

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

PRINTED: 04/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355091		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/10/2023	
NAME OF PROVIDER OR SUPPLIER ASHLEY MEDICAL CENTER NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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			F 000			
F 880 SS=D	The standard Medicare/Medicaid recertification survey started on 05/08/23 and concluded on 05/10/23. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;			F 880			6/1/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/24/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 04/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355091		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/10/2023	
NAME OF PROVIDER OR SUPPLIER ASHLEY MEDICAL CENTER NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 1 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow			F 880	F-880 Infection Prevention and Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)		

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

PRINTED: 04/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355091		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/10/2023	
NAME OF PROVIDER OR SUPPLIER ASHLEY MEDICAL CENTER NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 2 standards of infection control for 2 of 2 supplemental residents (Resident #9 and #10) observed during personal cares. Failure to follow infection control practices regarding hand hygiene has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: Review of the facility policy titled "Policy for Hand Hygiene" occurred on 05/10/23. This undated policy stated, " . . . Hand hygiene is required in the following situations. . . . Before and after assisting a resident with personal cares . . . After removing gloves . . . " - Observation on 05/08/23 at 4:15 p.m. showed two certified nurse aides (CNAs) (#2 and #3) donned gloves and checked Resident #10's brief. The CNA (#3) cleansed the rectal area of stool using a wet wipe and removed her gloves. Without performing hand hygiene, the CNA (#3) donned clean gloves and assisted in applying a clean brief, adjusted the resident's clothing, raised the head of bed, provided the resident a drink of water, gave the resident her rosary, moved the bedside table, removed her gloves, and exited the room without performing hand hygiene. The CNA (#3) failed to perform hand hygiene between glove changes and before exiting the room. - Observation on 05/08/23 at 4:52 p.m. showed two CNAs (#1 and #2) changing Resident #9 in bed. Both CNAs performed hand hygiene, donned gloves, and repositioned Resident #9 to remove the incontinent product. One CNA (#1)			F 880	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. All CNAs and Nurses were in-serviced on the policy/procedure on correct hand hygiene during peri cares during the CNA and Nurses meeting. These meetings were completed on 5/23/23 and 5/25/23. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents needing assistance with peri cares or brief changes are at risk for the deficient practice. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Incontinence/Perineal Care policy states that : Prepare Resident		

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

PRINTED: 04/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355091		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/10/2023	
NAME OF PROVIDER OR SUPPLIER ASHLEY MEDICAL CENTER NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 3 provided perineal cares and applied a new incontinent product while the other CNA (#2) positioned the resident. Both CNAs removed their soiled gloves following perineal care. One CNA (#1) failed to perform hand hygiene upon exiting the resident's room. During an interview on 05/10/23 at 4:40 p.m., two administrative nurses (#4 and #5) confirmed they expected staff to perform hand hygiene between glove change and before exiting the resident's room.			F 880	1. Identify self to resident. 2. Explain procedure to resident. 3. Provide privacy. Prepare equipment 1. Prepare equipment (moistened wipes, powder, barrier cream, etc.) 2. Perform hand hygiene 3. Put on gloves 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 (from the cleanest area to the area of greatest soiling). b. For male residents: Wash the penis from the urethral opening or top of the penis. Pull back the foreskin or uncircumcised males and clean under it. Wash the scrotum, pay attention to skin folds. 2. Repeat with a clean cloth as needed. If gloves become grossly contaminated with feces, etc., gloves should be changed before continuing. 3. Cleanse buttocks and peri-anal area without contaminating perineal area.		

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

PRINTED: 04/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/10/2023
NAME OF PROVIDER OR SUPPLIER ASHLEY MEDICAL CENTER NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 4	F 880	4. Remove wet incontinent pad/brief. Do not touch anything with soiled gloves after procedure (ex. curtain, side rails, clean linen, call light, etc.). 5. Remove gloves and wash hands or use alcohol-based hand sanitizer if situation permits with regards to resident safety/comfort. 6. Apply clean gloves when placing dry brief/pad. 7. Place a dry incontinence pad and/or brief underneath resident. 8. Return resident to comfortable position. 9. Perform hand hygiene with soap and water. This policy will be reviewed at the CNA and Nurses meeting, we will be doing direct observations, and we will be reviewing peri cares annually at each CNA competency. Each CNA and Nurse will need to sign off on this policy. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. There will be direct observations of residents peri cares performed by the Nurse Educator. These will be performed		

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

PRINTED: 04/22/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/10/2023
NAME OF PROVIDER OR SUPPLIER ASHLEY MEDICAL CENTER NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 880	Continued From page 5	F 880	on random residents needing peri cares and will be conducted weekly X 4, biweekly X 3, monthly X 3 and then quarterly X 4. 5. Dates when the corrective action will be completed. Corrective action completion date: June 1st, 2023		