "Problem: [Name of resident] desires to self administer her own oral medications once set up by nurse/CMA [certified medication aide]. Despite having dementia,	F 176	F176 Continued 2. All the residents who were deemed safe to self-administer their medications at mealtime have been reevaluated by the IDG. 3. It is the policy (see updated policy F176 A) that residents who desire to self-administer medications are permitted to do so after assessment by a licensed nurse. (See self-administration of Medication assessment form/F 176B) Self administration assessments will be completed by licensed nursing staff upon admission, quarterly, after a hospital stay, and upon a significant change. Education will be provided to nursing staff on Tuesday, 2/3/2015 and a roster will identify those in attendance. It will be noted in the meeting minutes the education provided on self-administration of medication.	

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F 176	Continued From page 5 [name of resident] consistently takes meds [medications] appropriately when brought by nurse/CMA. . . . Approaches: 1. [Name of resident] will be informed if certain medications should be taken with meals. 2. Initial evaluation done by lincensed [sic] nurse, reviewed by DON/pharmacist on 10-19-09 . . ." Resident #1's CAA [Care Area Assessment] Summaries, dated 10/08/14, stated, "ADL [Activities of Daily Living] Function . . . Staff anticipate her needs. She has a diagnosis of Alzheimer's Dementia with severe cognitive impairment . . . She is resistive to staff assist at times, staff assist as she allows and reapproach as needed. . . . Falls . . . She does have W/C [wheelchair] and bed alarms . . . is not aware of her capabilities and limitations. . . . Psychotropic Drug Use triggered d/t [due to] receiving an antipsychotic and antidepressant daily. . . . She has displayed some behaviors- verbal, physical and rejection of care. . . ." Resident #1's SAM assessment, dated 01/01/15, showed staff answered the following questions and deemed the resident able to safely self administer medications: "A. Resident Status (Able to understand what to do with the medication cup when the nurse sets down the medications for resident):" Staff answered "yes" to "Cognitively alert" and to "Mild confusion," and "no" to "Understands what the medication is for." "B. Physical function. Resident has the ability to:" Staff answered "yes" to "Pick the medication cup off the table," and "Bring hand/arms up to his/her mouth and place medications in mouth," and "no" to "Visually identify medication in order safely self	F 176	F176 Continued 4. QA (see F 176C) will be done on self-administration of medication monthly x 2 and quarterly x 3 and reported to the QA committee quarterly. Responsible party: DON	2/12/2015

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F 176	Continued From page 6 administer." The facility failed to consider Resident #1's severe cognitive impairment and behaviors as a contraindication to SAM. - On 01/08/15 at 8:35 a.m., observation showed Resident #13 left the dining room table and returned to her room. Observation showed a medication cup containing three pills by her plate on the table. During an interview on 01/08/15 at 8:44 a.m., Resident #13 stated when asked about her morning pills left at the table, "I forgot them again." Review of Resident #13's SAM assessment, dated 01/01/15, showed staff answered the following questions and deemed the resident able to safely self administer medications: "A. Resident Status (Able to understand what to do with the medication cup when the nurse sets down the medications for resident):" Staff answered "yes" to "Cognitively alert" and to "Mild confusion," and "no" to "Understands what the medication is for." "B. Physical function. Resident has the ability to:" Staff answered "yes" to "Pick the medication cup off the table," and "Bring hand/arms up to his/her mouth and place medications in mouth," and "no" to "Visually identify medication in order safely self administer." The facility failed to consider Resident #13's mild confusion, and episode(s) of leaving her medications on the table as a contraindication to SAM.	F 176		

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F 176	Continued From page 7 During an interview on 01/08/15 at 11:45 a.m., an administrative nurse (#6) agreed the above residents may not be appropriate to SAM, and stated they are going to change the SAM assessment process. The facility failed to ensure the appropriateness of SAM for two residents identified with mild confusion, who demonstrated cognitive inability to self administer (Resident #13), and/or were assessed with severe cognitive impairment (Resident #1).	F 176		
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: Based on observation, record review, policy and procedure review, and staff interview, the facility failed to assess resident behaviors for causative/precipitating factors, develop and implement timely specific, individualized interventions, monitor the effectiveness of these interventions, and revise them accordingly for 2 of 2 residents (Resident #4 and Resident #8) identified through record review as exhibiting resident to resident aggressive behavior. Failure to assess verbal and/or physical behaviors, implement interventions, and monitor resident response to interventions does not allow for planning and implementation of interventions to	F 250	F250 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.	

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F 250	Continued From page 8 prevent/minimize the occurrence of aggressive behaviors and has the potential to cause mental anguish to some residents and for residents to injure each other. Findings include: Review of the "Behavior Committee," policy occurred on the morning of 01/08/15. The policy, dated 11/07/13, stated, ". . . GOAL: of the behavior committee is to plan, study, act and implement approaches that will . . . improve dementia care and therefore support person centered care for our residents . . . Each resident has an individualized care plan that is reviewed at each committee meeting . . . Resources that are used: . . . Partnership to Improve Dementia Care in Nursing Homes . . . [which states] . . . Questions to Consider in Interdisciplinary Team Review of Individual Dementia Care Cases . . . If medical causes were ruled out, did the staff attempt to establish the root causes of the behaviors, using a careful and systematic process and individualized knowledge about the resident when possible? Were family caregivers or others who knew the resident prior to his/her dementia consulted about life patterns, responses to stress, etc? . . . Were specific target behaviors identified and desired outcomes related to those behaviors documented? . . ." Review of Resident #4's medical record occurred on January 5-8, 2015. The resident's diagnoses included anxiety, dementia with behavioral disturbance and paranoid personality disorder. The quarterly Minimum Data Set (MDS), dated 10/30/14, identified Resident #4 as cognitively intact with physical behaviors directed toward other such as hitting, kicking, pushing, scratching,	F 250	F250 Continued Care plans updated for Resident #4 (roommate Resident #2 deceased) to reflect interventions taken upon incident on 12/8 and being carried out at this time. Both residents receiving psychotropic medications and therefore, will continue to be monitored via weekly Behavior Committee meetings to ensure care plans reflect current interventions being used, determine need for care plan updates or changes related to behaviors, assess need for "Monthly Target Behavior Monitor" or "ABC Behavior Charting" related to increase in or development of target behavior of concern, review telemed notes from Dr. Capan and review medications and GDR recommendations.	

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F 250	Continued From page 9 grabbing, and abusing others sexually and verbal behaviors directed toward others such as threatening others, screaming at other, and cursing others. Resident #4's care plan, dated 08/01/13, identified, " . . . risk for . . . alteration in mood . . . encourage to participate in activities of interest . . . monitor and document mood/behaviors daily . . . visit with [resident's name] about problems/ concerns as they arise . . . " Resident #4's Nurse's Notes, Social Service Notes, and monthly Behavior Care Plan Meeting Minutes identified the following complaints regarding her roommate, threats towards her roommate, combined with Resident #4's hallucinations/delusions that placed Resident #4's roommate at risk for injury: *04/29/14 - ". . . resident asking often to be moved back into old room, overheard saying to son that she needs to start misbehaving so she gets moved. Resident will not be moved at this time. Instructed resident to pull privacy curtain in current room when she'd like to have more privacy." *04/30/14 - ". . . she was complaining about roommate, stating she took her hairbrush. She stated 'I should just bob her one on the head' I told her she is not allowed to do that . . . still wanting to try and get into my old room . . ." *05/02/14 - ". . . hallucinating thinking she seen [sic] snakes and mice . . ." *05/12/14 - " . . . stated she has a soft spot for roommate . . ." *05/27/14 - ". . . very protective of roommate . . ." *05/31/14, 1:30 a.m. - ". . . found resident standing beside roommate telling roommate to get up and help her . . . kept saying she needs to	F 250	F250 Continued Care plans updated for Resident #8 and spouse to reflect interventions in place related to verbal abuse by resident #8 towards spouse. Both residents receiving psychotropic medications and therefore, will continue to be monitored via weekly Behavior Committee meetings to ensure care plans reflect current interventions being used, determine need for care plan updates or changes related to behaviors, assess need for "Monthly Target Behavior Monitor" or "ABC Behavior Charting" related to increase in or development of target behavior of concern, review telemed notes from Dr. Capan and review medications and GDR recommendations.	

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F 250	Continued From page 10 get up and help her . . ." *05/31/14, 3:00 a.m. - ". . . yelling at roommate (who was sitting in bed) to go to sleep . . . c/o [complaints of] roommate keeping her awake . . ." *06/24/14 - " . . . heard animal breathing under floor boards in room . . ." *07/13/14 - ". . . A possum or armadillo under her roommate's bed as she heard it . . . informed no animals . . . res [resident] not convinced . . ." *07/30/14 - ". . . stated she gets along with roommate . . . [Social Service Note]" *07/30/14 - " . . . day of hallucinations . . . [Nurse's Note]" *08/07/14 - ". . . talking . . . roommate always playing with private area and that roommate will jump on her bed sometime soon . . ." *08/29/14 - " . . . making comments about her roommate saying 'I don't have to put up [with] that, I can't help it if she doesn't have any visitors also c/o that roommate doesn't ever talk to her . . ." *09/09/14 - " . . . Res stating not able to sleep d/t [due to] roommate's [alarm] alarming asking about private rm [room]." *09/25/14 - ". . . res threatening roommate b/c [because] she couldn't sleep last night. Went in to speak to res about what the problem was and res began talking about various unrelated things, Res keeps asking about private rooms . . . did not mention anything regarding roommate and threatening her. Told res she should pull privacy curtain to help for now." *10/16/14 - " . . . verbally abusive [to] roommate . . . threatened to beat up roommate . . . said 'I could have beaten her up already and I can if I want to' Told res that she cannot be making threats to roommate . . . c/o that all roommate does is make noise and keeps her awake and she can't sleep . Let res know that roommate was	F 250	F250 Continued "Monthly Target Behavior Monitor" (See F250-A) and "ABC Behavior Charting"(See F250-B) to be implemented by staff when a behavior exhibited by a resident becomes of concern via review of CNA flow sheet or reports from staff and there is a decision made my Behavior Committee to implement such tracking tool. Tools will used to determine what interventions are effective in reducing target behavior in order to effectively care plan in a timely manner.	

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F 250	Continued From page 11 being quiet . . . Res still angry and stated well she is quiet now your here. Told res again she can take a nap." *10/22/14 - ". . . Res upset with roommate . . . hid roommate's water . . ." *11/05/14 - ". . . Resident getting upset [with] roommate because alarm is going off . . ." *12/08/14, 4:30 p.m. - ". . . overheard res state she was going to hit her [roommate?] . . . [Resident #4's name] stated that her roommate is going to hit her [Resident #4's name] . . ." *12/08/14, 5:00 p.m. - ". . . continues to state roommate had threatened her . . ." *12/08/14, 5:05 p.m. - [Resident's name] stating that roommate had threatened her son [resident's name] hit back of roommate's head . . . took roommate out of room . . ." *12/08/14, 7:00 p.m. - "stating they were lying and someone would be 6 feet under and it wasn't going to be her, [resident's name] then went into her room and slammed door . . ." *12/09/14 - ". . . more easily annoyed threatens staff and other residents on 12/8 became physical with a res, hitting her on the back of the head . . . roommate who was hit has been moved to a different room . . . this res is to be kept alone in room until further notice for safety concerns of other res . . . This behavior has been exhibited before by resident and resident has been talked to many times about the responsibilities and rules of residents. . . Discussed how resident tends to be worse after son visits . . . Possible transfer of resident to more appropriate facility discussed, but [physician] feels changing medication will help . . . increased Seroquel [antipsychotic medication] . . . call son . . . if behavior continues . . she will be transferred . . . he needs to limit visits . . . monitor behaviors closely x1 week . . ." *12/09/14, 10:00 p.m. - ". . . room to room looking	F 250	F250 Continued Behavior Committee, consisting of LSW, SSD, DON, Ward Clerk, MDS Coordinator, MD, CNA Supervisor, Activities Director, Dietary Manager and Administrator, to be educated on new tracking tools to be implemented at behavior meeting on 2/10/15. CNA and Nursing staff to be educated on new tools for implementation and how to use them by 2/10/15. CNA and Nursing staff to be educated also on importance of clear, concise and descriptive charting related to behaviors by 2/10/15. QA study to be done monthly x3, quarterly x3 to ensure new tracking tools are being utilized effectively, care plans are updated in a timely manner and appropriate documentation has been completed. Responsible party: LSW	2/12/2015

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F 250	Continued From page 12 for roommate . . . removed name tag door . . ." *12/10/14 - ". . . someone pay tired of lies . . ." *12/10/14 - ". . . said she found out where her roommate got moved . . ." Review of these interdisciplinary notes revealed a lack of assessment for tracking/trending of behaviors and a lack of consistent/timely/resident specific interventions for exhibited behaviors. Review of Behavior Monitoring Forms for August through January included check marks that the following behaviors were exhibited by Resident #4: J. "Being short-tempered, easily annoyed" K."Hallucinations (perceptual experiences in the absence of real external sensory stimuli)" L."Delusions (misconception or beliefs that are firm held, contrary to reality)" M."Physical behavioral systems directed toward others (e.g. hitting, kicking, pushing, scratching, grabbing, abusing) N. Verbal behavioral systems directed toward others (e.g. threatening others, screaming at others, cursing at others) August (J, N) September (none) October (J, L, N) November (J, N) December (J, L, M, N) Review of behavior monitoring forms revealed it cannot be determined if each of these behaviors were directed at staff or other residents. A Psychiatric Note, dated 12/10/14, stated, ". . . seen today as add on because she had slapped one of the other residents . . . increased Seroquel	F 250		

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F 250	Continued From page 13	F 250		

about a day ago . . . We discussed that it is unclear how much of the medication would help with her behavior if this is related to the possible borderline personality disorder. They did voice concern about the patient being physically aggressive and we discussed that the patient is not psychotic. She is not confused or severely demented so if she continues to become physically aggressive they need to meet [with] her and set limits as far as consequences for those actions or behaviors. . . . "

During a resident interview on 01/05/15 at 2:55 p.m., Resident #4 stated she sets and thinks a lot and randomly stated, "Lady in the other bed. Something I did she didn't like? She seems to be pretty content now."

Observation on the afternoon of 01/05/15 showed Resident #4's roommate residing in the room next to Resident #4 across from the nurses' station. Facility staff failed to identify implementation of this on Resident #4's care plan and how to ensure this other resident remained safe from Resident #4, since living in the room next door. Observation throughout the survey showed Resident #4 and her former roommate spent the majority of their time in their own rooms and had no interaction.

During an interview on 01/07/14 at 12:00 p.m., a social services staff member (#15) stated she would receive a telephone call regarding Resident #4's behaviors or see the behaviors charted in the nurse's notes and would then talk to both parties involved. She stated Resident #4's roommate is unresponsive and Resident #4 would not remember or deny the incident. This staff member stated that Resident #4 did fine with

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F 250	Continued From page 14 some roommates in the past and with the current roommate the behaviors would go in waves. This staff member agreed Resident #4 is unpredictable and stated if she really had the intent to harm somebody she would. This staff member stated the behavior committee, responsible for implementing an "ABC Behavior Charting," had not implemented this assessment/monitoring form on any residents. Review of the form showed it included ". . . What was happening before behavior occurred?, What exactly did resident do?, and What happened after behavior occurred? . . ." -Review of Resident #8's medical record occurred on January 7-8, 2014. The resident's diagnoses included depression. The admission MDS, dated 11/23/14, identified physical behaviors directed toward other such as hitting, kicking, pushing, scratching, grabbing, and abusing others sexually and verbal behaviors directed toward others such as threatening others, screaming at others, and cursing others. Resident #8's care plan, dated 12/09/14, identified, "aggressive behaviors . . . has displayed s/s [signs/symptoms] of depression - easily angered physical and verbal abuse to staff, verbal abuse to his wife [another resident] . . . allow to vent his frustrations/feelings . . . identify stressors that increases agitation - becomes aggressive/belligerent when asked to leave spouse's room . . . staff and residents to keep a safe distance from [resident's name] during episodes of aggression . . . remove potentially harmful objects from environment . . . review at behavior committee meetings . . . do not place next to spouse at meals unless spouse requests to sit by [resident's name] . . ."	F 250		

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F 250	Continued From page 15 Resident #8's Nurse's Notes identified the following verbal behaviors towards Resident #8's spouse: *11/17/14 - "Has been taking wife's food and telling her she is too fat for desert [sic] so wife only eats small amts [amounts] of food and gives the rest to her husband." *12/03/14 - ". . . Has expressed wanting to room [with] spouse but spouse does not want this - he is unkind to her at times." *12/04/14 - "Staff reported that resident made a comment to wife, 'There's the fat bitch,' Staff then took resident out of wife's room and [resident] became angry and swore . . . One of the nurses talk [sic] to resident that he needs to be nice and pleasant to wife so he can go visit her when he wants to. Resident stated 'I don't know what you're talking about,' taken back to wife's room and calmer later on." *12/05/14 - In a.m. report that res called spouse a 'fat bitch' last night . . . spouse denies that res said this but staff have noted a difference in spouse's behavior since res admitted to [skilled nursing facility]. Will continue to monitor closely." *12/06/14 - "Resident refused supper states 'we are keeping him from his wife.' Wife did not want to see him at this time. Earlier today resident was calling her names and telling her to quit eating because she is fat. Staff has overheard him calling her 'Fat bitch' . . ." *12/07/14 - "Resident was visiting wife when staff overheard wife crying. Staff asked if she was ok. Wife very tired not feeling well and wants to go to bed. Resident was asked if he could go back to room so wife could get some rest. Resident made fists at CMA [certified medication aide] attempting to hit her. . . . Resident believes we are 'Lying Bastards.' and feels she is not ill . . . Staff left	F 250		

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F 250	Continued From page 16 room and allowed res [resident] to talk with wife. Wife begging him to go to his room." *12/08/14 - "Resident in visiting wife staff tried to ask him to leave room so cares could be done with [wife] . . . [resident's name] began swearing at staff and attempting to hit staff, left alone, and res did leave room went to visit another res staff reports he tried to tear decorations . . . off wall." *12/08/14, 10:00 a.m. - "Behavior care plan meeting held and resident discussed R/T [related to] wife, resident has been reported to be repeatedly rude and verbal abusive to wife. Wife has reported this to staff . . ." *12/08/14, 8:00 p.m. - ". . . heard spouse and res arguing, removed resident from room . . ." *12/18/14, 10:00 p.m. - ". . . telling wife he will not eat or drink until he can be in same room as wife." *12/28/14 - "Visiting with wife [after] supper and when staff took resident back to his room he was calling staff members 'Bitches.' Spouse was wanting to go to bed. This nurse asked spouse if she would want him as her roommate. Her reply was 'I hope that never happens.' Resident #8's Social Service Notes identified: *12/05/14 - In a.m. report that res called spouse a 'fat bitch' last night . . . spouse denies that res said this but staff have noted a difference in spouse's behavior since res admitted to [skilled nursing facility]. Will continue to monitor closely." *12/08/14 - Res [power of attorney] called and has concerns [with] this res being rude [with] his spouse who also is a resident here. She states she may try and have him go to [name of another nursing home] . . . can't give him something in his food or drink so he wouldn't be so nasty to his spouse. Discuss behavior meeting and keep in touch."	F 250		

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F 250	Continued From page 17 Resident #8's Behavior Care Plan Meeting Minutes: *12/19/14 - "Res added to discussion due to effect he is having on spouse. Res has been witnessed calling spouse a 'fat bitch' and becomes combative/belligerent when being removed from spouse's room . . . BIMS [Brief Interview for Mental Status] 9 [moderately cognitively impaired] . . . ordered Celexa [antidepressant] crushed in food/drink. Staff to keep res out of spouse's room. Monitor behavior closely." *12/23/14 - "In report that behaviors are improving . . . there have been no reports of verbal abuse towards spouse recently and staff are monitoring any time spent with spouse very closely . . . Discussed res wanting to move in with spouse, but concern voiced by many that would create more problems for spouse." *01/06/14 - "Res doing well, no reports of problems between res and spouse [Resident #8]. Discussed whether staff are continuing to limit interaction between the two to benefit res and prevent verbal abuse from spouse. CNA [certified nursing assistant] manager stated they are not limiting the interaction as res like the visits and the two are monitored closely during visits. Res is eating better now that the two are not sitting by each other. Review of these interdisciplinary notes revealed a lack of assessment for tracking/trending of behaviors and a lack of consistent/timely/resident specific interventions for exhibited behaviors. Review of Behavior Monitoring Forms for November through December included check marks that the following behaviors were exhibited	F 250		

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F 250	Continued From page 18 by Resident #8: J. "Being short-tempered, easily annoyed" L."Delusions (misconception or beliefs that are firm held, contrary to reality)" M."Physical behavioral systems directed toward others (e.g. hitting, kicking, pushing, scratching, grabbing, abusing) N. Verbal behavioral systems directed toward others (e.g. threatening others, screaming at others, cursing at others) November (J, M, N, O) December (J, L, M, N) Review of behavior monitoring forms revealed it cannot be determined if each of these behaviors were directed at staff or other residents. During an interview on 01/08/14 at 10:00 a.m., an administrative nursing staff member (#6) stated facility staff had implemented fifteen minute checks and stand outside Resident #8's wife's room during Resident #8's visits. Facility staff failed to identify implementation of these interventions on Resident #8's care plan. Failure to assess/monitor verbal behaviors, provide timely/appropriate resident specific interventions, and assess the effectiveness of the interventions placed residents at risk for potential injury.	F 250		
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.	F 281	F281 1. Resident #15 has expired.	

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F 281	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 2 closed record residents (Resident #15) with whom staff left medication unattended and another resident (Resident #6) ingested the medication. Failure to stay with a resident while administering medication, does not ensure the safety of other residents who may take the medication. Findings include: Berman and Snyder, "Kozier & Erb's 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. . . ." Review of Resident #15's medical record occurred on January 07-08, 2015. Diagnoses included dementia with psychotic behaviors. Medications included Haldol [antipsychotic] 2 milligrams (mg) at 4:00 p.m. A physician's order, dated 05/26/14, stated, "May place meds [medications] in food or drink." A Self Administration of Medication Assessment, dated 05/27/14, indicated Resident #15 could not safely administer his own medication. During an interview on the afternoon of 01/07/15, an administrative nurse (#6) identified Resident	F 281	F281 Continued 2. A policy has been implemented Medication Crushing Guidelines/ Medications administered in food/ drink (See F 281 A) 3. Medication Crushing Guideline/ Medications Administered in Food/ Drink policy has been written and will be implemented. Education will be provided to nursing staff on Tuesday, 2/3/2015 and a roster will identify those in attendance. It will be noted in the meeting minutes the education provided on crushing guidelines/administering medication in food/drink. 4. QA will be done on self-administration of medication monthly x 2 and quarterly x 3 and reported to the QA committee quarterly. Responsible party: DON	2/12/2015

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F 281	Continued From page 20 #15 and #6 were roommates on 10/03/14. Review of Resident #6's medical record occurred on all days of survey. Review of nurse's notes, dated 10/03/14, stated the following: * 3:45 p.m., "CNA [certified nurse aide] in to assist [Resident #6]'s roommate [with] his ice cream snack; was unaware that ice cream contained roommates med. and allowed [Resident #6] to eat this ice cream." * 4:00 p.m., "Incident [with] ice cream reported to [name of Family Nurse Practitioner], who told nurse to observe pt [patient] for any unusual behaviors." * 5:45 p.m., "pt alert, able to walk to supper per self . . . [no] unusual behavior." * 9:00 p.m., ". . . No problems noted" Review of an incident report regarding Resident #6, dated 10/03/14, stated, "Summary of injury: "pt was given ice cream in which roommates med was crushed. (Haldol 2 mg) . . . Comments/Interventions: Discussed with LPN [licensed practical nurse]" The staff failed to ensure Resident #15 ingested his medication and left the medication in his room unattended, which conflicted with the facility assessment of his inability to self administer medication. This failure led to Resident #6 erroneously receiving Resident #15's Haldol, and had the potential to cause unwanted effects and adverse reactions in Resident #6.	F 281		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	F323 It is the policy of the Ashley Medical Center to ensure that the residents environment remains as free of accident hazards a possible; and each resident receives adequate supervision and assistance devices to prevent accidents	

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F 323	Continued From page 21 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: SIDE RAIL 1. Based on observation, record review, professional reference review, and staff interview, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 of 1 sampled resident (Resident #2) who obtained multiple bruises from the side rails on her bed. Failure to evaluate the risks associated with side rail use has the potential to result in resident entrapment, injury, and/or death. Findings include: The "Guidance for Industry and FDA [Food and Drug Administration] Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," issued March 10, 2006, pages 1 and 13, stated, ". . . . This guidance provides recommendations intended to reduce life-threatening entrapments associated with hospital bed systems. It characterizes the body parts at risk for entrapment, identified the locations of hospital bed openings that are potential entrapment areas . . . The seven areas in the bed system where there is a potential for entrapment are identified . . . Zone 1: Within the Rail . . . Zone 4: Under the Rail, at the Ends of the Rail . . ."	F 323	F323 Continued F323 Side Rails Since the items require a policy and systemic change these methods will be used to assist in resolution. Please see F 323(a) Side Rail Policy.	

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F 323	Continued From page 22 Review of Resident #2 medical record occurred on January 5-8, 2015. The resident's diagnoses included macular degeneration, poor eyesight, weakness, and osteoarthritis. The quarterly Minimum Data Set (MDS), dated 11/19/14, identified short-term and long-term memory problems at a level unable to be determined and extensive assistance of one person with bed mobility and transfers. The care plan, dated 11/25/13, identified, ". . . Able to turn/reposition herself once in bed. May have 1/2 top side rails up as desired for bed mobility. . . ." All observations on January 5-8, 2015 showed Resident #2 lying in bed with two bilateral half side rails in the up position. A Nurse's Note, dated 12/28/14 at 5:00 a.m., stated, "CNA's [certified nursing assistants] noticed bruising on L [left] shin. There are four bruises ranging in size from one through three cm [centimeters]. Resident was laying [sic] crossways on bed with her legs between the side rails. Legs taken out from between rails, also noted old skin tear on R [right] shin reopened. TX [treatment] started. . . ." A facility incident report, dated 12/28/14, stated, "unwitnessed . . . Summary of Injury: CNA's noticed bruises on L shin. There are four bruises ranging in size from one to three cm. Resident was laying [sic] sideways on the bed with her leg through the bed rail. Areas on shin were dark purple in color. This nurse removed resident's legs from between side rails. Also noted old skin tear on R shin reopened and was steri stripped [thin adhesive strips applied to close wound]. . . . Comments/Interventions: . . . Staff to monitor	F 323	F323 Continued Resident #2 Due to the incident with this resident the Ashley Medical Center has implemented a Nurses Reporting for Entrapment or Near Miss Entrapment. Please see F 323(b) Staff will be educated on this form for entrapment. For Resident #2 the Ashley Medical Center has place padding around the siderails so that they are still available to the resident but the risk of injury is significantly less.	

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F 323	Continued From page 23 bruising, nurse (staff) recommended side rail padding to be beneficial." During an interview on the morning of 01/06/15, an administrative nursing staff member (#6) stated facility staff never implemented side rail padding as the full length padding available would limit the resident's ability to see and if she would crawl over the rails, the risks would then outweigh the benefits. This staff member stated Resident #2 uses the side rails for positioning. A "Side Rail Evaluation," dated 11/22/13, stated, "[Resident #2] was evaluated today for the use of side rails as an assistive device. The first attempt was without the use of the side rails, and the patient was unable . . . to rise from bed independently. The second attempt was with the use of . . . both side rails and the patient was able to rise from bed independently. The patient requests . . . both side rails be left up for patient independence with positioning and rising from bed. This device is used as an enabler. We will continue to review side rails prn [as needed] or yearly as appropriate." Upon request for a more recent side rail assessment, a "Physical Functioning," form, dated 2/21/14, was provided. This form stated, "Assistive Devices in Bed Top 1/2 Rails . . . Both . . . Transfers With Assist of One . . . Min [Minimum] . . ." During an interview on 01/07/15 at 12:10 p.m., an administrative nursing staff member (#6) stated, "Sometimes [Resident #2] lays with her head at the end of the bed." During an interview on 01/07/15 at 12:15 p.m., a nursing staff member (#16) stated, "Sometimes [Resident #2] lays crossways in bed."	F 323	F323 Continued The policy shall be put into place on 2-3-15 as well discussed at the all staff meeting. The therapist will have reviewed the resident in question and meet with the nurse on any other potential residents that are identified by 2-6-15. This will be the focus of a QA over the next 3 months and then quarterly times 3 after that. Immediate rectification will occur on the observations if there needs to be additional education. QA will be done monthly x 3, then quarterly x 3 Responsible parties: Physical Therapist.	2/12/2015

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	355091	A. BUILDING _____ B. WING _____	01/08/2015

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F 323	Continued From page 24 During an interview on 01/07/15 at 4:25 p.m., a night nursing staff member (#17), identified as the person who discovered Resident #2 with her legs in the side rail on 12/28/14, provided a description of the incident. This staff member indicated that Resident #2 head was positioned near the lower end of the right side rail, with her body lying crossways on the bed, and her left leg was through the vertical opening of the left side rail. This vertical section of the side rail measured 2.75 inches width by 17 inches height. This staff member stated Resident #2 likes to put her legs over the side rail. She stated the resident's left leg was through the side rail to mid shin. She stated when she told the resident, Resident #2 took her foot out from the side rail opening. This night nursing staff member (#17) further stated she had two observations in the last month of Resident #2 lying with her legs hanging over a side rail. She stated Resident #2 usually lies in her bed crossways at night. Facility staff failed to reassess Resident #2 for the appropriateness of side rail use when they determined Resident #2 sometimes laid in bed in positions and/or with movement that would place her at risk for entrapment. During an interview on 01/08/15 at 11:40 a.m., an administrative nurse (#6) stated the facility does not have a policy related to side rails, but uses an assessment by the physical therapist to determine if side rails should be used by the resident. Observation on the morning of 01/08/15, showed facility staff had padded Resident #2's bilateral	F 323		

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F 323	Continued From page 25 side rails. ELOPEMENT 2. Based on record review, facility policy review, and staff interview, the facility failed to ensure the safety needs for 1 of 1 sampled resident (Resident #6) who exhibited wandering behaviors and eloped from the building. Failure to routinely monitor the function and location of the resident's wanderguard does not ensure the resident's safety. Findings include: Review of the facility policy titled "Secure Care System for Wandering Residents" occurred on 01/08/15. This policy, dated March 2008, stated, "Each wandering resident will be evaluated individually to decide if the Secure Care System is applicable for them. Bracelet Application: The bracelet should be properly fitted to the resident's ankle or wrist . . . " The policy failed to address monitoring of the wanderguard system, such as, assessing for proper functioning of a resident's wanderguard, ensuring the wanderguard remained secured to the resident, and the frequency of these checks. Review of Resident #6's medical record occurred on all days of survey. Resident #6 was admitted in November 2013 and diagnoses included Alzheimer's disease, dementia with behavioral disturbance, unsteady gait, and history of suicidal ideation and falls. The care plan, dated 11/12/13, stated, "Problem: [Resident #6] has a history of anxiety and depression, risk for exacerbation d/t [due to] placement in facility, risk for trying to	F 323	F323 Continued ELOPEMENT 1. Resident #6 has a wander guard in place with CNA check daily for function and per shift check for placement. 2. A policy/procedure was written including a risk assessment for residents at high risk for elopement and a procedure to follow (See F323 A and F 323 B) 3. The wander guard policy was updated to include the daily assessment for proper function of a residents wander guard, and to ensuring the wander guard is intact (see F323C). Education will be provided to nursing staff on Tuesday, 2/3/2015 and a roster will identify those in attendance. It will be noted in the meeting minutes the education provided.	

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F 323	Continued From page 26 leave facility - cognitive impairment and expresses wanting to go home @ [at] times. . . . Approaches: 1. Wanderguard used. 8-4-13 [sic] [Resident #6] has cut his wanderguard off in the past; ensure wanderguard is on [with] routine checking . . . and be aware of his wherabouts [sic] @ all times. Assist him to the office to purchase candybars, outside of facility." Resident #6's nurse's notes stated the following: * 06/02/14 at 2:15 p.m., "Res [resident] had been found downstairs in lobby area was wanting to go outside was brought back upstairs by nursing staff . . . 2:30 p.m. Call received from office res outside [with] activity supervisor not wanting to come in. CNA went down and was able to get him back to his room. Noted that res did not have a [sic] alarm on anymore. . . ." * 06/28/14 at 4:00 p.m., stated, "Resident went outdoors and was walking down street when CNA [certified nurse aide] caught up to him. He claims he didn't want to eat and was going home. . . ." * 06/29/14 at 8:30 p.m., stated, "CNA assisting [with] HS [bedtime] cares & noticed res wanderguard not on his ankle, when asked where it was [resident] replied in the garbage, reapplied [with] new band." During an interview on 01/07/15 at 11:35 a.m., an administrative nurse (#6) stated on August 1st the facility implemented checking for wanderguard placement and function every shift, an increase from weekly checks. She added the wanderguard system only alarms on the second floor where the residents live, and not in the lobby on first floor. During an interview on 01/08/15 at 10:07 a.m., a CNA (#4) stated the CNAs check Resident #6's wanderguard every shift by taking him close to an	F 323	F323 Continued 1. QA study will be done monthly x 2 and quarterly x 3 and reported to the QA committee. See (F323D) Responsible party: DON	2/12/2015

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F 323	Continued From page 27 alarmed area; and if the alarm sounds, the wanderguard is working. She stated Activities staff always accompany the resident to the lobby, and the alarm goes off if he tries to get on the elevator himself. Failure to include in policy the assessment and monitoring of the wanderguard system does not ensure wanderguards worn by residents are intact and functioning. Failure to increase the frequency of weekly wanderguard checks immediately following the episode on 06/02/14, along with his history of removing the wanderguard, may have contributed to the resident leaving the building undetected on 06/28/14 and the potential for further elopements. GAIT BELTS 3. Based on observation, record review, facility policy review, and staff interview, the facility failed to appropriately utilize assistive devices for 2 of 3 sampled residents (Resident #1 and #2) observed transferred with a gait belt. Failure to follow proper technique in transferring residents with a gait belt has the potential to result in avoidable falls and/or injuries to the residents. Findings include: Review of the facility policy titled "Gait Belt Policy for Ashley Medical Center" occurred on 01/08/15. This policy, dated June 2010, stated, ". . . The belt should be placed near the waist unless previous diagnosis exist. (If that is the case under the arms is the second option). . . . Make sure the belt is snug on the user. Additional tightenings may be appropriate when the patient stands up. Hold onto the belt with the hand or hands under	F 323	F 323 Gait Belts Since the items require a policy and systemic change these methods will be used to assist in resolution. Please See F 323(a) Gait Belt Policy Addendum.	

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F 323	Continued From page 28 the belt versus the top . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnosis included Alzheimer's dementia, osteoarthrosis, abnormality of gait, and history of hip joint replacement and falls. On 01/06/15 at 4:27 p.m., observation showed two certified nurse aides (CNAs) (#1 and #2) changed Resident #1's brief, assisted her to sit at the edge of the bed, and placed a gait belt around her chest. One CNA (#1) lifted under the resident's right arm with one hand and the other hand on the gait belt. The other CNA (#2) lifted with the gait belt, which was loose and slid up Resident #1's back during the transfer to her wheelchair. The staff failed to place the gait belt around the resident's waist and tighten the gait belt once the resident stood. On 01/07/15 at 8:51 a.m., observation showed Resident #1 in her wheelchair and two CNAs (#3 and #4) placed a gait belt around her chest. One CNA (#3) lifted under the resident's right arm with her right arm and did not hold the gait belt. The other CNA (#4) lifted with the gait belt, which was loose and slid up Resident #1's back during the transfer to her bed. The staff failed to place the gait belt around the resident's waist, tighten the gait belt once the resident stood, and lift with the gait belt versus the resident's arm. On 01/07/15 at 10:52 a.m., observation showed two CNAs (#3 and #4) changed Resident #1's brief, assisted her to sit at the edge of the bed, and placed a gait belt around her waist. One CNA (#3) lifted under the resident's left arm and did not use the gait belt. The other CNA (#4) lifted under	F 323	F323 Continued The orientation sheet for new employees has been changed. (Enclosed See F 323(c)) This will allow us to better identify the importance of the tension on the belt and its adjustment. The PT is in charge of the orientation. As well he will attend the all staff in service on 2-3-15 and present that in service to all in attendance. Resident #1 Staff will be instructed to use new orientation on Gait Belt Protocols during in service on 2-3-15. (Enclosed See F 323(c)) During this in service staff will also be presented new policy addendum. Please See F 323(a) Gait Belt Policy Addendum	

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F 323	Continued From page 29 the resident's right arm and held the gait belt during the transfer to her wheelchair. The staff failed to lift with the gait belt versus the resident's arm. - Review of Resident #2's medical record occurred on January 5-8, 2015. The resident's diagnoses included osteoarthrosis and weakness. The quarterly Minimum Data Set (MDS), dated 11/19/14, identified extensive assistance of one person for transfers. Observation on 01/06/15 at 9:25 a.m., showed one CNA (#11) transferred Resident #2 from her wheelchair to her bed using a gait belt. The CNA failed to apply the gait belt snuggly allowing for an approximately six inch gap between the resident's back and the gait belt with standing. Observation on 01/06/15 at 3:45 p.m., showed two CNAs (#2 and #18) transferred Resident #2 from her wheelchair to her bed using a gait belt. A CNA failed to apply the gait belt snuggly allowing the belt to slide from the middle of the resident's back to her underarms. During an interview on 01/08/15 at 12:05 p.m., a physical therapist (#19), who completes CNA training on gait belt usage, stated the gait belt should be applied as tightly as possible and may need to be snugged up once the resident stands. WHEELCHAIR TRANSPORT 4. Based on observation, record review, and staff interview, the facility failed to ensure safety during staff transportation of residents for 4 of 6 sampled residents (Resident #1, #2, #6, and #7) and 2 supplemental residents (Resident #16 and #17)	F 323	F323 Continued Resident #2 Staff will be instructed to use new orientation on Gait Belt Protocols during in service on 2-3-15. (Enclosed See F 323(c)) During this in service staff will also be presented new policy addendum. Please See F 323(a) Gait Belt Policy Addendum PT will also be responsible to QA the usage monthly times 3 and Quarterly times 3 over the next year. Immediate rectification will occur on the observations if there needs to be additional education. QA will be done monthly x 3, then quarterly x 3 Responsible parties: Physical Therapist. F 323 Wheelchair Transport	2/12/2015

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F 323	Continued From page 30 observed transported in a wheelchair. Failure to cue residents to lift their feet during transport, or place foot pedals on the wheelchair if they are unable to lift their feet, placed the residents at risk of injury to their feet or legs and at risk of falling out of the wheelchair during transport. Findings include: During an interview on 01/08/15 at 11:40 a.m., an administrative nurse (#6) stated the facility does not have a policy related to wheelchair transport/use of foot pedals, but uses an assessment by the physical therapist to determine if/when the resident needs foot pedals. Review of the "Physical Functioning" form failed to identify the need to remind residents who do not require foot pedals to lift their feet while being transported in a wheelchair. The facility lacked a policy related to wheelchair transport, including staff responsibility for cueing residents to lift their feet off the floor while being transported by staff, and to place foot pedals if residents are unable to lift their feet. - Observation on 01/05/15 at 3:24 p.m. showed an activity aide (#7) transported Resident #7 in the corridor without utilizing foot rests. Observation showed Resident #7's feet brushing the floor. - Observation on 01/05/15 at 3:45 p.m. showed an activity aide (#7) transported Resident #6 in the corridor without utilizing foot rests. Observation showed Resident #6's feet brushing the floor. - On 01/06/15 at 11:30 a.m., observation showed a CNA (#2) pushed Resident #2 in her wheelchair	F 323	F323 Continued Since the items did not have a policy one has been implemented as well these systemic changes will be used to provide resolution. (Please See F 323(a) Wheelchair Foot Pedal Policy. The orientation sheet for new employees identifies what is considered appropriate for the residents when being pushed by an employee. . (Enclosed See F 323(c)) The therapist will have identified all residents with deficit by 2-6-15. These will be obvious to the employees as they will have a wheelchair pedal bag on the back of their wheelchair if the pedals are not on at all times. This system will be identified at the all staff in service on 2-3-15.	

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F 323	Continued From page 31 from her room to the dining room. The resident's feet brushing along the floor during the transport. - On 01/06/15 at 11:40 a.m., observation showed an activity aide (#7) pushed Resident #6 in his wheelchair from his room to the dining room. The resident wore tennis shoes, and his feet brushed along the floor during the transport. - On 01/06/15 at 12:30 p.m., observation showed a certified nurse aide (CNA) helper (#8) pushed Resident #6 in his wheelchair from the dining room to his room. The resident wore tennis shoes, and his feet brushed along the floor during the transport, with the resident making no effort to lift his feet. - On 01/06/15 at 12:30 p.m., observation showed a CNA (#1) pushed Resident #16 in his wheelchair from the dining room to his room. The resident's feet brushed along the floor during the transport. - On 01/06/14 at 12:30 p.m., observation showed an activity assistant (#7) pushed Resident #17 in her wheelchair from the dining room to her room. The resident's feet brushed along the floor during the transport. - On 01/07/15 at 8:35 a.m., observation showed an activity aide (#7) pushed Resident #1 in her wheelchair from the dining room to her room. The resident wore gripper socks, and her feet brushed along the floor during the transport. The aide then pushed the resident down the hall to the Sun Room and the resident lifted her feet during this transport. - Observation on 01/07/15 at 4:17 p.m. showed a CNA (#10) transported Resident #7 in the corridor without utilizing foot rests. Observation showed	F 323	F323 Continued Resident #7 The Physical Therapist will asses residents ability to hold their feet straight out in front of them or if only bending their knees to clear the floor by 1 inch. If the resident is not able to do this staff must put a pedal on the chair to assist them to their destination and then remove the pedal if they propel themselves in any capacity. Resident #6 The Physical Therapist will asses residents ability to hold their feet straight out in front of them or if only bending their knees to clear the floor by 1 inch. If the resident is not able to do this staff must put a pedal on the chair to assist them to their destination and then remove the pedal if they propel themselves in any capacity. Resident #2 The Physical Therapist will asses residents ability to hold their feet straight out in front of them or if only bending their knees to clear the floor by 1 inch. If the resident is not able to do this staff must put a pedal on the chair to assist them to their destination and then remove the pedal if they propel themselves in any capacity.	

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F 323	Continued From page 32 Resident #7's feet brushing the floor. - Observation on 01/08/15 at 8:20 a.m. showed an activity aide (#20) transported Resident #7 in the corridor without utilizing foot rests. Observation showed Resident #7's feet brushing the floor. - Observation on 01/08/15 at 9:10 a.m. showed an activity aide (#20) transported Resident #7 in the corridor without utilizing foot rests. Observation showed Resident #7's feet brushing the floor. The staff failed to cue the residents to lift their feet during the above transports. Failure to ensure the residents lifted their feet off the floor, or place foot pedals on the wheelchairs if the resident was unable to lift their feet, placed the residents at risk for injury.	F 323	F323 Continued Resident #1 The Physical Therapist will asses residents ability to hold their feet straight out in front of them or if only bending their knees to clear the floor by 1 inch. If the resident is not able to do this staff must put a pedal on the chair to assist them to their destination and then remove the pedal if they propel themselves in any capacity. Resident #16 The Physical Therapist will asses residents ability to hold their feet straight out in front of them or if only bending their knees to clear the floor by 1 inch. If the resident is not able to do this staff must put a pedal on the chair to assist them to their destination and then remove the pedal if they propel themselves in any capacity. Resident #17 The Physical Therapist will asses residents ability to hold their feet straight out in front of them or if only bending their knees to clear the floor by 1 inch. If the resident is not able to do this staff must put a pedal on the chair to assist them to their destination and then remove the pedal if they propel themselves in any capacity. QA will be done monthly x 3, then quarterly x 3 Responsible parties: Physical Therapist. Director Of Nursing	2/12/2015
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide fluids during cares to 3 of 3 sampled residents (Resident #1, #2, and #3) at risk for insufficient fluid intake and dependent on staff to provide fluids. Failure to offer fluids placed these residents at risk of dehydration and constipation.	F 327		

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F 327	Continued From page 33 Findings include: - Review of Resident #1's medical record occurred on all days of survey. Medications included Senna S twice daily and MiraLax daily, laxatives used to treat constipation. Her Care Area Assessment (CAA - areas of concern identified by Minimum Data Set [MDS] findings) Summaries, dated 10/08/14, stated, "#5 ADL [Activity of Daily Living] Function . . . Staff anticipate her needs. She has diagnosis of Alzheimer's Dementia with severe cognitive impairment . . . #14 Dehydration/Fluid Maintenance triggered d/t [due to] having a UTI [urinary tract infection] in the last 30 days. . . ." Resident #1's current care plan stated, ". . . Problem: Risk for skin breakdown . . . Approaches: . . . Encourage nutrition/hydration . . ." A care plan, dated 11/26/14 and resolved on 12/08/14, stated, "Resident has UTI . . . Approaches: . . . Encourage fluids . . ." On 01/06/15 at 8:41 a.m., observation showed Resident #1 asleep in bed with her breakfast tray untouched. At 10:35 a.m., observation showed two certified nurse aides (CNAs) (#3 and #4) woke Resident #1. The resident refused to get up for lunch and refused to be toileted. The CNAs failed to offer the resident fluids before leaving the room. On 01/06/15 at 3:00 p.m., observation showed two CNAs (#2 and #5) woke Resident #1 and repositioned her in bed. The CNAs failed to offer the resident fluids before leaving the room. Failure to offer fluids with all cares to this resident at risk for constipation and dehydration does not	F 327	F327 1. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Residents at risk for insufficient fluid intake and that are dependent on staff to provide fluids, will be offered fluids during staff care before leaving the room. The individual assignment sheet for Resident #1 and Resident #3 to include: after cares offer fluids before leaving the room. Resident #2 expired (See 327 A) 2. The policy/procedure for hydration will be reviewed by staff with education.	

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	355091	A. BUILDING _____ B. WING _____	01/08/2015

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

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F 327	Continued From page 34 allow her to achieve her highest practicable physical well-being. - Review of Resident #3's medical record occurred on all days of survey and diagnoses included history of urinary tract infections (UTIs), a cerebral vascular accident (stroke), and dementia. The quarterly MDS, dated 12/24/14, identified short and long-term memory impairment and limited staff assistance for eating. The current care plan stated, ". . . Problem: [Resident #3] has hx [history] UTI - risk for reoccurrance [sic] . . . Approaches: . . . Encourage fluids between meals . . ." Observations of care identified staff failed to offer/assist Resident #3 with fluids during the following interactions: * 01/05/15 at 4:05 p.m. - Two CNAs (#9 and #10) offered to assist with personal cares and the resident declined. * 01/05/15 at 4:38 p.m. - Two CNAs (#9 and #10) transferred the resident from her wheelchair to her bed, assisted with personal cares, and transferred the resident back to her wheelchair. * 01/06/15 at 10:56 a.m. - Two CNAs (#2 and #11) transferred the resident from her wheelchair to her bed and assisted with personal cares. * 01/06/15 at 4:30 p.m. - Two CNAs (#9 and #18) transferred the resident from her wheelchair to her bed, assisted with personal cares, and transferred the resident back to her wheelchair. * 01/07/15 at 9:20 a.m. - Two CNAs (#12 and #13) transferred the resident from her wheelchair to her bed and assisted with personal cares. - Review of Resident #2's medical record occurred on January 5-8, 2015. The resident's diagnoses included history of gastritis, history of	F 327	F327 Continued 3. Offering of fluids to residents will be practiced by staff. Interventions that are passed on in nurse's report when residents are at risk are to force fluids during the acute stages. Staff education will be provided on Feb 3rd provided on Tuesday, February 3 and a roster attendance will identify those in attendance. CNA direct observation worksheet will be completed with findings, action and follow up. 4. QA (see F327B) study will be done monthly x 2 and quarterly x 3. Responsible party: DON	2/12/2015

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F 327	Continued From page 35 gallstones, hypertension, and constipation. The quarterly MDS, dated 11/19/14, identified limited assistance of one person with eating. Facility staff identified Resident #2 as at risk for dehydration on the resident roster. Resident #2's care plan, dated 01/15/14, identified . . . inadequate fluid intake . . . encourage fluids. Palin [sic] [plain] water is her drink of choice . . . Monitor for signs of dehydration - decreased BP [blood pressure], fast pulse, skin tugar [sic], low cacocentrate [sic] [concentrated] urine . . ." During the following observations of care and/or staff interview, facility staff failed to offer/assist Resident #2 with fluids: *01/06/15 at 9:25 a.m. - One CNA (#11) transferred the resident from her wheelchair to her bed. *01/06/15 at 11:30 a.m. - Two CNAs (#2 and #11) transferred the resident from her bed to her wheelchair, assisted with personal cares in the bathroom, and transferred the resident back to her wheelchair. *01/06/15 at 1:30 p.m. - During interview, a CNA (#11) indicated she provided Resident #2 with water when the resident pressed her call light and asked for water. *01/06/15 at 2:20 p.m. - Two CNAs (#5 and #11) transferred the resident from her bed to her wheelchair. *01/06/15 at 3:45 p.m. - Two CNAs (#2 and #18) transferred the resident from her wheelchair to her bed. *01/07/15 at 9:20 a.m. - During interview, one CNA (#13) did not indicate he provided Resident #2 with water when he transferred the resident from her wheelchair to her bed.	F 327		

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F 327	Continued From page 36 *01/07/15 at 11:20 a.m. - One CNA (#13) assisted with personal cares and transferred the resident back to her wheelchair. During an interview on 01/08/15 at 10:00 a.m., an administrative nursing staff member (#6) stated facility staff should be offering more water.	F 327		
F 332 SS=E	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, facility policy review, review of professional reference, review of manufacturer's instructions, and staff interview, the facility failed to ensure a medication error rate of less than five percent affecting 2 of 10 residents (Resident #3 and #19) observed during medication pass. Failure to provide medication by the right time or technique (Resident #3) and right dose (Resident #19) may adversely affect the desired benefits of the medications or cause unwanted side effects for the residents. Three errors occurred during staff administration of 25 medications, which resulted in a 12 percent error rate. Findings include: Review of the facility policy titled "Medication Administration- Oral Medications" occurred on 01/07/15. This policy, revised 02/07/11, stated, ". . . 2. Nurse/CMA [certified medication aide] to	F 332	F332 Free of Medication Error 1. Resident #3 is now getting her novo log insulin 5-10 minutes prior to her meal per sliding scale. This has been written as a doctor order, and placed on the MAR and kardex. A medication card also indicates that administration is to be 5-10 minutes prior to the meal. Resident #19 requires Nasacort 2 sprays to each nostril. This has been highlighted on the MAR. Discussed the administration of 2 sprays to each nostril with the resident who is alert and oriented with a BIMS of 15 .	

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F 332	Continued From page 37 observe the 5 Rights of Medication- Right Medications, Right dose, Right Route, Right Residents, Right Time. . . ." "Nursing 2015 Drug Handbook," 35th ed., Wolters Kluwer, Pennsylvania, page 760, states for NovoLog insulin, "Administration:. . . . Give NovoLog 5 to 10 minutes before start of meal. . . ." Review of manufacturer's instructions for NovoLog FlexPen occurred on 01/08/15. These instructions stated, "Instructions For Use: . . . Step 2: Giving the airshot before each injection: Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing: * Turn the dose selector to 2 units * Hold your FlexPen with the needle pointing up, and tap the cartridge gently a few times. This moves the air bubbles to the top . . . Step 4: Taking the injection: . . . * : . . Insert the needle into your skin * Press the push-button all the way in . . . * Keep the needle in the skin for at least 6 seconds, and keep the push-button pressed . . . " - On 01/05/15 at 5:00 p.m., observation showed a licensed nurse (#14) checked Resident #3's blood sugar. The nurse obtained Resident #3's NovoLog FlexPen, dialed the FlexPen to 2 units, held the pen horizontally, and pushed the button to perform an airshot. The nurse dialed the FlexPen to 4 units per the sliding scale order, and injected the dose into Resident #3's abdomen. The nurse immediately withdrew the needle from the resident following the injection. The time of injection was 5:10 p.m. During an interview, the nurse (#14) stated she usually gives the sliding scale insulin around 5:00 p.m., and the resident is	F 332	F332 Continued 2. The policy/procedure for medication administration will be reviewed by staff who administers medication. Staff education will be done on Novolog insulin (to be administered 5-10 minutes prior to mealtime) and proper medication administration at the staff meeting on Tuesday, 2/3/2015 and a roster will identify those in attendance. 3. DON to spot check medication administration including nasal spray and insulin administration. 4. QA study (F332A) will be done monthly x 2 and quarterly x 3 and reported to QA Committee. Responsible party: DON	2/12/2015

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F 332	Continued From page 38 served supper around 5:40 to 5:45 p.m. The nurse (#14) failed to hold the FlexPen vertically with the needle pointing up to perform the airshot and failed to keep the needle in the skin with pressure on the push-button for at least 6 seconds after injecting the insulin, which could result in an inaccurate dose. The nurse administered Resident #3's insulin 30-35 minutes before the time supper is usually served, increasing her risk of hypoglycemia. - Review of Resident #19's physician's orders identified an order for Nasacort (anti-inflammatory nasal spray) two sprays per nostril daily. Observation on 01/06/15 at 8:53 a.m. showed a CMA (#23) administered one spray of Nasacort into each of Resident #19's nostrils. The nurse failed to follow the physician's order and administer two sprays into each nostril. - Observation on 01/06/15 at 11:08 a.m. showed a nurse (#22) administered four units (per sliding scale order) of NovoLog insulin via FlexPen to Resident #3. Resident #3 began eating her noon meal at 11:58 a.m., 50 minutes after receiving her fast-acting insulin.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 It is the policy of Ashley Medical Center to 1) procure food from sources approved or considered satisfactory by federal, state or local authorities; and 2) store, prepare, distribute and serve food under sanitary conditions. Refer to attachments F371-A and F371-B.	

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F 371	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy and procedure review, and staff interview, the facility failed store, prepare, and serve foods in a safe and sanitary manner in 1 of 1 kitchen. Failure to sanitize dishware used for food preparation and use of non-calibrated thermometers for properly cooling foods placed residents at increased risk for food borne illness. Findings include: Review of the facility's policy "Sanitization and Safety," occurred on the afternoon of 01/07/15. This policy, dated 09/07/07, stated, " . . . Policy: The sanitizer level of the pot/pan sink will be recorded daily. Level must be a minimum of 200 ppm [parts per million]. . . If the correct parts per million are not obtained, CDM [certified dietary manager] or Maintenance will be notified. The solution will be adjusted as needed, or the chemical provider will be contacted if necessary." A sign posted near the three compartment (pot/pan) sink stated, ". . . 1. While holding sanitizer dispensing knob in, fill sink with tepid water (about 75 degrees F [Fahrenheit]). 2. Use the phydrion papers to check the sanitizer level. Follow the instructions given on the package. The ppm level should be a minimum of 200 but not greater than 400. If the level is not within this range, drain the water, rinse the sink and repeat the procedure. If the water is still out of range, report level to CDM or maintenance. . . ."	F 371	F371 Continued 1. In-servicing of dietary staff regarding sanitizer levels and thermometer calibrations was done on 1-26-15 by the consultant RD, LRD and CDM. Refer to attachment F371-C. 2. Revised policies were discussed at in-service meeting on 1-26 -15 conducted by consultant RD, LRD and CDM. Thermometer calibration will be done on a monthly basis, but as part of our PoC, we will calibrate weekly for 1 quarter and then monthly for 3 quarters. Chemical levels for the 3rd sink and spray bottles will be done on a daily basis. Refer to attachments F371-D, F371-E and F371-F. 3. The Swisher chemical serviceman was contacted on 1-7-15 to report the inaccuracy of the metered amount of sanitizer that is being meted into the 3rd compartment sink.	

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F 371	Continued From page 40 An in-service record summary, dated 05/28/14, stated, ". . . A calibrated thermometer is critical to measuring food temps [temperatures]. . . . Thermometers must be calibrated regularly to be accurate. . . ." A dietary tour occurred on 01/07/15 at 1:45 p.m. with an administrative dietary staff member (#24). Upon request, the administrative dietary staff member (#24) measured the sanitizer concentration of a one quart spray bottle of quaternary sanitizing solution. The staff member obtained a level of 100 ppm. The staff member stated, "100 is good." The staff member measured the sanitizer concentration of three additional spray bottles, used to sanitize tabletops and countertops, and obtained a level of 100 ppm for each bottle. During an interview completed during the dietary tour, the administrative dietary staff member (#24) stated facility staff filled the spray bottles from the sanitizing solution in the three compartment sink. Upon request, this staff member (#24) measured the sanitizer concentration of this sanitizing solution in the three compartment sink and obtained a level of 100 ppm. Dietary staff member (#25) refilled the sink and added sanitizer from the dispenser, the sanitizing solution then measured more than 400 ppm. Dietary staff member (#25) questioned if the sanitizing solutions were at the required 75 degrees F temperature. The administrative dietary staff member (#24) obtained a dial/bimetallic stem thermometer. Measurement of the temperature of the sanitizing solution in the	F 371	F371 Continued He has installed a new dispenser tip which will more easily control and/or adjust the amount of chemical dispensed into the sink. Refer to attachment F371-K. The sanitizer levels will be checked daily and recorded on the chemical log sheet. Refer to attachment F371-F and F371-G. The thermometer calibration will be done on a weekly basis for 1 quarter, then monthly for 3 quarters. Refer to attachment F371-H. The sanitizer filled in the spray bottles will continue to be taken daily from the 3rd compartment sink after the correct concentration level has been obtained and recorded on the log sheet. The concentration should be no less than 100 PPM and no greater than 400 PPM. If the level is too high or too low, the temperature of the water may be tested to see that it is tepid water (about 75 degrees F.) If it is not tepid, or if the chemical level is incorrect, the sink must be drained, rinsed and refilled, then retested. Refer to attachments F371-D and F371-F.	

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F 371	Continued From page 41 three compartment sink and obtained a temperature of 60 degrees F. The administrative dietary staff member (#24) obtained a second thermometer. The surveyor and this staff member (#24) calibrated both thermometers used by dietary staff to measure food temperatures. One thermometer registered at 0 degrees F, (instead of the required 32 degrees F). A dietary staff member (#25) provided the "Dial Food Thermometer Calibrate Quarterly with Boiling Water or Ice" form. This form identified dietary staff last calibrated the two thermometers on 04/23/14 (more than eight months prior). During an interview on the morning of 01/08/15, an administrative dietary staff member (#24) stated the chemical company had been contacted for service of the sanitizing solution dispenser in the three compartment sink and confirmed dietary staff should use calibrated thermometers for measuring food temperatures.	F 371	F371 Continued 4. CDM will monitor chemical log sheet and a QA study will be done to insure that proper chemical amounts are achieved to properly sanitize dishes washed in the 3 compartment sink. The chemical levels will be tested and recorded daily x 4 quarters. This study will be completed in January of 2016. Refer to attachment F371-I. CDM will also monitor the thermometer calibration log sheet. A QA study will be done to insure that the thermometers are being calibrated according to the PoC. They will be calibrated weekly x 1 quarter, then monthly x 3 quarters. This study will be completed in January 2016. Refer to attachment F371-J. 5. Compliance for chemical levels in the 3rd compartment sink and spray bottles, and for calibration of thermometers will be complete by February 12, 2015. The CDM is the responsible party.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F 441 It is the policy of the Ashley Medical Center to implement infection control practices that are consistent with the acceptable professional standards of practice to maintain an infection control program to ensure the prevention, control, and, limit the spread of infection within the facility.	2/12/2015

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F 441	Continued From page 42 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of facility policy, the facility failed to follow standard infection control practices for 2 of 4 sampled residents (Resident #1 and #3) observed during perineal cares. Failure to perform hand hygiene after completing perineal cares has the potential to spread infection within the facility. Findings include: Review of the facility policy titled "Policy for Incontinent/Perineal Care" occurred on 01/08/15.	F 441	F 441 Continued 1. In-servicing of the nurses and CNAs on 2-3-15 regarding proper hand hygiene before and after using gloves will be presented by the Infection Control Nurse and Charge CNA. 2. Staff in-servicing will address: a. Hand hygiene when gloves are removed and before going on to the next task. b. After providing peri cares, discard soiled gloves and perform hand hygiene. Hand hygiene must be performed before touching the environment or moving on to the next task. 3. Hand hygiene and infection control staff education will be provided yearly. 4. New employees will be in-serviced with orientation and orientation videos.	

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F 441	Continued From page 43 This undated policy stated, " Procedure for Incontinent/Perineal Care: . . . Wash hands or use alcohol hand sanitizer. Apply gloves. . . . [cleanse perineal area] . . . Remove gloves and wash hands. Return resident to clean, comfortable position. Clean resident's unit, provide clean linen as needed, and return items to the appropriate place. Wash hands. . . . " In response to a request on 01/07/15 at 4:20 p.m. for a policy on hand hygiene, an administrative nurse (#6) provided a document titled "Hand hygiene." This undated document stated, "Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: . . . * Before and after coming in contact with a resident's intact skin . . . * Before and after assisting a resident with toileting . . . *After removing gloves . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnosis included history of urinary tract infection. On 01/06/15 at 4:27 p.m., observation showed two certified nurse aides (CNAs) (#1 and #2) washed their hands, donned gloves, and provided incontinence cares to Resident #1, who was lying on her bed. One CNA (#2) removed the brief, wet with urine and cleansed the resident's perineal area. Using the same gloved hands, this CNA opened and closed a bedside drawer looking for powder, then retrieved the container of powder from the bathroom. The CNA (#2) applied powder to the resident's buttocks, then opened a drawer on the bedside stand and placed the powder in the drawer. Then the CNA (#2) removed her gloves, failed to perform hand hygiene, and	F 441	F 441 Continued 01/06/15 4:27 pm Resident #1, CNAs #1 and #2- Refer to F 441 #2 (a, b)	

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F 441	Continued From page 44 assisted the other CNA (#1) to transfer Resident #1 with a gait belt to her wheelchair. - On 01/07/15 at 10:52 a.m., observation showed two CNAs (#3 and #4) washed their hands, donned gloves, and provided incontinence cares to Resident #1, who was lying on her bed. The CNAs removed the resident's brief, wet with urine, one CNA (#3) provided frontal perineal cares and the other CNA (#4) provided posterior perineal cares. Both CNAs removed their gloves, failed to perform hand hygiene, donned clean gloves, and performed other tasks, such as placing a gait belt on the resident, transferring her into a wheelchair, and combing her hair. Failure to remove soiled gloves prior to touching clean objects and failure to perform hand hygiene immediately after removing soiled gloves has the potential to spread infection. - Observation on 01/05/15 at 4:38 p.m. showed two CNAs (#9 and #10) transferred Resident #3 from her wheelchair to her bed and assisted with personal cares. During the observation, a CNA (#9) performed perineal cares, changed the brief (wet with urine), removed her gloves, and assisted transferring Resident #3 back to her wheelchair. The CNA (#9) placed the resident's foot pedals, handed her a clipboard with paper attached, covered the resident with a blanket, bagged the garbage, and exited the room. The CNA (#9) failed to perform hand hygiene after completing perineal cares and prior to performing other tasks. - On 01/06/15 at 10:56 a.m., two CNAs (#2 and #11) transferred Resident #3 from her wheelchair to her bed and assisted with personal cares.	F 441	F 441 Continued. 01/07/15 10:52 am Resident #1, CNAs #3 and #4- Refer to F 441 #2 (a, b) 01/05/15 4:38 pm Resident #3, CNAs #9 and #10- Refer to F 441 #2 (a, b) 01/06/15 10:56 am Resident #3, CNAs #2 and #11- Refer to F 441 #2 (a, b)	

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 _____	01/08/2015

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F 441	Continued From page 45 During the observation, a CNA (#2) checked the resident's brief (dry), removed her gloves, and exited the room. The CNA (#2) failed to perform hand hygiene after touching the resident's brief and removing her gloves, as per facility policy/procedure. - Observation on 01/06/15 at 11:45 a.m. identified a CNA (#2) checked Resident #3's brief (dry) and assisted another CNA (#4) to transfer the resident to her wheelchair. After removing her gloves, the CNA (#2) assisted Resident #3 to the dining room. The CNA (#2) failed to perform hand hygiene after touching the resident's brief and removing her gloves, as per facility policy/procedure. - On 01/07/15 at 9:20 a.m., observation showed two CNAs (#12 and #13) transferred Resident #3 to bed and assisted her with personal cares. During the observation, a CNA (#13) completed perineal cares, changed the resident's incontinence product (soiled with urine and stool), and removed his gloves. Without performing hand hygiene, the CNA (#13) adjusted the resident's clothing, raised the side rails, placed the call light within reach, repositioned the resident's leg, bagged the garbage, and exited the room. The CNA (#13) failed to perform hand hygiene after completing perineal cares and prior to performing other tasks.	F 441	01/06/15 11:45 am Resident #3, CNAs #2 and #4- Refer to F 441 #2 (a, b) 01/07/15 9:20 am Resident #3, CNAs #12 and #13- Refer to F 441 #2 (a, b) QA will be done monthly x 3, then quarterly x 3. Resident #1 and Resident #3 will be included in QA monitoring along with additional sample of residents requiring toileting cares. Responsible parties: Infection Control Nurse, Charge CNA	
F 492 SS=B	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles	F 492		2/12/2015

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F 492	Continued From page 46 that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on review of Medicare records, Centers for Medicare and Medicaid Services guidelines, and staff interview, the facility failed to delay billing for services provided the resident until after review by the Fiscal Intermediary for 1 of 1 resident (Resident #11). Failure to confirm the resident's or representative's decision regarding a request for a demand bill, limited the facility's ability to ensure residents were able to exercise their right to request a demand bill and/or appeal from Medicare. Findings include: The Centers for Medicare and Medicaid Services (CMS) outlined standards of practice regarding information provided Medicare beneficiaries regarding their rights related to billing. The facility must provide a liability notice . . . to the resident or his/her legal representative when the facility believes the skilled services will no longer be covered. Notification must be in writing, including the reason why they believe the services will no longer be covered. The facility must submit the bill to a fiscal intermediary (demand bill) when requested by the resident or his/her legal representative, and may not charge the resident for Medicare covered Part A services while waiting for the results of the demand bill. . . . Review of the list of residents who had their Medicare Coverage terminated in the previous six months occurred on 01/08/15 at 10:30 a.m.	F 492	F 492 It is the policy of the Ashley Medical Center to provide services in compliance with all applicable Federal, State, and local Laws regulations and codes and with accepted professional standards and principles. Billing agent will obtain the proper Denial Notices from the Social Service Department. Once both the Denial Notice and the Notice of Medicare Provider Non-Coverage forms are on file, it will be determined if the Resident or family member asked that the days beyond the Medicare Skilled ending date be filed to Medicare. If the family would like, a demand bill will be filed to Medicare at the end of the month. Upon learning the outcome of the Medicare demand bill, the billing department will then bill appropriately, either to Medicare or the Resident. Social Services to attempt to receive a signature from resident or legal representative on date notice of non-coverage is given. If neither party is able to sign in person, verbal confirmation of receipt will be accepted & notation made on denial notice & in SS notes to ensure timely processing is completed.	

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F 492	Continued From page 47 During an interview on 01/08/15 at 10:45 a.m., a business office supervisor (#21) confirmed the facility determined Resident #11 would no longer qualify for Medicare Part A benefits effective on 07/13/14. This staff member could not provide evidence a Denial Notice or a Notice of Medicare Provider Non-Coverage (CMS-10123) form had been provided to the resident or his/her legal representative. During an interview on 01/08/15 at 11:00 a.m., a business office supervisor (#21) stated Resident #11 had been billed for July 14-31, 2014 for services with the potential to be covered by Medicare Part A. The facility received payment from the resident/resident representative for the month of July on 08/01/14. During an interview on 01/08/15 at 11:30 a.m., a social services staff member (#15) stated the required notices had been sent to the resident's legal representative and had not been returned to the facility. This staff member stated when the required notices are not returned, the facility staff makes a mental note to have the notices faxed to the facility or obtain the legal representatives decisions and notifications by phone.	F 492	F 492 Continued. QA will be done monthly x 3, then quarterly x 3 Responsible parties: Office Manager and Licensed Social Service Worker.	2/12/2015