

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 06/05/2024
NAME OF PROVIDER OR SUPPLIER Ashley Medical Center Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 612 Center Ave N Ashley, ND 58413	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>37620</p> <p>Based on observation, record review, review of the facility policies, and staff interview, the facility failed to properly utilize assistive devices necessary to prevent accidents and/or injury for 1 of 3 sampled residents (Resident #12) observed during gait belt transfer and 1 of 4 sampled residents (Resident #19) observed during a mechanical stand lift transfer. Failure to use a gait belt or ensure proper use of a stand lift during transfers placed residents at risk for injury.</p> <p>Findings include:</p> <p>Review of the policy titled Gait Belt Policy occurred on 06/04/24. This undated policy stated, . The belt should be placed near the waist unless previous diagnosis exist. Make sure the belt is snug on the user. Additional tightenings [sic] may be appropriate when the patient stands up. Hold onto the belt with the hand or hands under the belt .</p> <p>Observations on 06/03/24 at 5:00 p.m. showed a certified nurse aide (CNA) (#2) assisted Resident #12 with a transfer from the wheelchair to the bed. The CNA (#2) placed a gait belt loosely around the resident's chest and proceeded to transfer the resident. During the transfer the resident had difficulty standing and turning. The gait belt slid up under the resident's arms and provided no support to the resident during the transfer. The CNA (#2) failed to place the gait belt at the resident's waist and failed to tighten the gait belt prior to transfer or when standing the resident.</p> <p>Observation on 06/04/24 at 1:25 p.m. showed a CNA (#3) assisted Resident #12 from the wheelchair to the bed. The CNA placed a gait belt loosely around the resident's waist and proceeded to transfer the resident. The resident had difficulty standing and turning. The resident's chair alarm sounded and a nurse (#4) entered the room and assisted with the transfer. During the transfer, the gait belt slid up under resident's arms and provided no support to the resident. The CNA (#3) failed to tighten the gait belt prior to transfer and the CNA (#3) and nurse (#4) failed to tighten and readjust the gait belt during the transfer.</p> <p>During an interview on 06/05/24 at 2:41 p.m., and administrative nurse (#5) confirmed staff are expected to place the gait belt around the resident's waist, make it snug, and readjust as needed.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #19's care plan identified, . Assist [Resident #19] with transfers for safety, provide varied level of assist as needed usually Medi-lift [mechanical sit to stand lift] for transfers, at times he does not comprehend to safely participate in transfers with Medi-lift, use Hoyer Lift [full body mechanical lift].</p> <p>Observations on 06/03/24 at 3:36 p.m., showed a CNA (#6) assisted Resident #19 to stand with a sit to stand lift from the recliner. After the CNA had the resident in a standing position, the CNA pulled down the resident's pants and removed the brief. The CNA left the resident unattended and obtained supplies. The resident let go of the handles on the lift and began to fidget and move around which caused the lift to move as the brakes were not locked in place. The CNA reminded the resident multiple times to hold onto the lift handles but the resident did not until the CNA completed all cares. The CNA then put the resident's hands on the lift handles, moved the stand lift over to the wheelchair, and lowered the resident into the wheelchair. The CNA failed to lock the wheels of the sit to stand lift and failed to ensure Resident #19 held onto the lift handles.</p> <p>46477</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>37620</p> <p>Based on observation, review of resident record, review of facility policy, and staff interview, the facility failed to ensure accurate labeling of medications for 1 of 1 sampled resident (Resident #26) observed during insulin administration. Failure to obtain a new medication label from the pharmacy for an insulin pen or affix a label noting change in the directions, may result in residents receiving an incorrect dose of insulin.</p> <p>Findings include:</p> <p>Review of the facility policy Medication Administration and Safe Handling Policy/Procedure occurred on 06/05/24. This undated policy stated, . The correct label should be on the medication from [name of pharmacy]. If the dose changes, [name of pharmacy] will be contacted for a new label, and the nurse will put a Change of Directions sticker on the medication to refer to the order until a new label comes.</p> <p>Observation on 06/03/24 at 11:48 a.m. showed a nurse (#1) removed a Novolog insulin pen from the top drawer of the medication cart to prepare for administration. The current label included the resident's name and directions for administration. The label instructions stated to administer 8 units in the morning, 14 units at lunch and 16 units in the evening. Review of Resident #26's current physician orders identified to administer 15 units at 8:00 a.m., 15 units at 11:30 a.m. and 16 units at 5:30 p.m. The nurse (#1) confirmed the label affixed to the insulin pen as incorrect and a new label should have been ordered.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39685</p> <p>Based on observation, review of facility policy, and staff interview, the facility failed to ensure staff followed enhanced barrier precautions for 1 of 2 sampled resident (Resident #20) observed during cares. Failure to follow infection control practices related to enhanced barrier precautions may result in the spread of infections within the facility.</p> <p>Findings include:</p> <p>Review of the facility policy titled Enhanced Barrier precautions occurred on 06/05/24. This policy, dated 04/29/24, stated . when implementing Enhanced Barrier Precautions it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use . disinfect lifts between each resident and adhere to recommended infection control prevention practices .</p> <p>Observation on 06/04/24 at 2:00 p.m. showed two certified nurse aides (CNAs) (#6 and #8) entered Resident #20's room. Signage identified enhanced barrier precautions. The CNAs donned gloves and gowns and assisted Resident #20 to bed using a full body lift. The CNAs removed the resident's soiled brief and provided incontinence cares. Without removing the soiled gloves and donning clean gloves, the CNAs, applied a clean brief, adjusted the residents clothing, bedding, catheter, and lift. The CNAs (#6 and #8) then removed their gloves, and exited the room with the lift. The CNAs failed to disinfect the lift after use and perform hand hygiene after leaving the room.</p> <p>During an interview on 06/04/24 3:27 p.m., an administrative nurse (#5) stated she expects staff to sanitize all mechanical lifts between residents.</p>		