DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	12/19/2012

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 12/17/12 and completed on 12/19/12, the sample included 2 residents for complete review, 7 residents for focused review, and 1 closed record for review.	F 000	Responsible party: DON See Attachment: L732 A, L732 B	
F 164 SS=B	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Admr/CED | (X6) DATE 1/15/2013

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 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to maintain the privacy and confidentiality of the residents' clinical records for 2 of 3 days of survey (December 17-18, 2012). Failure to maintain confidentiality of residents' clinical records could allow resident's medical information to be viewed by unauthorized individuals. Findings include: Review of a facility policy titled "Maintain Confidentiality" occurred on 12/19/12. This undated policy stated, ". . . ALL information confided to staff employees or physician . . . be kept confidential. . . ." - Observation of medication administration showed the following: * On 12/17/12 from 4:20 p.m. to 4:50 p.m., a licensed nurse (#9) obtained medications from a medication cart, entered four separate resident rooms, and administered medications. Observation showed the nurse (#9) left the medication administration record (MAR) opened and unattended on top of the medication cart in the hallway. The MAR contained confidential resident information including their name, room number, prescribed medications, and diagnoses. * On 12/18/12 at 11:00 a.m. a licensed nurse (#10) entered a resident's room to administer her scheduled medication. Observation showed the nurse left the MAR opened and unattended on top of the medication cart in the hallway. - A random observation on 12/18/12 at 4:32 p.m.	F 164	**F164** It is the policy of AMC to maintain confidentiality of resident's protected health information (PHI) in accordance with HIPAA and HITECH. Staff will be educated on the facility's policy and the importance of maintaining PHI confidentiality. The facility will provide solid, 8 1/2" x 11" dividers to cover PHI in the med book while nurse or med aid is away from the med book. On 1/11/13, the solid dividers were placed in the med book. On 1/22/13 and 1/23/13 the staff will receive education on confidentiality of PHI. This QA will be done monthly x 3 then quarterly x3. Responsible party: DON See Attachment: F164	1/23/2013

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F 164	Continued From page 2 showed a medication cart in a hallway with a MAR opened and unattended on top of the medication cart in the hallway. The MAR contained confidential resident information including their name, room number, prescribed medications, and diagnoses. During an interview on 12/18/12 at 4:20 p.m., an administrative nurse (#1) stated she expected facility staff to close the MAR when unattended.	F 164		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/20/11. Based on medical record review, review of facility policy, and staff interview, the facility failed to implement established policies and procedures that prohibit mistreatment, neglect, and abuse of residents for 1 of 1 sampled resident (Resident #5) with an injury of unknown origin. Failure to investigate an injury of unknown origin placed Resident #5 and other residents at risk for mistreatment and/or abuse. Findings include: Review of the facility policy titled "Patient	F 226		

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F 226	Continued From page 3 Abuse/Neglect" occurred on 12/19/12. This policy, revised January 2009, stated, ". . . Identification . . . Any staff witnessing or possessing reliable knowledge of any act or suspect act, involving mistreatment, neglect or abuse, including injuries of unknown source (such as bruising, fractures, skin tears) and misappropriation of patient property, must notify their department supervisor and or corporate compliance officer. . . . Injuries of unknown source must be regarded in the same regulatory light as mistreatment, neglect, and abuse and must be reported if there is reasonable cause to believe or suspect than [sic] an injury has been inflicted upon a resident by a nurse aide or individual used by the facility. . . . If in the course of the investigation, the facility decides that abuse or neglect was a factor the facility should thoroughly document this fact and report the incident at that time. . . ." Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia and depression. Quarterly Minimum Data Sets (MDSs), dated 10/01/12 and 07/02/12, identified extensive assistance for bed mobility, transfers, dressing, and toilet use; and total dependence on staff for locomotion and personal hygiene. Observations throughout the survey showed Resident #5 unable to propel himself in his wheelchair and dependent on staff for transfers using a sit-to-stand mechanical lift. A nurse's note, dated 05/23/12, stated, ". . . Reported by CNA [certified nursing assistant] that Resident has a sore on his shin. Resident has 2	F 226	**F226** It is the policy of the Ashley Medical Center that all residents be free from abuse and neglect. When a staff member (CNA/ Nurse) identifies an injury (bruise, skin tear, scratch, scab), a Resident Investigation Form (RIF) will be completed. When an injury is noted by the CNA, she will initiate the form and hand it to the nurse in charge. The charge nurse will complete the investigation, report to the medical provider and family if applicable, and start a treatment sheet if necessary. The Director of Nurses will be notified within 24 hours any suspicions of neglect or abuse. If abuse or neglect is suspected, the health department will be informed of the violation by the DON.	1/23/2013

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PRINTED: 01/03/2013
FORM APPROVED
OMB NO. 0938-0391

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F 226	Continued From page 4 cm [centimeter] [by] 0.5 cm scab on his Rt [right] shin [with] red edges. . . ." The record failed to identify any investigation as to the cause of this skin tear, and staff failed to recognize the injury as possible mistreatment/neglect based on Resident #5's dependence on staff for assistance. A "Resident Investigation Report" form, completed by facility staff, included information such as type of injury, summary of the incident, and corrective actions taken. Staff failed to complete a form for the incident above. During an interview on the morning of 12/19/12, a supervisory nursing staff member (#1) stated staff should report an incident such as this, and she would then complete an investigation.	F 226	F226 continued Education/documentation requirements/abuse/neglect issues will be provided on January 22 and January 23, 2013 at CNA/Nurse meetings, and thereafter as per DON. New staff will be educated on hire and will be part of the orientation process. The QA will be don monthly x3 and quarterly x3. For resident #5, a skin evaluation report was completed by the staff, and treatment was given from 5/23/12 to 6/7/12. The wound was cleansed daily, TAO and a non adhering dressing was applied. It was noted on 5/17/12, the resident was resistive to cares. The staff anticipates all needs for resident # 5 and the resident may have bumped his shin on the lift during the transfer. It was determined that the incident was not intentional, therefore abuse or neglect was not suspected. Responsible party: DON See Attachment F226 A, F226 B.	
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: Based on record review, review of professional reference and facility protocol, and staff interview, the facility failed to provide care in accordance with professional standards for 2 of 2 sampled residents (Resident #1 and #4) who experienced falls with a potential head injury. Failure to complete a neurological assessment following such a fall has the potential for a head injury to go undetected. Findings include:	F 281		1/23/2013

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F 281	Continued From page 5 Walters and Kluwar, Lippincott's Nursing Procedures, 5th Edition, 2009, pages 66-67 stated, "Managing Falls . . . Provide first aid for minor injuries as needed. Monitor the patient's status for the next 24 hours. Even if the patient shows no signs of distress or has sustained only minor injuries, monitor vital signs every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every 1 hour for 2 hours, or until his condition stabilizes. Monitor neurological assessments with vital signs, as per your facility protocol. . . ." Review of the facility protocol "Neuro Checks [a brief neurological assessment] Protocol" occurred on 12/18/12. The undated protocol stated, "MINOR EMERGENCIES- means resident does not need to go to ER [emergency room]. Neuro checks to be done once per hour for 4 hours. MAJOR EMERGENCIES- means the resident needs to go to the ER. The Dr. [doctor] in the ER will write neuro check time/frequency." A Post-It note attached to the protocol stated, "Nurses please be sure to follow this esp [especially] timing of checks. Thx [thanks]" Review of the facility form "Vital Signs, Neuro Checks" occurred on 12/18/12. This form includes spaces to record vital signs (temperature, pulse, respirations, and blood pressure), hand grasp, level of consciousness, movement [of extremities], and pupil size and reaction to light for both the left and right pupils. - Resident #1's medical record, reviewed on all days of survey, identified the following: * 03/11/12: 7:45 p.m. "A residents [sic] family member alerted	F 281	**F281** It is the policy of Ashley Medical Center that services will be provided to meet the professional standards and quality of care for the residents at AMC. Staff will complete a post fall injury assessment report on all residents who have a fall that includes a nursing assessment including but not limited to vital signs, a neurological exam and other investigative data that is included in the post fall injury assessment form. All residents who have an unwitnessed fall and or have hit their head will receive vital signs and neuro checks every 15 minutes for one hour, then every 30 minutes for one hour, and then every 1 hour for 2 hours or until his condition stabilizes. Training/Education to staff regarding the post injury fall assessment form and neuro check assessment will be provided by EMS January 16, 17, 18 and will again be presented at the January 22, 2013 nurses meeting. The QA will be done monthly x 3 and quarterly x 3. Responsible Party: DON See attachment F 281 A, F 281 B	1/23/2013

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F 281	Continued From page 6 staff that this resident fell in the Sun Room. A cut was noted on the right side of the residents [sic] head (2 cm [centimeters]) and a 3 cm bruise with pin point openings - Causing it to bleed slightly. Due to the head wound being deep I called the nurse from the hospital to come look at the head wound." 8:05 p.m. "We then decided to call the on call Dr. who came in and gave the resident 3 sutures in the ER. . . . She said she hit her head on the corner of the table in Sun room. Stated that her head and arm hurt (both right side), but refused Tylenol. Resident will be monitored throughout the night." Resident #1's record failed to identify orders from the ER physician regarding frequency of neuro checks. The record identified staff assessed Resident #1's vital signs at 8:05 p.m. and woke the resident every two to three hours during the night, but lacked evidence they performed neuro checks or performed additional vital sign monitoring for Resident #1 following the fall with a head injury. * 04/05/11: 2:25 p.m. "Found sitting on floor by recliner. Stated wanted to get up & [and] fell. Good ROM [range of motion] all extremities. 3 cm raised area noted on top of head starting to bruise. Stated did hit head but did not know on what. . . . See separate sheet for neurochecks." Record review identified staff performed neuro checks hourly for the first three hours, then every two hours for the next six hours. Staff failed to check vital signs during the last four checks, and did not assess the resident's pupil size and	F 281	Resident #1 was awakened every two hours during the night and continued to be alert and oriented. No adverse outcome was identified. Resident #4, according to nurse's notes, had no further outcomes that would be related to the fall on 10/05/13. Resident #1 Refer to previous PoC F281	

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F 281	Continued From page 7 response to light at any time. During an interview on 12/18/12 at 1:30 p.m., an administrative nurse (#1) stated staff should have performed neuro checks for Resident #1 following the fall on 03/11/12 and should have performed complete checks, including vitals signs and pupil size and response to light for all checks on 04/05/12. - Resident #4's medical record, reviewed on all days of survey, identified the resident had an unwitnessed fall on 10/05/12. The resident sustained a scrape on his right forehead which healed on 10/29/12. The fall tracking log failed to identify a fall on this date. The resident's "Vital Signs, Neuro Checks" form identified neurological checks and vital signs completed initially at the time of the fall, but lacked additional vital signs and neuro checks after the initial check. During an interview on 12/18/12 at 1:30 p.m., an administrative nurse (#1) reported the neurological checks should either be on the "Vital Signs, Neuro Checks" form or in the nurses notes. The nurse reviewed Resident #4's medical record which showed no further documentation of the vital signs and neurological checks following the initial checks completed after the resident's fall on 10/05/12.	F 281	Resident #4 Refer to previous PoC F281	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		

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F 309	Continued From page 8 and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's dietary manual, review of facility policy, and staff interview, the facility failed to ensure 3 of 3 sampled residents (Resident #1, #5, and #8) with thickened liquids received the proper consistency of fluids. Failure to determine appropriate consistencies through assessment and evaluation by a professional, and failure to specifically identify the fluid consistency each resident is to receive places them at risk for choking and/or aspiration pneumonia. Findings include: Review of the facility dietary manual, dated 2011, stated, ". . . Anyone displaying any of the previously noted signs should be referred to the physician, speech language pathologist (SLP), nurse, registered dietitian (RD), and/or dietetic technician (DTR). The interdisciplinary team should assess for problems with dentition, tongue movement, transit of food from the mouth through the esophagus, pocketing of food in the mouth, pooling of liquids, and suspected aspiration. . . . The SLP may do a bedside examination to assess for dysphagia. . . . If the SLP determines it is necessary, further tests will be requested. . . .The interdisciplinary team works together to determine the most appropriate strategies for each individual. . . . It is imperative to work with a SLP to determine the best therapy for each individual. . . ."	F 309	**F309** It is the policy of Ashley Medical Center that a resident, who displays difficulty or inability to swallow, will be identified by personnel of AMC prior to initiating thickened liquids. The nursing staff will make a referral to the medical provider who will provide an evaluation and make a determination as to the alteration in consistency of liquids. The medical provider will determine if further testing is needed and will make the requests in the resident medical record as an order. Nursing staff to follow. Further reevaluation by the medical provider or professional services when necessary will be provided upon significant change in resident condition. When the medical provider determines that further tests are necessary and with permission of the resident and or POA, a referral will be made to St. Alexius telemedicine department.	

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F 309	Continued From page 9 Review of the facility policy titled "Therapeutic/Textured Modified Diets" occurred on 12/19/12. This policy, dated 10/24/05, stated, "Policy: Therapeutic diets, included textured modified diets, as ordered by the physician are preplanned and approved by Consultant LRD [Licensed Registered Dietitian] . . . Procedure: . . . LRD approves . . . therapeutic diets based on the approved diet manual . . . Any additional therapeutic diets required by the facility must be written by the Consulted LRD." - Review of Resident #8's medical record occurred on December 18-19, 2012. Diagnoses included Parkinson's disease and dementia. On 09/05/12, Resident #8 returned from the hospital with a diagnosis of aspiration pneumonia. Physician's orders, dated 09/05/12, stated, "Diet: full liquid [with] thickened Resource 4 oz [ounces] tid [three times a day] with meals." On 09/26/12, a new order stated, "Pureed diet [with] thickened liquids." The order failed to specify what consistency of liquid staff were expected to provide for Resident #8. The medical record lacked an evaluation/assessment from an SLP or other staff prior to initiating thickened liquids. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia and esophageal disorder. A "Dietitian Routing Form," dated 07/03/12 and signed by the dietician, stated, "Please add Nectar TKN [thickened] liquids to diet order in chart." The medical record lacked an	F 309	**F309 Continued** Resident #8, Resident #5 and Resident #1 are scheduled to be evaluated by the FNP on 1/15/13. QA study will be done monthly x 3 and quarterly x 3. Responsible part: DON See Attachment F 309 A. Nursing Staff educated 1/22/13 regarding fluid consistency Per Telephone call & Jackie DON on 1/30/13 @ 3:00pm K. Beechie	1/23/2013

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F 309	Continued From page 10 evaluation/assessment from an SLP or other staff prior to initiating nectar thickened liquids. Nurses' notes and dietary notes failed to identify swallowing difficulties experienced by Resident #5. It is unknown what prompted staff to initiate nectar thickened liquids. - Resident #1's medical record, reviewed on all days of survey, identified diagnoses including reflux esophagitis, Alzheimer's dementia, and Parkinson's Disease. The record included a physician's order, dated 06/20/12, for "Thickened liquids." The order failed to specify the consistency of the "thickened liquids" staff should provide for Resident #1. "Dietary Progress Notes," dated 06/20/12, stated, ". . . aspiration risk . . . Receiving soft diet [with] pureed textures & [and] TKN liquids." The progress note failed to identify the specific consistency of thickened liquids staff provided for Resident #1. A progress note, dated 12/04/12, stated,". . . Receiving . . . pureed textures & nectar TKN liquids." Resident #1's record lacked evidence staff performed an assessment to determine nectar thick liquids were the appropriate consistency for Resident #1. During an interview on 12/17/12 at 3:10 p.m., an administrative nurse (#2) stated the consistency for thickened liquids should be ordered by the physician. She further stated the facility does not perform swallowing evaluations on-site. During an interview on 12/18/12 at 4:05 p.m., a supervisory dietary member (#6) stated nurses will try residents on a thickened liquid consistency	F 309	Resident #1 refer to PoC F309	

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F 309	Continued From page 11 if they show signs of swallowing problems. The staff member reported nursing tries nectar thick consistency and will "work up from there." This staff member also stated a physician order for "thickened liquids," which does not specify a consistency, means thickened liquids are on an as needed basis. On 12/19/12 at 8:15 a.m., the same supervisory dietary member (#6) stated this process had been occurring for 25 years and reported the dietitian will complete a "Nursing to Dietary Communication" form regarding which thickened liquid consistency is to be provided for residents. The staff member reported dietary does not check if the consistency has a physician order to coincide with it. During an interview 12/19/12 at 8:45 a.m., an administrative nurse (#1) identified staff nurses decide what thickened liquid consistency a resident tries if a physician had not previously ordered a consistency. This nurse stated if one consistency "does not work" the nurses will try a different consistency.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 323		

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	355091	A. BUILDING _____ B. WING _____	12/19/2012

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F 323	Continued From page 12 facility failed to ensure the resident's environment remained as free of accident hazards as possible regarding resident access to hazardous chemicals and a hydrocollator in 1 of 1 restorative therapy storage rooms for 2 of 3 days of survey. Failure to secure chemicals and the hydrocollator placed residents at risk for injury. Findings include: Observation of the restorative therapy room on 12/17/12 at 2:40 p.m. showed a spray bottle of "Neutral One Step Disinfectant" and an unsecured hydrocollator. The label affixed to the disinfectant stated, "Keep out of reach of children . . ." An interview with a restorative aide (#13) confirmed the storage room door could not be locked. The hydrocollator unit is an insulated thermostatically controlled unit containing hot water and water absorbing packs. The packs are placed in multiple layers of toweling before they are placed on residents for a form of local moist heat. Random observations on all days of survey showed residents walking or propelling their wheelchairs by the restorative therapy storage room with staff supervision. An environmental tour of the facility occurred on 12/18/12 at 3:50 p.m. with an administrative staff member (#11). Observation of the restorative therapy storage room showed the bottle of disinfectant and the hydrocollator remained unsecured. The staff member (#11) stated facility staff are instructed to store hazardous chemicals	F 323	F 323: It is the policy of the Ashley Medical Center that the facility must ensure that the resident remains as free of accident hazards as possible, and that each resident receives adequate supervision and assistive devices to prevent accidents. All hazardous chemicals will be secured in a locked cabinet when not in use A QA will be done monthly x 3 and then quarterly x3. Responsible Parties: Charge Nurses, CNA's, PT, restorative aide, and DON F323 It is the procedure of the Ashley Medical Center SNF to keep its residents as risk free as possible. In that capacity the Hydroculator shall be kept locked when the packs are not being readied for administration or returned to the Hydroculator for reheating or when the Hydroculator is being cleaned.	1/23/2013

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F 323	Continued From page 13 In a locked cabinet and the physical therapy department is responsible for the hydrocollator. An interview occurred on 12/18/12 at 4:05 p.m. with the physical therapist (PT) (#12). He stated the hydocollator is utilized by restorative therapy. The PT (#12) measured the temperature of the water in the hydocollator at 160 degrees Fahrenheit. He stated the hydocollator is an accident hazard to residents because of the high water temperature and should be secured.	F 323	**F323 continued** On Friday January 11, 2013 a closure that allows a padlock to be placed on the machine so that only those that need to administer Hot packs can get into the machine. Maintenance, PT, the nurses station and the restorative aid shall be the only ones to have access to this key/	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	code to get to the packs. A QA will be done monthly x 3 and then quarterly x 3. Responsible Party: PT Education provided to CNAs on 1-23-13 for hazardous Chemicals. Per telephone call with Jackie, DON on 1/30/13 @ 3:00pm K Beeler	1/23/2013

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F 329	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure a drug regimen free from unnecessary medications for 1 of 1 sampled resident (Resident #4) receiving a medication for anxiety on an as needed (prn) basis. Failure to adequately assess Resident #4's behavior and attempt non-pharmacological interventions, as well as the administrating an antianxiety medication (Ativan) with a medication to reduce pain (Percocet) simultaneously may have resulted in Resident #4 receiving unnecessary medications and experiencing adverse drug reactions related to their use. Findings include: The 2011 Nursing Drug Handbook, page 696-697, identified adverse reactions to Ativan as sedation, drowsiness, insomnia, agitation, dizziness, weakness, disorientation, and depression, and indicated a dose of Ativan for an elderly patient to be one to two milligrams (mg) daily with contraindications stating to be used cautiously in elderly, acutely ill, or debilitated patient. The handbook identified on page 1435 Percocet as a combination of the two pain relievers acetaminophen and oxycodone hydrochloride. Review of the facility policy titled "Psychotropic Medication Monitoring System" occurred on 12/19/12. This policy, dated September 2007, stated, " . . . The care plan should include: a. Why	F 329	**F329** It is the policy of the Ashley Medical Center that each resident's drug regime will be free from unnecessary drugs. Each resident is to receive medication in doses that are clinically indicated to treat the condition. Non-pharmacological interventions will be considered and used when indicated. The behavior of the resident will be reported to the charge nurse. The charge nurse will perform an adequate assessment including what behavior the resident is displaying, assess for pain, assess recent toileting, assess hunger, hot, cold, boredom, loneliness, etc. Non pharmacological approaches will be considered and used when indicated. The assessment and implementations will be documented in the medical record in the appropriate tab under nurses notes.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRIN: 01/03/2013
FORM APPROVED
OMB NO. 0938-0391

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F 329	Continued From page 15 the med [medication] is needed b. desired behavior/outcome c. Periodic evaluation of resident . . . . 6. Staff will be receive [sic] in-service on . . . a. Monitoring and assessing guidelines of psychotropic drug usage b. Side effects to be aware of, what they curtain [sic] and how to address their findings in the nurses's notes c. New policy and procedures that have been established and are in place. This is in reference to psychotropic drug use, State and Federal regulations, assessment and monitoring of their use and their side effects, through comprehensive and precise documentation in the resident's permanent records in the nurse's notes." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included anxiety, depression, degenerative arthritis of knees, and lumbar arthritis. Resident #4's quarterly Minimum Data Set, dated 10/29/12, identified moderate cognitive impairment; moderate depression; verbal and other behaviors towards others one to three days per week; wandering occurred four to 6 days per week but less than daily; extensive assistance with bed mobility, toilet use, and transfers; and occasional pain at moderate intensity with no effect on sleep and activities. The current care plan stated, " . . . Problem . . . Risk for pain . . . Approaches . . . 10-29-12 when resident agitated, rule out pain. . . . analgesics. PRN . . . May have theragesic [at] bedside for prn use . . . Warm packs . . . Problem . . . Self care deficit . . . ocassional [sic] confusion and agitation . . . Approaches . . . Redirect as needed for confusion. . . . Staff to turn/reposition [resident] for comfort when up [and] restless during night. If	F 329	F329 continued The outcome of the non pharmacological approaches will be documented. If the approaches are ineffective, the staff will provide the resident with the medication as is indicated. Staff will receive education/ training (including no more than one medication at a time), on January 23, 2013 at nurses meeting and quarterly education for one year . The medications of resident #1 were reviewed by the nurse practitioner and changes were made. The prn monitoring form was implemented for resident#1 and non-pharmacological approaches will be implemented before anti-anxiety medications are given. QA will be done monthly x 3 and quarterly x 3. Responsible party: DON Attachment F 329 A, F329 B	1/23/2013

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F 329	Continued From page 16 sleeping, allow him to sleep . . . Problem . . . Cognative [sic] status is decreased . . . 9-4-12 makes statements to staff he wants to die . . . Approaches . . . during times of confusion resident will look for help by exiting his room, halfway undirected- needing help with toileting. Offer assist as needed . . . Problem . . . displayed s/s [signs and symptoms] depression frustrated with his decline in health, aware that he is confused [at] times and this upsets him- sleeps poorly at night. 10-12-12 periods of [increased] aggitation [sic], hollers out. 10-29-12 . . . [increased] depression. . . . Approaches . . . lexapro (an antidepressant) as prdered [sic] . . . analgesics for pain . . .asssit [sic] to postions [sic] of comfort to promote sleep [at] night- ay[sic] sleep in recliner as desired . . . assess needs [at] times of [increased] aggitation0 [sic] ie [for example] ask if he has pain, needs toileting, thirst, humger [sic], repostioning [sic], etc. [etcetera] . . . 10-29-12 Ativan as scheduled and as needed . . ." Review of Resident #4's physician orders identified the resident started on 0.25 mg of prn Ativan every 4-6 hours on 09/23/12. On 10/11/12, the dose increased to 0.5 mg every 4 to 6 hours prn. On 10/29/12, the physician orders showed 0.5 mg Ativan scheduled at 4:00 p.m. with one more dose to be given prn through the night. On 11/15/12, the Ativan ordered showed 0.5 mg of Ativan prn every 6 hours in addition to the 0.5 mg at 4:00 p.m. The orders included Lexapro (an antidepressant) started on 09/07/12 at 10 mg; increased to 20 mg on 09/26/12; and on 10/29/12, 50 mg Trazodone (an antidepressant). Observation on 12/18/12 at 10:42 a.m., showed	F 329		

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F 329	Continued From page 17 two certified nurse assistants (CNAs #7 and #8) assisted Resident #4 onto the toilet using a stand lift. The CNAs cued the resident to use the call light and exited the bathroom. At 10:46 a.m., the resident's yelling could be heard in the hallway stating, "help me, help help help help help." The CNAs returned at 10:48 and assisted the resident with personal cares. The resident did not activate the call light. Review of the resident's prn MAR showed from 09/24/12 to 12/16/12 the resident received 96 doses of as needed Ativan. The reasoning on the MAR included for: anxiety, increased anxiety, agitation, restlessness and/or yelling/calling out. The MAR showed 59 Ativan doses which lacked evidence of attempting non-pharmacological interventions prior to administration. On 51 occasions Resident #4 obtained results including improvement, relief, asleep, "somewhat effect", "resting", "better" or a "little better." On five occasions, nursing staff identified Resident#4 had no relief or improvement. On three occasions, the MAR lacked follow up. Review of the prn MAR for Percocet showed the resident received the pain medication for knee and/or back pain at the same time Ativan ws administered for agitation or anxiety on the following dates: * October 6, 17, 18, 20 (two times), 23, and 26 * November 1, 9, 10, 12, 16, and 19 * December 10 and 15. The medical record identified the effectiveness of 37 out of 96 doses of prn Ativan administered between 09/24/12 through 12/16/12 had correlating nursing progress notes. The nursing	F 329		

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F 329	Continued From page 18 notes failed to consistently document non-pharmacological interventions and showed on : * 09/23/12 at 5:30 a.m., the resident #4 had increased agitation and activated call light up 16 times. At 8:45 a.m., the resident undressed in the hallway and was verbally abusive towards staff. At 8:50 a.m., the resident complained his pants were too tight, and an "aide" assisted the resident to change pants, and sat him in his recliner. The resident continued to complain his pants were tight, and the nurse then obtained an order for 0.25 mg Ativan. * 09/29/12 at 5:00 a.m. received Ativan after activating a call light eight times with a decrease in agitation. * 10/11/12 at 11:00 p.m., received Ativan after the resident increased agitation and repeatedly stated "what should I do" and "help me." * 10/14/12 at 12:15 a.m., received Ativan after calling out "help me" * 10/15/12 at 3:30 a.m., received Ativan and at 5:00 a.m., the resident continued to call out and ask for help. The note stated staff repositioned and changed the resident at 5:00 a.m. after he was not able to identify what he needed help with. * 10/21/12 at 6:00 a.m., the resident received Ativan at 10:30 p.m. and 2:00 am. after he slept "poorly," yelled, and "appeared" agitated. The resident received Percocet at 1:00 a.m. and fell asleep at 3:30 a.m. * 10/22/12 at 1:20 a.m. received Ativan after calling out "help me" with increasing agitation. At 4:00 p.m., a note stated the resident continued to call out until 3:30 a.m. after the Ativan at 1:20 a.m. * 10/23/12 at 5:00 a.m., received Ativan at 1:00	F 329		

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F 329	Continued From page 19 a.m. with some improvement in agitation. * 10/25/12 at 1:15 p.m., Ativan and Percocet provided after the resident repeatedly called out, complained of knee pain, and had stated, "I don't know what to do any more [and] wish I was dead. I cann't [sic] go on this way anymore." * 10/28/12 at 1:50 a.m., received Ativan after calling out "help me" and unable to state what he needed. * 10/29/12 at 5:00 p.m., a behavioral meeting held and the resident started on 50 mg of Trazodone and scheduled 0.5 mg Ativan at 4:00 p.m. * 11/01/12 at 11 p.m., resident received Ativan and Percocet after being restless, yelling "help help help," and complaining his knees hurt. * 11/06/12 at 1:30 a.m., received Ativan after being "restless" and "frequently" calling out * 11/07/12 at 2:30 a.m., received Ativan after "frequently" calling out "Help me" and after staff assisted to change bedding when the resident had an incontinent episode which caused increased agitation. * 11/08/12 at 4:30 a.m., received Ativan after yelling "help me," and after the resident had thrown his bedding and his incontinence product on the floor. * 11/10/12 at 2:10 a.m., received Ativan after calling out "help me" and had "Refused to wear gown or keep covered with sheets." * 11/12/12 at 5:00 a.m., received Ativan and Percocet with "little relief" after the resident had been calling out "help me," "frequently alarmed," removed clothes, and asked staff to "help me die". * 11/13/12 at 5:00 a.m., received Percocet which "helped" after being restless and calling out. * 11/14/12 at 7:30 a.m., received Ativan with "little	F 329		

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F 329	Continued From page 20 improvement" after calling out "help me" and getting agitated. The resident continued to call out and stated "why don't you take a hammer and hit me over the head." * 11/15/12 at 7:20 a.m., received Ativan after sleeping poorly and calling out with improvement in his agitation. * 11/15/12 at 8:30 a.m., the resident refused to allow staff to assist him after requesting to use the bathroom and became "extremely agitated," kicked at staff, and entered residents rooms and refused to leave. At 10:30 a.m. (2 hours later), an order for intramuscularly Ativan received and administered. At 12:30 p.m. the resident showed less agitation but continued to refuse help from staff. * 11/16/12 at 2:20 a.m., received Ativan and Percocet after calling out frequently, removing incontinence product and wetting the bed. At 5:00 a.m. the resident noted to have been quiet and resting the last hour. * 11/17/12 at 2:00 a.m., received Ativan after removing an incontinence product two times and yelling "Help, help" * 11/21/12 at 2:40 a.m., received Ativan after staff repositioned and changed the resident who yelled "help me" and was unable to say what he wanted. * 11/22/12 at 5:15 a.m., received Ativan after increased agitation and hollering with crying at times. * 11/25/12 at 7:30 a.m., received Ativan after increased agitation and calling out. * 11/26/12 at 7:30 a.m., received Ativan during the night after increased yelling and agitation with "little relief" * 11/28/12 at 5:00 a.m., received Ativan due to resident being agitated, yelling, and "unable to express needs."	F 329		

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F 329	Continued From page 21 * 11/28/12 at 8:00 p.m. received Ativan and at 10:00 a noted described the resident restless and refused pills with increasing agitation with staff. * 11/29/12 at 5:00 a.m., received Ativan which "helped a little" after yelling and increased agitation. * 11/30/12 at 4:50 a.m., received Ativan due to "becoming agitated" and "loudly calling out." and at 5:15 a.m., staff changed the resident and placed the resident in his wheelchair after he showed increased agitation and had removed his incontinence product and "voided". * 11/30/12 at 9:00 p.m., received Percocet for knee pain after he called out "Help, Help, Help." * 12/01/12 at 10:50 a.m., refused Ativan after being very agitated and physically/verbally abusive to staff and at 11:15 a.m. a note stated, "Res [resident] in dining room did take ativan at this time," and at 12:30 p.m., the resident refused medications stating "I take them tomorrow." * 12/01/12 at 9:00 p.m., the resident noted to be entering other residents' rooms and becoming verbally abusive and striking out at others. Ativan attempted at this time and the resident spit it out and then staff administered the medication rectally. * 12/06/12 at 5:30 a.m., received Ativan after yelling for 1/2 an hour. * 12/10/12 at 5:00 a.m., received Ativan and Percocet after yelling help "most of the night." * 12/13/12 at 1:30 p.m., received Ativan after hitting staff and wandering into other resident's rooms while in a wheelchair * 12/15/12 at 2:00 p.m., received Ativan at 1:30 p.m. after yelling at staff and unable to make needs known. During an interview on 12/19/12 at 8:45 a.m., an	F 329		

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F 329	Continued From page 22 administrative nurse (#1) stated Resident #4 will have pain and anxiety at the same time, and then staff will give both the antianxiety and pain medication at the same time. The nurse stated the facility had no policy related to behavioral interventions and antianxiety use. During an interview on 12/19/12 at 12:55 p.m., a nurse (#3) stated Percocet may be given with Ativan at times because the resident's agitation may be from pain. Staff failed to adequately assess Resident #4's needs, attempt non-pharmacological interventions, and evaluate the effectiveness of prn medications individually before administering a pain medication with an antianxiety medication. These failures may have resulted in unnecessary medications, adverse drug effects, and a decreased quality of life.	F 329		
F 371 SS=C	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 and staff interview, the facility failed to ensure 1 of 1 main kitchen	F 371		

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FORM APPROVED
OMB NO. 0938-0391

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 _____	12/19/2012

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 23 remained free of physical contaminates where food is stored, prepared, and distributed to residents. Failing to ensure the facility air conditioning and fan units in the main kitchen, storage room, and walk-in cooler were free of accumulated dust and debris placed food items at risk of contamination during preparation. Finding include: Observation during a kitchen tour on 12/18/12 at 4:10 p.m. showed the following vents to have a black film and dust covering: * 7 air conditioning exhaust vents on an air conditioning system which ran the length of the kitchen from the dish room to the other end of the kitchen including over the food preparatory area and steam table. The air conditioner was on and blew air from the vents around 3 foot above the counter, steam table, stove and other kitchen equipment. * A return air vent in the dry food storage area above the top rack of dry foods. * A air return vent on the walk in refrigerator's cooling unit. During the kitchen tour, a dietary manager (#6) stated cleaning of the vents had been an "oversight" and was unaware of the last time the vents had been cleaned.	F 371	F371 It is the policy of Ashley Medical Center to store, prepare, distribute and serve food under sanitary conditions. It is the Ashley Medical policy that all food proparation, storage and dishwashing areas shall be kept neat and clean. Since the survey, all vents have been cleaned(see attached.) Air vents will be routinely cleaned by housekeeping staff to keep dust build-up from forming. This will The vents were cleaned and a filter was installed on 12/26/12. The cleaning of the vents will be placed on a quarterly schedule thereafter. Dietary Manager will check to see that vents are properly maintained. If they are not, a work order will be filled out and given to Environmental Services Supervisor who will have them cleaned immediately. A QA study will be conducted monthly x 1 year to insure that this is being done. Study will be completed January 2014. Resonsible party Dietary Manager See Attachment F371	1/23/2013