STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355091	A. BUILDING _____ B. WING _____	01/12/2017

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 standard Medicare/Medicaid recertification survey started on 01/09/17 and completed on 01/12/17, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 203 SS=D	483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (b)(5) of this section. (c) (4) Timing of the notice. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 203		2/16/17

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

Electronically Signed | 01/27/2017

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F 203	Continued From page 1 resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (b)(1)(ii)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (b)(1)(ii)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (b)(1)(ii)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (b)(1)(ii)(A) of this section; or (E) A resident has not resided in the facility for 30 days. (c) (5) Contents of the notice. The written notice specified in paragraph (b)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which	F 203		

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F 203	Continued From page 2 receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. (c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. (c)(8) Notice in advance of facility closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State	F 203		

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F 203	Continued From page 3 Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and staff interview, the facility failed to notify 1 of 1 closed record resident (Resident #10) and the resident's family/legal representative, in writing, of a discharge, including the destination and the reason for the discharge, and the resident's right to appeal the action. Findings include: Review of the facility policy, titled, "Discharge of a Resident" occurred on 01/11/2017. This policy, revised 02/23/15, stated, "Purpose: to ensure the resident a safe and courteous departure. . . . A. Complete a Discharge Notice for office and Notice of Transfer or Discharge. The original notice must be given to the resident with a copy to the resident family/legal representative and a copy placed in the residents medical record. . . ." Review of Resident #10's medical record occurred on 01/11/17, and identified the facility discharged the resident home on 08/08/16. The record lacked evidence the facility provided the resident and the resident's family with a written notice of discharge. During an interview on the afternoon of 01/11/17, a medical records staff member (#2) confirmed Resident #10's medical record lacked a discharge notice.	F 203	F203 Notice Requirements Before Transfer/Discharge It is the policy and practice of the Ashley Medical Center to permit each resident to remain in the facility and not to transfer or discharge the resident unless required due to resident□s condition/behaviors, he or she has failed to pay or the facility ceases to operate. At least 30 days in advance or as soon as practicable before a transfer or discharge, Social Services must submit notice to the resident, their family member or legal representative that the transfer or discharge is to occur using the appropriate form that includes information regarding their right to appeal the transfer or discharge. A copy is to be given to the resident or their representative, kept in the medical record and submitted to the Office of the State LTC Ombudsman. Failure to provide this notice is a violation of the resident□s rights to appeal. All residents at AMC have the potential to be affected by the absence of proper notification of discharge or transfer. The facility will ensure that all residents who are transferred or discharged are given the proper notice as the current	

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F 203	Continued From page 4	F 203	Admission/Transfer/Discharge Policy has been revised to reflect changes making the Social Services Department responsible for giving the notice to the resident or their representative. Nursing staff will be updated on new procedure on 2/3/17. QA study will be monthly x3, quarterly x3 for swingbed and SNF residents to ensure proper procedure is followed and appropriate notices are given. Responsible Party: LSW	
F 226 SS=C	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also	F 226		2/16/17

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F 226	Continued From page 5 provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on review of facility policies and procedures, and staff interview, the facility failed to review and revise their written abuse prevention policies/procedures to include and ensure that nursing home staff are prohibited from taking or using photographs or recordings in any manner that would demean or humiliate a resident(s); and failed to provide staff education on this topic. Failure to review and revise their written abuse prevention policies/procedures; and failure to provide staff education on the need to protect each resident's privacy and prohibit mental abuse related to photographs and audio/video recordings has the potential for unauthorized, demeaning and/or humiliating photographs or videos of residents to be taken and/or used. Findings include: The Centers for Medicare and Medicaid Services (CMS) has identified nursing home staff includes employees, consultants, contractors, volunteers,	F 226	F226 Develop/Implement Abuse/Neglect Policies It is the policy of the Ashley Medical Center to develop and implement policies and procedures that prohibit and prevent verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion and misappropriation of property and establish investigative protocol that will occur should an allegation be made. All facility staff will receive training upon hire and annually, or as needed, on the facility□s established abuse policy and procedures. All residents at AMC have the potential to be victims of abuse, neglect or misappropriation of property. The facility will ensure that all residents are protected from abuse, including mental abuse caused by facility staff taking or using photographs or video recordings in a	

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F 226	Continued From page 6 and other caregivers who provide care and services to residents on behalf of the facility; and that the facility policies/procedures should reflect any type of equipment (e.g., cameras, smart phones, and other electronic devices) used to take, keep, or distribute photographs and recordings on social media. Review of the facility's policies/procedures on abuse prohibition occurred on the morning of 01/10/17. These policies/procedures failed to include and ensure that nursing home staff are prohibited from taking or using photographs or recordings in any manner that would demean or humiliate residents. During an interview on 01/10/17 at 2:25 p.m., two administrative staff members (#1 and #9) confirmed the facility lacked policies/procedures to include and ensure that staff are prohibited from taking or using photographs or recordings in any manner that would demean or humiliate residents, and failed to educate staff on this subject.	F 226	manner that is demeaning or humiliating by updating the current AMC Abuse/Neglect Policy and Social Networking and Social Media Policy (see attached). All facility staff will review the updated policies and complete verification that they have received such training. This training will be completed by February 16th for all current staff and will be included in new-hire packets for all new employees to review. QA study will be done monthly x 3, quarterly x3 to ensure that all necessary individuals have reviewed the revised policy and that any new staff are given above policies upon hire. Responsible Party: Social Services, LSW	
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed.	F 278		2/16/17

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F 278	Continued From page 7 (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: TURNING/REPOSITIONING PROGRAM 1. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 2 of 2 sampled residents on turning and repositioning program (Resident #4 and #5). Failure to code portions of the MDS correctly for items related to turning/repositioning does not provide an accurate assessment of a resident's current status and needs.	F 278	F 278 Accuracy of MDS It is the policy of the Ashley Medical Center to follow regulations of the Center for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument User'□s Manual for completion of the MDS 3.0. An item should not be coded unless it meets requirements outlined in the manual. A modification was completed on the significant change MDS for Resident #4	

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F 278	Continued From page 8 Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2016, pages M 38-39 stated, ". . . M1200C Turning/Repositioning Program: The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., [example given] reposition on side, pillows between knees) and frequency (e.g., every 2 hours). . . ." - Review of Resident #4's medical record occurred on January 09-11, 2017. The significant change MDS, dated 07/21/16, identified extensive assistance of one person required for bed mobility/transfers and on a turning/repositioning program. Resident #4's current care plan stated ". . . Focus . . . Risk for skin breakdown d/t [due to] decreased mobility, occasional urinary incontinence. . . . Interventions . . . Assist with repositioning as needed to ensure that [name of resident] is turned/repositioned at least every 2 hours. . . ." The CNA [certified nursing assistant] Flowsheet identified staff did not reposition Resident #4 during the seven day look-back period. The resident's medical record failed to identify an individualized repositioning program. - Review of Resident #5's medical record occurred on January 09-11, 2017. The significant change MDS, dated 07/21/16, identified extensive assistance of one person required for bed mobility/transfers and on a turning/repositioning program. Resident #5's current care plan stated ". . . Focus . . . has a self	F 278	with ARD date 7-21-16 to remove coding of M1200c. The modification was submitted to the CMS QIES and North Dakota Department of Human Services on 1-18-17. A modification was completed on the quarterly MDS for Resident #5 with ARD date 5-12-16 to remove coding of M1200c. The modification was submitted to the CMS QIES and North Dakota Department of Human Services on 1-18-17. MDS Coordinator reviewed the most current MDS for all residents and no other residents were found to be coded for M1200c. Review completed on 1-13-17 To assist in documentation of a turning/repositioning program, a template was added to the Electronic Medical Record (EMR) Point of Care for staff to include prompting for the turning/repositioning, the position resident turned to and time of turning/repositioning. Staff educated on importance of turning/repositioning and how to document turning/repositioning on the EMR. Education completed on 1-24-17 at nurse/CNA meeting.	

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F 278	Continued From page 9 care deficit and activity intolerance and some cognitive impairment. . . . Has impaired mobility, activity intolerance d/t [due to] various medical diagnoses. . . . Interventions . . . Bed mobility: needs extensive assist with bed mobility, repositioning. Turn/Reposition at least every 2 hours. . . ." The CNA Flowsheet identified staff did not reposition Resident #5 during the seven day look-back period. The resident's medical record failed to identify an individualized repositioning program. During an interview on the afternoon of 01/11/17, an administrative nurse (#8) confirmed Resident #4 and #5's medical record lacked sufficient evidence to support the coding of a turning/repositioning program on the MDS. ITEM Z0400 (ATTESTATION STATEMENT) 2. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility failed to use the entire required days of observation when completing Minimum Data Set (MDS) items on 9 of 9 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8 and #9), excluding demographic items and resident interview items in sections C, D, F and J. Failure to collect assessment information for the entire required observation period may result in an incomplete and/or inaccurate assessment of the resident. Findings include: The Long-Term Care Facility RAI User's Manual, page A-31 stated, ". . . As the last day of the	F 278	A QA study will be conducted to monitor that any residents coded for turning/repositioning program meets criteria outlined in RAI User'□s Manual. Study will be conducted weekly x 4, biweekly x3, monthly x 3, and quarterly x 3. Responsible party: MDS Coordinator. It is the policy of the Ashley Medical Center to follow regulations of the Center for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument User'□s Manual for completion of the MDS 3.0. Information on the MDS must be collected and dated following the guidelines established in the CMS Long Term Care Facility Resident Assessment Instrument User'□s Manual for completion of the MDS 3.0. Resident interviews are to be conducted during the reference period; demographics may be completed during the reference period; all staff interview and other MDS items must not be coded until after the ARD date. The MDS Coordinator educated staff completing portions of the MDS 3.0 on the acceptable completion dates and signature dates for Z0400. Staff education was completed on 1-23-17. All residents in the facility require completion of MDS assessments at intervals set in accordance with CMS guidelines. All items must be coded and	

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F 278	Continued From page 10 look-back period, the ARD [Assessment Reference Date] serves as the reference point for determining the care and services captured on the MDS assessment . . . For example, the MDS item with a 7-day look-back period ending on and including the ARD which is the 7th day of this look-back period . . . The look-back period includes observations and events through the end of the day (midnight) of the ARD . . ." Therefore, the earliest you can code items with a look-back period and attest to the accuracy in Z0400 would be the day after the ARD. Each person completing a section of the MDS is required to sign the attestation statement (Z0400) as identified on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . "Page Z-7 stated, ". . . All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed . . . "Legally, item Z0400 is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. - Review of Resident #1's medical record occurred January 09-11, 2017. A quarterly MDS with an ARD date of 10/22/16 identified the following: * Sections/Items in G0300, G0400, O0400, and O0420 completed with a Z0400 date of 10/22/16. * Sections/Items in K0510 and K0710 completed with a Z0400 date of 10/13/16. * Sections/Items in K0100, K0510, and K0710 completed with a Z0400 date of 10/20/16. * Sections/Items in B, L, C1310, Q0400, and	F 278	dated on MDS for all residents in the facility in accordance with CMS guidelines. A QA study will audit signature dates in section Z0400 to verify completion is done on appropriate dates. Study will be completed weekly x 4, biweekly x 3, monthly x 3, and quarterly x 3. Responsible party: MDS Coordinator.	

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F 278	Continued From page 11 Q0600 completed with a Z0400 date of 10/21/16. - Review of Resident #2's medical record occurred January 09-11, 2017. A significant change MDS with an ARD dated of 11/03/16 identified the following: * Sections/Items K0510 and K0710 completed with a Z0400 date of 10/31/16. * Sections/Items in B and L completed with a Z0400 date of 11/02/17. * Sections/Items in C1310, Q0400, and Q0600 completed with a Z0400 date of 11/03/16. - Review of Resident #3's medical record occurred January 09-11, 2017. A quarterly MDS with an ARD date of 12/16/16 identified the following: * Sections/Items in C1310, Q0400, and Q0600 completed with a Z0400 date of 12/15/16 * Sections/Items in B and L completed with a Z0400 date of 12/16/16. - Review of Resident #4's medical record occurred January 09-11, 2017. A quarterly MDS with an ARD date of 11/07/16 identified the following: * Sections/Items in C1310, G0300, G0400, O0400, O0500, Q0400, and Q0600 completed with a Z0400 date of 11/7/16. * Sections/Items in B and L completed with a Z0400 date of 11/07/16. - Review of Resident #5's medical record occurred January 09-11, 2017. A quarterly MDS with an ARD date of 11/10/16 identified the following: * Sections/Items in B, C1310, L, Q0400, and Q0600 completed with a Z0400 date of 11/10/16.	F 278		

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	355091	A. BUILDING _____ B. WING _____	01/12/2017

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F 278	Continued From page 12 - Review of Resident #6's medical record occurred January 09-11, 2017. A quarterly MDS with an ARD date of 11/15/16 identified the following: * Sections/Items in G0300, G0400, O0400, and O0500 completed with a Z0400 date of 11/14/16. * Sections/Items in B, C1310, L, Q0400, and Q0600 completed with a Z0400 date of 11/15/16. - Review of Resident #7's medical record occurred on 01/11/17. A quarterly MDS with an ARD date of 12/19/16 identified the following: * Sections/Items in B, C1310, L, Q0400, and Q0600 completed with a Z0400 date of 12/19/16. - Review of Resident #8's medical record occurred on 01/11/17. An annual MDS with an ARD date of 12/13/16 identified the following: * Sections/Items in K0510 and K0701 completed with a Z0400 date of 12/08/16. * Sections/Items in C1310 and F completed with a Z0400 date of 12/12/16. * Sections/Items in B, L, Q0400, and Q0600 completed with a Z0400 date of 12/13/16. - Review of Resident #9's medical record occurred on 01/11/17. The quarterly MDS with an ARD date of 01/01/17 identified the following: * Sections/Items in B and L completed with a Z0400 date of 12/29/16. * Sections/Items in C1310, Q0400, and Q0600 completed with a Z0400 date of 12/30/16. During an interview on the afternoon of 01/11/17, an administrative nurse (#8) stated she was unaware that some MDS sections should not be	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 13 completed prior to midnight of the ARD date.	F 278		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much	F 315		2/16/17

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	355091	A. BUILDING _____ B. WING _____	01/12/2017

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F 315	Continued From page 14 normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide appropriate perineal cares for 3 of 7 sampled residents (Resident #4, #5, and #6) observed during personal cares. Failure to provide appropriate perineal cares may result in urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Incontinence/Perineal Care" occurred on 01/11/17. This policy, revised October 2015, stated, ". . . The perineal area is a primary portal of entry for bacterial [sic] into the urinary tract, potentially causing infection. . . . Method 1. Wash the peri area. a. For female residents: Separate the labia, clean with moistened wipe, moving front to back, on each side of the labia and in the center over the urethra and vaginal opening, using a clean area of the wipe for each stroke. Always work from front to back . . ." - Review of Resident #4's medical record occurred on January 09-11, 2017. The quarterly Minimum Data Set (MDS), dated 11/07/16, identified extensive assistance of one person with toileting. Observation on 01/11/17 at 8:47 a.m. showed a certified nurse assistant (CNA) (#12) provide perineal cares for Resident #4. The CNA (#12) gloved both hands and wiped the perineal area from back to front with a moistened wipe.	F 315	F 315 No Catheter, Prevent UTI, Restore bladder page 13 The perineal area is a primary portal of entry for bacteria to enter into the urinary tract, potentially causing infection. Therefore, it is important that residents receive appropriate perineal care with less potential to introduce bacteria. It is the policy of the Ashley Medical Center that residents who require assistance with perineal care with follow the appropriate procedure. For residents #4, and #5, direct observation of perineal cares will be done. Resident #6 expired. The facility will ensure that staff are providing appropriate perineal cares to other residents who are requiring assistance. Education will be provided to staff at the monthly staff meeting (January 24, 2017.) Return demonstration will be done at the monthly meeting in February 2017. A QA will be done through direct observation of resident #4 and #5, and random choice of others who require assistance with perineal cares weekly x4, monthly x3 and quarterly x3. Responsible Party: DON	

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F 315	Continued From page 15 - Review of Resident #5's medical record occurred on January 09-11, 2017. The quarterly MDS, dated 11/07/16, identified extensive assistance of one person with toileting. Observation on 01/11/17 at 8:51 a.m. showed a CNA (#12) provide perineal cares for Resident #5. The CNA (#12) applied gloves, assisted the resident to a standing position, and wiped from back to front using a moistened wipe and then continued wiping back and forth using the same side of the wipe. - Review of Resident #6's medical record occurred on 01/11/17. Diagnoses included a current urinary tract infection (UTI). The quarterly MDS, dated 11/15/16, identified extensive assistance of two people and frequently incontinent. Observation on 01/11/17 at 9:03 a.m. showed two CNAs (#3 and #12) provided perineal cares for Resident #6. Both CNAs (#3 and #12) assisted Resident #6 to a standing position while a CNA (#12) wiped the perineal area from back to front using a moistened wipe. During an interview on 01/11/17 at 1:55 p.m. an administrative nurse (#1) stated she expected staff to wipe from front to back when performing perineal cares.	F 315		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free	F 323		2/16/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 16 from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE STANDARD SURVEYS COMPLETED ON 02/11/16 AND 01/08/15. GAIT BELT TRANSFERS 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate superivsion and and assistive devices necessary to prevent accidents for 2 of 3 sampled residents (Resident #1 and #6) observed during gait belt transfers. Failure to use the gait belt properly during transfers placed the residents at risk of accidents and injury.	F 323	F323 Gait Belt Transfers page 16 It is the policy of the Ashley Medical Center to ensure safety at all times and that the residents receive adequate supervision and assistive devices to prevent accidents. For resident #1, direct observation of gait belt transfers will be done. Resident #6 has expired. The facility will ensure that staff are providing appropriate gait belt transfers to all residents requiring assistance. Education will be provided to staff at the monthly staff meeting (January 24, 2017.) Return demonstration will be done at the	

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F 323	Continued From page 17 Findings include: Review of the facility policy titled "Gait Belt Policy" occurred on 01/11/17. This policy, revised 03/02/16, stated, ". . . Gait belts need to be used when transferring, positioning and ambulating all residents . . . The belt should be placed near the waist, or low back . . . Make sure the belt is snug on the user. Additional tightenings may be appropriate when the patient stands up. Hold onto the belt with the hand or hands under the belt versus the top that gives the user less control of the ambulator. Staff should never grab under the patients arms to lift or position them." -Review of Resident #1's medical record occurred on January 09-11, 2016. Diagnoses included Alzheimer's disease and abnormalities of gait and mobility. The quarterly Minimum Data Set (MDS), dated 10/22/16, identified the resident required extensive assist of two or more for transfers. Resident #1's current care plan stated, ". . . Risk for falls d/t [due to] unsteadiness, confusion, poor eyesight. . . . Transfers with assist of 2 . . . Use gait belts when assisting with ambulation/transfers . . ." Observation on 01/11/17 at 8:45 a.m. showed two certified nursing assistants (CNA) (#3 and #4), assisted Resident #1 to a standing position. One CNA (#4) held on to the gaitbelt and lifted under the resident's arm. The gait belt was loose and slid up the resident's back when standing her. The CNAs (#3 and #4) failed to readjust/tighten the gaitbelt.	F 323	monthly meeting in February 2017. A QA of gait belt transfers will be done through direct observation for resident #1, and random choice of others who require the use of gait belt transfers will be done weekly X4, monthly X3 and quarterly X3. Responsible Party: DON F 323 Unsecured Chemicals page 19 Tub Room It is the policy of the Ashley Medical Center to ensure safety at all times the facility will maintain an environment free of hazardous chemicals. The facility will ensure that the chemicals listed will be stored in the locked panels of the whirlpool tub, and the key will be either on person or at a secure location, ensuring that all residents will be free from hazardous chemicals. Education will be provided to staff at the monthly staff meeting (January 24, 2017.) All staff that provide bathing have been educated. A QA of the tub room chemicals will be done weekly X4, monthly X3 and quarterly X3. Responsible Party: DON F 323 Unsecured Chemicals carts and storerooms. It is the policy of the Ashley Medical Center to ensure safety of our residents at all times, the facility will maintain an environment free of hazardous chemicals. All hazardous cleaning supplies will be stored in locked cabinet or a locked room	

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F 323	Continued From page 18 Observation on 01/11/17 at 9:00 a.m. showed two CNAs (#5 and #6) applied a gaitbelt to Resident #1's waist and assisted her to a standing position. During the transfer, the gait belt slid up the resident's back and under her arms. The CNAs (#5 and #6) failed to readjust/tighten the gait belt. Observation on 01/11/17 at 11:20 a.m. showed two CNAs (#5 and #6) applied a gait belt to Resident #1's waist and transferred her from the bed to the wheelchair. During the transfer, the gaitbelt slid up the resident's back and under her arms. The resident was then transferred from the wheel chair to the toilet without the gait belt being tightened or readjusted. - Review of Resident #6's medical record occurred on 01/11/17. Diagnoses included osteoarthritis and joint disorder. The quarterly MDS, dated 11/15/16, identified extensive assistance of two people for toileting, bed mobility, and transfers. The care plan stated, ". . . Focus . . . The resident has ADL [activity of daily living] self-care performance deficit r/t [related to] weakness. Does not always alert staff to her needs. . . . Interventions . . . TRANSFER: Pivot transfer with 2 staff assist and pivot disc. . . ." Observation on 01/11/17 at 9:03 a.m. showed two CNAs (#3 and #12) transferred Resident #6 from her wheelchair to the toilet using a gait belt. During the pivot stand transfer onto the toilet, a CNA (#12) placed one hand on Resident #6's buttocks as she pushed her up to a standing position and the other CNA (#3) placed one hand on the gait belt and lifted under Resident #6's axilla with her other hand.	F 323	when not being used. All housekeeping carts will be placed in front of the door to the room that is being cleaned and remain in the housekeeper view at all times. When housekeeping carts are out of sight of housekeepers cart will be locked. We will ensure that no resident has access to hazardous chemicals at any time. Housekeeping staff will be educated to the need of maintaining an environment free of hazardous chemicals on February 14, 2017. A QA of the housekeeping chemicals will be done weekly X4, monthly X3 and quarterly X3. Responsible Party: Environmental Services	

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F 323	Continued From page 19	F 323		

During an interview on 01/11/17 at 4:30 p.m., an administrative nurse (#1) stated she expected staff to readjust and tighten the gait belt with transfers as needed.

UNSECURED CHEMICALS

2. Based on observation, review of facility policies and procedures, review of Material Safety Data Sheets (MSDS), and staff interview, the facility staff failed to maintain an environment free of hazardous chemical supplies on 1 of 1 wing of the nursing facility (Wing 200). Accessible hazardous chemicals places cognitively impaired and wandering residents at risk for accidents/injury.

Findings include:

Review of the facility's policy and procedure (dated 08/31/07) titled "HAZARDOUS CLEANING SUPPLY STORAGE occurred on 01/10/17. This policy/procedure stated, "Hazardous cleaning supplies will be stored in the following locked areas: . . . SNF [skilled nursing facility] Upper Floor.
1. Custodial Room: Locked in the custodial room, room to be locked at all times.
2. Custodial Cart: Cart will be locked at all times when not attended.
3. Dirty Soiled Room: Locked cabinet. . . ."

- Observations on the afternoon of 01/09/17 showed the door to the entrance of the tub room unlocked. Inside the tub room was a whirlpool tub, with removable side panels on both sides

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355091	A. BUILDING _____ B. WING _____	01/12/2017

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F 323	Continued From page 20	F 323		

that locked in place using a key. Observation showed one side panel removed from the whirlpool tub exposing the following liquid chemicals: Alpha HP Multi-Surface Disinfectant Cleaner and AFFLAB Softclean Cleaner. Observation showed the other side panel attached to the whirl pool tub, with the key left in the lock, allowing anyone access to the following liquid chemical: Penner Whirlpool Disinfectant Cleaner.

Observations on the afternoon of 01/09/17 showed the door to the entrance of the soiled utility room unlocked. Inside the soiled utility room (located across from room number 204) was a large opened container of Alpha HP Multi-Surface Disinfectant Cleaner.

Review of the MSDSs, on the above-stated chemicals, identified the following:
* Alpha HP Multi-Surface Disinfectant Cleaner - ". . . CAUTION. HARMFUL IF SWALLOWED. Moderately irritating to the eyes. Mild skin irritation . . . KEEP OUT OF REACH OF CHILDREN . . ."
* AFFLAB Softclean Cleaner - ". . . a) Skin & Eyes: Repeated contact with the skin may be irritating. Eye contact may be irritating. b) Ingestion: May be harmful. c) Inhalation: Inhalation of vapor or mist may be irritating . . ."
* Penner Whirlpool Disinfectant Cleaner - ". . . Danger: Corrosive. Keep out of reach of children . . . Causes severe skin burns and eye damage . . ."

During interview, on 01/09/17, an administrative maintenance staff member (#10) identified the expectation would be for chemicals to be stored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355091	A. BUILDING _____ B. WING _____	01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 21 in a locked location. - Observation on 01/10/17 at 8:50 a.m. showed a housekeeping cart in the hall outside of resident rooms with several residents walking past the cart. This unattended and unlocked housekeeping cart contained the following: * One bottle of general purpose spotter: the MSDS stated, ". . . Serious eye damage/eye irritation . . ." * One bottle of value scent: the MSDS stated, ". . .Serious eye damage/eye irritation . . . This chemical is considered hazardous . . ." * One bottle of endust sprayer: the MSDS stated, ". . . Inhalation: Remove to fresh air. Support Breathing (Give oxygen/artificial respiration). Eyes: flush with water for at least 15 minutes. . . INGEST: Drink milk or water freely. . . ." * Two reactivity spray bottles: the MSDS stated, ". . . Harmful if swallowed. . ." * One open container of toilet bowl cleaner on the outside of the cart: ". . . Harmful if swallowed. . . ." * Two Lysol spray cans: the MSDS stated, ". . . Causes moderate eye irritation . . ." Observation showed an unidentified housekeeping staff member removed the cart to a closet at 8:58 a.m.	F 323		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 431		2/16/17

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	355091	A. BUILDING _____ B. WING _____	01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 22 law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355091	A. BUILDING _____ B. WING _____	01/12/2017

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

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F 431	Continued From page 23 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: STORAGE OF MEDICATIONS 1. Based on observation, review of facility policy, and staff interview, the facility failed to store all medications in a secure manner on 1 of 2 days during medication pass, (January 11, 2017). Failure to store all medications securely may result in unauthorized access to medications. Findings include: Review of the facility policy titled "Storage of Medications" occurred on 01/11/17. This undated policy, stated, "Policy: Medications and biologicals are stored safely, securely, and properly . . . The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. . . . Medication rooms, carts and medication supplies are locked or attended by persons with authorized access. . . . During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. . . . No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. . . . "	F 431	F 431 Drug Records, Label/Store Drugs and Biologicals page 23 It is the policy of the Ashley Medical Center that medications carts are locked and medicated intended for administration be locked or attended by persons with authorized access. The facility will ensure that medication is not left unattended on the cart, ensuring that all residents will be protected from unsafe drugs and biologicals. Education will be provided to those that administer medications on 1/27/17. A QA of the medication cart will be done weekly X4, monthly X3 and quarterly X3. It is the policy of the Ashley Medical Center that medications are labeled in accordance with facility requirement and state and federal laws. Ashley Medical Center personnel will ensure proper medication labeling, including resident information and accurate physicians order, ensuring that all residents will be protected from unsafe drugs and biologicals. Improper or inaccurate labeled medications will be rejected and returned to the dispensing pharmacy. If the physician□s direction for	

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	355091	A. BUILDING _____ B. WING _____	01/12/2017

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F 431	Continued From page 24 Observation during medication pass on 01/11/17 at 11:30 a.m. showed a medication cart in the dining room contained multiple Over the Counter Medications (OTC's) on top of the cart. The medication aide II (MA) (#7), administered medications in the dining room with her back to the cart, and could not see the cart or the medications stored on top of the cart. During an interview on 01/11/17 at 4:55 p.m., an administrative staff member (#1) confirmed the medications should be locked in the cart. LABELING OF MEDICATIONS 2. Based on observation, review of facility policy, and professional reference review, the facility failed to ensure proper labeling of medications for 2 of 2 supplemental residents (Resident #11 and #12) observed during medication pass. Failure to ensure labeling of medications with the resident's information and the physician's order prevents staff from utilizing the 6 rights of medication administration and may result in medication errors. Findings include: Berman and Snyder, "Kozier & Erb's Fundamentals of Nursing: Concepts, Process and Practice," 10th Edition, Pearson Education, Inc, New Jersey, page 776 states, ". . . Compare the label of the medication container or unit-dose package against the order on the MAR [medication administration record] . . . "	F 431	use changes or the label is inaccurate because of order change, the nurse may place a sticker directions changed refer to chart. A new label with correct directions has been placed on resident #12 medication on 1/12/17. Education will provided to all personnel who receive and administer medication. It is the policy of the Ashley Medical Center that medications are labeled in accordance with facility requirements and state and federal laws. The facility will ensure that labels are permanently affixed to each prescription container (including insulin pens.) The facility will ensure that each insulin pen has a permanent label affixed to it, when stored in the cart, ensuring that all residents will be protected from unsafe drugs and biological. A pharmacy label will be affixed to the Humalog insulin pen on 1/27/17. A QA of insulin pens will be done monthly x3 and quarterly X3. Responsible Party: DON	

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F 431	Continued From page 25 Review of the facility policy titled "Medication Labels" occurred on 01/11/17. This undated policy stated, ". . . A. Labels are permanently affixed to the outside of the prescription container. . . . If a lable does not fit directly onto the product, . . . the lable may be affixed to an outside container or carton, but the resident's name, at least, must be maintained directly on the actual product container. . . . Each prescription medication label includes: 1) Resident's name 2) Specific directions for use, including route of administration. . . . D. Improperly or inaccurately labeled medications are rejected and returned to the dispensing pharmacy. . . . I. If the pharmacy or a dispensing physician labels a medication incorrectly, a medication discrepancy report should be completed. . . . " - Observation during medication pass on 01/10/17 at 9:15 a.m. showed MA II (#7) administered flonase (nose spray) to Resident #12 with one puff to each nare. The flonase medication label stated "flonase 50 micrograms (mcg) two sprays in each nare." The current physician order stated "flonase 50 mcg one spray in each nare." The facility failed to update the medication label to coincide with the physician order. - Observation during medication pass on 01/11/17 at 11:45 a.m. showed a nurse (#11) administered Resident #11's Humalog insulin. Resident #11's name was hand written on the Humalog insulin pen. The insulin pen failed to contain a pharmacy label.	F 431		