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 _____	C 06/20/2017

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 unannounced complaint survey conducted June 20, 2017, the sample included four (4) residents for focused review and two (2) closed records for review.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving	F 225		7/19/17

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

Electronically Signed | 07/12/2017

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F 225	Continued From page 1 abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, staff interview, and information received from the complainant, the facility failed to report and investigate a bruise/injury of unknown origin for 1 of 1 sampled resident (Resident #1). Failure to investigate and report circumstances surrounding	F 225	F 225 #1. Regarding specific corrective action for resident #1, facility incident report was completed on 7/9/17 and investigation process initiated/completed on 07/11/17.	

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F 225	Continued From page 2 a bruise and then a major injury for Resident #1, placed all residents at risk for abuse and/or neglect, and did not allow the facility to determine causative factors for the injury and implement corrective actions. Findings include: Review of the facility policy titled "Resident Abuse/Neglect" occurred on 06/20/17. This policy, revised January 2017, stated, ". . . All 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. . . . [Facility] will thoroughly investigate all alleged violations through established procedures and will prevent further potential abuse while the investigation is in process. The results of all investigations will be reported to the Administrator/Administrative Designee and to other officials in accordance with State law, including the North Dakota Health Department within 5 working days of the incident. . . . Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator and to other officials in accordance with state law, including the state survey and certification agency. . . . An injury of unknown origin is classified as such when both the following conditions are met: *The source of the injury was not observed by any person OR the source of the injury could not be explained by the resident; AND *The injury is suspicious because of the	F 225	#2. AMC will put in place the following interventions so that other residents are not affected by the same deficient practice. " At change of shift, the charge nurses will review high priority progress notes as well as the clinical alerts through the clinical dashboard to ensure all issues are addressed. " Certified Nursing Assistant (CNA) personnel will be re-educated by the EMR Coordinator & SNF DON on July 18, 2017 at the nurses/CNA meeting to document narrative custom alerts to ensure nurses/other staff are alerted through the clinical dashboard. " Facility incident reports will be reviewed at team meetings Monday thru Friday to ensure that appropriate interventions are in place. " Allegations of unknown source of injury and/or suspected abuse will be reported within 2 hours and/or not later than 24 hours with completion of investigation by facility within 5 days. " Abuse policy was updated on July 7, 2017 by LSW. " Staff will be re-educated on the reporting protocols of bruises by DON at the nurses/CNA meeting on July 18, 2017. " State reporting checklist of duties has been added to the initial allegation form as of July 7, 2017 to ensure the proper procedure is followed.	

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F 225	Continued From page 3 extent of the injury . . . 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 #1's medical record occurred on 06/20/17. Diagnoses included Alzheimer's disease, Parkinson's disease, dementia, weakness, glaucoma, and chronic fatigue. Quarterly Minimum Data Sets, dated 05/25/17 and 02/23/17, identified rarely/never for ability to understand or be understood by others, unclear speech, severely impaired vision, severely impaired for daily decisions, extensive assist with bed mobility, transfer, dressing, eating, and personal hygiene. Review of the progress notes identified the following: * 12/28/16 at 8:27 a.m. - Administered Aleve capsule 220 milligram (mg) as needed (PRN) "crushed and put in pudding for arm pain" * 12/28/16 10:28 a.m. - "Provider Visit . . . I saw this resident, [Resident Name] . . . had no falls or hospitalizations in the past 60 days. . . . is non verbal, staff deny any changes or concerns with patient. Review of Systems: Negative . . . Resident and nurse had no further questions or concerns. . . ." * 12/28/16 2:16 p.m. - [Family] phoned . . . with concern of resident's condition. Informed son did grimace with pain this am [morning] when sleeve to shirt applied to right arm and Aleve given at breakfast with relief. Also unformed [sic] son that resident seen today by FNP [family nurse practitioner] for 60 day check-up." * 12/28/16 at 5:59 p.m. - Administered Aleve	F 225	#3. Ashley Medical Center has put the above interventions in place including improvements to communication, documentation, and assessments to ensure that alleged violations are thoroughly investigated. Staff Nurse Education will be completed on 7/18/17 regarding completing a timely assessment upon notification of a concern. Staff Nurses & Aides will be re-educated on 7/18/17 by the EMR Coordinator on how to customize alerts that will flow to the clinical dashboard for nurse review. Staff Nurse Education will be provided on 07/18/17 on alleged violations reports and procedure to follow to comply with regulation. #4. The nurse shift audit will be implemented to document the observation of the clinical dashboard by the charge nurses. The process of QA will be done by the DON, utilizing clinical alert reporting and review of progress notes, ensuring alerts have been addressed. The QA will monitor all incidents of unknown origin, abuse, and neglect, ensuring all are reported and investigated per proper procedures. QA will be done weekly x 3, monthly x 3, and quarterly thereafter.	

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F 225	Continued From page 4 capsule 220 mg for right shoulder pain. Noted as effective at 6:31 p.m. * 12/29/16 at 8:29 a.m. - Administered Aleve capsule 220 mg for arm pain. Noted as effective at 9:30 a.m. * 12/29/16 at 11:09 a.m. - Communication with FNP regarding resident's complaint of pain that morning and order received for Aleve 220 mg daily in am for pain control * 12/29/16 at 11:58 p.m. - "Residents right wrist noted to be swollen with light tannish bruising visible. PRN Aleve given at HS [hour of sleep] with relief. . . ." * 01/03/17 at 2:58 a.m. - Weekly Progress Note "Received PRN Aleve x [times] 4 for pain to right wrist with some relief." * 01/07/17 1:00 p.m. - "Resident weak today and transferred with medi-lift and assist of 2." * 01/11/17 3:35 p.m. - ". . . FNP here to see resident regarding swelling and pain to Rt. [right] lower forearm/wrist area over a period of time. Noted to have more pain with touch today per CNA [certified nursing assistant] staff." * 01/11/17 5:25 p.m. - "FNP here to see resident again, results from Rt. wrist x-ray received at this time. . . . Noted to have Rt. wrist fracture at this time. . . . Rt. wrist splint in place for 6 weeks. . . ." * 01/11/17 6:19 p.m. - Provider note ". . . Staff called reporting swollen right wrist . . . Swollen for about 2 weeks. . . . Resident unable to say what happened. Has advanced dementia. . . . Right wrist tender to palpation. C/o [complains of] pain with rotation of wrist. Appears slightly swollen. . . . Fx [fracture] right wrist. . . . Family informed of fracture." * 01/17/17 at 3:00 p.m. - "[Family] here and inquired abt [about] resident's condition. Informed resident seemed to have pain to right wrist for abt	F 225	Responsible Party: DON	

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F 225	Continued From page 5 2 weeks and FNP saw her and ordered x-ray to right wrist and showed fx to wrist. Informed resident did not fall but does strike out at staff occasionally." During an interview on the afternoon of 06/20/17, an administrative nurse (#1) confirmed staff failed to complete an investigation on Resident #1's bruise and/or fracture. The facility failed to investigate and report Resident #1's injury of unknown origin to the State Survey Agency within the required timeframe and submit the follow-up report within five days.	F 225		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:	F 309		7/19/17

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F 309	Continued From page 6 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: PAIN 1. Based on record review, review of facility policy, staff interview, and information received from the complainant, the facility failed to provide the necessary care and services to maintain overall well-being for 1 of 1 sampled resident (Resident #1) who sustained a bruise of unknown origin with swelling to the area, complained of pain, and thirteen days later diagnosed with a fracture. Failure to investigate the bruise of unknown origin, and the continued pain and swelling in a timely manner resulted in a fracture not being diagnosed until approximately thirteen days later. Findings include: Review of Resident #1's medical record occurred on 06/20/17. Diagnoses included Alzheimer's disease, Parkinson's disease, dementia,	F 309	F 309 #1 Regarding corrective action, fracture has been resolved and pain monitoring will be ongoing using PAINAD scale. #2. AMC will put in place the following interventions so that other residents are not affected by the same deficient practice. " All nonverbal residents who have a new onset of pain will be provided a timely assessment using the PAINAD scale for cognitively impaired. Provider on call will be notified depending on assessment findings. " All scheduled pain medication started for new pain onset will be re-evaluated 30	

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F 309	Continued From page 7 weakness, glaucoma, and chronic fatigue. A quarterly Minimum Data Set, dated 02/23/17, identified rarely/never for ability to understand or be understood by others, unclear speech, severely impaired vision, severely impaired for daily decisions, extensive assist with bed mobility, transfer, dressing, eating, and personal hygiene, and daily pain assessed from resident's expression. Review of the progress notes identified the following: * 12/28/16 at 8:27 a.m. - Administered Aleve capsule 220 milligram (mg) as needed (PRN) "crushed and put in pudding for arm pain" (First time arm pain identified) * 12/28/16 10:28 a.m. - "Provider Visit . . . I saw this resident, [Resident Name] . . . had no falls or hospitalizations in the past 60 days. . . . is non verbal, staff deny any changes or concerns with patient. Review of Systems: Negative . . . Resident and nurse had no further questions or concerns. . . ." * 12/28/16 2:16 p.m. - [Family] phoned . . . with concern of resident's condition. Informed son did grimace with pain this am [morning] when sleeve to shirt applied to right arm and Aleve given at breakfast with relief. Also unformed [sic] son that resident seen today by FNP [family nurse practitioner] for 60 day check-up." (Provider did not address this pain) * 12/28/16 at 5:59 p.m. - Administered Aleve capsule 220 mg for right shoulder pain. Noted as effective at 6:31 p.m. (No documentation on how the shoulder pain was identified or the pain level.) * 12/29/16 at 8:29 a.m. - Administered Aleve capsule 220 mg for arm pain. Noted as effective	F 309	days after initiation for appropriateness and/or ongoing need. " Upon receiving a concern from an authorized representative, based on the release of information listing, the nurse will complete a timely evaluation with appropriate documentation on Family Communication Progress Note and provide feedback to authorized representative in a timely manner. #3. Ashley Medical Center has put the above interventions in place including improvements to communication, documentation, and assessments to ensure deficient practice will not recur. #4. QA will be done ensuring that all nonverbal residents are assessed for pain using the weights and vitals summary report. QA will be done to ensure that orders are reevaluated in 30 days. QA will be done assessing the high priority notes/Family Communication Progress Notes. QA will be done weekly x 3, monthly x 3, and quarterly thereafter. Responsible Party: DON #1. Resident #6 has expired. #2. AMC will put in place the following	

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F 309	Continued From page 8 at 9:30 a.m. (No documentation on how the shoulder pain was identified or the pain level.) * 12/29/16 at 11:09 a.m. - Communication with FNP regarding resident's complaint of pain and an order received for Aleve 220 mg daily in the am for pain control * 12/29/16 at 11:58 p.m. - "Residents right wrist noted to be swollen with light tannish bruising visible. PRN Aleve given at HS [hour of sleep] with relief. . . ." (No documentation regarding the investigation of the swelling/bruising or communication to the provider) * 01/03/17 at 2:58 a.m. - Weekly Progress Note "Received PRN Aleve x [times] 4 for pain to right wrist with some relief." * 01/07/17 1:00 p.m. - "Resident weak today and transferred with medi-lift and assist of 2." * 01/11/17 3:35 p.m. - ". . . FNP here to see resident regarding swelling and pain to Rt. [right] lower forearm/wrist area over a period of time. Noted to have more pain with touch today per CNA [certified nursing assistant] staff." * 01/11/17 5:25 p.m. - "FNP here to see resident again, results from Rt. wrist x-ray received at this time. . . . Noted to have Rt. wrist fracture at this time. . . . Rt. wrist splint in place for 6 weeks. . . ." * 01/11/17 6:19 p.m. - Provider note ". . . Staff called reporting swollen right wrist . . . Swollen for about 2 weeks. . . . Resident unable to say what happened. Has advanced dementia. . . . Right wrist tender to palpation. C/o [complains of] pain with rotation of wrist. Appears slightly swollen. . . . Fx [fracture] right wrist. . . ." * 01/17/17 at 3:00 p.m. - "[Family] here and inquired abt [about] resident's condition. Informed resident seemed to have pain to right wrist for abt 2 weeks and FNP saw her and ordered x-ray to right wrist and showed fx to wrist. . . ."	F 309	interventions so that other residents are not affected by the same deficient practice. " A Behavior Communication Slip has been created and staff is to complete and forward to LSW when resident exhibits behaviors. These Behavior Communication Slips are reviewed at the weekly behavior meeting and also forwarded to consulting psychiatrist. " Notes from AMC weekly behavioral meetings now available on PointClickCare/Point of Care (our EMR) for staff to view in the Communications section. Staff will be educated on this on July 18, 2017. " Upon nursing evaluation of an escalating behavior, all non pharmacological interventions will be documented using the Nurses PRN Monitoring Form in an attempt to alleviate behaviors. If these non pharmacological interventions are ineffective, the provider will be notified. " Staff will be re-educated on July 18, 2017 on assessment and documentation of behaviors that result in the initiation of non pharmacological interventions. When interventions are exhausted, provider contact will be initiated. As of 07/07/17 all PRN benzodiazepines have been discontinued. " Staff was educated on June 20, 2017	

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F 309	Continued From page 9 During an interview on the afternoon of 06/20/17, an administrative nurse (#1) confirmed staff failed to complete an investigation of Resident #1's initial and continued pain, bruising, and swelling, before the diagnosis of a right wrist fracture approximately thirteen days later. Failure to investigate Resident #1's pain and bruise/injury of unknown origin in a timely manner resulted in the resident's continued pain during the thirteen days before the x-ray and diagnosis of a fracture. BEHAVIORS 2. Based on record review, review of facility policy, and information received from the complainant, the facility failed to provide the necessary care and services to maintain overall well-being for 1 of 2 closed records (Resident #6) reviewed with a diagnoses of dementia and behavioral disturbances. Failure to monitor behaviors, provide non-pharmacological interventions, and consider the administration of a physician prescribed antianxiety medication (Ativan), may have resulted in Resident #6's increased behaviors and resulted in an increase of Risperdal, an antipsychotic medication. Findings include: Review of the facility policy titled "Psychotropic Medication Monitoring System" occurred on 06/20/17. This policy, dated November 2013, stated, ". . . The resident's mood/behaviors will be documented daily by CNA [certified nursing assistant] on CNA Flowsheet. The nurse will also	F 309	and will be re-educated on July 18, 2017 on the use of the Behavior Communication Slips. #3. Ashley Medical Center has put the above interventions in place including improvements to communication, documentation, and assessments in an attempt to alleviate increased behaviors and unnecessary use of antipsychotics. #4. LSW will continue to track behaviors through CNA charting, Behavior Progress Notes, and behavior slips to ensure that appropriate documentation is produced across the care continuum. QA weekly x 3, monthly x 3 and quarterly thereafter. Responsible Party: LSW	

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F 309	Continued From page 10 document any changes in mood/behavior in nurses notes or Weekly Progress Notes. . . ." Review of Resident #6's medical record occurred on June 20, 2017 and identified an admission date of 03/08/17. Diagnoses included anxiety, dementia with behavioral disturbances, and hallucinations. Medications on admission included Risperdal 0.25 milligrams (mg) twice a day (increased to 0.5 mg twice a day on 03/24/17), and Ativan 0.5 mg every 6 hours as needed (PRN). Resident #6's care plan stated, "[name] has history of delusions, anxiety, upsetting dreams. . . . 5-22-17 May have Ativan prn for anxiety . . . Interventions: Ativan prn for anxiety, agitation, restlessness . . ." Even though the provider ordered Ativan PRN on the resident's admission to the facility, the facility failed to included the antianxiety medication on her care plan until 05/22/17. Review of Resident #6's progress notes identified the following: * 03/18/17 (Saturday) at 12:08 a.m. - "Resident is waking up very confused. Resident said that people were stealing money and jewelry from the cart. She was wondering if her kids and her were safe. Resident was redirected and assured that she was safe. Will continue to monitor." * 03/21/17 (Tuesday) at 12:28 p.m. - "Faxed Dr. [name] with concerns regarding resident's hallucinations and delusions after discussing cares with staff. Reported that resident had rough weekend and was frequently crying stating that her spouse was 'throwing her babies out the window' or 'cheating with hooker.' Resident had these hallucinations in hospital as well. Awaiting correspondence back from Dr. [name]."	F 309		

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(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 309	Continued From page 11 A note to the provider, faxed 03/24/17 (Friday) at 3:45 p.m., stated, "This resident was just seen as a new patient of yours. She has been continuing to have hallucinations/delusions. Was reported by staff to LSW [licensed social worker] that over the weekend resident became very upset, crying and accusing spouse of being with another woman and stating that he was with 'hookers' and 'throwing my babies out the window.' She also stated she was walking down the hall (resident unable to walk as she has undergone amputation) and a man was following her and exposed himself to her. . . . Her current psychotropic medications are: . . . Risperidone [Risperdal] 0.25 mg BID [twice a day] [and] PRN Ativan 0.5 mg every 6 hours as needed." The provider responded on 03/24/17 and stated, "increase Risperdal to 0.5 mg BID." The facility failed to locate and provide the CNA flowsheets for the weekend of March 17-19, 2017, additional nurses' notes which showed Resident #6's increased behaviors, and the non-pharmacological interventions attempted to alleviate the behaviors. Review of Resident #6's March 2017 medication administration record (MAR) showed an order for Ativan 0.5 mg every 6 hours as needed for anxiety. The facility failed to administer the medication even though the progress notes and the faxed note to the provider identified increased behaviors. Facility staff failed to document Resident #6's behaviors and identify interventions provided/attempted to alleviate the behaviors,	F 309		

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 _____	C 06/20/2017

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F 309	Continued From page 12 provide non-pharmacological interventions, and consider the administration of Ativan. These failures resulted to the increase of Risperdal, an antipsychotic medication.	F 309		