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	355091	A. BUILDING _____ B. WING _____	02/12/2019

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 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification started on 02/10/19 and concluded on 02/12/19.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a bed-hold notice upon	F 625	F-625 1. Immediate actions taken for the	3/20/19

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

Electronically Signed | 02/28/2019

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F 625	Continued From page 1 transfer to the hospital for 1 of 3 sampled residents (Resident #13). Failure to provide the facility's bed-hold policy does not allow residents or their legal representatives to make informed choices regarding their readmission rights. Findings include: Review of Resident #13's medical record occurred on all days of survey and identified the facility transferred the resident to the hospital on 11/30/18. The medical record lacked evidence the facility staff provided Resident #13 and/or their legal representative written notice of the bed-hold policy upon transfer to the hospital. During an interview on the morning of 02/12/19, a administrative nurse (#1) confirmed the facility failed to provide the bed-hold notices.	F 625	residents found to have been affected include: Charge Nurses were immediately educated on the proper procedures for bed holds, both for hospital admissions and therapeutic leaves. The bed hold policy was recently updated. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected, as they could be out on hospital and/or therapeutic leave. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Charge Nurses will read and review updated Bed Hold Policy and Bed Hold Form and sign the acknowledgement form that this was completed. Continued feedback from the audit results will be discussed at the monthly Nursing Meeting. 4. How the corrective action will be monitored to ensure the practice will not recur: The Director of Nursing or Nurse Manager will complete audits of the Charge Nurses performing bed hold form being completed for each hospitalization and/or therapeutic leave per our policy/procedure. The audits will be conducted weekly X 4weeks, biweekly X 3, monthly X 3 and then quarterly X 3. Responsible party: Director of	

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F 625	Continued From page 2	F 625	Nursing/Nurse Manager	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to assess nutritional needs and implement appropriate interventions for 1 of 3 sampled residents (Resident #28) with an identified weight loss. Failure to develop and implement interventions in a timely manner may result in Resident #28 experiencing a decline in function, and/or continued unplanned weight loss. Findings include:	F 692	F-0692-483.25(g)(1)-(3) Nutrition/hydration Status Maintenance S-S=D 1. Immediate actions taken for the residents found to have been affected include: The weekly weights (or more frequently if ordered by provider) are completed on resident's bath day and/or by assigned day shift CNA if daily weights are ordered. The weight is recorded in the EMR.	3/20/19

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F 692	Continued From page 3 Review of Resident #28's medical record occurred on all days of survey. The record identified a diagnosis of dementia. The quarterly Minimum Data Set (MDS), dated 12/19/18 identified Resident #28 weighed 156 pounds, experienced a weight loss of 5% or more in the last month, and is not on a physician-prescribed weight-loss regimen. Observation on 02/10/19 at 12:00 p.m. showed Resident #28 sleeping at the dining room table. At 12:23 p.m., a certified nurse aide (CNA) (#2) served the resident, sat down and attempted to feed the resident. The CNA (#2) encouraged the resident to wake up multiple times, first offering multiple choices, and the resident would not eat. A certified medication aide (CMA) (#3) sat down to help and the two staff members (#2 and #3) assisted the resident to eat less than 25% of the meal. Comparisons showed the following significant weight loss: 180 days: 08/18/18 weight 156.4 (12.2% weight loss) 90 days: 11/09/18 weight 158 (13.34% weight loss) 30 days: 01/11/19 weight 147.2 (5.6% weight loss) Resident #28 weighed 139.4 on 02/08/19. Nursing Progress Notes identified the following: - 12/21/18 Plan of Care Note " . . . Is noted [Resident #28] had a 5% weight loss in past 30 days. Message left for dietary manager to notify dietitian of weight loss, [Resident #28] continues to eat approx [approximately] 75-100% of meals."	F 692	Our Weight Loss Policy was updated to reflect the monthly weight loss meetings and what disciplines will attend these meetings. The participating departments include: Dietician or Dietary Manager, Director of Nursing/Nursing Manager/MDS Coordinator, Social Services, Activities, Ward Secretary, and/or the Provider (when possible). Director of Nursing coordinated with Dietary Manager to determine first meeting will be held on March 19th, 2019 at 9:30 am. Resident #28 has a new order for her food portions to be returned to regular portions effective 3/1/19. She also continue to have weekly weights recorded along with an additional weight to confirm findings. Weekly weight will be reviewed with Dietary Manager and Provider for the month of March, to monitor any weight changes since her portions have been changed. Per policy, if a 3 pound gain or loss is noted, the CNA will re-weigh resident to ensure accuracy of the weight. Bath Aides have been re-educated regarding this procedure and they know to notify charge nurse. Charge nurse will notify the provider and await further instruction. Charge nurses have been re-educated on this procedure. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected since all could be at risk of having weight	

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F 692	Continued From page 4 - 01/4/2019 Plan of Care Note Late Entry: "Dietitian had been notified of [Resident #28] having a 5% weight loss when completing quarterly MDS with reference dates 12/13 - 12/19/18. Did review that she receives small portions, her intake is usually good. Dietitian will continue to monitor." The medical record lacked documentation the dietitian and physician addressed Resident #28's continued weight loss since the quarterly MDS, of 12/19/18. During an interview on 02/11/19 at 3:41 p.m., administrative dietary staff members (#5 and #6) identified they were aware of the weight loss at the time of the MDS. They were not aware Resident #28 had continued weight loss. When asked, they identified nursing staff would share a resident's weight loss at morning stand up. A dietary staff member (#6) identified when a resident is on a planned weight loss, the expectation is a slow weight loss of two or three pounds a month. (Resident #28 lost eight pounds in the last month.) The staff members (#5 and #6) identified the dietician comes to the facility three times a month. During a telephone interview on 02/11/19 at 5:14 p.m., the consultant dietician (#7) identified she could not recall being told Resident #28 had experienced a significant weight loss. During an interview on 02/12/19 at 8:54 a.m., an administrative nursing staff member (#8) reported the plan of care note from 01/04/19 confirmed dietary had indeed notified the dietician about the 5% weight loss noted for Resident #28. The staff	F 692	loss. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Dietary Manager will schedule a weight loss team meeting monthly. March team meeting is scheduled for March 19th, 2019 at 9:30 am. Dietary Manager will print out monthly reports from EMR for all team members to review at meeting. Resident weight changes will be monitored at the monthly meeting. Ward Secretary will take minutes of the meetings. Resident's with weight loss will be identified and Dietary Manager/Dietitian will write notes in EMR and update the care plan with interventions. If the Provider is unable to attend the meetings for some reason, they will be made aware of the team findings by Director of Nursing/Nursing Manager so that they can write any new orders. Social Services will notify family members about the weight loss and the planned interventions. 4. How the corrective action will be monitored to ensure the practice will not recur: All residents' weights will be reviewed at monthly team meeting. Dietary Manager will do quality analysis to ensure that the weight loss team is meeting monthly, (that the provider is notified if they are not able to attend), and that the care plan interventions are updated. The audits will be conducted weekly X 4 weeks, biweekly X 3, monthly X 3 and then quarterly X 3. Responsible party: Dietary	

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F 692	Continued From page 5 member (#8) identified the charge nurse checks the weights and signs off on the bath aide sheet. During an interview on 02/12/19 at 10:15 a.m., a charge nurse (#4) identified there is a slip they fill out and send to dietary when a concern with a resident's weight is noted. The facility identified a significant weight change for Resident #28 in December. The resident continued to lose weight at a significant rate. The record lacked documentation the facility notified the physician or the dietician to assess and add interventions if deemed necessary.	F 692	Manager/Dietitian, Director of Nursing/Nursing Manager, Social Services/MDS Coordinator/Ward Secretary	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows:	F 732		3/20/19

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F 732	Continued From page 6 (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to post nursing staff data in a prominent place accessible to residents and visitors for 3 of 3 days of survey (February 10-12, 2019). Failure to post staffing data in an accessible place does not allow residents and visitors to be aware of the numbers of licensed and unlicensed staff on duty for each shift. Findings include: Observations at the nurses' station on 02/10/19 at 2:07 p.m., 02/11/19 at 7:49 a.m., and 02/12/19 at 10:35 a.m., showed the daily nursing staff data posted on a cork board within the nurses' station. The location of the board, made it difficult for residents, family, and visitors to read the posted staffing information.	F 732	F-732 1. Immediate actions taken for the residents found to have been affected include: Immediate action(s) taken was that the posted nursing staffing information clip board was moved to the bulletin board in the hallway so residents and/or family members have access to this information. The clip board was hung so that residents in a wheel chair could read this information. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected, since it pertains to caregivers for all residents.	

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F 732	Continued From page 7	F 732	3. Actions taken/systems put into place to reduce the risk of future occurrence include: Nursing staff will be educated on the importance of keeping the clip board with staffing information on the bulletin board so that residents and/or family members can easily access it. The Charge Nurse is responsible to fill out the form with staff per each shift. The Scheduler takes down the prior day(s) form(s) and files them in a folder. 4. How the corrective action will be monitored to ensure the practice will not recur: The Director of Nursing/Nursing Manager will complete audits to see if the clip board with this information is posted in the correct location. Audits will be conducted weekly X 4 weeks, biweekly X 3, monthly X 3 and then quarterly X 3. Responsible party: Director of Nursing/Nursing Manager	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758		3/20/19

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F 758	Continued From page 8 resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, Review of the Psychotropic Medication Use Detail Report, and	F 758	F-0758-483.45(c)(3)(e)(1)-(5)- Free From Necessary Psychotropic Meds/prn Use	

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F 758	Continued From page 9 staff interview, the facility failed to ensure a medication regimen free from unnecessary medications for 1 of 6 sampled residents (Resident #13) receiving an antipsychotic medication. Failure to attempt a gradual dose reduction (GDR) unless contraindicated, in an effort to reduce or discontinue medication use, may result in residents receiving unnecessary medications and experiencing adverse drug effects related to their use. Findings include: Review of Resident #13's medical record occurred on all days of survey. Medications included Risperdal (antipsychotic) 0.5 milligrams (mg) daily (QD). Resident #13's care plan stated, ". . . Mental wellness/Well being . . . I have regular appointments with Dr. [name] or his associate, psychiatrist to help staff and myself manage my mental wellness . . . I take a medication called Risperdal to help decrease feeling upset and agitated . . . My provider will consider decreasing the dose of my Risperdal at least once each year . . ." Review of the Psychotropic Medication Use Detail Report, dated October 2018, showed the pharmacist identified, ". . . 10/25/17 . . . No change. 'Any dose reduction will result in exacerbation of symptoms.' . . ." The record lacked documentation of a completed GDR since 10/25/17. During an interview on the morning of 02/12/19, an administrative nurse (#1) confirmed the Resident #13 lacked documentation regarding yearly GDR review of antipsychotic.	F 758	S-S=D 1. Immediate actions taken include: Consulting pharmacist was informed about the deficiency finding. Consulting Pharmacist completed a medication review on resident #13 and made recommendation to provider, including a possible GDR. Provider reviewed the Pharmacist□s findings and acted upon these recommendations. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents who have a psychotropic medication ordered have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Consultant Pharmacist will review residents□ medication orders for suggested changes. The Consultant Pharmacist will complete the Medication Review form with recommended changes for GDR (at least annually). These forms will come to the Director of Nursing who gets the form to the provider for consideration. Once the provider accepts the change, then the Charge Nurse shall enter these orders and let the resident and their family members know. If the provider rejects the changes, then they need to identify why the suggestion was rejected. If resident or family members are not in agreement with the provider□s new	

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F 758	Continued From page 10	F 758	orders, then Charge Nurse will share these concerns with the Provider. Provider will talk with resident and/or family to reach a compromise that both parties agree with. 4. How the corrective action will be monitored to ensure the practice will not recur: The Director of Nursing and Consulting Pharmacist will meet monthly and review pharmacy recommendations for GDR□s. Director of Nursing will audit the resident□s charts to ensure that there is documented GFR on each resident□s psychotropic medications are completed at least annually. Director of Nursing will audit weekly X 4 weeks, biweekly X 3, monthly X 3 and then quarterly X 3. Responsible party: DON/Consulting Pharmacist Corrective action	