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 _____	01/26/2017

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 For the standard Medicare/Medicaid recertification survey started on January 23, 2017 and completed on January 26, 2017, the sample included five (5) residents for complete review, fifteen (15) residents for focused review, and three (3) closed records for review. The sample included three (3) additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 157		3/6/17

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

Electronically Signed | 02/22/2017

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F 157	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure timely notification of a health care provider for 2 of 20 sampled residents (Resident #8 and #13) who experienced a change in health status. Failure to promptly notify the resident's health care provider of complaints of pain with a change in transfer status (Resident #8) and shortness of breath with low oxygen saturation levels (Resident #13) may have resulted in delayed treatment. Findings include: Review of the facility policy titled "Physician Notification" occurred on 01/26/17. This policy, revised September 2011, stated, " . . . Purpose:	F 157	1. Corrective actions for residents #8 and #13 was completed by coaching the staff involved in these observations that occurred in December 2016 and January 2017. 2. Residents who have a significant change in their physical, mental, or psychosocial status have the potential to be affected. 3. The following measures have been put into place: a. Re-education to charge nurses regarding when to update a provider. Feb. 27, 2017. 4. Quality monitoring of Physician Notification Tools (PNT□s) will be	

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F 157	Continued From page 2 Will prompt nurses as to when to update the provider regarding a change in condition. Procedure: 1. Refer to Physician Notification Tool to determine if need to notify MD/Mid-level is immediate or non-emergent. 2. Complete Physician Notification Tool 4. Notify MD/Mid level if appropriate. . . . 8. Bethany Retirement Living has taken the approach regarding changes in residents' status that 'When in Doubt, give the MD and family a Shout.' . . ." The Provider Notification Tool (PNT) stated, " . . . Check all that apply. If any of the below boxes are marked, you must CALL provider. Change in Baseline Vitals - . . . O2 sats [oxygen saturations] < [less than] 88% . . . Sudden onset or Uncontrolled Pain . . ." - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease and reactive airway disease. Physician orders included Albuterol Sulfate/Ipratropium Bromide 1 unit inhale via nebulizer every 4 hours for SOB (shortness of breath) /cough, Albuterol inhaler 2 puffs every six hours as needed and oxygen 2 liters as needed. Nursing Progress notes stated the following: * 12/24/2016 at 11:45 p.m. "Health status change: . . . SOB/wheezing/low O2 sats Assessment completed . . . [Resident] is experiencing extreme SOB and wheezing to bilateral lungs after BR [bathroom] ambulation in room. Skin is pink to lips and extremities. She denies chest pain.[resident] is able to carry a conversation of short sentences, and her cognition is as normal; she is alert and oriented x4. Vitals signs: T: [temp] 98.5 R: [respiration] 20	F 157	completed by the Unit Managers with the following schedule: Review 4 PNT□s/week for 4 weeks, and then 4 PNT□s / 2 weeks for 4 weeks, then 4 PNT□s/month for 3 months. The Quality and Education Department will continue to audit and report on results 2x per year at the Quality/Medical Director meetings.	

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F 157	Continued From page 3 BP: [blood pressure] 127/58 O2: 79% RA. Immediate intervention provided: Sat up straight at edge of bed, calming and therapeutic communication, low stimulus environment; PRN [as needed] Albuterol inhaler- 2 puffs, no change to health status or O2 sats; Administered scheduled nebulizer treatment - [Resident] states feeling less SOB, but still wheezing and O2 sats only raised to 83% on RA [room air]; Initiated PRN O2 2L [liters] per standing order via nasal cannula- effective in reducing wheezing, SOB and raised O2 sats to 89%. Representative updated . . . Yes - [daughter name] left voicemail at 0016 [12:16 a.m.] on 12/25/16. Provider contacted . . . Yes - PNT left for [provider name] 12/25/16. A PNT completed on 12/25/16 summarized the above documentation and a message on the bottom of the page stated, "This was 3 days ago? Oncall updated?" The record lacked evidence the facility staff called Resident #13's medical provider although the PNT stated to call the medical provider for O2 sats < 88%. Review of Resident #13's nursing progress respiratory notes identified the following lung sounds and O2 levels before and after scheduled nebulizer treatments: 09/04/16 at 6:59 a.m. * Before treatment - inspiratory wheezes bilaterally - O2 sat 91% * After treatment - inspiratory wheezes (fewer) - O2% sat 94% 09/04/16 12:06 p.m. * Before treatment - inspiratory and expiratory	F 157		

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F 157	Continued From page 4 wheezes - O2 sat 91% * After treatment - fewer - O2 sat 95% 09/04/16 4:25 p.m. * Before treatment - clear - O2 sat 93% * After treatment - clear - O2 sat 97% 09/04/16 9:26 p.m. * Before treatment - clear - O2 sat 95% * After treatment - clear - O2 sat 97 % 09/05/16 7:52 a.m. * Before treatment - expiratory wheezes present throughout bilaterally - O2 sat 92% * After treatment - no change - O2 sat 95% 09/05/16 4:26 p.m. * Before treatment - light crackles - O2 sat 95% * After treatment - clear - O2 sat 97% 09/05/16 9:23 p.m. * Before treatment - clear - O2 sat 95% * After treatment - clear - O2 sat 97% 09/06/16 7:17 a.m. * Before treatment - bilateral inspiratory wheezes - O2 sat 90% * After treatment - fewer inspiratory wheezes O2 - sat 97% Nursing progress notes stated the following: * 09/06/16 at 07:30 a.m. " . . . Resident continues to have severe inspiratory and expiratory wheezes. She can't breathe and feels like giving up. She has appointment with Pulmonary on 9/16 . . . daughter is aware and concerned about depression and wheezing . . . blue sheet left for [name of nurse practitioner]. * 09/06/16 at 3:04 p.m. . . . "Resident is breathing with more ease after duoneb tx [treatment] and Solumedrol IM [intramuscular] at 1100. . . ." A nurse practitioner progress dated 09/06/16 stated the following:	F 157		

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F 157	Continued From page 5 Impression/Plan 1. SOB (Shortness of breath) 2. Cough Tight chest noted w/ [with] exam 3. Wheezing 4. Labored breathing new I am very concerned regarding the presentation with this patient, especially given the fact that I'm not quite sure how long she's been labored, wheezing etc. I want to send her to ED [Emergency Department] for further eval. [evaluation] She is declining this option. I called her PCP [primary care physician] [name], I think it would be good idea to do Solu-Medrol injection to try and get some quicker relief. We agreed to 60mg [milligrams] x1. I am also starting Predinsone 20 mg po [by mouth] Once Daily x5 days starting tomorrow. . . . will do a CXR [chest x-ray] . . . . in the NH [nursing home], STAT. . . . Nursing Home visit . . . I am seeing [Resident] today for a visit, after a nurse informed me she heard the pt's nurse discussing her decline. I looked in my folder in NH and found a note written today, states [Resident] respiratory status has deteriorated. Sats remain good but wheezing has worsened. VS [vital signs] documented on the sheet, and pt [patient] is documented as being congested and having inspiratory and expiratory wheezing. . . . Sunday 9/4/16 pt started to experience wheezing (documented). Prior to that, lung sounds remarked clear. On Monday 9/5/16, crackles were documented, I do not believe on call was updated. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included a history of a right and left femur fracture, osteoporosis, and Alzheimer's disease. Resident #8's medical record identified the resident returned from the hospital on 01/06/17	F 157		

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F 157	Continued From page 6	F 157		

with a diagnosis of pneumonia. A physical therapy (PT) evaluation completed 01/06/17 identified the following, ". . . Prior Residence and Living Arrangement: Assist X1 Walker with WC [wheelchair] to follow, history of falls & self transfers. . . . Initial Assessment . . . Patient stood at Walker with min [minimal] assist x2. He attempted to Amb [ambulate] but B LE [bilateral lower extremities] buckled. He had c/o [complaints of] pain R LE [right lower extremity]. Retrieved standing lift and patient lifted to full stand. Denied pain in standing in lift. . . . Recommend standing lift currently for transfer. . . ."

Nurses' notes identified the following:
*01/06/17 at 11:47 p.m.: ". . . Pain . . . Location of Pain: Right leg . . . Observed symptoms of pain . . . Resident grimaces and voiced pain when right leg is repositioned or touched/moved. . . . PRN [as needed] Tylenol . . ."
*01/07/17 at 2:56 a.m.: ". . . He requires an assistance of two and full body lift. . . ."
*01/07/17 at 1:29 p.m. (recorded as a late entry): ". . . Currently requires assistance of two with transfers and he does not ambulate. This was a recent change from assist of one with transfers and ambulation. . . ."
*01/10/17 at 12:18 p.m.: ". . . Right leg, hip, knee pain since his return from the hospital [on 01/06/17]. Unable to use EZ stand [a sit-to-stand mechanical lift] due to pain. . . . Left PNT for provider. . . ."

Resident #8's medical record identified a transfer from the ortho walk in clinic to the emergency room on 01/11/17 with a diagnosis of a right hip fracture. Resident #8 returned to the facility on

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F 157	Continued From page 7 01/17/17 after undergoing right hip surgery. During an interview on 01/25/17 at 1:12 p.m., a therapy staff member (#6) identified nursing staff are able to "downgrade" a resident's lift status (i.e., going from a sit-to-stand lift to a full body lift) without consulting therapy. The staff member identified nursing staff had changed Resident #8 to a full body lift because the resident was experiencing pain over the weekend (January 6-8, 2017) and could not stand. The staff member stated the nursing department informed therapy of Resident #8's use of the full body lift on Monday (01/09/17). Although Resident #8 expressed right lower extremity pain upon his return from the hospital on 01/06/17 and a functional decline in his ability to transfer and ambulate, staff failed to notify the medical provider until 01/10/17, at which time the provider ordered X-rays.	F 157		
F 332 SS=E	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 2 sampled residents (Resident #8 and #9) and 3 supplemental residents (Resident #24, #25, and #26) observed during medication pass. Eight medication errors occurred during	F 332	1. Corrective actions for residents #8, #9, #24, #25, and #26 was completed by coaching the staff involved after learning of the survey team observations. 2. Residents who receive medications have the potential to be affected. 3. The following measures have been	3/6/17

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F 332	Continued From page 8 staff administration of 29 medications, resulting in a 27% error rate. Failure to ensure medications are administered correctly may result in adverse side effects. Findings include: Review of the facility policy titled "Insulin, Administration (Flex Pen)" occurred on 01/26/17. This policy, revised December 2013, stated, " . . . 1. Verify resident, dose, medication, time, and route with the MAR [Medication Administration Record] . . . 9. Pull off the needle cap 10. Turn the dose selector to select 2 units. 11. Hold the Novolog Flex Pen with the needle pointing up towards the sky. . . . 12. With the needle pointing upwards, press the push button all the way in. . . . 13. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure . . . 14. Select the dose prescribed. . . " - Observation on 01/23/17 at 5:15 p.m. showed a licensed nurse (#1) prepared Resident #25's Novolog insulin pen for injection. After placing the needle on the insulin pen, the nurse (#1) failed to remove the needle cap before priming the insulin pen. The nurse (#1) was unable to visualize the insulin at the needle tip. - Observation on 01/23/17 at 5:24 p.m. showed a licensed nurse (#1) prepared Resident #26's Novolog insulin pen for injection. After placing the needle on the insulin pen, the nurse (#1) failed to remove the needle cap before priming the insulin pen. The nurse (#1) was unable to visualize the insulin at the needle tip.	F 332	put into place: a. Re-education to staff who pass medications will be conducted. Feb. 27, 2017. b. Did You Know Education (DYK) will be conducted by the Quality and Education team for insulin administration, inhaler administration, eye drop administration as well as buccal morphine order entry. 4. Quality monitoring of medication administration will be completed by the Unit Managers with the following schedule (the following medications will be involved in this audit process insulin, inhalers, eye drops and buccal morphine administration): Review 4 Medication passes/week for 4 weeks and then, 4 Medication passes/2 weeks for 4 weeks and then, 4 Medication passes/month for 3 months. The Quality and Education Department will continue to audit and report on results 2x per year at the Quality/Medical Director meetings. Our Consultant Pharmacist will also review buccal morphine orders when completing monthly Pharmacy Drug Review process.	

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F 332	Continued From page 9 - Observation on 01/24/17 at 11:55 p.m. showed a licensed nurse (#2) prepared Resident #26's Novolog insulin pen for injection. The nurse (#2) reviewed the resident's accucheck and medication administration record (MAR). The nurse stated the resident will receive seven units of insulin for a blood glucose of 287. The nurse dialed the dose selector to five units. The surveyor questioned the nurse (#2) about the dose of insulin and the nurse dialed the dose selector to seven units. Review of the facility policy titled "Medication Administration - General Guidelines" occurred on 01/26/17. This policy, revised April 2015, stated, ". . . When administering potent medications in liquid form or those requiring precise measurement, such as digoxin, devices provided by the manufacturer or obtained from the provider pharmacy, (e.g., oral syringes) are used to allow accurate measurement of doses. . . . Medications are administered in accordance with written orders of the attending physician. . . ." Gauwitz's "Administering Medications Pharmacology for Healthcare Professionals," 7th edition, New York, page A-31 and A-32, stated, ". . . Oral Inhalation of Metered-Dose Inhalant . . . Apply medication as follows: . . . Wait 1 minute before administering additional puffs. . . ." The "Medication Guide" for Symbicort (an inhaled steroid/bronchodilator) found at www.mysymbicort.com, revised January 2017, identified a dose of two puffs and instructions to shake the inhaler for five seconds between puffs. - Observation of medication pass for Resident #9	F 332		

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occurred on 01/23/17 at 4:43 p.m. The medication order identified Artificial Tears one drop in right eye four times a day. Observation showed a nursing staff member (#3) administered one drop in both of Resident #9's eyes.

- Observation of medication pass for Resident #8 occurred on 01/23/17 at 5:11 p.m. The medication order identified Morphine Sulfate Solution 5 mg/ml (milligrams per milliliter) 2.5 mg every four hours (0.5 ml total volume). Observation of the Morphine Solution available to staff identified a concentration of 20 mg/ml (0.125 ml total volume). The nursing staff member (#3) drew up slightly more than 0.12 ml in a syringe and tipped the syringe so the air bubble rested against the rubber syringe plunger. The staff member identified he measured the dose by using the lower edge of the air bubble. The staff member then administered the oral Morphine to Resident #8. Observation showed the ordered concentration did not match the available concentration, and the syringe used by staff lacked measurements to accurately measure 0.125 ml.

- Observation of medication pass for Resident #24 occurred on 01/24/17 at 7:48 a.m. The medication order identified Symbicort 160-4.5 mcg/act (micrograms per actuation) two puffs twice a day. Observation showed the nursing staff member (#4) assisted Resident #24 to take two puffs of the inhaler, but failed to shake the inhaler or wait one minute between puffs.

- Observation of medication pass for Resident #8 occurred on 01/24/17 at 9:11 a.m. The

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F 332	Continued From page 11 medication order identified Morphine Sulfate Solution 5 mg/ml (milligrams per milliliter) 2.5 mg every four hours (0.5 ml total volume). Observation of the Morphine Solution available to staff identified a concentration of 20 mg/ml (0.125 ml total volume). The nursing staff member (#4) drew up slightly more than 0.12 ml in a syringe and tipped the syringe so the air bubble rested against the rubber syringe plunger. The staff member stated, "[The syringe] doesn't have the little lines between the numbers so we just have to kind of guess." The staff member administered the oral Morphine to Resident #8. Observation showed the ordered concentration did not match the available concentration, and the syringe used by staff lacked measurements to accurately measure 0.125 ml. - Observation of medication pass for Resident #8 occurred on 01/26/17 at 8:04 a.m. The medication order identified Morphine Sulfate Solution 5 mg/ml (milligrams per milliliter) 2.5 mg every four hours (0.5 ml total volume). Observation of the Morphine Solution available to staff identified a concentration of 20 mg/ml (0.125 ml total volume). The nursing staff member (#5) drew up slightly more than 0.12 ml in a syringe and tapped the side of the syringe to expel the air bubble. The staff member stated she expels the air bubble because otherwise the resident might not get the correct dose. Observation showed the ordered concentration did not match the available concentration, and the syringe used by staff lacked measurements to accurately measure 0.125 ml.	F 332		