STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355091	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLEY MEDICAL CENTER NURSING HOME	612 CENTER AVE N PO BOX 450, ASHLEY, North Dakota, 58413

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F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 06/30/25 and concluded 07/02/25.	F0000		08/04/2025
F0557 SS = D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to provide access to a personal phone for 1 of 1 sampled resident (Resident #13). Failure to place a resident's personal phone within reach limits the residents' ability to communicate with friends and family and may result in loneliness. Findings include: Review of the facility admission packet occurred on 07/02/25. This packet contained "A Guide to Your Rights as a Resident of a Nursing Facility in North Dakota." Page 16 of this document stated, "You have the right to safe, clean and comfortable surroundings, allowing you to keep your personal belongings to the extent space permits. The facility must provide you with reasonable accommodation for your personal needs and preferences." Observations of Resident #13 occurred on 07/01/25 at 10:25 a.m., 11:50 a.m., 1:25 p.m., and 07/02/25 at 11:00 a.m. The resident was in her recliner, wheelchair, or bed and the personal phone on the	F0557	Plan of Correction for F-0557 Immediate actions taken for the residents found to have been affected include: · The resident's phone was immediately placed on the bedside table, within reach. · Ensured the phone was properly connected and functional for the resident's use. · The resident was reassured of their right to access personal belongings at all times. · Posted on the communication board in Point Click Care on 7-2-25 for all direct care staff to follow the instructions on the signage posted in the residents room. Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected by this deficiency. · We reviewed other residents' care plans to determine if similar failures occurred in ensuring personal property, such as phones were within reach, and interviewing staff to identify any patterns or oversights. None determined at this time. Actions taken/systems put into place to reduce the risk of future occurrence include: · Direct care staff were educated on the importance of	08/06/2025

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 reverse for further 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.

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

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F0557 SS = D	Continued from page 1 windowsill behind the resident's recliner. A sign on the wall stated, "Please put phone on table daily. Replace on jack [charger] PM Bedtime. Thank you." On 07/02/25 at 11:00 a.m., Resident #13 stated, "I would like the phone where I can reach it." During an interview on 07/02/25 at 1:05 p.m. two administrative staff members (#1 and #2) confirmed the resident has the right to access her phone.	F0557	Continued from page 1 following posted instructions and maintaining resident access to personal property, respect and dignity. Staff also educated of Residents' Personal Property Rights. · Staff were educated that failure to follow these directions compromises the resident's rights. · Staff educated on residents rights yearly on Health Streams, per policy. They sign that they have read and understand these rights. How the corrective action will be monitored to ensure the practice will not recur: · Social Services will complete QA to ensure personal property is placed within residents' reach as indicated. QA will be conducted weekly x 3 months, monthly x 3 months, then quarterly x 2 quarters. · Responsible Party: Social Services · Corrective Action Completion Date: August 6, 2025	
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F0641	F 641 Coding errors Corrective action taken for the residents found to be affected include: The Social Service Designee (SSD), Ward Clerk and MDS Coordinator were educated on the proper documentation necessary for coding item E0100B on the MDS. A Modification was made to the Quarterly MDS and OSA MDS for Resident #13 with ARD 4-18-25 to item E0100B to indicate that no delusions were present during the reference period of 4/12 – 4/18/25. The modified MDSs were transmitted to CMS and the ND DHS on 7-2-25. The MDS Coordinator was educated on proper documentation necessary for coding item N0300 on the MDS. A Modification was made to the Significant Change MDS with ARD 5-4-25 for Resident #11 to item N0300 indicating that injections were administered 0 days during the reference period of 4/28 – 5/4/25. The modified MDS was transmitted to CMS and the ND DHS on 7-2-25.	08/04/2025

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F0641 SS = D	Continued from page 2 (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. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. 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 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 12 sampled residents (Resident #11 and #13). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan, and the care provided to the residents. Findings include: SECTION E: Behavior The Long-Term Care Facility RAI User's Manual, revised October 2024, pages E-1 to E-2 stated, ". . . E0100: Potential Indicators of Psychosis . . . Hallucinations . . . Delusions . . . Review the resident's medical record for the 7-day look-back period. . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. . . ." Review of the medical record for Resident #13 occurred on all days of survey. The review of the quarterly MDS, dated 04/08/25, showed staff coded delusions. Review of the medical record for the seven-day look-back period failed to identify Resident #13 experienced delusions. SECTION N: Medications The Long-Term Care Facility RAI User's Manual, revised	F0641	Continued from page 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 based on the practice that MDSs are completed for all residents. Actions taken/systems put into place to reduce the risk of future occurrence include: When coding a delusion on item N0300 on an MDS, the SSD, Ward Clerk or MDS Coordinator will create a note on the MDS to include the location and date of the documentation supporting a delusion during the reference period. When coding any injection in item N0300, the MDS Coordinator will create a note on the MDS to include all injections received during the reference period. The note will include the injection substance, date and location of documentation. Prior to transmitting MDSs, the nurse will review items N0300 and E0100B on all MDSs and verify the documentation to support coding of presence of delusions or any days of injections received. How the corrective action will be monitored to ensure the practice will not recur: The MDS Coordinator will complete an audit of all MDSs prior to transmitting MDSs. The audits will be conducted weekly x 3, monthly x 3 and then quarterly x 3 Date the corrective action will be completed: Responsible Party: MDS Coordinator Corrective action completion date: August 4, 2025	

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F0641 SS = D	Continued from page 3 October 2024, pages N-1 to N-4 stated, ". . . N0300: Injections: . . . Coding Instructions . . . "Record the number of days during the 7-day look-back period . . . that the resident received any type of medication, antigen, vaccine, etc., by injection. . . ." - Review of Resident #11's medical record occurred on all days of survey. A significant change MDS, dated 05/04/25, showed facility staff coded section N0300 indicating Resident #11 received an injection one time during the seven-day look back period. The medical record failed to identify the resident received an injection. During an interview on 07/02/25 at 10:44 a.m., an administrative staff member (#2) confirmed the MDSs were coded incorrectly for Resident #11 and Resident #13.	F0641		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F0657	F657 Care Plan Revision Corrective action taken for the residents found to be affected include: A care plan was created for the anticoagulant medication for Resident #3 on 7-2-25. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents that receive anticoagulant medication have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: Obtained a listing of all residents that receive anticoagulant medication. Audited the care plans of these residents to ensure that care plans were in place. This audit was completed on 7-18-25. To prevent future occurrences, MDS Coordinator will conduct weekly reviews of all medication orders. This screening will ensure prompt updates to care plans and appropriate monitoring.	08/04/2025

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F0657 SS = D	Continued from page 4 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the resident's current status for 1 of 2 sampled residents (Resident #3) reviewed for anticoagulation (blood thinner) therapy. Failure to update care plans limited the staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Ashley Medical Center Baseline Care Plan and Care Plan Policy" occurred on 07/02/25. This policy, dated January 2019, stated, ". . . The development, implementation, and maintenance of a resident's comprehensive plan of care is an interdisciplinary process. . . . Care Plans are to be reviewed within 7 days of MDS [Minimum Data Set] completion every 3 months unless otherwise specified by goal time frames. . . ." Review of Resident #3's medical record occurred on all days of survey. A physician's order included Coumadin (an anticoagulant) daily. The admission MDS dated 04/28/25, identified an anticoagulant use. Resident #3's current care plan lacked problem, goals, or interventions for anticoagulation therapy. During an interview on 07/02/25 at 11:49 a.m., an administrative nurse (#1) confirmed staff failed to revise Resident #3's care plan.	F0657	Continued from page 4 How the corrective action will be monitored to ensure the practice will not recur: MDS Coordinator will complete an audit of care plans for all residents that receive anticoagulant medication to ensure that care plans are in place for each of these residents. The audits will be conducted monthly x 3 and then quarterly x 3 Date the corrective action will be completed: Responsible Party: MDS Coordinator Corrective action completion date: August 4, 2025	