| 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 _____ | 02/28/2018 |

| 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<br><br>The standard Medicare/Medicaid recertification survey started on February 25, 2018 and concluded on February 28, 2018. The total sample size was 23 residents. | F 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's status for 1 of 23 sampled residents (Resident #103). Failure to ensure Section N (Medications) of Resident #103's MDS accurately reflected his current status/needs, has the potential to affect the accurate development of his comprehensive care plan and the care provided.<br><br>Findings include:<br><br>The Long-Term Care Facility RAI User's Manual, revised October 2017, page N-7 stated, ". . . N0410E, Anticoagulant (e.g. [example given], warfarin, heparin, or low- molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period . . ."<br><br>Review of Resident #103's medical record | F 641 | 1. A correction MDS was submitted for the one resident noted to have been affected (resident #103). This was done on February 28th, 2018. Coaching was provided to staff member who completed this MDS.<br><br>2.Residents who have Section N completed on an MDS have the potential to be impacted.<br><br>3.Education to MDS staff was completed on 3-1-2018 in person as well as by email education done on 3/5/2018.<br><br>4. Starting on 3/4/18 Quality monitoring of MDS will be completed by the MDS Coordinators with the following schedule: Review 3 MDS/week for 4 weeks and then 4 MDS/month for 3 months and then 1 MDS per month until 12/31/18. The Quality and Education Department will continue to audit and report on results 1x year at the monthly Quality Meeting. | 4/1/18 |

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

Electronically Signed | 03/19/2018

| 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 _____ | 02/28/2018 |

| 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 641 | Continued From page 1<br>occurred on all days of survey. Review of the resident's Significant Change MDS, dated 02/14/18, showed Resident #103 received an anticoagulant medication every day of the 7-day look-back period. The February electronic medication administration record (eMAR) failed to show this resident received any anticoagulant medication during the 7-day look-back period.<br><br>During an interview on 02/07/18 at 12:08 p.m., an MDS Coordinator (#5) agreed she failed to accurately code Section N of the MDS. | F 641 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and review of professional reference, the facility failed to follow professional standards of practice regarding physician's orders for 1 of 23 sampled residents (Resident #10). Failure to carry out physician's orders regarding psychotropic medications may result in inadequate monitoring and adverse drug effects related to their use.<br><br>Findings include:<br><br>Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, states, ". . . Carrying Out a Physician's Orders . . . If the order is | F 658 | 1. A follow up appointment for the one resident noted to have been affected (resident #10) was completed on March 13th, 2018. Coaching was completed with staff that did not carry out setting up the follow up appointment.<br><br>2. Residents who have follow-up appointments have the potential to be impacted.<br><br>3. 2/28/18 Refresher education provided to Nurses and Nurse Managers on reviewing orders & using stamper to assist in completing follow up appointments. | 4/1/18 |

| 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 _____ | 02/28/2018 |

| 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 658 | Continued From page 2<br>neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ."<br><br>Review of Resident #10's medical record occurred on February 27-28, 2018. Diagnoses included anxiety, insomnia, and depression.<br><br>A faxed "Provider Notification of Psychotropic Drug Gradual Dose Reduction" (GDR), signed by the provider on 10/16/17, stated, ". . . Trazodone [an antidepressant] 25 mg [milligrams] PO [by mouth] HS [bedtime] for insomnia . . . [decreased] 7/12/17 . . . Tolerated last GDR well. Does spend a lot of time in bed. Continue [with] GDR? . . ." The provider responded, "last seen 4-25-17. Please schedule." A second provider notification, signed on 01/09/18, stated, ". . . Trazodone 25 mg PO @ HS for insomnia . . . [decreased] 7/12/17 . . . Did well [with] recent GDR. Continue? . . ." The provider responded, "last seen 4-25-17. Please schedule."<br><br>A nurse's note, dated 01/10/18, stated, ". . . [Resident #10] is due for a GDR for Trazadone [sic] 25 mg. GDR is not accepted by [provider's name] at this time. [Resident #10] was last seen in April so Provider is requesting a new appointment be scheduled before any changes are made. . . ."<br><br>The record lacked evidence of follow-up regarding the provider's requests for an appointment. | F 658 | 4. Starting on 3/6/18 Quality Audits of resident medical provider orders will be conducted by the Nurse Manager Team. The Team will conduct 4 audits/week X4 weeks and then 4 audits/week X 4 weeks and then quarterly until 12/31/18. The Quality Department will continue audits thereafter and report 1x year at our monthly Quality Meeting. | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that - | F 689 | | 4/1/18 |

| 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 _____ | 02/28/2018 |

| 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 689 | Continued From page 3<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and record review, the facility failed to provide supervision and assistive devices necessary to prevent accidents for 1 of 7 sampled residents (Resident #81) observed during a transfer. Failure to use the correct transfer method placed Resident #81 at risk for falls and injury.<br><br>Findings include:<br><br>Observation on 02/26/18 at 11:12 a.m. showed two certified nursing assistants (CNAs) (#6 and #7) and one nurse (#8) in Resident #81's room. A CNA (#7) brought a full body mechanical lift into the room. The nurse indicated Resident #81's transfer method had changed after working with therapy the previous week and stated she was now a two person transfer with a gait belt. The nurse then left the room. The CNA's placed a gait belt around Resident #81's waist and assisted the resident to stand from her wheelchair and pivot to the bed using a walker. During the transfer, the gait belt was loose and slid up into the resident's axillae. The resident's knees were bent, and one CNA (#6) held the waistband of the resident's pants with one hand while holding the gait belt with the other. The CNAs repeatedly told Resident #81 to stand up during the transfer. Upon completion of the transfer, a CNA (#7) checked and changed the resident's brief and | F 689 | 1. Coaching was provided immedatiely for staff involved in the one transfer for the resident affected (resident #81).<br><br>2. Residents who require assistance with transfers have the potential to be impacted.<br><br>3. The following measures were put into place:<br>a. 2/28/18 Refresher education provided to CNAs and Nurses regarding referring to ADL Sheet for transfer modalities.<br>b. 2/28/18 Refresher education provided to CNAs and Nurses regarding proper placement of gait belts.<br><br>4. Starting on 3/4/18 Quality Audits of transfers will be conducted by the Nurse Manager and Quality Team. These teams will conduct 4 audits/week X 4 weeks and then 4 audits/week X 4 weeks and then quarterly until 12/31/18. After 12/31/18 the Quality Department will continue audits thereafter and report 1x year at the monthly Quality Meeting. | |

| 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 _____ | 02/28/2018 |

| 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 689 | Continued From page 4<br>called for the nurse to perform a dressing change. After the dressing change, the CNA (#7) asked the nurse (#8) for help with the transfer and stated, "It didn't go very well the first time." During the transfer from the bed to the wheelchair, the resident's knees were again bent, and the resident made shuffling movements with her feet. The nurse (#8) instructed Resident #81 to stand up multiple times and stated the resident needs a lot of cuing.<br><br>Resident #81's physical therapy progress notes, dated 02/23/18, stated, ". . . Pt [patient] continues to have great difficulty following commands safely, spoke with nursing on recommendations to continue Hoyer [full body mechanical lift] transfers and no ambulation. Pt. had planned to d/c [discharge] today, but due to change will continue to assess transfers and gait. . . ." The CNA's current care plan identified a full body lift and two person assist to transfer Resident #81. | F 689 | | |
| F 759 SS=D | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 01/26/17.<br><br>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 3 of 6 residents (Resident #31, #51 | F 759 | 1. Immediate education provided to staff providing insulin, symbicort and albuterol medications to residents #31, #51, and #130.<br><br>2. Residents receiving insulin via Novolog Flex Insulin pens and residents receiving | 4/1/18 |

| 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 _____ | 02/28/2018 |

| 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 759 | Continued From page 5<br>and #130) observed during medication administration. Five medication errors occurred during staff administration of 27 medications, resulting in a 18% error rate. Failure to administer medications correctly may result in adverse side effects.<br><br>Findings include:<br><br>Review of the facility policy titled "Insulin, Administration (Insulin Pens)" occurred on 02/28/18. This policy, revised December 2017, stated, " . . . 4. Prime the insulin pen: a. Dial 2 units by turning the dose selector clockwise. b. Remove the cap on the needle. c. With the pen pointing up, push on the plunger, and watch to see that at least a drop of insulin should appear at the needle tip. If no, change the needle and repeat the procedure . . ."<br><br>Review of the facility policy titled "Metered Dose Inhaler (MDI)" occurred on 02/28/18. This policy, revised December 2017, stated, " . . . 6. If more than one puff of medication is required, (whether the same medication or a different medication) wait at least one minute between puffs. . . . Noe (sic): If a resident requires the use of more than 1 inhaler a minimum of 3 minutes must pass before administering a second inhaler."<br><br>- Observation on 02/25/18 at 4:48 p.m. showed a licensed nurse (#3) prepared Resident #31's Novolog insulin pen for injection. After placing the needle on the insulin pen, the nurse (#3) failed to remove the needle cap before priming the insulin pen. The nurse (#3) was unable to visualize the insulin at the needle tip. | F 759 | inhaler medications have the potential to be impacted.<br><br>3. The following measures were put into place:<br><br>a. Refresher education via Healthcare Academy to CMAs and Nurses.<br>b. Education on providing insulin, symbicort and albuterol medications conducted in 1:1 meetings with CMAs and Nurses on proper priming of Insulin pens as well as proper timing when giving Albuterol and Symbicort inhalers.<br><br>4. Starting on 3/1/18 Quality Audits will be conducted 1x/week X 4 weeks by the Nurse Manager Team and then monthly by our Quality Department until 12/31/18. After 12/31/18 the Quality Department will continue audits and report 1X year at the monthly Quality Meeting. | |

| 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 _____ | 02/28/2018 |

| 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 759 | Continued From page 6<br>- Observation on 02/25/18 at 5:19 p.m. showed a licensed nurse (#3) prepared Resident #51's Humalog insulin pen for injection. After placing the needle on the insulin pen, the nurse (#3) failed to remove the needle cap before priming the insulin pen. The nurse (#3) was unable to visualize the insulin at the needle tip.<br><br>- The Physician's orders for Resident #130 identified "Albuterol Sulfate Aerosol . . . 108/(90 base) mcg/act (micrograms per actuation) two puffs inhale orally every 6 hours . . . Wait one minute between puffs . . ." and "Symbicort 80-45 mcg/act two puffs inhale orally two times a day . . . Wait one minute between puffs. . . ."<br><br>Observation of medication pass for Resident #130 occurred on 02/26/18 at 7:55 a.m. The medication assistant (#4) assisted Resident #130 to take two puffs of the Albuterol inhaler, but failed to wait one minute between puffs. After administering the first inhaler, the medication assistant (#4) waited one minute. The staff member (#4) then assisted Resident #130 to take two puffs of the Symbicort inhaler, but failed to wait one minute between puffs. The staff member (#4) failed to wait the minimum of 3 minutes before administering the second inhaler.<br><br>During an interview at 5:15 p.m. on 02/26/18, an administrative staff member (#2) confirmed staff should visualize the insulin when priming the pen and wait the required time between inhaler puffs. | F 759 | | |