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 _____	01/06/2022

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 01/03/22 and concluded 01/06/22.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. 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 reasonable accommodation of needs regarding call lights for 2 of 4 sampled residents (Resident #8 and #53) utilizing an alternative soft-touch call light. Failure to assess the residents' ability to effectively use alternative soft-touch call lights and/or place the soft-touch call lights within the residents' reach may result in an inability to call for help, discomfort, incontinence, and/or skin breakdown. Findings include: Review of the facility policy titled "Routine Care" occurred on 01/06/22. This policy, revised January 2018, stated, ". . . Each of the following is part of the routine care provided by care givers . . . Each item is based on the abilities of the resident to participate in their care and needs based on physical and mental limitations. . . . Call light within reach when resident is in room . . ."	F 558	1. Resident #8 no longer resides with us. Resident #53 had an evaluation for Therapy to assess call light options and use. 2. Residents who have a call light have the potential to be impacted. 3. On 1-6-2022, staff re-education was conducted on proper location of resident call light and resident ability to demonstrate use of the call light. Education was provided electronically, at daily huddles, shift change, departmental meetings and unit meetings. Care Teams will request therapy screening on an as needed basis for diagnosis such as: Multiple Sclerosis, Stroke, ALS, Paralysis, etc. 4. Current residents were assessed for proper call light location and ability to	2/7/22

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

Electronically Signed | 01/20/2022

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F 558	Continued From page 1 - During an interview on 01/03/22 at 3:51 p.m., when asked questions pertaining to call lights/response times, Resident #8 stated, "I have a call light around my neck, but it is hard to push. I don't have fine motor skills, so they gave me the other one [soft-touch call light]. I have another call light down there [hanging from the bed rail], but I can't reach it. Sometimes I can't push that either. Sometimes they reposition me and the call light is underneath me and I have to try to pull it out." Observation at the time of the interview showed Resident #8 lying in bed with a call light pendant around her neck and a soft-touch call light hanging from the left bed rail, approximately two inches from the floor and not within Resident #8's reach. Review of Resident #8's medical record occurred on all days of survey. Diagnoses included multiple sclerosis, weakness, and palliative care. The quarterly Minimum Data Set (MDS), dated 12/25/21, identified Resident #8 as cognitively intact and totally dependent on two or more persons for bed mobility. Observation on 01/04/22 at 11:10 a.m. showed a certified nursing assistant (#1) assisted Resident #8 to reposition in bed. Resident #8 wore a call light pendant and the soft-touch call light continued to hang from the left bed rail, approximately four inches from the floor and not within Resident #8's reach. During an interview on 01/06/22 at 11:44 a.m., when discussing Resident #8's concerns regarding her ability to access a call light, an administrative nurse (#2) acknowledged, "The	F 558	demonstrate correct use of call lights. Call Light location and ability to use call light audits will be conducted by the Unit Manager weekly for one month, monthly for 3 months and then quarterly thereafter for one year. Audit results will be reported by the Director of Quality and Education at the bi-monthly Quality/Medical Director meeting.	

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F 558	Continued From page 2 [soft-touch call light] was a preference of hers." - Review of Resident #53's medical record occurred on all days of survey. The quarterly MDS, dated 11/04/21, identified the resident required total assistance with bed mobility, transfer, dressing, eating, toileting and personal hygiene. Observations and interviews of Resident #53 showed the following: * 01/03/22 at 2:33 p.m., resting in bed and a soft-touch call light set on the pillow adjacent to the resident's face. When asked how she asks for help when needed, the resident stated, "With the soft call light on my pillow" and further stated, "I can't get to it [the call light] most of the time." The resident stated she is unable to raise both arms, needs to yell for help, and when she yells, is told, "[Resident's name] don't yell. You'll wake everyone up." * 01/04/22 at 8:57 a.m., seated in a wheelchair in her room and a call light pendant hanging around her neck. When asked to demonstrate use of the call light pendant, the resident unsuccessfully attempted to raise both arms, and stated she cannot use the call light pendant. * 01/04/22 at 12:24 p.m., lying in bed with the soft-touch call light next to her left cheek. When asked to demonstrate her ability to turn on the soft-touch call light, the resident was unable to turn her head far enough to activate the light. The resident stated, "Even if they [facility staff] put it [the soft-touch call light] in my hands, I can't turn it on," and the resident expressed concern about not being able to get help without yelling. When asked to demonstrate her ability to grasp/pinch with both hands, the resident was unable to close	F 558		

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F 558	Continued From page 3 her fingers enough to turn on a call light.	F 558		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that 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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED 02/02/20 Based on observation, resident interview, and record review, the facility failed to ensure appropriate care and services to manage symptoms of edema (fluid retention) for 1 of 1 sampled residents (Resident #43) with order for leg wraps. Failure to ensure timely and consistent implementation of leg wraps may result in worsening edema and increased pain. Findings include: During an interview on 01/03/22 at 2:20 p.m., Resident #43 stated, "sometimes staff wrap my legs and other times they do not." The resident complained of leg pain related to the edema. Review of Resident #43's medical record occurred on all days of survey. Diagnoses include edema. A physician's order dated 12/22/21, stated, "Ace wraps to calves on in AM	F 684	1. On 1-6-2022, coaching was provided for staff who didn't apply wraps as documented and ordered for resident #43. 2. Residents who wear leg wraps have the potential to be impacted 3. On 1-6-2022, staff re-education was conducted on importance of applying ace wraps as ordered. Education was provided electronically, at daily huddles, shift changes, departmental meetings and unit meetings. 4. Ace Wrap audits will be conducted by the Unit Manager weekly for one month, monthly for 3 months and then quarterly thereafter for one year. Audit results will be reported by the Director of Quality and Education at the bi-monthly Quality/Medical Director meeting.	2/7/22

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F 684	Continued From page 4 & [and] off NOC [night]." The current care plan identified, ". . . edema to their bilateral lower extremities. . . ." Observations during the following dates and times identified no ace wraps present: * 01/03/22 at 2:20 p.m. * 01/04/22 at 10:04 a.m. * 01/04/22 at 2:00 p.m.. * 01/05/22 at 10:00 a.m. * 01/05/22 at 12:00 p.m..	F 684		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility policy, and staff interview, the facility failed to provide proper respiratory care consistent with standards of practice and physician's orders for 3 of 8 sampled residents (Resident #86, #92 and #164) and 3 supplemental residents (Resident #16, #38 and #72) receiving oxygen therapy. Failure to administer oxygen as ordered, document oxygen use, and change oxygen tubing per facility policy may complicate the residents' respiratory status. Findings include:	F 695	1. On 1-6-2022, coaching and re-education was provided for staff caring for resident #s 16, 38, 72, 86, 92, and 164. Education provided on oxygen use, oxygen orders and oxygen tubing change out. 2. Residents who have oxygen ordered have the potential to be impacted. 3. Treatment records were updated to include date oxygen tubing needs to be changed out. On 1-6-2022, facility	2/7/22

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F 695	Continued From page 5 Review of the policy titled "SKILLED - ADMINISTRATION OF OXYGEN" occurred on 01/05/22. This policy, revised February 2019, stated, ". . . Oxygen should be administered under orders of the provider . . . Set the flow meter to the rate ordered by the physician . . ." Review of the facility form titled "Oxygen Checklist" stated, ". . . Every Friday NOC [night], change . . . tubing (including tubing on tanks). . . ." - Review of Resident #16's medical record occurred on all days of survey. Diagnoses included chronic congestive heart failure (CHF) (heart disease that causes shortness of breath), Chronic Obstructive Pulmonary Disease (COPD) (lung disease that obstructs the flow of air), and obstructive sleep apnea (a sleep disorder that affects breathing). A physician's order, dated 12/18/21, stated, ". . . Oxygen 2 L [liters] NC [nasal cannula] PRN [as needed] for SOB [shortness of breath] . . ." Observation on 01/04/22 at 10:39 a.m. showed Resident #16's oxygen tubing/nasal cannula labeled "11/12" (indicating the date the staff changed the tubing). The facility failed to change the oxygen tubing/nasal cannula per policy. - Review of Resident #38's medical record occurred on all days of survey. Diagnoses included CHF, COPD, chronic sleep apnea and chronic respiratory failure. A physician's order, dated 01/21/20, stated, "Oxygen 2 L via NC three times a day. Call [providers name] if sats [oxygen	F 695	provided re-education to staff on following orders for oxygen use and updating providers if PRN oxygen is used frequently. 4. Oxygen use/orders and oxygen tubing audits will be conducted by the Unit Manager weekly for one month, monthly for 3 months and then quarterly thereafter for one year. Audit results will be reported by the Director of Quality and Education at the bi-monthly Quality/Medical Director meeting.	

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F 695	Continued From page 6 saturation levels] drop below 90%." Observation on 01/04/22 at 10:36 a.m. showed Resident #38 seated in a wheelchair in her room wearing oxygen via nasal cannula and the oxygen flow meter set at 4 L (not 2 L as ordered). The facility failed to follow Resident #38's physician's order for 2 L of oxygen. - Review of Resident #72's medical record occurred on all days of survey. Diagnoses included chronic COPD, chronic respiratory failure, and dependence on supplemental oxygen. A physician's order, dated 08/18/21, stated, "Oxygen 1.5 L as needed for comfort . . ." Observations on 01/03/22 at 1:26 p.m. and 01/04/22 at 8:40 a.m. showed Resident #72 sitting in a wheelchair wearing oxygen via NC and the oxygen flow meter set at 2 L (not 1.5 L as ordered). The TAR, dated January 1-5, 2022, lacked documentation of Resident #72's oxygen use on January 3-4, 2022. - Review of Resident #86's medical record occurred on all days of survey. A physician's order, dated 03/13/19, stated, "Nurse: O2 [oxygen] continuous @ (at) 2 Liters NC-SOB." An observation on 01/06/22 at 8:25 a.m., showed Resident #86's oxygen tubing, from the room oxygen system, dated 12/11 indicating the date staff changed the tubing. Staff failed to change the oxygen tubing weekly as per policy.	F 695		

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F 695	Continued From page 7	F 695		

- Review of Resident #92's medical record occurred on all days of survey. Diagnoses included malignant pleural effusion (the build up of fluid and cancer cells that collects between the chest wall and the lungs), pulmonary embolism (a condition in which one or more arteries in the lungs become blocked by a blood clot), and dyspnea (difficult or labored breathing). A physician's order, dated 11/30/21, stated, "Oxygen 3 L via NC as needed for comfort."

Observations showed the following:
* Resident #92 wore a nasal cannula on all days of survey. The oxygen tubing attached to the humidifier/bubbler showed a date of "12/11" (the date staff last changed the tubing.)
* On 01/05/22 at 12:20 p.m., Resident #92 wore a nasal cannula with the flow meter set at 2.5 L. Observation showed staff failed to set the oxygen flow rate at 3 L as ordered by her physician.

The TAR, dated January 1-5, 2022, identified staff failed to document Resident #92's continuous use of oxygen throughout the survey.

The "Oxygen Checklist," dated 12/01/21-01/05/22, identified staff checked the humidifier/bubbler, filled it with distilled water, and changed the bubbler/tubing every Friday night. Observation showed staff failed to change the tubing after Saturday, December 11th.

During an interview on 01/06/22 at 9:00 a.m., a managerial nurse (#3) reported, "Resident #92's oxygen] order was changed to continuously yesterday. [It was] as-needed before."

- Review of Resident #164's medical record

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F 695	Continued From page 8 occurred on all days of survey. A physician's order, dated 12/18/21, stated, "Nurse: Oxygen at 2-4L PRN via Nasal Cannula. Refer to care pathway for guidelines. as needed for DYSPNEA [difficult breathing]." Observations made on all days of survey showed Resident #164 wore oxygen continuously. Review of the TAR on 01/05/22 at 5:30 p.m., showed nursing staff failed to sign off Resident #164's oxygen use January 3-5, 2022.	F 695		