DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	01/05/2012

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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 01/03/12 and completed on 01/05/12, the sample included four residents for complete review, nine residents for focused review, and three closed records.	F 000	**This plan of correction is our allegation of compliance.** **Submission of this Plan of Correction is not an admission by Bethany that the Statement of Deficiencies cited are accurate in any respect.**	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	1. Corrective actions for residents #2, #4,# 6 and #9 regarding eating and coding is unable as these MDS's have been submitted and it would be difficult to determine when the changes were noted. ADL self-performance may vary from day-to-day or shift-to-shift which also could contribute to these findings. Residents #1, #2, #6, and #9 have had a Bowel and Bladder Diary completed and reevaluated by the MDS Coordinator. Their Plans of Care and ADL sheets have been updated to reflect this most current assessment. 2. Residents having an MDS completed would have the potential to be affected by this practice. 3. Bethany on 42nd will initiate the following education to assist staff in correctly documenting and coding ADL's, and in furthering their education of individualized toileting programs: A. Did You Know Education Posters and Email –See Attachment A & B. B. Review of ADL Coding at our Annual Skills Fair on April 9th, 2012. C. Review of Toileting Plans at our Annual Skills Fair on April 9th, 2012.	

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

President & CEO | 2-8-2012

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 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 4 of 13 sampled residents regarding eating (Resident #2, #4, #6, and #9) and 4 of 13 sampled residents regarding a toileting program (Resident #1, #2, #6, and #9). Failure to accurately code the MDS for these residents limited the facility's ability to develop and implement individualized care plans consistent with their needs and functional status. Findings include: The Long-Term Care Facility RAI User's Manual, page 2-1 stated, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . .," and page Z-6 states, ". . . The importance of accurately completing and submitting the MDS cannot be overemphasized. The MDS is the basis for the development of: * an individualized care plan * the Medicare Prospective Payment System * Medicaid reimbursement programs . . ." Section G: Functional Status, page G-1 stated, ". . . Extensive assistance - resident involved in activity, staff provide weight-bearing support." Section H: Bladder and Bowel, page H-6 stated, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated . . . A toileting program does not refer to:	F 278	D. Mandatory Education via HealthCare Academy for Nurses and CNAs titled "Coding and Documentation of ADL's" (Done in February 2012, and then annually for CNAs and Nurses) - See Attachment C. E. Education at Unit Meetings—See Attachments D & E. F. Bethany's Bladder Management Policy has been updated—See Attachments F & G. G Self Study Education and Quiz titled, "Understanding Toileting Programs and Meal Coding" - See Attachment H. 4. Quality Audits will compare careplans, ADL sheets and ADL Coding to actual care provided. Quality audits specific to toileting and specific to mealtime assistance (See Attachments I & J) will be conducted by the Nurse Manager team 5x/week for a period of 2 weeks, and then 3x/week for 2 weeks, and then 1x/week for a total of 2 weeks. Based on compliance, the audits would then be turned over to our Quality Program for monitoring and review at our monthly Quality Meeting. 5. Corrective actions will be completed by 4/5/2012. Shawn S. via telephone date change 2/14/2012 JB	4/5/2012

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F 278	Continued From page 2 * simple tracking continence status, * changing pads or wet garments, and * random assistance with toileting or hygiene." - Review of Resident #2's medical record occurred on all days of survey. The current MDS, dated 10/11/11, identified the resident as cognitively intact, required extensive assistance with eating, continent of bladder, and on a urinary toileting program. Observations of meals on 01/04/12 at 8:50 a.m. and 12:50 p.m. showed Resident #2 ate her meals independently. These observations show a contradiction between the resident's actual status (independent or supervised assistance) and the status coded on the MDS (extensive assistance). Resident #2's medical record failed to identify a decline or improvement in her status from the date of the MDS to the date of the observations. Review of the CNA activities of daily living (ADL) information sheet identified Resident #2's toilet plan as assistance every two hours and habit training daily at 8:30 a.m. The resident's most current three day bladder and bowel diary, dated July 13-15, 2011, identified "pad changed" once on 07/13/11 at 9:00 a.m., once on 07/14/11 at 9:00 a.m., and twice on 07/15/11 at 10:00 a.m. and 7:00 p.m. Based on the diary findings, the facility concluded Resident #2 required "schedule toilet @ [at] 0830 [8:30 a.m.]" Observation on 01/04/11 at 9:30 a.m. showed Resident #2's call light on and the resident seated in her wheelchair in her room. The nurse manager (#11) entered the room and the resident asked for assistance to her recliner and stated,	F 278		

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F 278	Continued From page 3 "Can I go to the bathroom first?" The nurse (#11) assisted her to the bathroom and observation showed the resident's brief dry and she voided on the toilet. Observation on 01/04/11 at 12:05 p.m. showed Resident #2 seated in the dining room. An unidentified certified nursing assistant (CNA) stated the resident requested to use the bathroom before going into the dining room. Observation on 01/04/11 at 4:00 p.m. showed Resident #2 attempted to rise from her recliner just as a CNA (#12) walked by the room. The resident stated she needed to use the toilet. The CNA assisted her into the bathroom and Resident #2 had a bowel movement on the toilet. Observation showed her brief dry. The above observations show a contradiction between Resident #2's actual status (requested to use the bathroom) and the status coded on the MDS (a scheduled toileting program). Assistance to the bathroom at 8:30 a.m. everyday alone does not meet the definition of a scheduled toileting program. Resident #2's medical record lacked evidence the facility documented, monitored, and evaluated the resident's current toileting plan. - Review of Resident #6's medical record occurred on all days of survey. The current MDS, dated 11/25/11, identified the resident as cognitively intact, required extensive assistance with eating, occasionally incontinent of urine, and on a urinary toileting program. The resident utilized a motorized wheelchair for mobility. Observation on all days of survey showed	F 278		

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F 278	Continued From page 4 Resident #6 did not come out of her room for meals and chose to eat her in her room. Facility staff delivered the resident's meal tray to her room and she ate at her leisure. The observations show a contradiction between the Resident #6's actual status (independent) and the status coded on the MDS (extensive assistance). Review of the CNA activities of ADL information sheet identified Resident #6's toilet plan as assistance every two hours and habit training daily at 3:00 p.m. An administrative staff member (#10) and a nurse manager (#11) provided an MDS summary, dated 06/03/10, which stated, ". . . [Resident #6] in [sic] continent of bowel, and had one episode of bladder incontinence . . . a toileting program is in place . . ." On 01/04/12 at 10:05 a.m. two CNAs (#13 and #14) assisted Resident #6 to the toilet. Observation showed the resident's brief dry and she voided on the toilet. The resident stated she sleeps until 10:00 a.m. every morning and staff do not wake her to use the bathroom. The CNA (#13) confirmed this statement. No further observations of toileting occurred during the survey. During an interview on 01/05/12 at 11:15 a.m., Resident #6 stated facility staff do not ask her to go to the bathroom every two hours. She stated her practice is to pull the call light in the bathroom. Staff are alerted by the call light and know she needs to use the toilet. The above observations and interviews show a contradiction between Resident #6's actual status (requested to use the bathroom) and the status	F 278		

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F 278	Continued From page 5 coded on the MDS (a scheduled toileting program). Assistance to the bathroom at 3:00 p.m. everyday alone does not meet the definition of a scheduled toileting program. Resident #6's medical record lacked evidence the facility documented, monitored, and evaluated the resident's current toileting plan. - Review of Resident #9's medical record occurred on all days of survey. The current MDS, dated 12/22/11, identified the resident with severely impaired cognition, required extensive assistance with eating, frequently incontinent of bowel and bladder, and on a urinary toileting program. Observations of Resident #9 during meals showed the following: * 01/03/12 at 4:20 p.m. - positioned at a dining room table and drinking a cup of coffee independently. * 01/04/12 at 8:55 a.m. - seated in the dining room cutting his french toast and sausage and eating independently. * 01/04/12 at 12:50 p.m. - seated in the dining room eating soup, pears, a sandwich, and muffin independently. * 01/05/12 at 8:50 a.m. - seated in the dining room eating a pancake independently after an un-identified staff member cut it into smaller pieces. These observations show a contradiction between the Resident #9's actual status with eating (independent or limited assistance) and the status coded on the MDS (extensive assistance).	F 278		

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F 278	Continued From page 6 Review of Resident #9's CNA ADL information sheet identified a scheduled toileting plan of every two hours and habit training daily at 8:00 p.m. The resident's most current bladder and bowel diary, dated September 22-24, 2011, identified the following: * 09/22/11 - brief/pad wet and changed at 5:00 p.m., 9:00 p.m., and 2:00 a.m. * 09/23/11 - brief/pad wet and changed at 6:00 a.m., 8:00 a.m., 9:00 a.m., 11:00 a.m., 5:00 p.m., 6:00 p.m., 9:00 p.m., 12:00 a.m., and 3:00 a.m. * 09/24/11 - brief/pad wet and changed at 8:00 p.m., 9:00 p.m., 11:00 p.m., 4:00 a.m., and 5:00 a.m. Based on the diary findings, the facility concluded Resident #9 required scheduled toileting every two hours and habit training daily at 8:00 p.m. "d/t [due to] being incontinent @ [at] 9pm x [for] 3 days in a row." Observation on 01/04/12 at 12:15 p.m. showed Resident #9 seated in his recliner is his room and a CNA (#15) stated the resident is a "check and change" every two hours. She stated she checked and changed the resident when he got up this morning and after breakfast. Observations that morning failed to show Resident #9 assisted to the bathroom or checked and changed after breakfast. Observation on 01/04/12 at 1:20 p.m. showed two CNAs (#14 and #15) assisted Resident #9 into the bathroom. The resident stated, "Better hurry or I'll crap in my pants." The CNA (#15) stated the resident lets staff know when he needs to have a bowel movement and is rarely incontinent of stool but his brief is usually wet with urine.	F 278		

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F 278	Continued From page 7 Observation on 01/05/12 at 10:50 a.m. showed Resident #9 seated in his recliner. A CNA (#16) asked the resident if he needed to use the bathroom for a bowel movement and the resident declined. The CNA stated she checked the resident's brief before she assisted him to his recliner at 9:00 a.m. and found it dry. Another CNA (#17) stated she checked and changed Resident #9's wet brief at 6:30 a.m. The above observations and interviews show a contradiction between Resident #9's actual status (requested to use the bathroom for bowel movements and check and change for urine incontinence) and the status coded on the MDS (a scheduled toileting program). Assistance to the bathroom at 8:00 p.m. everyday and a check and change schedule does not meet the definition of a scheduled toileting program. Resident #9's medical record lacked evidence the facility documented, monitored, and evaluated the resident's current toileting plan. - Review of Resident #4's medical record occurred on all days of survey. The resident's current MDS, dated 12/07/11, indicated extensive assistance of one person for eating. Observations on 01/03/12 at 5:40 p.m. and on 01/04/12 at 12:30 p.m. showed an unidentified staff member providing tray set-up for Resident #4. Resident #4 proceeded to eat his meal with no further assistance from staff. The above observations indicate a contradiction between the resident's actual status (limited assistance on 01/04/12) and the status coded on the MDS (extensive assistance on 12/07/11, 28	F 278		

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F 278	Continued From page 8 days prior). - Review of Resident #1's medical record occurred on all days of survey. Resident #1's current MDS dated 11/02/11 identified the resident as cognitively intact and on a urinary toileting program. Review of Resident #1's care plan and activity of daily living sheet identified habit scheduled toileting times of 11:30 a.m. and 9:00 p.m. and to toilet per resident request. A bowel and bladder diary, dated 04/25/11 through 04/27/11, showed that Resident #1 remained continent during the three day assessment period. Observations on 01/04/12 at 1:20 p.m. showed Resident #1 in the bathroom and from an interview with a nursing staff member (#2), the resident put on her call light for staff to assist her to the bathroom. Observation showed the resident's brief remained dry and she voided in the toilet. During an interview on 01/05/12 at 10:55 a.m., Resident #1, identified by the facility as interviewable, reported she asks staff to assist her to the bathroom since she uses a lift. The resident reported incontinent episodes occur less than once per week, and stated she lets staff know when she needs to use the bathroom if they ask. During an interview on 01/05/11 at 12:20 p.m. a supervisory staff nurse (#6) agreed toileting before meals, before bed, and then every two or	F 278		

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F 278	Continued From page 9 three hours does not meet the definition of an individualized program. This staff member stated bowel and bladder diaries identify times for habit scheduled toileting, and agreed that if a resident asks to be taken to the bathroom and remains continent during the assessment then the facility should re-evaluate the resident's toileting program.	F 278		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview, the facility failed to store and handle food under sanitary conditions in 5 of 5 kitchen preparatory and food serving areas (the main kitchen, 42nd Street Diner, Prairie Chateau/Cottage Oaks household, River Terrace/Transitional Care Unit (TCU) household, and Crestwood/Sterling household). Failure to ensure facility staff disposed of outdated food items and restrained hair appropriately placed residents, staff, and visitors who consume food served at the facility at risk for consuming contaminated food and for acquiring a foodborne illness.	F 371	1. As noted by the survey team, the facility failed to store, prepare, distribute and serve food under sanitary conditions due to failure to dispose of outdated foods found in the household kitchens, main kitchen and Diner, and failure to have hair appropriately restrained when working in all food service areas. No residents were found to be effected by this deficient practice. 2. Our current sanitation policy is to follow the North Dakota Century Code Sanitary Requirements for Food Establishments Chapter 33-33-04 as the minimum standard for sanitation practices. This will not change. 3. Changes made to current practices to enhance compliance in these areas are: A. Items in the main kitchen store room will be labeled on the front side of cases to ensure proper rotation of stock and disposal of outdated items. B. Night CNAs will monitor the beverage bar refrigerators in each household daily for undated or outdated items – See attachment K.	

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F 371	Continued From page 10 Findings include: Review of a facility policy titled "Food Storage and Cleaning of Household Kitchens 42nd St" occurred on 01/05/12. This policy, dated September 2009, stated, " . . . Food Storage . . . All foods in the household refrigerators will be labeled with an appropriate expiration date. Food items in the cupboards will follow the manufacturer's expiration dates . . . Dining Services staff will discard all outdated food daily . . ." - Observations on 01/03/12 at 11:15 a.m. showed the following: * the dry storage area in the main kitchen contained eight honey-thick milks with a use by date of 12/01/11. * a refrigerator on Prairie Chateau/Cottage Oaks household contained four honey-thick orange juices dated 11/13/11. * refrigerators on River Terrace/TCU households contained three nectar-thick orange juices dated 11/13/11 and one honey-thick orange juice dated 11/12/11. * a refrigerator on Crestwood/Sterling household contained one honey-thick milk with a use by date of 12/1/11, two honey-thick orange juices dated 10/08/11, and four honey-thick orange juices dated 11/12/11. The milk base products including thickened milk, Kefir, and yogurt, and hashbrowns are classified as potentially hazardous foods. - Observations on 01/04/12 at 9:50 a.m. showed the following:	F 371	C. Additional instructions for stock rotation and discarding of undated/outdated food items will be added to the job schedule of the Dining Services Assistant responsible for stocking the household kitchens – See attachment L. D. Par levels for stocking items in the Households will be adjusted based on usage. E. Dining Services staff will be educated regarding these changes in a departmental staff meeting held on February 13, 2012. Minutes of the meeting and signs regarding changes will be posted in the Dining Services Department. See Attachment M. All staff will sign off on education and completion will be tracked by the Dining Services Manager. A power point presentation will be developed to include the federal guidance, Century Code requirements and departmental policy on dating and discarding food items and hairnet use. The slides will be printed and distributed to all departments by 2/13/2012 along with a quiz to be completed by all staff. See Attachment N. 4. The Dining Services Manager will conduct the following audits three times per week for a period of two weeks, weekly for three weeks and then, based on compliance, moved to monthly monitoring as part of the Quality Program. If concerns are noted while audits are being conducted, staff will be coached immediately.	

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F 371	Continued From page 11 * refrigerators in the 42nd Street Diner contained three chocolate milks dated 01/03/2012 and an undated, opened carton of hashbrowns that staff added water to. * refrigerators on River Terrace/TCU households contained one honey-thick milk with a use by date of 11/16/11 and one bottle of Kefir (a fermented milk based product) opened and undated. * refrigerators on Crestwood/Sterling households contained one yogurt (a potentially hazardous food) with sell by date of 12/5/11, one yogurt with sell by date of 12/15/11, and four yogurts with sell by date of 12/24/11. - Observations showed staff failed to properly restrain hair during the following times: * 01/03/12 at 11:15 a.m. in the main kitchen, an administrative dietary staff member (#7) failed to properly secure bangs, and at 11:50 a.m. in the Crestwood/Sterling household an unidentified maintenance staff member (#8) entered the household kitchen without a hair restraint. * 01/03/12 at 3:40 p.m. in the 42nd Street Diner, an unidentified dietary staff member (#9)prepared and served food without restraining bangs. * 01/04/12 at 8:10 a.m. in the Crestwood/Sterling household, a dietary staff member (#5), a certified nurse assistant (#4), and one administrative dietary employee (#3) entered in and out of the kitchen to serve breakfast without completely restraining hair by allowing longer hair and/or bangs to hang out of a hair restraint. * on 01/04/12 at 1:15 p.m. in the Cottage Oaks household, an unidentified environmental services staff member (#1) came out of the kitchen with hair not contained in a hair restraint. During an interview on 01/04/11 at 11:00 a.m.,	F 371	A. Household refrigerators and cupboards for undated/outdated items. See Attachment O. B. The main kitchen storeroom for compliance with dating practices and stock rotation. See Attachment O. C. Random checks in the household serving kitchens during mealtimes and afternoon activities. See Attachment P. 5. Corrective actions will be completed by 4/5/2012. Shawn S via telephone date changed 02/14/12 JB 4/5/12	

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 _____	01/05/2012

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 371	Continued From page 12 the administrative dietary staff member (#2) agreed staff failed to date the hashbrowns and the Kefir when opened to ensure safety of the products, and failed to discard outdated milk, orange juice containers, and yogurt, which should be discarded after seven days past the sell by date. This staff member also stated the facility expects staff to fully restrain hair while working in food serving and preparatory areas.	F 371		
F 454 SS=D	483.70 LIFE SAFETY FROM FIRE The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, review of profession reference, and staff interview, the facility failed to comply with Life Safety Code requirement NFPA 99 for Health Care Facilities to protect the health and safety of residents, personnel, and the public, regarding oxygen storage in 1 of 1 resident (Resident #5) room observed with an unsecured oxygen tank. Findings include: Life Safety Code requirements state, "Nonflammable medical gas systems and equipment used for the administration of inhalation therapy and for resuscitative purposes comply with NFPA 99, 13-5.1, 7-1.2, NFPA 70." Standard for Storage, Use, and Handling of Compressed Gases and Cryogenic Fluids in Portable and Stationary Containers, Cylinders,	F 454	1. Corrective action for Resident #5 involved immediate removal of the unsecured oxygen tank. 2. Residents currently utilizing a portable oxygen tank would have the potential to be affected by this practice. 3. Bethany on 42nd will initiate the following education to assist staff in understanding how to secure an oxygen tank: A. Did You Know Education Posters and Email - See Attachment Q. B. Education at Unit Meetings See Attachments (same as above) 4. Quality audits will be completed for residents utilizing a portable oxygen tank by completing an observation of their room and oxygen storage rooms on both floors 2x/week for two weeks and then 1x/week for two weeks and turned over to our Quality Program for monitoring and review at our monthly Quality Meeting - See Attachment R. 5. Corrective actions will be completed by 4/5/2012. change per Shawn S. via telephone 02/14/12 KB	4/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 454	Continued From page 13 and Tanks, NFPA 55, 7.1.4.4 states, "Securing Compressed Gas Containers, Cylinders and Tanks. Compressed gas containers, cylinders, and tanks in use or in storage shall be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted by 7.1.4.4.2.7." Review of a facility policy titled "Oxygen, Administration of" occurred on 01/05/12. This policy, dated December 2012, stated ". . . Equipment: 1. Oxygen cylinder on stand, or concentrator. 2. Safety strap or chain (if using oxygen cylinder on a stand). . . ." Observation on 01/04/12 at 9:30 a.m., 12:20 p.m., and 1:30 p.m. identified a portable oxygen cylinder standing on end between a dresser and built in desk with approximately six inches of space on either side of the cylinder. The cylinder lacked a mechanism to secure it from tipping over. During an interview on 01/04/12 at 5:00 p.m. an administrative nursing staff member (#10)confirmed staff should secure oxygen cylinders and that staff removed the unrestrained tank from the resident's room.	F 454		