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 _____	12/20/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on December 18, 2011 and completed on December 20, 2011, the sample included two (2) residents for comprehensive review, eight (8) residents for focused review, and one (1) closed record for review.	F 000	F 167 It is the policy of the Ashley Medical Center that all residents will have the right to examine the results of the most recent survey of the facility, conducted by Federal or State surveyors, and any plan of correction in effect, with respect to the facility. The Life Safety survey completed on October 3, 2011 results have been posted, and these survey results and the accepted plan of correction will be posted upon approval of our plan of corrections. Our LSW will be instructed on what the facility must make available for examination, and that the facility must post in a place readily accessible to resident and post a notice of the survey's availability. A QA will be completed monthly x3 and quarterly x 3 to ensure that all results of the most recent State survey results, along with the Life Safety Code surveys are posted in a place readily accessible to residents. See Exhibit(QA) F167 #1 Responsible Party: LSW	1/24/2012
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON JANUARY 3-5, 2011. Based on observation and staff interview, the facility failed to ensure the most recent Life Safety survey results were available for examination by residents for 3 of 3 days (December 18-20, 2011) of survey. Findings include: Observation on December 18-20, 2011 showed	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Adm/CEO	1/18/2012

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 167	Continued From page 1 the results of the Health survey posted. The facility staff failed to post the results of the previous Life Safety Code survey conducted on 10/03/11. During interview on 12/19/11 at 12:20 p.m., an administrative maintenance staff member (#1) stated the facility failed to post the Life Safety Code survey results. During interview on 12/19/11 at 5:35 p.m., an administrative nurse (#2) agreed the facility failed to post the current Life Safety Code survey dated 10/03/11.	F 167		
F 226 SS=E	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: Based on observation, policy review, record review, and staff interview, the facility failed to implement policies and procedures to assure that the facility prevents, identifies, and investigates occurrences of possible abuse or neglect for 6 of 10 sampled residents (Resident #1, #2, #3, #7, #8, and #10). The facility failed to implement procedures to investigate injuries of unknown origins for Resident #1, #3, #7 and #8; and failed to provide supervision and implement policy and procedure to investigate interactions between staff members and Resident #2, #3, and #10. Failure to report possible abuse or neglect	F 226	F226 It is the policy of the Ashley Medical Center that all residents have the right to be free from abuse. A. Reports of unknown origin when referring to residents who have bruising, skin tears, scratches, etc. will be investigated by charge nurse and documented on Resident Incident Report. Reports are given to Nurse Administrator and LSW for review and/or follow-up investigation. See Exhibit F226 #1 Resident Incident Report See Exhibit F226#1-A See Exhibit F226#1-B	1/24/2012

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F 226	Continued From page 2 incidents in a timely manner to administrative staff did not allow the facility to determine causative factors of the incidents, implement corrective action, and placed the residents at risk for potential injury or abuse. Findings include: Review of the facility policy titled "Patient Abuse/Neglect" occurred on 12/20/11. This policy, revised January 2009, stated: "Purpose: All patients at the Ashley Medical Center have the right to be free from . . . abuse . . . All staff will be educated . . . to report any and all suspected and observed incidents of abuse . . . alleged violations involving mistreatment: neglect or abuse including injuries of unknown source . . . will be reported immediately to the Administrator/ Administrative designee and to other officials in accordance with State law, through established procedures, including the North Dakota Health Department. . . . 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) . . . must notify their department supervisor . . . Injuries of unknown source: Injuries of unknown source . . . 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 by the facility . . . Protection: . . . Residents' will also be evaluated for any abusive potential toward themselves, other residents, and employee. . . ." - Review of Resident #7's medical record occurred on all days of survey. Current	F 226		

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F 226	Continued From page 3 diagnoses included anxiety and depressive disorder. The resident's annual Minimum Data Set (MDS), dated 10/23/11, identified the resident as able to make herself understood, able to understand others, highly visually impaired, moderate impairment in cognition, and required extensive assistance of two or more persons for transfers and toileting. Resident #7's current care plan identified the resident with a "SELF CARE DEFICIT" with approaches including "1. WALKS WITH RA [RESIDENT ASSISTANT] IN HALLWAY WITH WALKER AND ASSIST . . . 3. POOR VISION - LEAVE ITEMS IN THEIR PLACE SO [RESIDENT] CAN FIND THEM . . . 10. W/C [WHEELCHAIR] FOR LOCOMOTION PROPELLED BY OTHERS. ASSIST WITH ALL - TYPICALLY NEEDS WT [WEIGHT] BEARING ASSIST. 12. ASSIST WITH ALL TOILETING . . . 13. . . . TRANSFERS: WT BEARING ASST [ASSIST] WITH 1-2 STAFF. DRESSING: ASST WITH UPPER AND LOWER BODY DRESSING. . . ." Resident #7's nurse's notes identified the following: * 11/01/11 at 11 a.m.: "CNAs [certified nursing assistants] report a series of long red thin marks on pts [patients] back; pt would have been unable to do this per self. ? [question] origin." * 11/07/11 at 9 p.m.: "CNAs report bruise on LFA [left forearm] ? origin. Will monitor." * 11/23/11 at 4:30 p.m.: "Resident was trying to get curling iron out of bottom drawer, fell out of w/c; [no] injuries noted. . . ." * 11/26/11 at 9 p.m.: "CNA report resident had bruising to R [right] forearm. Resident don't know	F 226	Resident # 7 refer to response A.	1/24/2012

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F 226	Continued From page 4 what or where it came from. Will monitor." * 12/19/11 at 8:40 a.m.: "CNA reported res has bruise drk [dark] purple in color on Lt elbow & smaller purple bruise on upper left arm of unknown origin. Will monitor." During interview with an administrative nurse (#2) on the afternoon of 12/19/11, the nurse stated she was unaware and had not been informed the marks on Resident #7's back on 11/01/11 and stated she became aware of the bruise on the left forearm during report on 11/07/11. She stated the bruise on 11/26/11 occurred from the fall on 11/23/11 and stated she had not been informed of the bruise which occurred today. The administrative nurse (#2) stated she would expect staff to complete an incident report for injuries of unknown origin and then an investigation should be completed. The administrative nurse (#2) stated she conducted an investigation of the bruise which occurred to Resident #7's left forearm on 11/07/11, however, did not provide a copy of the investigation, or document the results of the investigation. - Review of Resident #8's medical record occurred on December 19-20, 2011. Current diagnoses included intracranial hemorrhage, dysphagia (difficulty swallowing), and neurogenic bladder. The resident's quarterly MDS, dated 08/18/11, identified the resident as sometimes able to make himself understood, usually understands, with a short and long term memory problem, moderately impaired for daily decision making, and required extensive assistance of two or more persons for transfers and toileting.	F 226	Resident #8 refer to response A.	1/24/2012

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F 226	Continued From page 5 On the morning of 12/20/11, observation showed two CNAs (#7 and #8) transfer Resident #8 from his wheelchair to the bathroom utilizing an EZ stand lift. Resident #8's nurse's notes identified on 08/23/11 at 9:15 p.m. "Noted u-shaped 1.5 cm [centimeter] skin tear on Lt. [left] hand. Cleansed, steri strips & [and] non-adhering drsg [dressing] applied. Bruising noted around area." A weekly progress note, dated 08/26/11, also noted this skin tear and described it as located on the "top of left hand." Further review of the record lacked additional information as to causative factors for the injury. During interview on 12/20/11 at 11:00 a.m., a staff nurse (#9) stated nurses document injuries of unknown origin in the nurses notes and then inform the Director of Nursing. During interview on 12/20/11 at 12:30 p.m., an administrative staff nurse (#2) stated nursing staff did not inform her of Resident #8's skin tear on 08/23/11 and therefore, no investigation occurred. - Review of Resident #1's medical record occurred on all days of survey. Current diagnoses included Alzheimer's dementia, anxiety, benign essential tremor, and depression. The most recent MDS, dated 11/13/11, identified Resident #1 severely impaired in daily decision making and required extensive assist of two or more persons for bed mobility, transfers, bathing, and total assist of staff for dressing. Resident #1's care plan, revised 11/28/11, stated	F 226		

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F 226	Continued From page 6 "PROBLEM. . . [Resident's name] HAS A SELF CARE DEFICIT . . . APPROACHES . . . TRANSFERS WITH MECHANICAL HOYER LIFT - 2 ASSIST WHEN ALERT AND PARTICIPATING . . . PROBLEM . . . RISK FOR SKIN BREAKDOWN D/T [DUE TO] DECREASED MOBILITY . . . APPROACHES . . . MONITOR SKIN DAILY. . . PROBLEM . . . Skin tear back of [left] upper arm . . . APPROACHES. . . Tx [treatment] as ordered . . . monitor progress on skin eval [evaluation] report . . . monitor for s/s [signs and symptoms] of infection . . . ." Resident #1's nurse's progress notes stated on: *11/23/11 "sustained a 2 cm [centimeter] skin tear to his left upper arm" *12/03/11 "no skin breakdown" and "total assist with cares" *12/10/11 "staff assist with position changes" and "skin tear left upper arm open to air, healed" Resident #1's skin evaluation report identified documentation on the left upper arm wound from 11/23/11 through 12/13/11, and lacked documentation of origin. During an interview on 12/20/11 at 2:30 p.m., an administrative nurse (#2) stated she lacked awareness of how the skin tear occurred and failed to find further documentation regarding the cause of the skin tear. - Review of Resident #3's medical record occurred on all days of survey. Resident #3's medical diagnoses included diabetes, depression, aggressive behaviors, and Alzheimer's dementia with behaviors. The resident's most recent MDS, dated 09/19/11, identified the resident with severe	F 226	Resident #1 refer to response A.	1/24/2012

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F 226	Continued From page 7 cognitive impairment, required extensive assistance of two or more persons for bed mobility and total assistance for transfers and toileting. Resident #3's "Nurse's Notes" identified the following: * 03/10/11 at 7:30 a.m.: "Has small abrasion to right knee of unknown origin. Cleansed and drsg [dressing] (protective) applied. Monitor until healed." * 09/04/11 at 5:00 p.m.: "Resident was slipping out of w/c [wheelchair] CNA's [and] nurse boosted resident in chair. Resident scratching, hitting [and] trying to bite CNAs, also verbally abusive . . . Unable to calm or redirect. Very mean [with] staff. . . ." * 09/05/11 at 6:45 a.m.: CNA's report bruise to top of R [right] hand." Resident #3's "CNA Flow Sheet" identified the following: * 09/04/11 (not timed): "Resident was slidding [sic] out of her wheelchair. Staff went in to help her. Resident became enragged [sic] at staff. Scratching, hitting, biting, yelling in English [and] German. It took four of us to restrain her. Got resident on to bed to change her. She settled down a little after we got her back to the wheelchair. She seemed defeated [and] got very quiet." An interview with an administrative nurse (#2) and a social service staff member (#10) occurred on 12/20/11 at 1:40 p.m. The administrative nurse (#2) stated she was not aware of Resident #3's abrasion of unknown origin to her right knee (March 10, 2011), that four staff members	F 226	F226 B. CNA's were in-serviced on 1/18/12 as to proper and improper staff interaction with residents. Staff instructed on how to handle aggressive behaviors during direct care of residents, appropriate and inappropriate language when speaking to residents, i.e. threats of not answering call lights, and inappropriate signs of affection, i.e. kissing residents. See Exhibit #2 Copy of F226 - handout during training Resident #3 refer to response A Resident #3 refer to response B.	1/24/2012 1/24/2012

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F 226	Continued From page 8 restrained the resident on September 4, 2011 to get her to calm down, or the bruise to the top of the resident's right hand (September 5, 2011). The social service staff member (#10) stated she was aware of Resident #3's aggressive behavior on September 4, but did know four staff members restrained the resident. The staff member (#10) stated "we don't want residents to feel defeated." - Review of Resident #2's medical record occurred on all days of survey. The resident's current diagnoses included cerebral vascular accident with left sided weakness, depression, Parkinson's, aggressive behavior, and dementia. Review of Resident #2's most recent MDS, dated 09/28/11, identified the resident with severe cognitive impairment and required extensive assist of two or more persons for bed mobility, transfer, and toilet use. Resident #2's care plan, revised 12/5/11, stated, "PROBLEM: . . . AGGRESSIVE BEHAVIORS . . . HX [history] OF EASILY ANGERED . . . APPROACHES: . . . HAS HISTORY OF PHYSICAL/VERBAL ABUSE TO STAFF AND RESIDENTS . . . MONITOR FOR S/S OF DEPRESSION . . . IF RESIDENT IS AGGRESSIVE [Resident's name] SHOULD BE TOLD THAT BEHAVIOR IS UNACCEPTABLE-REMOVE ANY OTHER RESDIENT [sic] FROM HARMS WAY- STAFF MAY TRY REAPPROACHING . . ." Resident #2's CNA Behavior Flowsheet, dated 10/21/11, stated, ". . . when I take off medilift [sic] belt he start hitting me I told him to quite [sic] then he keep on doing it what I did I hold his hands go	F 226	Resident #2 refer to response B. Yearly staff education regarding proper charting and reporting of injuries of unknown origin and as needs are identified throughout the year and/or on an individual basis. New employees to the nursing staff will receive the information as part of orientation. QA will be monthly x3 and quarterly x3 thereafter. Investigations of all injuries of unknown origin and inappropriate staff/resident interactions. Responsible parties: Nurse Administrator and LSW	1/24/2012 1/24/2012

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F 226	Continued From page 9 to hit me tell him next time he wants to go to the bathroom will not putting him then he calm down his mad because I take off the belt . . . [sic]" During an interview on 12/20/11 at 3:00 p.m., two supervisory staff members (#2 and #10) lacked awareness of the incidences involving Resident #2. - Review of Resident #10's medical record occurred on December 19-20, 2011. The "CNA Flow Sheet" dated 11/07/11 identified, "When CNA tryed [sic] to kiss her, she shook her fist at her and said she didn't want to be kissed." During interview, on 12/20/11 at 2:00 p.m., an administrative nurse (#2) stated she was not aware staff tried to kiss Resident #10, nor the resident's response. The staff member confirmed staff members should not kiss residents.	F 226	Resident #10 refer to response B.	1/24/2012
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to enhance residents' dignity and self worth during 3 of 3 meals observed. Facility staff failed to engage and/or include residents in conversations and failed to allow residents to participate in an activity designated for the residents. These facility practices failed to	F 241		

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F 241	Continued From page 10 enhance the residents' dignity, self esteem or self worth and failed to recognize their individuality. Findings include: Observations in the resident's dining room showed: * On 12/19/11 at 12:15 p.m., two certified nurse assistants (CNAs) (#15 and #16) and an administrative activity staff member (#18) conversed about personal issues at a dining table during lunch while the CNAs assisted two residents with their meal. The administrative activity staff member (#18) charted in an activity log and conversed with the CNAs. At 12:25 p.m., an activity staff member (#21) used a microphone and asked trivia questions during lunch. Three CNAs (#12, #14, and #21) answered the questions and laughed. The three CNAs continued to discuss the trivia questions and one CNA referred to them as "scholars." During the trivia activity, a CNA (#16) and an activity staff member (#18) discussed another table's seating arrangement related to a family member visiting an unidentified resident. The CNAs failed to converse or engage the residents in the activity while seated at the table. * On 12/20/11 at 8:05 a.m., while assisting residents at breakfast, two CNAs (#7 and #16) discussed personal holiday plans while two unidentified staff discussed their work schedules as well as other staff member's schedules. * On 12/20/11 at 12:10 p.m., two unidentified CNAs discussed personal plans while assisting	F 241	F241 It is the policy of the Ashley Medical Center to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Staff in-service on Dignity and Respect will be 1/17/12 and 1/18/12. Staff will also be given a copy of F241. See Exhibit #3 F241 Exhibit #4 Dining room QA Staff will be in-serviced yearly, as new employee, and as needs arise in new situations and/or ongoing individual basis. QA will be monthly x3 and quarterly x3. Charge nurse responsible for day shift and pm shift will monitor the CNA's who assist residents at meal times for appropriate resident/staff interaction. Report will be given to LSW to monitor and address as needed. Responsible party: LSW	1/24/2012

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F 241	Continued From page 11 two unidentified residents with their meal. At another table, three staff members (CNA #15 and #17, and one unidentified staff member) sat with two residents and conversed about a missing cat. The staff members failed to include the residents in the conversation. During an interview on 12/20/11 at 2:30 p.m., two supervisory staff members (#2 and #10) agreed that facility staff disregarded the residents by conversing about personal issues and not allowing resident's to participate in a facility activity.	F 241		
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, facility policy review, and staff interview, the facility failed to provide essential social services related to resident behavior assessment for causative/precipitating factors, develop and implement specific and individualized interventions, monitor the effectiveness of these interventions, and revise them accordingly for 2 of 4 sampled residents (Resident #1 and #2) identified by the facility as exhibiting behaviors. Failure to assess behaviors, implement interventions, and monitor resident response to interventions resulted in residents striking out at	F 250	F250 It is the policy of 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 12 other residents, intruding on others, and having comments of self-depreciation which do not allow for planning and implementation of interventions to prevent/minimize the occurrences. Findings include: Based on review of the North Dakota Department of Health, Division of Health Facilities provider files, this facility has not sustained correction of this issue. This requirement was found to be out of compliance during the previous surveys completed on January 21, 2010 and January 7, 2009. Review of the facility policy titled "Patient Abuse/Neglect" occurred on 12/20/11. This policy, revised January 2009, stated, " . . . The patients' interdisciplinary team will identify, care plan, and monitor intervention effectiveness for residents with needs, and behaviors that might lead to conflict or neglect, i.e. history of aggressive behavior, enter other patients' rooms, self injurious behaviors, communication disorders, require heavy nursing care and or totally dependent on staff. . . . upon admission, quarterly and pm [as needed] . . . each Residents' [sic] will also be evaluated for abusive potential toward themselves, other residents. . . . Resident to resident contact will be denoted per filing of incident report form. DON [Director of Nursing] will share all unusual occurrence forms with Social Services. If inappropriate contact exceeds isolated occurrences facility placement will be analyzed in addition to individualized care plan approaches. . . " - Review of Resident #1's medical record	F 250		

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F 250	Continued From page 13 occurred on all days of survey. Current diagnoses included depression, anxiety, Alzheimer's Dementia, and behavioral disturbance. Current medications include Risperdal and Haldol (antipsychotic drug), and Aricept (an Alzheimer's drug). Resident #1's quarterly Minimum Data Set (MDS), dated 11/13/11, identified short and long-term memory impairment; sometimes able to make self understood and understand others; highly visually impaired; severely impaired with daily decision making; and had trouble with concentration such as reading the newspaper or watching television nearly every day. Behaviors that occurred one to three days during the assessment period included physical behavioral symptoms directed towards others, other behavioral symptoms not directed towards others, and wandering. Observations of Resident #1 on the morning of 12/18/11, and on the afternoon of 12/19/11 showed the resident going up and down the hallway in his wheelchair using the hand rail to propel himself. On 12/19/11 at 1:10 p.m., observation showed two CNAs (#15 and #21) assisted Resident #1 to lay down. As CNA (#21) took off the resident's right shoe, the resident kicked at the CNA. Review of Resident #1's care plan, revised 11/07/11, identified "... PROBLEM: [Resident's name] HAS A SELF CARE DEFICIT, HAS DIAGNOSIS OF ALZHEIMER'S DEMENTIA. RISK FOR FALLS- D/T [Due to] WEAKNESS, CONFUSION. HISTORY OF FAINTING EPISODES ... APPROACHES ... MONITOR	F 250	F250 Wandering Resident #1. Family interview at time of admit to facility revealed his interests are farming, machinery, card playing and when retired he enjoyed driving the streets of Ashley, watching the neighbors. Resident #1's wandering reflects his desire to "drive the neighborhood". Appropriate activities reflecting Resident #1's interest will be provided by the Activity Department 2 - 4 times each day. During times when the Activity Department is off, other staff will have access to a variety of activities that interest Resident #1, and staff will be trained by Activity Department on there proper use. See Exhibit # 5 Activity Care Plan. Physical Behaviors directed toward others - Staff will be in-serviced/trained on 1/17/12 and 1/18/12 on approaches that work for Resident #1, i.e. explain procedures before staff proceed, as explained on his care plan. See Exhibit #6 Behavior Care Plan Responsible party LSW	1/24/2012

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F 250	Continued From page 14 FOR S/S [signs/symptoms] OF ANXIETY, AGITATION, RESTLESSNESS, C/O [complaints of] ANXIETY. . . PROVIDE KIND AND CARING ENVIRONMENT . . .MONITOR MOOD BEHAVIOR DAILY . . . WHEN RESIDENT IS ANGRY LEAVE RESIDENT ALONE AND REAPPROACH LETER [sic] . . .PROBLEM: . . . [Resident's name] HAS A HISTORY OF ANXIETY AND AGITATION R/T [related to] HIS DEMENTIA. UTILIZES PSYCHOTHERAPEUTIC MEDS [medications] FOR THESE BEHAVIORS. HAS DEPRESSIVE DISORDER . . . APPROACHES 1. PSYCHOTHERAPEUTIC MEDS AS ORDERED. 2. FOLLOW UP PSYCH TELE MED [telemedicine] AS RECOMMENED [sic] . . . PROBLEM . . .10. HX OF RESIDENT TO RESIDENT ABUSE- VERBAL OR PHYSICAL . . . APPROACHES 1. ENSURE IMMEDIATE SAFETY OF RESDEINTS [sic] AND STAFF INVOLVED. 2. NOTIFY MD OR FNP [medical doctor or family nurse practitioner] OF ABUSIVE BEHAVIORS. . . . PSYCH TLE [sic] MED TO BE FOLLOWED THROUGH. . . . CONTINUE ANY ALREADY UTILIZED PSYCHOTROPIC MEDS . . . YELLOW STRIPS AT NURSES STATION IF RESIDENT WANDERS INTO ROOM TO PLACE AT OTHER REISDENTS [sic] ROOMS. . . . SPEAK IN CALM MANNER EXPLINING [sic] WHAT YOUR DOING FOR [resident's name]. . . . USE SIMPLE YES AND NO QUESTIONS WITH [resident's name] TO AVOID AGGITATION [sic]. . . " Reviewed of Resident #1's behavior charting identified the following: * July 2011: two occasions where resident had little interest or pleasure in doing things; one occasion of feeling or appearing down,	F 250		

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F 250	Continued From page 15 depressed, or hopeless, two incidences of physical behaviors directed towards others; and three incidences of wandering. * August 2011: one occurrence of feeling or appearing down, depressed or hopeless; * September 2011: two incidences of physical behaviors directed toward others; and 12 occurrences of wandering; * October 2011: one incidence of trouble falling or staying asleep, or sleeping to [sic] much; two incidences of physical behaviors directed toward others; and six incidences of wandering; * November 2011: one time of little interest or pleasure in doing things; one incidence of feeling or appearing down, depressed or hopeless; one incidence of feeling tired or having little energy; one occasion of being short-tempered, easily annoyed; one incidence of physical behaviors directed toward others; one incidence of other behaviors and four occasions of wandering. Review of CNA and Nurses Notes identified: * 07/08/11 "Resident asked to have his throat cut when we asked why, he laughed, when we checked & [and] changed him" * 07/20/11 "Resident got into a bit of arm-to-arm confrontation in the dining room before lunch. I didn't see the beginning but I believe he was in the other resident's way to get to the table and he struck out at him & pulled his shirt and this resident reacted." * 08/12/11 "Resident asked me to cut his throat also had a little refusal when getting him ready for bed" * 10/03/11 at 9:30 a.m., "Resident . . . wheeled in front of another resident. That resident grabbed [Resident #1's name] lt. [left] arm hard. [Resident #1's name] kicked at resident holding his arm.	F 250		

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F 250	Continued From page 16 Resident's [sic] separated by CNA. . . ." * 11/05/11 "Resident had a bit of arm-to-arm confrontation with another resident when their wchairs [wheel chairs] bumped each other [at] the entrance to the dining room." * 11/17/11 "Resident was wandering in and out of other residents' rooms. Staff needed to take him out 3x [three times]" * 11/26/11 "CNA's reported resident had 2 scratches on back - unknown origin. Will monitor . . ." An AIMS (Abnormal Involuntary Movement Scale) screening, completed on 05/23/11, stated, ". . . can be resistive to cares - HOH [hard of hearing]- staff need to anticipate his needs. Remains confused, propels self up and down hall in w/c [wheelchair]. Another AIMS screening completed on 11/23/11, stated ". . . Has displayed no behavior problems . . ." Review of physician notes showed evaluation done by psychiatry occurred on 01/11/11 with no changes in psychiatric medication. During an interview on 12/20/11 at 3:00 p.m., an administrative staff nurse (#2) and an administrative social services staff member (#10) lacked awareness of the comment regarding Resident #1 wanting someone to cut his throat. During this interview, these staff members identified the facility failed to review the Resident #1's documented behaviors. - Review of Resident #2's medical record occurred on all days of the survey. Current diagnoses included depression, Parkinson's, dementia, aggressive behavior, and left sided	F 250		

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F 250	Continued From page 17 weakness with history of cerebral vascular accident. Current medications include Seroquel (an antipsychotic) and Effexor XR (an antidepressant). Resident #2's most recent quarterly MDS, dated 09/28/11, identified the resident as sometimes able to make self understood and understand others; severe cognitive impairment; and behaviors including physical behavioral symptoms directed towards others, verbal behavior, and other behavioral symptoms not directed towards others on one to three days during the assessment period. Review of Resident #2's care plan, revised 12/05/11, identified ". . . PROBLEM 6. NEED FOR PSYCHOTROPIC MEDICATION DEPRESSION, ANXIETY, AGGRESSIVE BEHAVIORS MOOD SWINGS- HX [history] OF EASILY ANGERED CAN BE VERY DEMANDING [at] TIMES. GETS JEALOUS WHEN ROOMMATE GETS MORE ATTENTION . . . SEROQUEL INCREASED D/T [due to] BEHAVIORS . . . APPROACHES . . . PARKINSONISM MED AS ORDERED. . . PSYCHOTHERAPEUTIC MEDS AS ORDERED . . .HISTORY OF PHYSICAL/VERBAL ABUSE TO STAFF AND RESIDENTS . . . PSYCH TELEMEDS AS SCHEDULED. . . . STAFF TO MONITOR AND ASSESS FOR . . . CHANGE IN COGNATIVE [sic] BEHAVIOR . . . PROFESSIONAL NURSE TO DOCUMENT WEEKLY FOR SIDE EFFECTS OR ABNORMAL BEHAVIORS. . . MAINTAIN CALM, QUIET ATMOSPHERE . . . MONITOR FOR S/S DEPRESSION, CRYING, INSOMNIA, LOSS OF APPETITE, WITHDRAWN BEHAVIOR,	F 250	F250 Resident #2 Behaviors Physical behaviors directed toward other residents, specifically Resident #1. Staff will be in-serviced 1/17/12 and 1/18/12 regarding approaches that work for Resident #2. Resident #2 will be redirected by staff at the times it is most anticipated Resident #2 would have altercations with other residents. Staff identified Resident #2 as most apt to have a physical encounter with others when he is in the public areas of the facility, i.e. hallway and dining room. All staff will be aware of these times and assist Resident #2 to his destination, removing other residents out of his way to avoid a physical encounter. See Exhibit # 7 Behavior Care Plan QA will be monthly x3 and quarterly x3. A sample of residents who receive psychotropic medications and/or antidepressants will be reviewed at the monthly behavior meeting. LSW will track behaviors by attending morning report, reviewing behavior charting, nurses notes and telemedicine meetings with Dr. Capan, Interdisciplinary Team Meetings and the consultant pharmacists monthly reports. The behavior meetings will review psychotropic medications for GDR and appropriateness of behavior modification on residents care plan. Responsible party LSW.	1/24/2012

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F 250	Continued From page 18 SELF-DEPRECIATING VERBALIZATION . . . DOCUMENT MOOD AND BEHAVIOR DAILY . . . FACILITY NURSE PRACTIONER [sic] OR MD [medical doctor] TO CONSULT AS NEEDED . . . ALLOW TO VENT FEELINGS . . . IF RESIDENT IS AGGRESSIVE [Resident's name] SHOULD BE TOLD THAT BEHAVIOR IS UNACCEPTABLE-REMOVE ANY OTHER RESDIENT [sic] FROM HARMS WAY- STAFF MAY TRY REAPPROACHING [Resident's name]. . . ALERT STAFF OF MOOD SWINGS, ESP NEW EMPLOYEES. . . . remove res. when hitting/kicking tablemats [sic] at dining room. . . do a UA [urinalysis] when behaviors are more often . . ." Review of Resident #2's CNA and Nurses Notes identified the following: * 07/20/11 "Resident got into arm-to-arm confrontation in the dining room before lunch. I didn't see the beginning, but I believe the other resident was in his way when he was trying to get to his spot [at] the table and first thing I noticed was him pulling [at] other resident's shirt and arms clashing" * 10/03/11 "Resident got mad at another resident. He started pinching the other resident, other resident started kicking at him. Separated the two of them as quickly as possible." * 11/05/11 "Resident had a bit of arm-to-arm confrontation w/ [with] another resident when their chairs bumped [at] entrance to dining rm. [room]" * 11/12/11 at 8 a.m., " . . . hit [and] scratch the other res. [resident] in the face. Bleeding around mouth. Tried to hit other res. again. . . ." * 11/26/11 "Resident was leaving dining room another resident was blocking his way so [Resident #2's name] punched him in the back. . .	F 250		

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F 250	Continued From page 19 ." * 12/03/11 "Resident wanted to be put on the floor. When Res wheeling himself to DR [dining room], asked if he still wanted to be put on the floor [and] he replied, "Yeah, 6 feet under the floor." Resident #2's medical record showed gradual dose increases of the residents Seroquel between September 17 and December 03, 2011. Resident #1 received Seroquel 50 mg at night daily prior to September 17, 2011. By 12/03/11, the Seroquel dose increased to the current dose of 50 mg in the morning and 75 mg at night. Review of the resident's psychiatric Telemed Meeting note, dated 12/03/11, identified increased physical and verbal behaviors towards staff and residents during this time. Review of a "Resident Injury Investigation Report" provided by an administrative staff nurse occurred on 12/20/11. This document completed on 11/28/11, stated, ". . . Resident B leaving residents D/R [dining room] when Resident A came up behind in his w/c [wheelchair]. Resident B did not move so then Resident A struck other resident B in the back. Resident B is confused. Received a scratch on his back . . . Action Taken and Precautions Implemented . . . Resident A was reminded this is inappropriate behavior . . . Resident B staff anticipate his needs and for resident B to be removed from the area by CNA . . ." During an interview on 12/20/11 at 8:45 a.m., the administrative nurse (#2) identified Resident #1 and #2 as the residents involved in the incident above and reported that staff should anticipate	F 250		

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F 250	Continued From page 20 Resident #1's needs and intervene before the resident is able to come in contact with Resident #2. The facility lacked documentation of interventions to address specific instances with Resident #2 on Resident #1's care plan. During an interview on 12/20/11 at 12:30 p.m., an administrative staff nurse (#2) and an administrative social services staff member (#10) stated CNAs should let them know of residents' behavioral problems. The social services staff member (#10) reviews behavior charting for residents followed by a psychiatrist. Both staff members (#2 and #10) agreed all documented behaviors on monitoring forms and CNA flow sheets should be reviewed by social services or nursing . The facility failed to assess causative/ precipitating factors of the multiple confrontations that occurred on 07/20/2011, 10/03/11, 11/05/11, 11/12/11 and 11/26/11 between Resident #1 and #2. Failing to assess the precipitating factors and then develop and implement interventions resulted in Resident #2 bleeding around the mouth on 11/12/11 and injury to Resident #1 obtaining scratches on 11/26/11.	F 250		
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	F 329	F329 It is the policy of the Ashley Medical Center that each resident's drug regime will be free from unnecessary drugs. 1. The Pharmacist Consultant was informed of this repeat deficiency on 1/12/2012.	

refer to exhibits set with POC regarding resident #1 and #7

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F 329	Continued From page 21 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. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON JANUARY 3-5, 2011. Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure a drug regimen free from unnecessary medications for 2 of 5 sampled residents on antipsychotic medications (Resident #1 and #7). Failure to adequately monitor residents on antipsychotics and to attempt a gradual dose reduction (GDR), unless contraindicated, may result in residents receiving unnecessary medications and experiencing adverse drug reactions related to these medications. Findings include:	F 329	2. The Pharmacist Consultant will be addressing GDR with each monthly drug review regime. This information will be given to the DON, who in turn will be reporting the information to the Charge Nurse and the LSW. The nurses will address the request for GDR to the primary physician. The LSW will address the GDR attempts with those residents scheduled for Psych telemeds. The attempts will be addressed with the psychiatrist, Dr. Capon at the resident's earliest Psych. telemed and/or to indicate the attempt may be clinically contraindicated. 3. AIMS screenings continue to be done every 6 months. 4. Tracking of medication reductions will be followed up by the LSW and QA committee member. 5. GDR will be addressed on Care Plan per regulation. QA will be done monthly x3, then quarterly x1 year. Responsible parties: Pharmacist Consultant and DON	1/24/2012

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F 329	Continued From page 22 Review of an undated facility policy titled "Medication Management" occurred on 12/20/11. This policy stated ". . . facility staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use. When selecting medications and nonpharmacological interventions, members of the interdisciplinary team participate in the care process to identify, assess, address, advocate for, monitor, and communicate the resident's needs and changes in condition. . . . Procedure . . . When a resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, and/or non-pharmacological interventions, including behavioral interventions, have been effective in reducing the symptoms, the resident is evaluated for appropriateness of a taper or gradual dose reduction . . . Antipsychotics. If a resident is admitted on an antipsychotic medication or the facility initiates antipsychotic therapy, the facility must attempt a GDR in two separate quarters (with at least one month between attempts) within the first year, unless clinically contraindicated. After the first year, a GDR must be attempted annually . . . A GDR is considered clinically contraindicated if: . . . Target symptoms returned or worsened . . . and the physician documents the clinical rationale for why any additional attempted dose reductions would likely impair the resident's function, increase distressed behavior, or causes psychiatric instability by exacerbating an underlying medical or psychiatric disorder. . . ." - Review of Resident #1's medical record	F 329	Resident #1 See Exhibit F329 #1 Resident 1	1/24/2012

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F 329	Continued From page 23 occurred on all days of survey. Current diagnoses included depression, anxiety, Alzheimer's Dementia, behavioral disturbance, congestive heart failure, atrial fibrillation, and chronic systolic dysfunction. Current medications include Risperdal (an antipsychotic) 0.25 milligrams (mg) every morning and 0.5 mg every night, initiated 02/15/10, and Haldol (an antipsychotic) 0.5 mg three times a day initiated 05/05/2010. Review of Resident #1's care plan, revised 11/07/11, identified a problem of "[Resident's name] HAS A HISTORY OF ANXIETY AND AGITATION R/T [related to] HIS DEMENTIA. UTILIZES PSYCHOTHERAPEUTIC MEDS [medications] FOR THESE BEHAVIORS. HAS DEPRESSIVE DISORDER," approaches included "1. PSYCHOTHERAPEUTIC MEDS AS ORDERED. 2. FOLLOW UP PSYCH TELE MED [telemedicine] AS RECOMMENED (sic)" The care plan also identified the problem of " HX OF RESIDENT TO RESIDENT ABUSE- VERBAL OR PHYSICAL," with the approaches of "2. NOTIFY MD OR FNP [medical doctor or family nurse practitioner] OF ABUSIVE BEHAVIORS AND OBSSERVE (sic) ANY ORDERS. . . PSYCH TLE (sic) MED TO BE FOLLOWED THROUGH. . . . CONTINUE ANY ALREADY UTILIZED PSYCHOTROPIC MEDS UNTIL PSYCHOTROPIC MEDICATIONS ULTILPPSYCH (sic) TELE MED /OR(sic) AS ORDERED BY IN HOUSE MD/FNP.S (sic) . . ." Review of Resident #1's mental health telemedicine progress note, dated 01/11/2011, stated ". . . the patient was doing well up until 2 weeks ago . . . he has increased restlessness, agitation, and he has been more resistant to	F 329		

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F 329	Continued From page 24 cares. . . . sleeping okay at night and he has a good appetite. . . . has been off his Zoloft since August and it seems that he was weaned off that medication after he had a fainting spell. . . . discuss that there is a possibility that we are just starting to see the effects of the patient not being on Zoloft. . . . he could also have a possible UTI [urinary tract infection]. . . . DIAGNOSES AND TREATMENT PLAN: . . . continue all his current psychiatric medication. . . . order a UA [urinary analysis] with micro [microanalysis] and will wait the results of that until deciding what to do with the patient's medication. . . ." Review of nurses notes identified the resident's physician reviewed the UA results and did not treat the resident for a UTI. Resident #1's monthly drug regimen review stated on: * 01/14/11 "Psych following [arrow up] behavior issues" * 06/20/11 "AIMS done 5/23/11 no comment" * 09/02/11 ". . . on Haldol 0.5 mg TID and Risperdal 0.25 Q AM 0.5 Q PM no comment. . ." * 11/03/11 "AIMS due November no comment" Resident #1's drug review lacked any other mention of the antipsychotics, or GDR for the past year. Resident #1's physician's progress notes failed to provide clinical rationale for the continued use of the Haldol and Risperdal or the contraindications for a dose reduction attempt for Resident #1 who has been on the same dose of Risperdal since 02/15/10 and the same dose of Haldol since 05/05/2010.	F 329		

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F 329	Continued From page 25 During an interview on 12/20/11 at 8:35 a.m., an administrative staff nurse (#2) reported that the facility had not considered a dose reduction for Resident #1. During an interview in the afternoon of 12/20/11, the administrative nurse (#2) and an administrative social services staff member (#10) lacked awareness of the last time Resident #1's behavior charting had been reviewed, and reported Resident #1 had not been seen via telemedicine by a psychiatrist since January 2011. Failure to attempt a GDR of Resident #1's Haldol and Risperdal may have resulted in the resident receiving an unnecessary medication for a prolonged period of time in the absence of monitoring or adequate indications. - Review of Resident #7's medical record occurred on all days of survey. Current diagnoses included anxiety, depressive disorder, congestive heart failure, status post (s/p) myocardial infarction, stent replacement, and s/p cerebrovascular accident. Current medications included Seroquel (an antipsychotic) 25 mg two times a day, and Celexa (an antidepressant) 10 mg every evening, both initiated on 09/28/10. The resident's annual MDS, dated 10/23/11, identified resident #7 as able to make herself understood, able to understand others, and highly visually impaired. An annual MDS, dated 10/23/11, identified the resident "feeling tired and having little energy" "2-6 days (several days)" a week and no other indications of mood or behavioral symptoms.	F 329	Resident #7 Refer to Exibit F329 #2 Resident#7	1/24/2012

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F 329	Continued From page 26 Review of Resident #7's care plan identified the problem of "[RESIDENT HAS HISTORY OF ANXIETY AND DEPRESSION BECOMES ANXIOUS WHEN SHE DOES NOT FEEL WELL" with approaches of "1. PSYCHOTROPIC MEDICATION AS ORDERED. 2. MONITOR FOR S/S [SIGNS/SYMPTOMS] ANXIETY- ASST. [ASSIST] TO CALM RESIDENT AS ABLE. 3. MONITOR FOR ADVERSE SIDE EFFECTS - TREMORS, ORTHOSTATIC HYPOTENSION, DRY MOUTH, NAUSEA, VOMITING, ANORXIA [sic], CONSTIPATION, RASH. 4. TELEMED [TELEMEDICINE] SESSIONS DR. [DOCTOR] [PSYCHIATRIST NAME] AS NEEDED/RECOMMENDED. . . . 7. KEEP FAMILY, MD [MEDICAL DOCTOR] INFORMED OF BEHAVIOR, MOOD." Review of Resident #7's Social Service Notes stated the following: * 04/27/11: "Quarterly MDS . . . scored a 14 on BIMS [brief interview of mental status] and 4 on PHQ-9 [staff assessment of resident mood - minimal depression score]. She states she sleeps to much at times. . . . No behavior problems. . . ." * 06/15/11: ". . . daughter . . . no longer wants [resident] . . . taken to any telemed appointments. She stated she feels her mom is doing well now and stated she thinks she had problems when she had infection. I told her that we will cancel, but if we feel she needs to be seen in the future we will contact her. . . ." The notes lacked evidence of the resident displaying any behaviors the entire quarter. * 07/26/11: ". . . Quarterly MDS . . . Resident scored an 11 on BIMS moderate impairment and a 4 on PHQ-9 minimal depression. She has had	F 329		

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F 329	Continued From page 27 no behavioral problems in this time frame. She states is feeling pretty good. She does have some occasional confusion. . . ." * 10/24/11: "Annual MDS. Resident scored a 11 on BIMS moderate impairment, no Delirium, She scored a 1 on PHQ-9 minimal depression. She is doing well is somewhat forgetful and occasional confusion. . . ." The notes lacked evidence of the resident displaying any behaviors the entire quarter. Review of CNA behavior flow sheets from October 1, 2011 through December 19, 2011 for Resident #7 lacked evidence of mood and behavior problems: Review of Resident #7's March 2011 mental health service (telemed) notes stated, "overall the patient has been really doing well and the patient stated that except for the pain in her hand, she noted that overall she is doing okay and has no concerns. . . . She sleeps well during the night . . . Overall the patient is doing well and seems to be tolerating the medication well . . ." The resident's daughter requested the resident seen once yearly by the mental health service in June 2011. Resident #7's physician's progress notes failed to provide clinical rationale for the continued use of the Seroquel or the contraindications for a dose reduction attempt for Resident #7 who has been on the same dose of Seroquel since 09/28/10. During interview on the afternoon of 12/20/11, an administrative social services staff member (#10) stated she reviewed all residents on psychotropic medications, however, did not review Resident #7's psychotropic medications. The staff member	F 329		

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F 329	Continued From page 28 (#10) stated Resident #7 does not have any behaviors. Failure to attempt a GDR of Resident #7's Seroquel may have resulted in the resident receiving an unnecessary medication for a prolonged period of time in the absence of adequate indications.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of monthly pharmacy review forms, and staff interview, the facility's consultant pharmacist failed to identify medication regimen irregularities for 2 of 10 sampled residents (Resident #1 and #7). Failure to recognize and report the need for an attempt at a gradual dose reduction for psychotropic medications and failure to recommend lab monitoring after a dose reduction of potassium chloride could result in residents receiving unnecessary medications and experiencing adverse consequences related to these medications.	F 428	F428 It is the policy of the Ashley Medical Center that the drug regime of each resident must be reviewed at least monthly by a licensed pharmacist 1. The Pharmacist Consultant was informed of the repeat deficiency addressing free of unnecessary drugs on 1/11/2012. 2. The Pharmacist Consultant will be addressing GDR with each monthly drug review regime. This information will be given to the DON, who in turn will be reporting the information to the Charge Nurse and the LSW. The nurses will address the request for GDR to the primary physician. The LSW will address the GDR attempts with those residents scheduled for Psych telemeds. The attempts will be addressed with the psychiatrist, Dr. Capon at the resident's earliest Psych. telemed and/or to indicate the attempt may be clinically contraindicated.	1/24/2012

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F 428	Continued From page 29 Findings include: Review of an undated policy titled "Consultant pharmacist services provider requirements" occurred on 12/20/11. This document stated, "Procedure . . . C. The consultant pharmacist agrees to render the required service in accordance with local, state, and federal laws, regulations and guidelines; facility policies and procedure; community standards of practice and professional standards of practice. . . . E. The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility. This may include but is not limited to: 1) Working with facility staff on . . . implementation, evaluation, and revision of pharmaceutical services procedures that reflect current standards of practice. . . . 6) Assist in identifying a current medication references to facilitate medication information on contraindications, side effects and/or adverse effects, dosage levels and other pertinent information. . . . F. Specific activities that the consultant pharmacist performs includes . . . 1) reviewing the medication regimen (medication regimen review) of each resident at least monthly . . . and documenting the review and findings in the resident's medical record. 2) Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings related to medication use at least monthly. . . ." Review of an undated facility policy titled "Medication Management" occurred on 12/20/11. This policy stated "Policy . . . facility staff, the attending physician/prescriber, and the consultant	F 428	3. The Consultant Pharmacist will be reviewing medication orders and reviewing for lab orders with medication drug reduction and will recommend a follow up lab after this dose reduction. Resident #7 Refer to response #1,2, & 3. A follow up K+ level was done. Resident #1 Refer to response #1 and #2. QA will be done monthly x3, then quarterly x1 year. Responsible parties: DON, LSW, and Pharmacist Consultant	1/24/2012

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F 428	Continued From page 30 pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use. When selecting medications and nonpharmacological interventions, members of the interdisciplinary team participate in the care process to identify, assess, address, advocate for, monitor, and communicate the resident's needs and changes in condition. . . ." - Review of Resident #7's medical record occurred on all days of survey. Medications included Seroquel (an antipsychotic) 25 milligrams (mg) two times a day, initiated on 09/28/10. Review of Resident #7's physician progress notes failed to provide clinical rationale for the continued use of the Seroquel. Although the facility's consultant pharmacist reviewed Resident #7's medications monthly, the pharmacist failed to report the drug regimen report irregularity (the failure to do a GDR on an antipsychotic) to the physician and director of nursing. Record review identified Resident #7's physician decreased the resident's dose of Potassium Chloride (KCL) 10 milliequivalent (mEq) to every other day on 08/09/11 without orders for a recheck. Record review showed Resident #7 received a Chemistry panel laboratory checks every six months (next scheduled for February). The pharmacist failed to recommend a follow up lab after the dose reduction. During an interview on 12/19/11 at 2:20 p.m., an administrative staff nurse (#2) stated she would have expected the consultant pharmacist on the follow-up review to address the need for lab	F 428		

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F 428	Continued From page 31 monitoring after the medication change. - Review of Resident #1's medical record occurred on all days of survey. Current medications included Risperdal (an antipsychotic) 0.25 mg every AM (morning) and 0.5 mg every night initiated on 02/15/10, and Haldol (an antipsychotic) 0.5 mg three times a day initiated on 05/05/2010. During an interview in the afternoon on 12/20/11, the administrative staff nurse (#2) stated the facility relies on the consultant pharmacist to inform them when residents need a gradual dose reduction of their psychotropic medications. Although the facility's consultant pharmacist reviewed Resident #1's medications monthly, the pharmacist failed to report the drug regimen irregularity (the failure to do a GDR on antipsychotics) to the physician and director of nursing.	F 428		
F 441 SS=E	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	F441 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.	

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F 441	Continued From page 32 (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, facility policy review, and staff interview, the facility failed to follow accepted infection control practices for hand hygiene and glove usage on 3 of 3 days of survey (December 18-20, 2011). Failure to follow proper hand hygiene after assisting with personal cares and before administering medications has the potential to contaminate clean surfaces and clothing and to spread infection to residents, visitors, and staff. Findings include:	F 441	1. In-servicing of the nurses and CMA on 1/17/2012 and the CNA's on 1/18/2012 regarding proper hand washing before and after using gloves will be presented by the infection control nurse. 2. New employees will be in-serviced with orientation videos. 3. Infection control and hand hygiene will be addressed yearly. 4. The CNA helpers will be instructed to attend the meeting on 1/18/2012. 5. Handouts will be provided. 6. The proper and appropriate area for gloves to be worn will be addressed. 7. Staff will be in-serviced addressing: a. Hand hygiene before and after resident contact when administering medication. b. After providing peri cares and toileting with voiding or bowel movement, discard the soiled gloves and wash hands with soap and water. Wash hands with soap and water before leaving the resident's room, dressing the resident, providing drinking water, touching the resident's straw, touching the inside bathroom handle, etc.	1/24/2012

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F 441	Continued From page 33 Review of a facility policy, "Hand Hygiene," occurred on 12/20/11. This undated policy 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 resident contact . . . Before and after assisting a resident with personal care . . . Before and after assisting a resident with toileting*. . . After handling soiled or used linens . . . After performing personal hygiene actions . . . After removing gloves or aprons . . . Note: * These situations require that hands must be washed with soap and water. . . ." Review of the facility "Procedure for Incontinent/Perineal Care" occurred on 12/20/11. This undated policy stated, ". . . wash hands or use alcohol hand sanitizer. Apply gloves. . . . Remove gloves and wash hands. Return resident to clean, comfortable position. Clean resident's unit, provide clean linen as needed, and return items to appropriate place. Wash hands. . . ." - Observation of medication pass on 12/18/11 at 5:10 p.m., showed a certified medication aide (CMA) (#6) passing medications to residents in the dining room. The CMA (#6) carried a used water glass to the sink area within the dining room. The CMA (#6) returned to the medication cart and without observed hand hygiene prepared and completed medication administration to three residents. The CMA (#6) failed to perform hand hygiene between these three residents. During an interview on 12/19/11 at 5:35 p.m., an administrative nurse (#2) stated the expectation is	F 441	Regarding CMA #6 The agency the CMA is employed with was contacted on 12/21/2011 at 2:30 pm to inform the agency of the deficiency. They will as well continue to educate their staff regarding hand hygiene protocol and that hand hygiene between residents is required as there is hand sanitizer in the medication cart.	1/24/2012

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F 441	Continued From page 34 for the CMA to perform hand hygiene after touching used dishware during the medication pass. This staff member (#2) stated hand hygiene with hand sanitizer would have been sufficient, and facility staff keep a supply of hand sanitizer on the medication cart. - Observations of improper glove usage and hand hygiene after personal cares occurred on all days of survey and included the following: * 12/18/11 at 2:25 p.m.: After providing pericares to Resident #1 , a CNA (#8) pulled up the resident's incontinence product and pants, placed the lift sling under the resident, and then removed her gloves. Without washing her hands, the CNA placed a shoe on the resident's left foot and used a Hoyer lift (with the assistance of another CNA) to transfer the resident to his wheelchair. While Resident #1 sat in his wheelchair, the CNA (#8) tucked in his shirt, folded blankets on his bed, opened the room door, and took a bag of garbage to the dirty utility room. The CNA (#8) failed to perform hand hygiene after pericares. * 12/18/11 at 3:55 p.m.: After assisting Resident #7 with toileting (which including voiding), a CNA (#12) performed pericares and removed her gloves. Without washing her hands, the CNA (#12), with assistance of another CNA (#11), transported Resident #7 by wheelchair back to the room from the bathroom. The CNA (#12) combed the resident's hair, placed the resident's glasses on her face, pulled the privacy curtain between the resident and her roommate, returned to the bathroom, picked up the garbage bag and contents out of the garbage can (included the soiled brief the resident wore), walked to the	F 441	12/18/2011 2:25 pm CNA #8 after providing peri cares to resident #1 should have discarded the gloves and wash their hands before proceeding to continue with the other cares and before leaving the resident's room. Also refer to response F441 #7 (b). 12/18/2011 3:55 pm Resident #7, CNAs #11 & #12 - Refer to F411 #7 (b)	1/24/2012 1/24/2012

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F 441	Continued From page 35 soiled utility room outside of the resident's room, disposed of the garbage, and then washed her hands. * 12/19/11 at 8:45 a.m.: After providing pericares to Resident #1, a CNA (#21) pulled up the resident's incontinence product and pants, lowered the right side rail, and then took off her gloves. Without washing her hands, the CNA (#21) removed the battery from the Hoyer lift, opened the resident's room door, and left the room. The CNA (#21) failed to perform hand hygiene after she removed her gloves after providing pericares. * 12/19/11 at 8:50 a.m.: After assisting Resident #7 with toileting (which included a bowel movement), a CNA (#13) performed pericares and then removed her gloves. Without washing her hands, the CNA (#13), with the assistance of another CNA (#14), transported Resident #7 back to bed with a stand lift, removed the resident's glasses, raised a side rail, pulled the privacy curtain between the resident and her roommate, pushed the stand lift back to a storage space within the room, and then returned to the bathroom to wash her hands. * 12/19/11 at 10:35 a.m.: After assisting Resident #7 to the toilet and removing her soiled, wet brief, the CNA (#13) removed her gloves and failed to perform hand hygiene. The CNA (#13), while allowing the resident privacy in the bathroom, entered the resident's room, straightened the resident's bed linens with her hands. When the resident completed toileting, another CNA (#14) donned a pair of gloves, provided pericares, removed the gloves and failed to perform hand	F 441	12/19/2011 8:45 am Resident #1, CNA #21- Refer to F411 #7 (b) 12/19/2011 8:50 am Resident #7, CNAs #13 & #14 - Refer to F411 #7 (b) 12/19/2001 10:35 am Resident #7, CNAs #13 & #14 - Refer to F411 #7 (b)	1/24/2012 1/24/2012 1/24/2012

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	355091	A. BUILDING _____ B. WING _____	12/20/2011

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F 441	Continued From page 36 hygiene. The two CNAs (#13 and #14) then transported the resident (via stand lift) out of the bathroom to the room. The CNA (#14) positioned and straightened Resident #7's clothing in the wheelchair, provided the resident a drink of water including touching the resident's straw, combed the resident's hair, touched the stand lift, touched the bathroom door handles, and then entered the bathroom to wash her hands. The CNA (#13) then emptied the garbage with the soiled brief and announced she would go to the soiled utility room to wash her hands. Observation showed her carry the garbage to the soiled utility room across the hall, enter the soiled utility room and use a sink in the soiled utility room to wash her hands. * 12/19/11 at 1:10 p.m.: Two CNAs (#15 and #21) provided pericares for Resident #1 and both CNA's pulled up the resident's incontinence product and pants. The CNA (#15) placed the linen into a garbage bag, and the other CNA (#21) removed her gloves and took the linen out of the room. Continuing to wear her gloves, the CNA (#15) removed the resident's shoes. The CNA (#21) brought in a clean soaker pad and with the other CNA (#15), placed the pad under Resident #1 and pulled up a blanket over the resident. The CNA (#15) removed her gloves prior to taking the garbage and exiting the resident's room. The CNAs (#15 and #21) failed to provide hand hygiene prior to exiting the resident's room. * 12/20/11 at 8:25 a.m.: After providing pericares to Resident #8, a CNA (#7) pulled up the resident's incontinent product and pants and removed her gloves. Without washing her hands,	F 441	12/19/2011 1:10 pm Resident #1, CNAs #15 & # 21 - Refer to F411 #7 (b) 12/20/2011 8:25 am Resident #8, CNA #7 - Refer to F411 #7 (b)	1/24/2012 1/24/2012

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F 441	Continued From page 37 the CNA (#7) donned a second pair of gloves while using a stand lift to transport the resident back to his chair in the room. Once the resident sat in his chair, the CNA (#7) covered the resident with a blanket, gave him his remote control, and then removed her gloves. The CNA (#7) moved the resident's lift, moved the resident's wheelchair, scratched her face, and then proceeded to the bathroom to wash her hands. * 12/20/11 at 9:00 a.m.: After donning gloves and assisting Resident #9 to the toilet, the CNA (#8) removed the resident's brief, and placed the resident's pants wet with urine on his wheelchair. Without removing her gloves or washing her hands, the CNA obtained clean pants from the closet and placed them on the resident, while he sat on the toilet. The CNA (#8) took the wet pants from the wheelchair and placed them on the resident's bed. While wearing the same gloves, the CNA (#8) took Resident #9's electric razor, opened the bathroom door, and shaved the resident. The CNA left the bathroom, plugged the razor into an outlet, removed the resident's wheelchair pad and placed it on his bed, next to the wet pants. The CNA (#8) opened a dresser drawer to obtain a clean wheelchair pad and placed it on the wheelchair. The CNA picked up the pants and touched the wet area of the pants stating, "See it's wet here." After the resident finished toileting, the CNA (#8), wearing the same gloves, opened the bathroom door, provided pericares, and pulled up the resident's pants and brief. Again without removing her gloves and washing her hands, the CNA (#8) assisted the resident to his recliner via a mechanical stand lift, with the assistance of another CNA (#15). During	F 441	12/20/2011 9:00 am Resident #9, CNAs #8 & #15 - Refer to F411 #7 (b)	1/24/2012

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F 441	Continued From page 38 the transfer, the CNA (#8) touched the handle on the lift as well as the resident's left hand. The CNA (#8) removed the sling from behind the resident, pushed the button on the recliner to lower the resident, placed a blanket over him and a pillow behind his head. The CNA took the linen from the bed, placed it in a garbage bag and took it out of the resident's room to the dirty utility room. During this 25 minute observation, the CNA (#8) continued to wear the same gloves. * 12/20/11 at 9:05 a.m.: Observation showed two CNA's (#17 and #22) assisted Resident #10 to her bed using a mechanical Hoyer lift. The CNA (#22) removed Resident #10's incontinent product, which was wet with urine and a small amount of stool, and performed pericares. Without removing her gloves, the CNA (#22) opened the door of the room, and moved Resident #10's wheelchair into the hall, and wheeled the bath-chair into the room. With the same gloves on, she removed Resident #10's hearing aide, attached the Hoyer pad straps to the lift, and transferred the resident to the bath-chair. The CNA then left the room with a blanket, which had fallen on the floor, placed it in the soiled linen cart, and then used alcohol-based hand rub to sanitize her hands. During interview on 12/20/11 at 12:30 p.m., an administrative staff nurse (#2) stated she would expect staff to wash their hands after glove removal, upon completion of incontinence cares.	F 441	12/20/2011 9:05 am Resident #10, CNAs # 17 & #22 - refer to F411 #7 (b) QA will be done monthly x3, then quarterly x1 year Responsible parties: Infection Control Nurse, DON, Charge Nurse	1/24/2012
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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F 520	Continued From page 39 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON JANUARY 3-5, 2011. Based on review of North Dakota Department of Health (ND DoH), Division of Health Facilities provider files, and staff interview, the facility failed to ensure quality assurance activities as identified by the facility's plan of correction for the 01/05/11 recertification survey for 4 of 4 quarters in 2011 and failed to sustain compliance with federal requirements as evidenced by repeat citations at	F 520	F 520 The AMC Quality Assurance committee meets quarterly and consists of Administrator, Director of Nursing, Medical Staff representative and facility designated department heads, and the QA coordinator. Quality Assurance studies that are driven from deficiencies note by the survey will be monitored by QA coordinator. A list of deficiencies that have a QA study as plan of correction was made. (See exhibit F-520 #1) A checklist was developed to track the QA studies that need to be completed. (see exhibit F-520 #2) A list of deficiencies that have a QA study as plan of correction will be listed on a QA checklist. (see exhibit F520 #3) The checklist will be completed at quarterly QA meetings to assure required studies are completed as noted in plan of correction. Study will continue quarterly for one year.	1/24/2012

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F 520	Continued From page 40 F167, F250, F329 and F520. Failure to conduct quality assurance activities for analysis of quality issues may impact the quality of life for all residents. Findings include: - During an interview on 12/20/11 at 2:00 p.m., a quality assurance committee member (#3) reviewed the quality assurance committee meeting minutes and lacked quality assurance reports for the citations at F167 and F329. This committee member (#3) stated the facility failed to complete quality assurance activities as identified by the plan of correction for citations at F167 and F329 from the Health Survey completed 01/05/11. Review of the Health Survey report plan of correction, for the survey completed 01/05/11, showed the facility failed to complete quality assurance monitoring as identified for the citation at F520. - The facility's ND DoH, Division of Health Facilities provider file, reviewed in preparation for the survey, identified a citation at F167 regarding survey results in January 2011. The team identified current concerns with this requirement. Refer to F167. Review of the file also identified a citation at F329 regarding unnecessary drugs, antipsychotic drugs, dose reductions and behavioral intervention in January 2011. The team identified continued concerns with this requirement. Refer to F329.	F 520		

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F 520	Continued From page 41 Review of the file showed Health Survey reports from 01/07/09 and 01/21/10 showed the current citation at F250 medically related social services, reflected similar occurrences. Refer to F250. Failure to maintain compliance through quality assurance monitoring resulted in residents not receiving care and monitoring for inappropriate behavior.	F 520		