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 _____	02/04/2016

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 02/01/16 and completed on 02/04/16, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review. The sample included 1 additional resident to verify specific concerns during the survey.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and staff interview, the facility failed to assess the safety of self-administration of medication (SAM) for 1 of 1 supplemental resident (Resident #25) observed with medications left at the bedside table. Failure to determine if SAM is a safe practice has the potential to result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "SELF-ADMINISTRATION OF MEDICATIONS (S.A.M. PROGRAM)" occurred on 02/04/16. This policy, revised March 2011, stated, ". . . Purpose . . . 1. To maintain or foster independence . . . 4. To ensure safety of others; residents, visitors, and staff . . . Medications cannot be left at bedside for Resident to take on their own unless	F 176	1. Resident #25 verbally stated she consumed remaining ½ glass of Metamucil. Education was provided for the nurse noted. 2. Residents who take medications and are not on SAM have the potential to be impacted by this practice. 3. Education was provided to the nurse and to staff who administered medications. Education will also be provided at the Plan of Correction Meeting on February 22nd, 2016 (Attachment A). Healthcare Academy module on Medication Administration assigned to nurses and CMA's (Attachment B) 4. An audit will be conducted by the Nursing Team of medication administration 1 x/week for 4 weeks; then	3/3/16

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

Electronically Signed | 02/17/2016

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F 176	Continued From page 1 they are assessed to be appropriate to self administer medications. A CMA [certified medication aide] or nurse must be present while residents take their medications. . . ." Observation on 02/02/16 at 7:55 a.m. during the morning medication pass showed a nurse (#1) left Resident #25's medication at the bedside table. The nurse (#25) signed off the medications on the medication administration record before ensuring the resident took all of the medications. During an interview on 02/03/16 at 5:08 p.m., a managerial nurse (#2) confirmed Resident #25 had not been assessed to self-administer medications. The facility failed to assess Resident #25 to determine if SAM is a safe practice.	F 176	monthly for 3 months; then quarterly for one year. Results will be reviewed quarterly at the Quality Meeting for one year. (Attachment C & D)	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of a facility document, and staff interview, the facility failed to provide care in a manner that enhanced dignity for 2 of 21 sampled residents (Resident #6 and #9). Failure to provide privacy during blood glucose monitoring (Resident #6), speak to the resident in a dignified manner (Resident #9), and to respect the resident's requests for additional	F 241	1. Staff involved in the cares noted for Resident #6 and Resident #9 were provided education as soon as facility was informed of the concerns by the surveyor. 2. Residents residing at this facility have the potential to be affected. 3. The Dignity In-services conducted	3/3/16

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F 241	Continued From page 2 assistance with cares and to eat in her room (Resident #9) did not enhance the residents' dignity and self-respect. Findings include: Review of the facility document titled "Dignity and Respect" occurred on 02/04/16. This document, undated, stated, "Dignity and Respect: . . . Residents have the right to be treated with dignity and respect. . . . To make independent person decisions. . . . To receive reasonable accommodation from the facility for your personal needs and preferences. . . ." - Review of Resident #9's medical record occurred on all days of survey. The record identified the resident sustained a fall on 01/25/16, and on 01/26/16 was sent to the emergency room for complaints of left leg pain. A left ankle fracture was identified. The resident currently has a splint in place. A significant change in status Minimum Data Set (MDS), dated 01/08/16, identified Resident #9 as cognitively intact. Observation on 02/01/16 at 4:56 p.m. showed a certified nursing assistant (CNA) (#5) entered Resident #9's room to provide cares. The CNA (#5) lowered the resident's pants and the resident stated, "You're supposed to treat me with respect, not like a dirty dog!" The CNA (#5) proceeded with perineal cares and the resident stated, "Please respect me, you're just after a paycheck." The CNA responded, "Yeah, I know" then asked the resident to roll on her right side. The resident stated, "Go get help, I feel I'm going to fall." The CNA (#5) responded, "You're ok, just	F 241	quarterly will continue and education will be provided to staff at the Plan of Correction Meeting on February 22nd, 2016 (Attachment A). The Dignity and Standards of Care policies will be reviewed with staff at the Plan of Correction Meeting. (Attachment E) 4. The Social Services and Nursing team will audit dignity for residents #6 and #9 and random residents daily for 2 weeks; 3x/week for 2 weeks; then 2x/week for 4 weeks; then monthly for one year. Results will then be reviewed quarterly at the Quality Meeting for one year. (Attachment D & F)	

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F 241	Continued From page 3 use the rail" and continued to attempt to roll the resident to her right side. Resident #9 resisted being rolled to the right side and the CNA (#5) asked, "What's happening?" Resident #9 responded, "Get help!" then slapped the CNA's hand. The CNA (#5) stated, "Oh, no" and went to the bathroom to wash her hands, leaving Resident #9 exposed on the bed. The CNA (#5) donned new gloves, replaced the same brief on the resident, left her pants down, placed a blanket over her, and stated, "I'll come back later when you're ok." The resident responded, "I'm not ok you hurt my leg." The CNA (#5) washed her hands then exited the room. The CNA (#5) failed to perform cares for Resident #9 in a dignified manner and failed to get additional help when the resident asked for it. During an interview with an administrative staff member (#7) on 02/03/16 at 2:15 p.m., the staff member (#7) stated that the CNA's (#5) behavior was "unacceptable." Observation on 02/02/16 at 7:49 a.m. showed two CNAs (#3 and #4) entered Resident #9's room to transfer her to a wheelchair. Resident #9 stated she would like to stay in bed and the CNA (#4) stated, "Guess what, [a resident's name] would like to see you out, you need to socialize a bit." Resident #9 responded, "They can come see me here." Despite Resident #9's request to stay in her room, the CNAs (#3 and #4) got the resident up and ready to go to the dining room. While a CNA (#4) combed Resident #9's hair, the CNA's staff communication device came on and staff asked if Resident #9 was being brought to the dining room, Resident #9 responded, "No!" The CNAs exited the resident's room, taking her	F 241		

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F 241	Continued From page 4 to the dining room. The CNAs (#3 and #4) failed to respect Resident #9's personal decision to stay in her room. Observation on 02/02/16 at 9:30 a.m. showed two CNAs (#3 and #4) entered Resident #9's room to assist her to the toilet. The CNA (#3) stated to Resident #9, while applying the Hoyer sling (full body mechanical lift), "We are getting you up so you can go wee wee [Resident name]." - Observation on 02/02/16 at 7:48 a.m. showed a staff nurse (#1) tested Resident #6's blood glucose level in the hallway. Another resident, seated in her wheelchair in the same hallway, watched as the nurse performed the test for Resident #6.	F 241		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policies, and resident/staff interviews, the facility failed to provide the necessary care and services to maintain the highest practicable psychosocial well-being for 1 of 21 sampled residents (Resident #5). Failure to ensure staff provided the necessary care and services in a timely	F 309	1. For Resident #5, a formal investigation was initiated when the facility was given the details by the survey team. Investigation concluded staff performed appropriately. 2. Residents who reside at this facility have the potential to be affected.	3/3/16

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F 309	Continued From page 5 manner when responding to Resident #5's call lights resulted in bowel incontinence and caused her psychosocial harm. Findings include: Review of the facility policy titled "Call Light - Use . . . " occurred on 02/04/16. This document, revised April 2015, stated, ". . . Once a resident activates the system . . . a message is immediately sent to all designated staff carrying an I-touch [call light system]. . . If the staff within the household is unable to answer the call light in a reasonable amount of time, the system provides them with the ability to escalate the call to other staff members. This majority of the staff working in skilled care will have an I-touch while working and have the ability to respond accordingly. . . . Resident alerts through the call system will automatically clear when it senses that a staff member is in a close proximity . . . to the resident for 10 seconds. . . ." During an interview on 02/04/16 at 10:15 a.m., two administrative staff members (#7 and #8) confirmed the resident's call light automatically clears as soon as a staff member enters the resident's room. They also reported they are unable to determine whether or not the staff member actually provided cares after entering the room. - During the initial tour on 02/01/16 at 11:25 a.m., Resident #5, later identified by the facility as interviewable, volunteered, "[The facility] is definitely short-staffed." She reported having to wait an average of 15-20 minutes for staff to respond to her call light, and then went on to	F 309	3. The facility will continue to highlight Time of Transition letter (Attachment G) with families and residents. 4. The facility will continue to monitor call light concerns, will continue to follow up with individual residents on concerns noted and will continue to encourage residents to voice concerns either 1:1 with their Manager or Social Worker, thru the Ombudsmen program or via Resident Council.	

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F 309	Continued From page 6	F 309		

describe one particular episode during which she waited approximately 35-45 minutes for staff assistance. She stated, "[I was] so upset! No one came! I pooped in my pants."

- During the group interview on 02/01/16 at 4:00 p.m., when asked if staff respond to call lights in a timely manner, Resident #5 elaborated on the statements she made during the initial tour. In front of seven of her peers, Resident #5 described the incident that had occurred "approximately two weeks" prior. She reported self-transferring to the bathroom, after waiting 25 minutes for assistance. She was unable "to get [to the bathroom] fast enough" which resulted in a "big mess [bowel movement (BM)]." She went on to say a male CNA (certified nursing assistant) entered her room, observed the mess, and exited the room in search of gloves. Resident #5 noted there were gloves present in the bathroom, and reported the male CNA "never came back [to her room]." Several minutes later, a female CNA entered her room and provided the needed cares. Resident #5 reported the incident to the female CNA. She described the incident as "horrible." [The female CNA failed to report the incident as possible neglect.]

- During an interview on 02/02/16 at 9:35 a.m., when asked if staff respond to call lights in a timely manner, Resident #5 elaborated on the statements she made during the initial tour and the group interview. She reported self-transferring to the bathroom, after waiting 25 minutes for assistance. She stated, "By the time I got there, I pooped all over, [even on the] floor. I was crying. If they got here in time, it wouldn't have happened." She went on to say the [male]

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F 309	Continued From page 7 CNA entered her room, "saw the poop," and exited the room in search of gloves. Resident #5 noted there were gloves present in the bathroom, and reported the [male] CNA "never came back." Several minutes later, another [female] CNA entered her room and stated, "I thought [the male CNA] had helped [you]." Resident #5 said she "started crying again. It was humiliating . . . horrible!" In closing, Resident #5 stated, "They got after me for not waiting. What am I supposed to do?" Review of Resident #5's medical record occurred on all days of survey. Diagnoses included traumatic subdural hemorrhage (stroke), gait unsteadiness, and history of falls. The admission Minimal Data Set (MDS), dated 12/31/15, identified extensive assistance of two or more people required for transfers, toileting, and personal hygiene. An "MDS Summary," dated 01/21/16, stated, ". . . [Resident #5] was . . . incontinent of bowel x 1 during the reference period. . . ." The facility staff's failure to provide the necessary care and services to Resident #5 in a timely manner placed her at risk for falls while she attempted to self-transfer to the bathroom and resulted in her episode of bowel incontinence and increased her risk of skin irritation. Staff failed to report the incident to supervisory staff as possible neglect. Resident #5 repeated her story three times to different members of the survey team and in front of her peers, describing her persistent feelings of humiliation. - During an interview on 02/01/16 at 4:13 p.m., when asked if staff respond to call lights in a	F 309		

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F 309	Continued From page 8 timely manner, Resident #7, identified by the facility as interviewable, responded, "When I do need help, it can be [a] 15-45 minute . . . wait to use the bathroom. When they didn't come, then I take my walker and go to [the] bathroom myself." - During an interview on 02/01/16 at 5:00 p.m., when asked if staff respond to call lights in a timely manner, Resident #6, identified by the facility as interviewable, responded, "[It takes staff a] long time to answer call lights." He reported being incontinent of bowel/bladder while "waiting for help."	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, and record review, the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents for 2 of 3 sampled residents (Resident #8 and #9) observed being left alone in the bathroom. Failure to provide adequate supervision and assistance may result in avoidable falls or injury. Findings include:	F 323	1. Staff working with Residents #8 and #9 were provided education as soon as facility was aware of concerns. 2. Residents who require assistance for cares have the potential to be affected. 3. Education will be provided to CNAs and Nurses at the Plan of Correction Meeting on February 22nd, 2016. (Attachment A). 4. The Nursing Team will audit care observations (Attachment H) for	3/3/16

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F 323	Continued From page 9 - Review of Resident #8's medical record occurred on all days of survey. The current care plan stated, ". . . Falls: Risk for falls related to bilateral lower extremity pain and use of multiple medications. . . . Ensure (Resident Name) safety. . . . Fall prevention devices per ADL [activities of daily living] sheet (frequent checks, do not leave alone in BR [bathroom]). . . ." The resident's ADL sheet stated, ". . . Do not leave alone in bathroom. . . ." Observation on 02/02/16 at 9:05 a.m. showed a certified nursing assistant (CNA) (#3) assisted Resident #8 to the bathroom and transferred her to the toilet. The CNA (#3) closed the bathroom door and performed tasks in the resident's room. At 9:16 a.m. the CNA (#3) knocked on the bathroom door, asked the resident if she needed more time, encouraged the use of the call light when finished on the toilet, and exited the resident's room. At 9:22 a.m., the CNA (#3) returned to Resident #8's room and assisted the her off the toilet. Leaving Resident #8 alone in the bathroom may result in an avoidable fall/injury. - Review of Resident #9's medical record occurred on all days of survey. The current care plan stated, ". . . Falls: . . . potential for falls related to. . . medication use, history of falls, and dx [diagnoses] of HTN [hypertension], pain. . . Fall prevention devices per Resident ADL sheet: . . . Do not leave alone in BR. . . ." The resident's ADL sheet stated, ". . . Do not leave alone in the BR. . . ." Observation on 02/02/16 at 9:30 a.m. showed	F 323	Residents #8 and #9 as well as random residents daily for 2 weeks; 3x/week for 2 weeks; then 2x/week for 4 weeks; then monthly for one year. Results will then be reviewed quarterly at the Quality Meeting for one year.	

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F 323	Continued From page 10 two CNAs (#3 and #4) assisted Resident #9 to the toilet using a hoyer lift (full body mechanical lift). One CNA (#3) exited the room while the other CNA (#4) shut the bathroom door and performed tasks in the resident's room. The CNA (#4) then sat on a chair outside the bathroom and waited for the resident to finish on the toilet. At 9:57 a.m. the other CNA (#3) returned the room and the CNAs assisted Resident #9 off the toilet. Leaving Resident #9 alone in the bathroom may result in an avoidable fall/injury.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked,	F 431		3/3/16

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F 431	Continued From page 11 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: Based on observation, review of facility procedure, and staff interview, the facility failed to store medications in a secure manner in 1 of 8 medication carts (Cottage Oakes cart). Failure to lock the medication cart when unattended could result in unauthorized access to medications. Findings include: Review of the facility policy "PHARMACY - STORAGE OF MEDICATIONS" occurred on 02/04/16. The policy, revised in September 2009, stated, ". . . PROCEDURE . . . B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications such as medication aides are allowed access to medications. Medication rooms, carts, cabinets, and medication supplies are locked or attended by person with authorized access. . . ." Observation of the Cottage Oakes medication cart occurred on 02/03/16 at 5:14 p.m. and showed the unlocked medication cart unattended in the hall next to the dining room. Between 5:14 p.m. and 5:23 p.m., two unlicensed staff	F 431	1. The one nurse involved in this occurrence was educated as soon as facility was aware of concern. 2. Residents who receive medications have the potential to be affected. 3. Education will be provided to staff administering medications at the Plan of Correction Meeting on February 22nd, 2016 (Attachment A). . Healthcare Academy module on Medication Administration assigned to nurses and CMA's (Attachment B) 4. An audit will be conducted of medication carts 1 x/week for 4 weeks; then monthly for 3 months; then quarterly for one year. Results will be reviewed quarterly at the Quality Meeting for one year. (Attachment C & D).	

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 _____	02/04/2016

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 431	Continued From page 12 members walked by the unattended cart. At 5:23 p.m. the licensed nurse (#6) returned to the cart. Facility staff's failure to secure the medication cart prior to leaving the area may have resulted in unauthorized access to the medications stored in the cart.	F 431		