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 _____	03/14/2024

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 03/11/24 and concluded on 03/14/24.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment.	F 640		4/1/24

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

Electronically Signed | 03/25/2024

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 640	Continued From page 1 (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), and staff interview, the facility failed to ensure timely electronic data submission of required Minimum Data Sets (MDS) assessments for 1 of 1 supplemental residents (Resident #32) and one closed record (Resident #30). Failure to follow the MDS data submission specifications does not meet the intended regulatory requirements. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.18.11), page 2-34 stated, ". . . The MDS must be transmitted (submitted and accepted into iQIES [Internet Quality Improvement and Evaluation System]) electronically no later than 14 calendar days after	F 640	1. The noted MDS for resident # 32 and # 30 was submitted on 3/13/24 when the facility was informed of this deficiency. 2. Residents who have an MDS completed have the potential to be impacted. 3. Since this deficiency was isolated to one MDS nurse; immediate education was provided when facility was made aware. Re-education to facility MDS coordinators was also done at MDS huddle meeting on 3/18/24 on the proper MDS submission process. The Director of Admissions and MDS will also be reviewing the submission reports and cross referencing to the MDS schedule. 4. The Director of Admissions and MDS	

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F 640	Continued From page 2 the MDS completion date (Z0500B + 14 calendar days). . . ." and page 5-1, stated, "Transmitting MDS Data. All Medicare and/or Medicaid-certified nursing homes . . . must transmit required MDS data records to CMS [Center for Medicare and Medicaid Services] Internet Quality Improvement and Evaluation System . . . Required MDS records are those assessments and tracking records that are mandated under OBRA [Omnibus Budget Reconciliation Act] . . ." - Review of Resident #30's medical record occurred on 03/13/24 and showed a discharge MDS dated 01/03/24. - Review of Resident #32's medical record occurred on 03/13/24 and showed a quarterly MDS dated 01/24/24. During a phone interview on 03/14/24 at 8:16 a.m., an administrative nurse (#1) stated staff submitted Resident #30 and #32's MDS and confirmed the MDSs were not accepted by CMS. The facility failed to ensure CMS accepted the submitted assessments.	F 640	and/or their designee(s) will complete audits on MDS submission with the following schedule; 5 MDS/week for 4 weeks, then 5 MDS every other week for 4 weeks, then 5 MDS per quarter for one year. Results will be reported at each scheduled bi-monthly Quality Meeting.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to	F 641	1) The facility corrected the MDS assessments for residents #44, #9, #6, #51, and #85 that were found to be coded inaccurately.	4/1/24

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F 641	Continued From page 3 ensure accurate coding of the Minimum Data Set (MDS) for 3 of 25 sampled residents (Resident #6, #9 and #51) and two supplemental residents (Resident #44 and #85). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION A: IDENTIFICATION INFORMATION The Long-Term Care Facility RAI Manual, revised October 2023, pages A-30 thru A-32, ". . . A1500: Preadmission Screening and Resident Review (PASRR) . . . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . . . and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. . . ." - Review of Resident #44's medical record occurred all days of survey. A Level 1 PASRR, dated 08/07/23, stated, ". . . You meet PASRR inclusion criteria for Serious Mental Illness . . ." Resident #44's Admission MDS dated 08/30/23 identified diagnoses of manic depression (bipolar disorder). Facility staff coded item A1500: "Is the resident currently considered by the state level II PASRR process to have a serious mental illness . . ." as no. During an interview on 03/13/24 at 10:55 a.m. two administrative staff (#2 and #3) confirmed staff failed to code Resident #44's admission	F 641	2) Residents who have the appropriate diagnosis/diagnoses to be considered by the PASRR level II process could have the potential to be impacted. Residents who have aspirin ordered or who have a fall could have the potential to be impacted. 3) Upon notification of section A1500 of resident #44's MDS being coded inaccurately, immediate education was provided to staff member who completed this question. Email re-education related to appropriately coding the MDS was provided to the social services department who complete section A1500 of the MDS. This same education was provided at an in-service to the social services department on 03/14/24. Electronic education course on MDS section A1500 PASRR via HealthCare Academy was also assigned to social services staff. For section N and section J, immediate education was provided to individual nurses who did not code these items. Re-education to the MDS Coordinators was also done via email as well as at MDS huddle meeting on 3/18/24 on how to code aspirin and falls. Healthcare Academy MDS sessions were assigned to the MDS Coordinators. 4) The Director of Admissions and MDS and the the Director of Social Services and/or their designee(s) will conduct 5 MDS accuracy audits weekly for four consecutive weeks. The audits will then	

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F 641	Continued From page 4 MDS correctly. SECTION J: FALLS The Long-Term Care Facility RAI Manual, revised October 2023, page J-37, states, " . . . If this is not the first assessment . . . the review period is from the day after the ARD [assessment reference date] of the last MDS assessment to the ARD of the current assessment. . . Determine the number of falls that occurred since . . . prior assessment . . . and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury. . . . " - Review of Resident #9's medical record occurred all days of survey. The medical record identified a fall with head laceration on 02/03/24. Resident #9's quarterly MDS, dated 03/06/24, identified no falls since previous assessment. SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2023, pages N-1, and N-6 to N-8 stated, "Section N Medications . . . N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., [for example] aspirin/extended release . . .) was taken by the resident at any time during the 7-day observation period . . ." - Review of Resident #6's medical record occurred all days of survey. Physician's orders included aspirin 81 milligrams (mg) daily, initiated on 07/28/23. The quarterly MDS, dated 01/24/24, showed staff coded aspirin as an anticoagulant (blood thinner) rather than an antiplatelet	F 641	move to 5 every two weeks for four weeks and then move to 5 audits quarterly for one year. Results will be reported at each scheduled bi-monthly Quality Meeting.	

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F 641	Continued From page 5 medication. - Review of Resident #51's medical record occurred on all days of survey. Physician's orders included aspirin 81 mg daily, initiated on 08/08/23. The quarterly MDS, dated 01/17/24, showed staff coded aspirin as an anticoagulant and antiplatelet medication. - Review of Resident #85's medical record occurred on 03/12/24. Physician's orders included aspirin 81 milligrams (mg) daily, initiated on 01/29/24. The quarterly MDS, dated 03/06/24, showed staff coded aspirin as an anticoagulant (blood thinner) rather than an antiplatelet medication. During an interview on 03/14/24 9:45 a.m., an administrative nurse (#1) confirmed staff failed to code Resident #6, #9, #51, and #85's MDSs correctly.	F 641		