STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355123	A. BUILDING _____ B. WING _____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

(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 02/03/20 and concluded on 02/06/20.	F 000		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident/staff interviews the facility failed to provide activities of daily living (ADL) assistance for 7 of 25 sampled residents (Resident #2, #34, #38, #63, #107, #158, and #159) who required staff assistance for toileting/check and change. Failure to provide assistance in a timely manner to residents who cannot independently carry out ADL's may result in poor grooming/hygiene and decreased self-esteem. Findings include: Review of the facility policy, revised on 12/16 titled "Bladder Management" occurred on 02/06/2020. This policy stated, ". . . Scheduled/Habit Toileting: A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits or needs . . . Check and Change: Involves checking the resident's dry/wet status at regular intervals and using incontinence devices and products per manufacturer's recommendations. Identified by 'CC' on ADL	F 677	1.The facility is unable to provide corrective action for residents #2, #34, #38, #63, #107, #158 and #159 as these events have already occurred. Coaching for staff was completed when facility was able to determine which staff member was involved. 2.Residents with a toileting plan have the potential to be impacted. 3.CNA and Nurse Re-education on how to follow a toileting plan and how to follow the Toileting Pathway was completed at shift change huddles and Unit Meetings. This item has also been added to the bi-annual Skills Fair education list. 4.Audits of resident toileting plans and schedules will be conducted by the Care Review Team starting on February 18th, 2020. The team will conduct 4 audits/week x 4weeks and then 4 audits/2 weeks x 4 weeks and then 4 audits quarterly for one year. The Quality	3/10/20

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

Electronically Signed | 02/25/2020

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F 677	Continued From page 1 (Activities of Daily Living) sheet . . ." - Review of Resident #2's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 10/25/19, identified Resident #2 required total (dependent) assistance of two staff for toileting, and the resident was always incontinent of bowel and bladder. The resident's current care plan stated, ". . . [Resident #2] has incontinent episodes due to TBI [Traumatic Brain Injury], neurogenic bladder, medication use, impaired cognition and decreased mobility. Refer to ADL sheet for toileting schedule/plan. [Resident #2] requires assist with ADL's related to history of MVA [motor vehicle accident], TBI, cognitive deficit, aphonia, and left side spastic hemiparesis . . ." Resident #2's ADL sheet stated, ". . . Check and Change every 2 hours . . ." The skin assessment, dated 01/31/20, identified reddened areas to groin. The toileting log, dated January 29 through February 4, 2020, identified fourteen occasions where staff failed to check and change Resident #2 as care planned. The log showed gaps of approximately 2.5 to 9 hours. - Review of Resident #34's medical record occurred on all days of survey, and identified diagnoses including cerebral infarct (stroke) with aphasia and hemiplegia. The quarterly MDS, dated 11/28/19, identified the resident required extensive assistance for toileting, was on a current toileting program, and was frequently	F 677	Department will continue audits thereafter and The Director of Quality and Education will report the results yearly at the Quality Meeting starting March 2020.	

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F 677	Continued From page 2	F 677		

incontinent.

The current care plan identified, ". . . [Resident #34] has potential for incontinent episodes due to limited mobility and medication use . . . Refer to ADL sheet for toileting schedule/plan . . ." The current care card identified, ". . . TOILETING . . . S = Scheduled Q [every] 2 HRS [hours] . . ."

The Bladder Assessment, dated 12/09/19, identified, "Habit time to remain in effect due to decreased incontinence episodes."

On 02/05/20 at 8:26 a.m., Resident #34 indicated/wrote that he had to wait "twice 1/2 hour for the night nurse" and pointed to the bathroom.

The toileting log, dated January 30 through February 5, 2020, identified twenty four occasions where staff failed to toilet Resident #34 as care planned. The log showed gaps of approximately 2.5 to 15 hours.

- Review of Resident #38's medical record occurred on all days of survey. The quarterly MDS, dated 12/02/19, identified Resident #38 required total (dependent) assistance of two staff for toileting, and the resident was always incontinent of bowel and bladder.

The resident's care plan stated, ". . . [Resident #38] has a dx [diagnosis] of urinary incontinence and hypertonicy of bladder. Refer to ADL sheet for toileting schedule/plan. [Resident #38] requires assist with ADL's d/t [due to] dx of osteoarthritis, dementia . . ." Resident #38's ADL sheet stated, ". . . Check and change every two

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F 677	Continued From page 3	F 677		

hours . . ."

The toileting log, dated January 29 through February 4, 2020, identified fourteen occasions where staff failed to check and change Resident #38 as care planned. The log showed gaps of approximately 2.5 to 10 hours.

- Review of Resident #63's medical record occurred on all days of survey, and identified diagnoses including dementia and chronic kidney disease. The quarterly MDS, dated 12/20/19, identified the resident required extensive assistance for toileting and was frequently incontinent.

The current care plan identified, ". . . [Resident #63] is incontinent of bladder at times d/t [due/to] impaired mobility, dx of dementia . . . Refer to ADL sheet for toileting schedule/plan . . ." The current care card identified, ". . . TOILETING . . . S = Scheduled Q [every] 2 HRS [hours] . . ."

The toileting log, dated January 30 through February 5, 2020, identified eighteen occasions where staff failed to toilet Resident #63 as care planned (none of which were due to Resident #63 refusing cares). The log showed gaps of approximately 3 to 11.25 hours.

- Review of Resident #107's medical record occurred on all days of survey. The annual MDS, dated 01/20/20, identified Resident #107 required total (dependent) assistance of two staff for toileting, and the resident was always incontinent of bowel and frequently incontinent of bladder.

The resident's care plan stated, ". . . [Resident

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F 677	Continued From page 4	F 677		

#107] is incontinent due to decreased mobility, dementia and hypertonic bladder. Refer to ADL sheet for toileting schedule/plan. [Resident #107] requires assist with ADL's due to dementia and CHF [congestive heart failure] . . ." Resident #107's ADL sheet stated, ". . . Check and Change every two hours . . ."

The skin assessment, dated 01/30/20, identified redness to coccyx.

The toileting log, dated January 29 through February 4, 2020, identified nine occasions where staff failed to check and change Resident #107 as care planned. The log showed gaps of approximately 2.5 to 8 hours.

- Review of Resident #158's medical record occurred on all days of survey, and identified diagnoses including Alzheimer's disease and dementia. The quarterly MDS, dated 01/21/20, identified the resident required extensive assistance from two persons for toileting and always incontinent.

The current care plan identified, ". . . [Resident #158] has incontinence related to dementia or Alzheimer's Disease . . . Refer to ADL sheet for toileting schedule . . ." The current care card also identified, ". . . CC = Check and Change Q 2 HRS . . ."

The Skin Assessment, dated 02/06/20, identified, ". . . blanchable redness to perineal area - tx [treatment] applied . . ."

The toileting log, dated January 30 through February 5, 2020, identified twenty eight

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F 677	Continued From page 5 occasions where staff failed to toilet Resident #158 as care planned. The log showed gaps of approximately 2.5 to 11.75 hours. - Review of Resident #159's medical record occurred on all days of survey, and identified diagnoses including chronic kidney disease. The current care plan identified, ". . . [Resident #159] has potential for incontinent episodes due to decreased mobility . . . Refer to ADL sheet for toileting schedule/plan . . ." The current care card identified, ". . . TOILETING . . . S = Scheduled Q 2 HRS . . ." The toileting log, dated January 30 through February 5, 2020, identified eighteen occasions where staff failed to toilet Resident #159 as care planned (none of which were due to Resident #159 refusing cares). The log showed gaps of approximately 2.5 to 11.25 hours. During an interview on 02/06/20 at 9:20 a.m., a managerial nurse (#2) stated she expected staff to follow each resident's toileting schedule and/or check and change as indicated on the care plan and ADL sheet. During an interview on 02/06/20 at 11:45 a.m., a managerial nurse (#1) stated, "If a resident is care-planned to be repositioned or toileted every 1-2 hours, staff should follow the resident's care plan."	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		3/10/20

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F 684	Continued From page 6 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 facility policy, record review, observation, and staff interviews, the facility failed to provide the necessary care and services to maintain the highest practicable physical well-being for 7 of 25 sampled residents (Resident #2, #37, #38, #49, #82, #107, and #158) requiring staff assistance for repositioning. Failure to consistently provide assistance with repositioning may result in pain/discomfort or skin breakdown. Findings include: Review of facility policy titled "Turning and Positioning Program" occurred on 02/06/20. This policy, revised August 2013, stated, ". . . To provide pressure relief, maintain skin integrity, prevent pressure ulcers . . . Unit nurse will notify the unit clerk to enter the appropriate tasks in POC [plan of care] for the corresponding care plan . . . [and] will add the additions and/or changes to the ADL [activities of daily living] care sheet . . ." - Review of Resident #2's medical record occurred on all days of survey, and identified diagnoses including Traumatic Brain Injury (TBI) and hemiplegia. The quarterly Minimum Data Set (MDS), dated 10/25/19, identified the resident	F 684	1. The facility is unable to provide corrective action for residents #2, #37, #38, #49, #82, #107 as these events have already occurred. Coaching for staff has been completed when facility was able to determine which staff were involved. 2. Residents with a turning and repositioning plan have the potential to be impacted. 3. CNA and Nurse Re-education on how to follow a turning and repositioning plan and how to follow the Turning and Repositioning Pathway was completed at shift change huddles and Unit Meetings. This item has also been added to our bi-annual Skills Fair education list. 4. Audits of resident turning and repositioning schedules/care plans will be conducted by the Care Review Team starting on February 18th, 2020. The Care Review team will conduct 4 audits/week x 4weeks and then 4 audits/2 weeks x 4 weeks and then 4 audits quarterly for one year. The Quality Department will continue audits thereafter	

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F 684	Continued From page 7 required extensive assistance for bed mobility and total (dependent) assist for transfers and was at risk of developing pressure ulcers. The current care plan identified, ". . . [Resident #2] is at risk for developing pressure ulcer due to . . . decreased sensory perception, moisture, decreased activity, decreased mobility . . . Turn and reposition every 2 hours and prn [as needed] . . ." The current care card also identified, ". . . T2 = TURN 2 HOURS . . ." The Skin Assessment, dated 01/31/20, identified, ". . . redden [sic] areas to groin . . ." The repositioning log, dated January 29 through February 4, 2020, identified eighteen occasions where staff failed to reposition Resident #2 as care planned. The log showed gaps of approximately 2.5 to 9.5 hours. - Review of Resident #37's medical record occurred on all days of survey, and identified diagnoses including dementia and Parkinson's disease. The significant change MDS, dated 11/30/19, identified the resident required extensive assistance for bed mobility/transfers, had a history of deep tissue injury, and was at risk of developing additional pressure ulcers. The current care plan identified, ". . . [Resident #37] is at risk for developing a pressure ulcer due to: moisture, decreased activity, decreased mobility, friction/sheer . . . T/R [turning/repositioning] every 2 hours due to history of skin breakdown . . ." The current care card also identified, ". . . T2 = TURN 2 HOURS . . ."	F 684	and the Director of Quality and Education will report the results yearly at the Quality Meeting starting March 2020.	

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F 684	Continued From page 8	F 684		

The repositioning log, dated January 30 through February 5, 2020, identified thirteen occasions where staff failed to reposition Resident #37 as care planned. The log showed gaps of approximately 2.5 to 8 hours.

- Review of Resident 38's medical record occurred on all days of survey, and identified diagnoses including dementia and urinary incontinence. The quarterly MDS, dated 12/02/19, identified the resident required extensive assistance for bed mobility and total (dependent) assist for transfers and was at risk of developing pressure ulcers.

The current care plan identified, ". . . [Resident #38] is at risk for developing pressure ulcer due to . . . decreased mobility, incontinence of bowel and bladder, and history of refusals of cares/assistance, history of pressure ulcers . . . Turn and repo [reposition] at 2 hours . . ." The current care card also identified, ". . . T2 = TURN 2 HOURS . . ."

The repositioning log, dated January 29 through February 4, 2020, identified fifteen occasions where staff failed to reposition Resident #38 as care planned. The log showed gaps of approximately 2.5 to 9.5 hours.

- Review of Resident #49's medical record occurred on all days of survey, and identified diagnoses including quadriplegia. The quarterly MDS, dated 12/07/19, identified the resident required extensive assistance from two persons for bed mobility/transfers and was at risk of developing pressure ulcers.

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F 684	Continued From page 9	F 684		

The current care plan identified, ". . . AT RISK - PRESSURE ULCER - HIGH RISK: [Resident #49] is at high risk for Skin Breakdown related to limited mobility, scoliosis, hx [history] of pressure ulcers . . . He also has a history of refusing turning and repositioning . . . Turn and repo q [every] 2 hr [hours] and PRN . . ." The current care card also identified, ". . . T2 = TURN 2 HOURS . . ."

The repositioning log, dated January 30 through February 5, 2020, identified eighteen occasions where staff failed to reposition Resident #49 as care-planned (none of which were due to Resident #49 refusing cares). The log showed gaps of approximately 2.5 to 6 hours.

- Review of Resident #82's medical record occurred on all days of survey, and identified diagnoses including stage 3 kidney disease and palliative care. The quarterly MDS, dated 01/02/20, identified the resident required extensive assistance from two persons for bed mobility/transfers, received Hospice care, and was at risk of developing pressure ulcers.

The current care plan identified, ". . . [Resident #82] is at risk for developing a pressure ulcer due to decreased sensory perception, moisture, decreased activity, decreased mobility, nutrition . . . At risk for pressure ulcer: turning/repositioning program determined by tissue tolerance assessment . . ." The current care card identified, ". . . T2 = TURN 2 HOURS . . ."

The repositioning log, dated January 30 through February 5, 2020, identified seventeen occasions

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F 684	Continued From page 10	F 684		

where staff failed to reposition Resident #82 as care planned. The log showed gaps of approximately 2.5 to 7.75 hours.

- Review of Resident #107's medical record occurred on all days of survey, and identified diagnoses including dementia and history of pressure ulcers. The annual MDS, dated 01/20/20, identified the resident required extensive assistance for bed mobility and total (dependent) assist for transfers and was at risk of developing pressure ulcers.

The current care plan identified, ". . . [Resident #107] is at risk for developing pressure ulcer due to . . . hx of pressure ulcers, decreased mobility, bowel and bladder incontinence . . . Continue T/R every 2 hours and prn . . ." The current care card also identified, ". . . T2 = TURN 2 HOURS . . ."

- Observations on 02/04/20 showed Resident #107 in the following positions:
* 8:38 a.m. - In the bed on her back with a pillow on each side of her.
* 11:27 a.m. - In the bed on her back with a pillow on each side of her.

- Observations on 02/06/20 showed Resident #107 in the following positions:
* 8:14 a.m. - In the bed on her back, with no pillows used for positioning. Two pillows noted in the recliner beside the bed.
* 12:50 p.m. - In the bed on her back, with no pillows used for positioning. Two pillows noted in the recliner beside the bed.

The Skin Assessment, dated 01/30/20, identified, ". . . redness to coccyx . . ."

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F 684	Continued From page 11	F 684		

The repositioning log, dated January 29 through February 4, 2020, identified twelve occasions where staff failed to reposition Resident #107 as care planned. The log showed gaps of approximately 2.5 to 9 hours.

- Review of Resident #158's medical record occurred on all days of survey, and identified diagnoses including Alzheimer's disease and dementia. The quarterly MDS, dated 01/21/20, identified the resident required extensive assistance from two persons for bed mobility/transfers and was at risk of developing pressure ulcers.

The current care plan identified, ". . . [Resident #158] is at risk for developing a pressure ulcer due to moisture, decreased activity, decreased mobility, nutrition . . . TTA [Tissue Tolerance Assessment] completed 01/29/20. Redness noted after 1 hour. Turn/reposition q 1 hour . . ." The current care card also identified, ". . . T1 = TURN EVERY HOUR . . ."

The Skin Assessment, dated 02/06/20, identified, ". . . blanchable redness to perineal area - tx [treatment] applied . . ."

The repositioning log, dated January 30 through February 5, 2020, identified twenty three occasions where staff failed to reposition Resident #158 as care planned. The log showed gaps of approximately 1.5 to 5 hours.

During an interview on 02/06/20 at 11:45 a.m., a managerial nurse (#1) stated, "If a resident is care-planned to be repositioned or toileted every

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F 684	Continued From page 12 1-2 hours, staff should follow the resident's care-plan." During an interview on 02/06/20 at 12:44 a.m., a managerial nurse (#2) stated, "If a resident is care-planned to be repositioned every 2 hours, staff should follow the resident's care-plan."	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: THIS IS A REPEAT DEFICIENCY FROM THE	F 761	1. The facility is unable to provide	3/10/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355123	A. BUILDING _____ B. WING _____	02/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

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F 761	Continued From page 13 STANDARD SURVEY COMPLETED ON 01/24/2019 Based on observation, review of facility policy, and staff interview the facility failed to label and document refused medications located in 1 of 4 medication carts (First floor, Dakota Plains), observed during medication storage review. Failure to ensure refused medications are properly labeled increased the risk of residents receiving the wrong medications. Findings include: Review of the policy titled "Medication Administration - General Guidelines" occurred on 02/05/20. This policy, revised July 2019, stated, "B. Administration: 4) The person who prepares the dose for administration is the person who administers the dose. 5) If resident refuses medication leave it in the top drawer of the medication cart, label with resident initials. Complete a refusal of care note. . . " Observation on 02/05/20 at 4:55 p.m. showed an unlabeled medication cup in the top drawer of the medication cart with unknown amount of pills in a dark brown solution. The staff nurse (#4) stated she is unaware of who the medication is for and the nurse whom she took over from must have put the medication cup in the drawer. She stated she would report it to her nurse manager. The nurse who placed the medication cup in the medication cart drawer failed to label the medication cup with the resident's initials and to document in the electronic medication record the resident's refusal.	F 761	corrective action as there was not a resident identified. Coaching for the nurse involved in this practice was immediately completed. 2. Residents who receive medications that are crushed and then refuse them have the potential to be impacted. 3. Nurse and CMA re-education completed regarding importance of having items labeled with resident name/identifier if left in a medication cart. This item has also been added to our bi-annual Skills Fair education list. 4. Audits of medication carts will be conducted by Nurse Manager Team as well as Consultant Pharmacist. The team will conduct 4 audits/week x 4weeks and then 4 audits/2 weeks x 4 weeks and then 4 audits quarterly for one year. The Quality Department will continue audits thereafter and the Director of Quality and Education will report the results yearly at the Quality Meeting starting March 2020	

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F 761	Continued From page 14 During an interview on the morning of 02/06/20 an administrative nurse (#3) stated she expected staff to label refused medication, put it in the top drawer of the medication cart and document it in the electronic medication record.	F 761		