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 _____	02/11/2016

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 02/09/16 and completed on 02/11/16, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
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. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/08/2015. Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 supplemental resident (Resident #11) with whom staff left medication unattended in the dining room. Failure to stay with a resident while administering medication, does not ensure the safety of the resident or 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	F 281	F 281 It is the policy of the Ashley Medical Center to ensure that professional and quality of care standards and practices are followed at all times. Resident #11 assessments have identified her as having severely impaired cognition, therefore is unable to self-administer her medication. The AMC SNF policy/procedure for self-administration follows professional standards of practice, and staff has been reeducated on February 24th 2016. The roster of those who are able to Self-Administer will be reviewed by staff and DON. Medication Staff will be instructed on all residents on the roster who are unable to self-administer medication, and instructed that they must ensure that medication is swallowed before initialing the medication	3/17/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/26/2016

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 _____	02/11/2016

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 281	Continued From page 1 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. . . ." Observation of medication administration, on 02/10/16 at 12:05 p.m. showed a certified medication assistant (CMA #3) prepared medications for Resident #11, placed the medication cup with the medications on the dining room table by the resident, and then immediately returned to the medication cart to prepare medications for another resident. When asked if Resident #11 could self administer her medications, the staff member (#3) said the resident could, but when she reviewed the checklist on the Medication Administration record, Resident #11 was not on the list to self-administer medications. Review of Resident #11's medical record occurred on the afternoon of 02/10/16. A Self Administration of Medication (SAM) assessment, dated February 2015, identified Resident #11 could not safely self administer medications. Resident #11's annual Minimum Data Set, dated 12/28/15, identified the resident as having severely impaired cognition. During an interview on the morning of 02/11/16, an administrative staff member (#1) confirmed nursing staff should stay with the resident to ensure the medications are taken.	F 281	administration form indicating that the medication was administered. A QA will be performed though direct observation ensuring that the medication is properly administered and swallowed. DON and staff will be responsible to QA weekly X 4 and quarterly X3 and report to QA committee.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		3/17/16

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 _____	02/11/2016

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 323	Continued From page 2 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/08/15. Based on observation, record review, facility policy review, and staff interview, the facility failed to appropriately utilize assistive devices for 3 of 6 sampled residents (Resident #1, #4 and #7) who required extensive assist with transfers. Failure to use assistive devices may have the potential to result in falls and/or injuries. Findings include: Review of the facility policy titled "Gait Belt" occurred on 02/11/16. This policy, dated 02/02/15, stated, ". . . gait belts may be used at any time but especially in these situations: 1. When transferring a resident unless using a Hoyer lift [full body lift] . . . 2. After engaging an ambulator that needs assist whether in the room or hallway. . . ." - Review of Resident #1's medical record occurred on all days of survey. A quarterly MDS, dated 01/23/16, identified the resident required extensive assist of one person for transfer and toilet use. Resident #1's current care plan stated, "Problem:	F 323	F323 It is the policy of the Ashley Medical Center to at all times ensure safety and that the resident receives adequate supervision and assistive devices to prevent accidents. Resident #1, Resident #4 and Resident #7: During the meeting on 2/24/16, CNA Staff received instruction that they may wear gait belt over their clothes and around their waist to use in transfer and position for above named residents. The language of using gait belts if applicable was removed from the care plan of resident #1, 4 and 7. Staff received instruction on 2/24/16, that gait belt will be used for the transferring of residents who are considered a P1 (pivot transfer 1 assist), P2 (pivot transfer 2 assist), M1 (medi lift transfer 1 assist), and/or M2 (medi transfer 2 assist). This transfer mode is noted at each of the resident□s foot end of bed. The following statement Gait belts need to be used when transferring, positioning and ambulating all resident with grade P1, P2, M1 and M2 has been added and will be explained to new hires during their orientation on positioning and lifting.	

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 _____	02/11/2016

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 323	Continued From page 3 . . . has a self care deficit due to poor vision, unsteady gait, confusion. Approaches: . . . 5. Transfer: Assist/Pivot with transfers for safety. . . . Problem: Safety [Resident #1] has poor vision, occasional dizziness, risk for falls D/T [due to] unsteadiness, confusion, poor eyesight. . . . Approaches: . . . 7. Use gait belts when ambulating/transfering [sic] when applicable. . . ." Observation on 02/10/16 at 8:40 a.m. showed a CNA (#6) asked Resident #1 if she needed to use the bathroom, the resident stated 'yes'. The CNA (#6) pushed Resident #1's wheelchair into the bathroom, assisted the resident onto the toilet, and back into her wheelchair. During the transfers, the CNA failed to utilize a gait belt. Observation on 02/10/16 at 11:10 a.m., identified two CNAs (#7 and #8) assisted Resident #1 into the bathroom. While one CNA pushed the wheelchair into the bathroom, the other CNA assisted the resident onto the toilet and then back into her wheelchair. During the transfers, the CNAs failed to utilize a gait belt. - Review of Resident #7's medical record occurred on 02/11/16. An annual MDS, dated 11/11/15, identified the resident required extensive assist of one person for transfer and toilet use. Resident #7's current care plan stated, "Problem: Self care deficit d/t [due to] weakness, has Parkinson's disease, tremors. . . . Risk for falls D/T unsteadiness and weakness. . . . Approaches: . . . Transfers: . . . wt [weight] bearing assist d/t weakness . . . Problem: Safety - Risk for fall D/T impaired mobility, generalized	F 323	In response to resident #4, the following statement has been added to the orientation on positioning and lifting worksheet, You should never grab under the patients arms to lift or position them. Measures will be put into place that on hire, the orientation will include specific training/education/instruction on lifting, positioning and transferring using a gait belt. All staff will be required to use a gait belt on resident with a grade of P1, P2, M1, and M2. A QA study will be implemented monitoring that a gate belt is used on all residents that require assists with transfers and have been given a grade of P1, P2, M1, and M2. DON and staff will be responsible to QA weekly X 4 and quarterly X 3 and report to QA committee.	

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 _____	02/11/2016

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 323	Continued From page 4 weakness. . . . Approaches: . . . Use gait belts when transfering (sic) when applicable . . ." Observation on 02/11/16 at 9:15 a.m. showed a CNA (#4) assisted Resident #7 to stand and pivot transfer from the recliner to the wheelchair and then from the wheelchair to the toilet. After toileting, the CNA (#4) assisted Resident #7 to stand and pivot transfer from the toilet to the wheelchair and from the wheelchair to the recliner. During the transfers, the CNA (#4) failed to utilize a gait belt. During interview, on 02/11/16 at 10:45 a.m., an administrative staff member (#10) confirmed using a gait belt is good practice for Resident #1 and #7. Observation on 02/11/16 at 11:30 a.m. showed a CNA (#4) assisted Resident #7 to stand and pivot transfer from the recliner to to the wheelchair. During the transfer, the CNA failed to utilize a gait belt. - Observation on 02/09/16 at 3:30 p.m. showed a CNA (#4) assisted Resident #4 to walk from the bathroom to the recliner with a walker and a gait belt. Observation showed Resident #4 sat at the front edge of the recliner. The CNA encouraged the resident to move herself back in the recliner, but when the resident was unable to do so, the CNA (#4) removed Resident #4's gait belt and lifted under the resident's arm/shoulder area to move her back in the recliner. The CNA failed to utilize the gait belt when repositioning the resident in the recliner. - Observation on 02/10/16 at 9:05 a.m. showed a	F 323		

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 _____	02/11/2016

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 323	Continued From page 5 CNA (#4) assisted Resident #4 to walk from the bathroom to the recliner with a walker and a gait belt. Observation showed Resident #4 sat at the front edge of the recliner. Two CNAs (#4 and #5) removed the gait belt and each lifted under Resident #4's arm/shoulder area to move the resident to the back of the recliner. The CNAs failed to use a gait belt when repositioning the resident in the recliner.	F 323		
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 This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and staff interview, the facility failed to store, prepare, and serve foods in a safe and sanitary manner in 1 of 1 kitchen. Failure to sanitize dishware and failure to clean fans has the potential to place residents at increased risk for food borne illness. Findings include: Review of the facility policy, "Sanitation and Safety - Dishwashing" occurred on 02/11/16. This policy, dated 08/22/07, stated, "Policy: Dishes will	F 371	F371 It is the policy of Ashley Medical Center to: (1) Procure food from sources approved by Federal, State or local authorities; and (2) store, prepare, distribute food under sanitary conditions. Our policy for dishwasher chemical checks will be updated to state that chemical levels will checked and recorded 3 times a day before dishes are washed. The chemical recording logs will be updated to include entries 3 times a day. The 50 ppm minimum will be included on	3/17/16

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 _____	02/11/2016

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 371	Continued From page 6 be cleaned and sanitized after each use. Procedure: 1. Turn on machine, checking temperatures to assure proper wash and rinse temperatures for your cleaning chemicals (wash tank and rinse temperature should be a minimum of 120 degrees F for low temperature dish machine and sanitizer level should be a minimum of 50 ppm [parts per million].) Chemical sanitizer level and temperature are recorded daily in the AM [morning]. . . ." Observation of a dietary staff member (#9) using the dishwashing machine occurred on 02/11/16 at 1:45 p.m., with the dietary supervisor (#2). The dietary supervisor (#2) stated the dishwashing machine is a low-temperature machine and sanitizes the dishes with a chemical, and staff check the concentration once per day, in the morning. When asked to check the chemical concentration, the dietary staff member (#9) used a Chlorine test strip, which showed no change in color after contact with the water/chemical solution. The test strip remained white, indicating less than 10 ppm of chlorine. The staff member (#9) stated the concentration should be between 50 - 100 ppm, and when she checked the concentration in the morning, it was 100 ppm. The dietary supervisor (#2) confirmed the concentration of the chemical should be greater than 50 ppm and that checking the concentration only once a day in the morning would not ensure that the concentration would be correct when washing the lunch and dinner dishes. Observation in the kitchen on 02/11/16 at 2:00 p.m. showed a fan above the hand washing sink in the food preparation area with a heavy accumulation of dust and debris on the blades	F 371	the log form. If chemical level is lower than 50 ppm, Maintenance will be notified. Dishes will not be run through the dishwasher until the sanitizer level is once again in the proper range. We will do instruction for dietary employees at our monthly inservice on March 15, 2016. Corrections will be in place by March 17, 2016. A QA study will be conducted to insure that the new measures are being followed. This will be done weekly for 1 month, monthly for 2 months and quarterly for 9 months. This study will be done by the CDM and will be complete in March 2017. Fans in the dish room are on a weekly schedule for cleaning. The cleaning log will be updated to show ALL fans are to be cleaned weekly. Instruction will be done on March 15, 2016 at the dietary meeting. Corrections will be in place by March 17, 2016. A QA study will be done to insure that the fans are being cleaned weekly. Any fan not cleaned may not be used until it is cleaned. This will be monitored weekly for 1 month, monthly for 2 months and quarterly for 9 months. This study will be done by CDM and will be complete in March 2017.	

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 _____	02/11/2016

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 371	Continued From page 7 and outer grid/shield. The dietary supervisor (#2) confirmed staff should clean the fan.	F 371		