STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355091	A. BUILDING _____ B. WING _____	12/15/2021

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 The standard Medicare/Medicaid recertification started on 12/13/21and concluded on 12/15/21.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		1/19/22

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

Electronically Signed | 01/05/2022

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F 550	Continued From page 1 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide care for 2 of 7 sampled residents (Residents #10 and #15) observed during assistance with activities of daily living (ADL), in a manner and environment that maintained, enhanced, and respected each resident's dignity and individuality. Failure to provide cares in a respectful manner does not preserve the residents' personal dignity or enhance their quality of life. Findings include: Review of the policy titled, "Personal & Privacy Rights" occurred on 12/15/21. This undated policy, stated, ". . . The facility staff must treat you courteously, fairly, and with dignity. . . ." Observations showed the following: * 12/13/21 at 1:18 p.m., a certified nurse aide (CNA) (#4) entered Resident #15's room, called the resident's name twice, crouched down, looked him in the face, and said, "Hello, are you in there?" A second CNA (#3) entered the room to assist with a transfer and a brief change. During the brief change, the CNA (#3) pulled up the front of the brief to secure the adhesive tabs and stated, "The gems are in, lock it up!"	F 550	F-550 Resident Right/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) 1. Immediate actions taken for the residents found to have been affected include: Each resident was re-educated on A Guide to your Rights as a Resident of a nursing facility in North Dakota. This information is available to them at all times. 2. Identification of other residents having the potential to be affected was accomplished by: Any resident has the potential to be affected by violating resident rights. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All SNF staff will be educated on the policy of personal and privacy rights. This states the facility staff must treat the resident courteously, fairly and with dignity. The CNA's that worked during the time of the survey were educated on this deficiency on 12/29/21 at the monthly	

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F 550	Continued From page 2 * 12/13/21 at 3:30 p.m., a CNA (#4) assisted Resident #10 with a transfer. During the transfer, and in front of Resiudent #10, the CNA (#4) stated, "I don't know which one of you [surveyors] has [a different resident] but he is very needy he is by the book that way." During an interview on 12/15/21 at 8:35 a.m., an administrative nurse (#5) agreed the CNAs failed to speak to the residents courteously and with dignity, she she expects staff to refrain from speaking about other residents while providing cares.	F 550	CNA meeting. The Resident Abuse/Neglect policy was read to them and the Resident Rights guideline. There is also education yearly on Healthstream that goes through the Resident Abuse/Neglect Policy and the Resident Rights Guideline. 4. How the corrective action will be monitored to ensure the practice will not recur: Random CNA observations will be completed to ensure that all residents are treated with respect at all times. If we find that this does not happen, the CNA will be corrected immediately on proper communication. If it continues in the same employee they will be disciplined per facility protocol. The audits will be conducted weekly X 4 weeks, biweekly X 3, monthly X 3 and then quarterly X 3. Responsible party: DON/ADON/Nurse Corrective action completion date: January 19th, 2022	
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.	F 551		1/19/22

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F 551	Continued From page 3 (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose	F 551		

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F 551	Continued From page 4 decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the resident's legal representative signed a vaccine consent for 1 of 6 sampled residents (#10), identified as incapable of making medical decisions. Failure to ensure the resident's legal representative gives consent has the potential for the resident to receive unwanted treatment. Findings include: Review of the facility policy titled "Provider Statement/Code Level Directive" occurred on 12/14/21. This policy, revised 07/14/16, stated, ". . . The provider statement identifies if the resident is capable, or incapable of making decisions independently. . . ." Review of the facility policy titled "Advanced Directive Policy" occurred on 12/14/21. This undated policy stated, ". . . In the event that a patient or resident . . . is unable to make or communicate responsible decisions about his/her health care, the following persons, are authorized to make health care decisions for the individual . . . a court appointed guardian who is authorized to	F 551	F-551 Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) 1. Immediate actions taken for the residents found to have been affected include: Each provider statement form for the residents affected will be looked at and changed to ensure the information is correct and is signed by provider and legal representative. 2. Identification of other residents having the potential to be affected was accomplished by: Every residents chart will be gone through to ensure the provider statement is correct and that it is signed by the provider and the legal representative or the resident. 3. Actions taken/systems put into place to reduce the risk of future occurrence include:	

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F 551	Continued From page 5 make healthcare decisions or a court appointed custodian of the patient . . ." Review of Resident #10's medical record occurred on all days of survey. The Provider Statement dated, 02/04/20, identified the resident as incapable of making medical decisions. Review of the vaccine consent form showed staff obtained the resident's signature instead of the required legal representative's signature, failed to date the consent form, and administered the vaccine on 01/06/21. During an interview on 12/14/21 at 4:44 p.m., an administrative nurse (#1) confirmed that staff use the Provider Statement form to identify who should sign consent forms and staff should have obtained Resident #10's legal representative's signature for consent of the vaccination.	F 551	A new form was made that states either the resident is capable of making medical decisions or is incapable of making medical decisions. There is no more option of unable to determine at this time. Education will be given to the providers and the nurses on the new form. 4. How the corrective action will be monitored to ensure the practice will not recur: All charts will be gone through initially and then each new admit will be monitored by the ADON or DON. The audits will be conducted monthly X 3 and then quarterly X 3. Responsible party: DON/ADON Corrective action completion date: January 19th, 2022	
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		1/19/22

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F 578	Continued From page 6 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the medical record for 5 of 12 sampled residents (Resident #9, #10, #11, #13 and #18) accurately reflected the resident's code level directive. Failure to ensure the resident or the resident's legal representative signed the code level directive has the potential to inaccurately reflect the resident's wishes for life-sustaining services. Findings include:	F 578	F-578 Request/Refuse/Dscntnue Trmnt; Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) 1. Immediate actions taken for the residents found to have been affected include: Each residents Code Level Directive form will be looked at to ensure the information is correct, and is signed by the provider and legal representative.	

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F 578	Continued From page 7 Review of the facility policy titled "Provider Statement/Code Level Directive" occurred on 12/14/21. This policy, revised 07/14/16, stated, ". . . The provider statement identifies if the resident is capable, or incapable of making decisions independently. If the admitting provider is unable to determine this at the time of admission, it will be reviewed within one month. . . ." - Review of Resident #9's medical record occurred on all days of survey. The Provider Statement for Code Level Directive dated, 12/09/20, identified the resident as incapable of making medical decisions, and the code level directive stated, "NO CODE." The code level directive lacked a signature from the resident's representative. - Review of Resident #10's medical record occurred all days of survey. The Provider Statement for Code Level Directive, dated 04/19/21, identified the resident as capable of making medical decisions, and the code level status stated, "NO CODE." The code level directive lacked the resident's signature. - Review of Resident #11's medical record occurred on all days of survey. The Provider Statement for Code Level Directive, dated 06/15/20, identified the provider was unable to determine if the resident could make medical decisions and to review in one month, and the code level status stated, "NO CODE." The code level directive lacked a signature from the resident's representative, and the medical record failed to show documentation the provider reviewed the resident's ability to make medical decisions.	F 578	2. Identification of other residents having the potential to be affected was accomplished by: Every residents chart will be gone through to ensure the Code level is correct and that it is signed by the provider and the legal representative or the resident. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: A new code form was made that includes either CODE/NO CODE. This form must be signed by the legal representative if the resident is incapable of making medical decisions. Education will be given to the providers and the nurses on the new form. 4. How the corrective action will be monitored to ensure the practice will not recur: All charts will be gone through initially and then each new admit will be monitored by the ADON or DON. The audits will be conducted monthly X 3 and then quarterly X 3. Responsible party: DON/ADON Corrective action completion date: January 19th, 2022	

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F 578	Continued From page 8 During an interview on 12/14/21 at 2:10 p.m., an administrative nurse (#1) confirmed she was unable to find the provider's review of Resident #11's decision making ability and confirmed staff should have obtained a resident representative's signature. - Review of Resident #13's medical record occurred all days of survey. The Provider Statement for Code Level Directive, dated 07/23/21, identified the resident as capable of making medical decisions, and the code level status stated, "CODE." The code level directive lacked the resident's signature. - Review of Resident #18's medical record occurred all days of survey. The Provider Statement for Code Level Directive, dated 05/31/19, identified the provider was unable to determine if the resident could make medical decisions, and the code level status stated, "CODE." The code level directive lacked a signature from the resident or the resident's representative, and the medical record failed to show documentation the provider reviewed the resident's ability to make medical decisions. During an interview on 12/14/21 at 4:44 p.m., an administrative nurse (#1) confirmed staff should obtain the resident's or their legal representative's signature for all Code Level Directive forms.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		1/19/22

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F 641	Continued From page 9 resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 2 sampled residents (Resident #18) reviewed for Preadmission Screening and Resident Review (PASRR). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2019, pages A-21-23 stated, "A1500: Preadmission Screening and Resident Review (PASRR) . . . Review the PASRR report provided by the State if Level II screening was required . . . Coding Instructions . . . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . . . continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. . . " Review of Resident #18's medical record occurred all days of survey. A PASRR Level II screening, dated 06/05/19, stated, ". . . is within compliance with inclusion criteria for PASRR population because of her primary mental health history of Schizophrenia. . . ."	F 641	F-641 Accuracy of Assessments CFR(s): 483.20(g) ¿483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. It is the policy of the Ashley Medical Center to ensure that the MDS assessment accurately reflects the residents status. Information on the MDS must be coded following the guidelines established in the CMS Long Term Care Facility Resident Assessment Instrument Users Manual for completion of the MDS 3.0. 1. Immediate actions taken for the residents found to be affected include: The Social Service Staff and MDS Coordinator was immediately educated on the proper procedure for completing section A1500 on MDS. A Modification was made to the MDS with ARD 5-28-21 for resident #18 to A1500 indicating a PASSR Level II Screening was completed. Modification was received and accepted by CMS on 12-15-21. 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.	

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F 641	Continued From page 10 An annual MDS dated 05/28/21 identified section A1500 coded NO indicating Resident #18 did not have a PASRR Level II screening which determined a serious mental illness. During an interview on 12/14/21 at 2:30 p.m., an administrative nurse (#8) agreed staff failed to correctly code section A1500 of the MDS.	F 641	3. Actions taken/systems put into place to reduce the risk of future occurrence include: Social Service Designee and MDS Coordinator will implement a new checklist, which will determine Level 1 or Level 11 PASRR either on admission on new mental or psych diagnosis. Staff may refer back to this checklist for proper coding of A1500 on MDS. 4. How the corrective action will be monitored to ensure the practice will not recur: Social Service and MDS Coordinator will complete audit and checklist. The audits will be conducted monthly X 3 and then quarterly X 3. Responsible party: Social Service Designee, MDS Coordinator Corrective action completion date: January 19th, 2022	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's	F 644		1/19/22

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F 644	Continued From page 11 assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure an accurate Pre-Admission Screening and Resident Review (PASARR) for 1 of 2 sampled residents (Resident #13), who triggered for PASARR services. Failure to complete a change in status assessment with a new serious mental illness diagnosis may result in a lack of necessary mental health services. Findings include: Review of Resident #13's medical record occurred on all days of survey. On 07/28/21, a physician newly identified a psychotic disorder, which required the completion of a PASARR. Facility staff failed to complete a change in status assessment with a new diagnosis. During an interview on 12/14/21 at 5:50 p.m., a social services staff member (#6) and a social services director (#5) confirmed staff should have completed a new PASARR with the psychotic disorder diagnosis.	F 644	F-644 Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) ¿483.20(e) Coordination. It is the policy of the Ashley Medical Center to coordinate assessments with the pre-admission screening and resident review (PASRR) program under Medicaid subpart C and referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability or a related condition for level II resident review upon a significant change in status assessment. 1. Immediate actions taken for the residents found to have been affected include: The Social Service Staff and MDS Coordinator was immediately educated on the proper procedures for completing a PASRR change in status when a new psychotic or new serious mental illness is newly diagnosed. A level II PASRR screening was	

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	355091	A. BUILDING _____ B. WING _____	12/15/2021

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F 644	Continued From page 12	F 644	submitted for resident #13 on 12-29-21, awaiting response of level. Should a level II be determined, a modification to resident□s MDS would be made to reflect appropriate PASRR screening in A1500. 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. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Social Service Designee will audit all residents PASRR and diagnosis documentation. Social Service Designee makes rounds with Psychiatry, so Social Service Designee and MDS Coordinator will implement a new diagnosis checklist for new mental illness and psych diagnosis that will trigger a change of status of PASRR. Will implement same checklist with all SNF providers as provider visits are completed. 4. How the corrective action will be monitored to ensure the practice will not recur: Social Service and MDS Coordinator will complete audit and checklist. The audits will be conducted monthly X 3 and then quarterly X 3. Responsible party: Social Service Designee, MDS Coordinator	

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F 644	Continued From page 13	F 644	Corrective action completion date: January 19th, 2022	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide care and services to ensure proper skin care for 1 of 1 sampled resident (Resident #15) with a skin infection. Failure to initiate skin assessments for residents with an identified skin condition has the potential to cause adverse health effects and continued physical discomfort. Findings include: Review of the facility guideline titled "Wound/Ulcer Assessment" occurred on 12/15/21. This guideline, dated 06/29/18, stated, ". . . enter your treatment order and do a wound/ulcer assessment x [times] 3 days and then weekly until healed. . . ." Review of Resident #15's medical record occurred on all days of survey and identified the resident has a tinea rash (fungal infection of the skin). A Physician's order, dated 10/28/21, stated,	F 684	F684 Quality of Care CFR(s): 483.25 1. Immediate actions taken include: The Residents order was changed to ensure that they did not have Nystatin and Vaseline ordered at the same time. The residents Vaseline order was D/C□d. An order was written for daily skin assessments until healed. 2. Identification of other residents having the potential to be affected was accomplished by: One other resident has a skin issue at this time. An order was written for daily skin assessments until healed. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: A new skin assessment and policy are being made in Point Click Care that will	1/19/22

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F 684	Continued From page 14 ". . . Vaseline to groin prn [as needed] for redness or irritation . . ." and order, dated 12/09/21, stated, ". . . Nystatin Cream [anti-fungal medication] 100000 UNIT/GM [gram] Apply to groin topically two times a day for yeast/rash for 10 Days apply to bilateral thigh/scrotum rash, also retract foreskin and apply around entire head of penis . . ." Observation on 12/13/21 at 1:18 p.m. showed two certified nurse aids (CNAs) (#3 and #4) performed perineal cares for Resident #15. The resident's scrotum, penis, and bilateral groin appeared red, moist, macerated, and scaly in appearance; and extended outward to both thighs/inner legs. The resident groaned and tightened his legs together when the CNA (#3) cleansed area with moistened wipes and applied Vaseline to both groin areas. Review of Resident #15's progress notes showed the following: * 10/27/21 at 3:37 a.m., "Note was sent to clinic regarding groin that is red and sore looking - would like to use Vaseline prn for redness . . ." * 12/09/21 at 4:00 p.m., "Provider Visit ". . . Staff has noticed a rash on the bilateral upper groin and scrotum. They have been using vasoline [sic]. It was noted that there was some blood from the penis as well. Patient with signiifcant [sic] dementia . . . Tinea rash to bilateral upper groin and both lateral sides of scrotum. Foreskin retracted and tip of penis with some excoriation wo [without] active bleeding." During an interview on 12/14/21 at 4:44 p.m., an administrative nurse (#1) stated the nursing staff failed to follow the policy to complete the wound	F 684	have the availability to chart any skin issue, from bruise, skin tear, wound, or rash. The nurses will be educated on the new skin assessment and policy. 4. How the corrective action will be monitored to ensure the practice will not recur. The skin assessments QA will be done monthly X 3 months, and then quarterly X 1 year. Responsible party: DON/ADON Corrective action completion date: January 19th, 2022	

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F 684	Continued From page 15 assessment for three days and then weekly until healed.	F 684		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of 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: Based on observation, review of facility document, and staff interview, the facility failed to discard expired medications in 2 of 2 medication storage areas (medication cart and medication room). Failure to discard expired medication increases the risk of residents receiving outdated	F 761	F-761 Label/store Drugs and Biologicals 483.45(g)(h)(1)(2) 1. Immediate actions taken include: The outdated meds were disposed of immediately.	1/19/22

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F 761	Continued From page 16 medications with reduced efficacy. Findings include: Review of the facility document titled "Medications with Shortened Expiration Dating Once Opened" occurred on 12/14/21. This undated document, identified Novolog (Aspart) insulin vial should be discarded 28 days after opened. Observation of the medication cart occurred on 12/14/21 at 2:43 p.m. with a licensed nurse (#2) and showed a bottle of Lactulose (laxative) expired on 11/05/21. Observation of the medication room occurred on 12/14/21 at 3:15 p.m. with a licensed nurse (#2) and showed an undated open vial of Aspart insulin located in the medication refrigerator. The licensed nurse (#2) confirmed the expired bottle of Lactulose and undated vial of insulin should be discarded. During an interview on 12/14/21 at 3:56 p.m., an administrative nurse (#1) confirmed staff should discard the undated insulin vial and expired Lactulose medication.	F 761	2. Actions taken/systems put into place to reduce the risk of future occurrence include: A new policy was made for monitoring outdated medication. This states: Medication outdates must be checked monthly. Medication outdates include E-kit, Narcotics (cupboard and cart), Stock (Eye drops, inhalers, ointment-date when opened), Insulin, and Medication fridge. This is to be done by the night nurse once per month. The nurse will initial each box on the checklist after they have checked their outdates. You can follow the guidance of Shortened Expiration Dates for Medications as to when a medication expires after opened. Insulin vials must be labeled when opened. Insulin pens must be labeled with the date opened/expiration date. The nurses will be educated on the new policy/procedure. 3. How the corrective action will be monitored to ensure the practice will not recur: The ADON or DON will audit the outdates of medications monthly X 3 and then quarterly X 3. Responsible party: DON/ADON Corrective action completion date: January 19th, 2022	
F 804	Nutritive Value/Appear, Palatable/Prefer Temp	F 804		1/19/22

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F 804 SS=E	Continued From page 17 CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, resident interviews, review of resident council meeting minutes, and meal test tray, the facility failed to serve foods at palatable temperatures for 1 of 1 meal observed (noon meal 12/14/21). Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include: Review of the facility policy titled "Food Holding Temperatures" occurred on 12/14/21. This form, dated 1998-1999, stated, ". . . Serve/Hold: Hot Foods - above 140 degrees Fahrenheit (F) . . . check temperature of item every 30 minutes . . . Cold Foods - at 41 degrees F or below . . ." Review of the 09/02/21 Resident Council meeting minutes occurred on 12/13/21. The meeting minutes stated, "Food is not always brought up early enough at noon and not warm enough for some residents." - During an interview on 12/13/21 at 2:20 p.m.,	F 804	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) 483.60(d) Food and drink Each resident receives and the facility provides- 1. Immediate actions taken for the residents found to have been affected include: In person monitoring of food service along with active temperature monitoring of all foods served to residents. 2. Identification of other residents having the potential to be affected was accomplished by: Temperature sampling has been monitored during food service of all meals. It was determined that the current food transport equipment utilized for maintaining accurate temperature was unable to maintain a temperature of 140 degrees.	

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F 804	Continued From page 18 Resident A stated, "Food is often served cold or lukewarm." - During an interview on 12/13/21 at 3:02 p.m., Resident B stated, "The food is terrible, it is too cold." - During an interview on 12/13/21 at 3:16 p.m., Resident C stated, "The soup isn't warm enough." On 12/14/21, at 12:16 p.m., the survey team received a test tray. Food temperatures taken showed roast turkey at 123.5 degrees F, gravy at 123 degrees F, mashed potatoes at 132 degrees F, stuffing at 129.7 degrees F, corn at 128 degrees F, cranberry sauce at 64.2 degrees F, chocolate cream pie at 63.5 degrees F, and juice at 58.7 degrees F. During an interview on 12/14/21 at 4:35 p.m., a dietary staff member (#9) stated he expects staff to serve hot foods at 140 degrees F or higher and confirmed he failed to complete audits or follow-up on cold food temperatures since the September Resident Council meeting.	F 804	3. Actions taken/systems put into place to reduce the risk of future occurrence include: Implementation of updating food transport equipment. We have purchased a plate warmer and ordered an updated Dinex thermal Insulated plate transport system. Dome cover model # DX340061, Smart Therm Induction Base model #821061. Dinex induction charger #DXSMA2081 for the heating of the bases. This will be in use for all residents at AMC. 4. How the corrective action will be monitored to ensure the practice will not recur: Food service temperature monitoring will be completed and recorded daily at all meal service. This will include a temperature monitoring of a dummy tray x 4 tray per week. This tray will be sent to the SNF floor along with the resident trays and temped after all resident trays are delivered. The audits will be conducted weekly X 4 weeks, biweekly X 3, monthly X 3 and then quarterly X 3. Responsible party: AM & PM Cook/Dietary Manager Corrective action completion date: January 19th, 2022	
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician.	F 808		1/19/22

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F 808	Continued From page 19 §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received foods served in the appropriate consistency for 1 of 6 sampled residents (Resident #5) with an altered diet. Failure to serve diets consistent with the physician's order may result in coughing, choking, and/or the development of aspiration pneumonia. Findings include: Review of the facility policy titled "Consistency-Altered Diets" occurred on 12/14/21. This policy, dated 2011, stated, ". . . Level 1 Dysphagia (difficulty swallowing) Pureed: Pureed homogenous, cohesive, pudding-like food that is in the form of an easy to swallow bolus; Moist, pudding-like consistency without particles . . ." Review of Resident #5's medical record occurred on all days of survey. A provider's order, dated 11/22/21, identified on a pureed diet. Observations showed staff served Resident #5 the following items: * 12/14/21 at 8:22 a.m.: round banana slices and unaltered scrambled eggs; resident had 2 episodes of coughing during breakfast. * 12/14/21 at 12:12 p.m.: chocolate cream pie	F 808	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) ¿483.60(e) Therapeutic Diets ¿483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. 1. Immediate actions taken for the residents found to have been affected include: AMC Dietary Inservice for all dietary staff members what was completed on Dec 21st 2021 covering the importance of following the prescribed diets. We reviewed and updated process currently in place. 2. Identification of other residents having the potential to be affected was accomplished by: Any resident with a special diet has the potential to be affected. We have acknowledged that our current process did not have a form of closed loop communication for our kitchen staff. We needed to amend our current process for verification of diet changes ordered by the providers. Monitoring of this process is done by the Dietary Manager at various meal services.	

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F 808	Continued From page 20 with sprinkles and an intact crust During an interview on 12/15/21 on 8:12 a.m., a dietary manager (#9) agreed the observed foods served to Resident #5 did not meet the ordered diet texture.	F 808	3. Actions taken/systems put into place to reduce the risk of future occurrence include: Our current process has been updated as follows. We have implemented a spreadsheet with SNF resident names indicating diet, texture & liquid specifics. This spreadsheet data is verified by the dietary manager against the diet ordered in Point Click Care. The kitchen assistant/dishwasher will read the clients name, diet & texture to the serving cook. Upon completion of the tray the resident name and diet card is once again verified and attached to the tray. After each meal service is complete, the spreadsheet will be initialed by the cook and kitchen assistant/dishwasher ensuring dual diet verification of diet orders. 4. How the corrective action will be monitored to ensure the practice will not recur: Dietary Manager will observe a meal service weekly x 4, biweekly X 3, monthly X 3 and then quarterly X 3. Responsible party: AM & PM Cook/dishwashers/Dietary Manager Corrective action completion date: January 19th, 2022	
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum,	F 886		1/19/22

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F 886	Continued From page 21 for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an	F 886		

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F 886	Continued From page 22 individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and staff interview, the facility failed to include all elements required for 1 of 1 facility policy reviewed for resident and staff refusal of SARS-CoV-2 (COVID-19) testing. Failure to have a process in place for testing refusal may lead to a lack of further required interventions. Findings include: Review of the facility policy titled "Testing Residents and Healthcare Personnel for SARS-Cov-2" occurred on 12/15/21. This undated policy lacked a procedure for staff and residents who refused COVID-19 testing. During an interview on 12/15/21 at 9:10 a.m., an administrative staff member (#1) confirmed the facility failed to have a procedure established for	F 886	F886 - COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) 1. Immediate actions taken for the residents found to have been affected include: Every healthcare worker, resident or volunteer is offered a rapid Covid 19 test upon their request or required scheduled testing set by the facility utilizing ND Department of Health guidelines. All parties are also allowed to refuse testing. 2. Identification of other residents having the potential to be affected was accomplished by: The resident & Healthcare personal policy was reviewed and found to have specific information regarding refusal to test for	

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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 886	Continued From page 23 staff and/or residents who refused COVID-19 testing.	F 886	employees and volunteers. Healthcare workers and volunteers have been required to test based on state scheduling guidelines. If the Healthcare worker or volunteer tests positive or refuses a test, they must remain excluded from the workplace until the return-to-work criteria are met. Residents have also been tested with the frequence indicated by the ND Department of Health, however we did not have a specific line item spelling out what we have done with residents the refused testing. If the resident refuses testing they were educated on the importance of testing for other resident safety and encouraged to test. They were all given transmission precautions, instructed on their use and required to social distance as well as remain masked during group activites. We have since added a line item to the policy spelling out how the residents will need to be cared for should they refuse testing. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The AMC OSHA-Covid plan has been updated and dated to indicate the change for Healthcare worker and resident refusal to test. 4. How the corrective action will be monitored to ensure the practice will not recur: All Resdient & Healthcare Personnel will continue to be tested following the state	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355091	A. BUILDING _____ B. WING _____	12/15/2021

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F 886	Continued From page 24	F 886	guidelines requard testing frequeceny based on outbreak status. During weekly testing the healthcare worker testing log will continue to be updated and reported to the state. Resident testing is conducted and tracked via registration log at AMC as well as through state reporting. Audits will be conducted monthly X 3 and then quarterly X 3. Responsible party: CEO/DON Corrective action completion date: January 19th, 2022	