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 _____	03/04/2020

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 survey started on 03/02/20 and concluded 03/04/20.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment.	F 640		3/6/20

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

Electronically Signed | 03/17/2020

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.

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F 640	Continued From page 1 (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17), the facility failed to ensure resubmission of a required Minimum Data Set (MDS) assessment for 1 of 1 supplemental resident (Resident #1) whose MDS was rejected for submission. Failure to follow the MDS data submission specifications does not meet the intended regulatory requirements. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual, page 5-5 stated, ". . . Fatal Record Errors result in rejection of individual records by the QIES (Quality Improvement Evaluation System) ASAP (Assessment Submission and Processing) system. The provider is informed of Fatal Record Errors on the Final Validation	F 640	F 640 Encoding/Transmitting Resident Assessments It is the policy of the Ashley Medical Center to ensure that MDSs are completed and transmitted at the time intervals following the guidelines established in the CMS Long Term Care Facility Resident Assessment User□s Manual for completion of the MDS 3.0. 1. Reason for Fatal Error and rejected MDS for Resident #1 was identified as an outdated Medicaid number. A MDS was submitted in 3-5-20 for Resident #1 with the updated Medicaid number. The CMS Submission Report MDS 3.0 NH Final Validation Report from QIES verified that it was accepted on 3-5-20.	

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F 640	Continued From page 2 Report. Rejected records must be corrected and resubmitted. . ." Review of Resident #1's MDSs occurred on 03/03/20. The facility completed a quarterly MDS, dated 01/01/20, and QIES ASAP informed the facility of a fatal error for this MDS on the Final Validation Report. Review of the Center for Medicare and Medicaid Services (CMS) MDS reports for Resident #1 identified an annual MDS, dated 10/02/19, as the last accepted MDS by QIES ASAP. During an interview on 03/04/20 at 10:06 a.m., an administrative nurse (#1) confirmed the facility had received a fatal error report on the validation report for Resident #1 and had not resubmitted the CMS quarterly MDS.	F 640	2. The facility has determined that all residents have the potential to be affected. All residents must have MDSs transmitted at the intervals specified in the CMS Long Term Care Facility Resident Assessment User□s Manual for completion of the MDS 3.0. 3. The staff person that does MDS submissions was educated on submission error messages and necessary actions that need to occur for error messages by viewing CMS (2016, October 12). MDS 3.0 Data Submission and CASPER Reports [Video file]. YouTube. https://www.youtube.com/watch?v=FFvnLGpyeDo on 3-12-20 4. The MDS Coordinator will conduct a random audit of 3 MDS submission reports weekly x 4, biweekly x 3, monthly x 3 and quarterly x 3. The submission reports will be reviewed to ensure that each MDS is accepted and any Fatal Error messages are addressed and corrected. Responsible Party: MDS Coordinator The Ward Clerk will print the CASPER Report (ND) MDS 3.0 Error Detail by Facility. This report will be reviewed to ensure that there are no standing Fatal Error Warnings for any MDS submissions.	

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F 640	Continued From page 3	F 640	This will be done monthly x 6. Responsible Party: Ward Clerk, MDS Coordinator 5. The corrective action was completed on 3-5-20. The first QA audit will be completed by 3-27-20.	