

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 07/02/2025
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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>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 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.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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: BehaviorThe 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 [DATE], 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: MedicationsThe Long-Term Care Facility RAI User's Manual, revised 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 [DATE], 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.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [NAME] 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 [DATE], 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.</p>		