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 _____	11/21/2012

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 11/19/12 and completed on 11/21/12, the sample included four residents for complete review, nine residents for focused review, and three closed records.	F 000		
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, policy and procedure review, and resident interview, the facility failed to provide care in a manner and in an environment that maintained and enhanced dignity and respect for privacy for 3 of 13 sampled residents (Resident #4, #6, and Resident A). Findings include: Review of the facility's policy titled "Personal Privacy and Confidentiality" occurred on the afternoon of 11/21/12. The policy, dated January 2009, stated, ". . . 2. Staff will knock on the resident's door and seek affirmative response from the resident prior to entering. 3. Staff will not enter resident's room(s) when medical treatment and/or personal cares are being provided. . . ." - An interview occurred on the afternoon of 11/19/12 with Resident A, identified by the facility as interviewable. When asked if facility staff	F 241	1. Immediate education was done through email and in shift-to-shift report re: dignity and privacy. Staff were educated on the importance of knocking on resident room doors and waiting to enter until a response and invitation has been received. 2. All residents in the facility have the potential to be affected by this practice. 3. Bethany on 42nd will continue to provide the following education to staff: a) Email education to nurses and CNA's as well as education to staff through shift-to-shift report. b) Social Services will continue to address this in New Employee Orientation. Will continue to educate all new employees on privacy and dignity and emphasize the importance of knocking and waiting for an invitation before entering a resident's room. Our policy and procedure entitled, "Personal Privacy and Confidentiality" will also be handed out to new employees and volunteers. See **Attachment A.** c) Did You Know Education will be done at Plan of Correction Meeting on 12/20/12. See **Attachments B, C.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	President/CEO	12-11-12

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 241	Continued From page 1 respect his/her privacy, Resident A stated staff members usually knock before they enter his/her room, but fail to wait for a reply. Resident A stated there have been times when he/she had just finished on the toilet and needed to pull up his/her pants quickly because staff entered without waiting for a reply. - Review of Resident #6's medical record occurred on 11/19-21/12. Diagnoses included dementia with behavior disturbances and anxiety. The most recent Minimum Data Set (MDS), dated 08/25/12, identified her as cognitively intact. Observation on 11/20/12 at 10:30 a.m., showed two CNAs (#4 and #5) assisting Resident #6 with toileting. An activities staff member (#6) knocked on the door and entered the resident's room without waiting for a response. The staff member entered into the resident's room, observed her on the toilet, and then left the room. The resident stated, the staff member entered the resident's room to "see if exercising and she saw me on the toilet." - Observation of medication pass occurred on 11/20/12 at 8:10 a.m. A nursing staff member (#7) entered Resident #4's room to administer medications and then shut the door. At 8:14 a.m., a CNA (#3) knocked on the door as she opened it and immediately entered the room. The CNA failed to wait for a response prior to entering the resident's room.	F 241	d) We will continue to provide annual education via Health Care Academy regarding resident's rights and vulnerable adult protection. See **Attachment D.** e) Social Services department conducts an annual dignity in-service which includes topics regarding resident privacy. All new employees are required to attend "Virtual Dementia Training" which educates on the importance of resident dignity. See **Attachment E, F.** 4. 12/26/2012 5. Social Services department will be conducting weekly audits (starting on 12/3/12) on every household to assure that staff are knocking and waiting for an invitation before entering resident's rooms. Audits will be completed on the following schedule: • 12x/week on each unit/floor for a period of 2 weeks. • Then 6x/week on each unit/floor for a period of 2 weeks. • Then 3x/week on each unit/floor for a period of 2 weeks. Audits will be completed on various shifts. Follow up with staff will be completed immediately if policy is not followed. Once compliance is met, Social Services will continue to audit this monthly through our usual quality monitoring program. See **Attachment G.**	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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F 323	Continued From page 2 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, medical record review, and review of facility policy, the facility failed to provide assistive devices necessary to prevent accidents for 3 of 11 sampled residents (Resident #4, #5, and #11) observed during gait belt and mechanical sit-to-stand lift transfers. Failure to use gait belts and mechanical lifts appropriately placed the residents at risk for falls and injuries. Findings include: Review of the facility policy titled "Gait Belt, Application And Use Of" occurred on 11/21/12. This policy, revised April 2012, stated, ". . . Procedure . . . 5. Apply snugly around resident's waist. 6. Use belt to assist resident to standing position, provide security and stability when transferring and ambulating, and to prevent any tugging or lifting under the resident's arms. . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, Parkinson's disease, and generalized pain. The current Minimum Data Set (MDS), dated 10/31/12, identified extensive assistance from two or more people for transfers. Resident #4's current care plan identified the use of a	F 323	1. Corrective actions for residents #4, #5, and #11 involved immediate therapy screenings to determine appropriate level of transfer assistance. Staff that were identified by the Survey Team were immediately coached and reeducated. 2. Residents requiring assistance with transfers would have the potential to be affected by this practice. 3. Bethany on 42nd will initiate the following education to assist staff in understanding safety with transfers: a) Did You Know educational posters to be emailed to nursing staff and displayed throughout the facility. See **Attachment H, I.** b) Review of transfers (gait belt use, sit-to-stand, and full body lifts) at the Plan of Correction Staff Meeting 12/20/12 See **Attachment C, J.** c) Health Care Academy online education session to be assigned December 2012 to Nursing Staff and then annually. See **Attachment K.** d) Nursing staff's skills in this area will be assessed at their 90 day and annual evaluations. See **Attachment L, M, N.** 4. 12/26/12 5. Quality Audits will be completed for residents requiring assistance with transfers (gait belt, sit-to-stand, full body)by the Nurse Manager Team as follows: • 5 audits/floor or unit for 2 weeks; • Then 3 audits/floor or unit for 2 weeks;	

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F 323	Continued From page 3 sit-to-stand lift or two person assistance for transfers. Observation on 11/20/12 at 11:40 a.m. showed a certified nursing assistant (CNA) (#3) applied a gait belt around Resident #4's waist and, with help from another CNA (#8) and a front-wheeled-walker, assisted the resident from his loveseat to the bathroom. During ambulation, the gait belt loosened and slipped up to Resident #4's chest area and under his axilla. The CNAs failed to adjust and tighten the gait belt when it moved upward. Resident #4's knees buckled and the two CNAs held onto the back of his pants and slid him onto the commode. Observation on 11/20/12 at 2:15 p.m., showed two CNAs (#2 and #3) assisted Resident #4 to transfer from his loveseat to the bathroom. While applying a gait belt to the resident, the resident stated, "Ouch," and the CNA (#2) responded "[the gait belt] will loosen when you stand." The staff members assisted Resident #4 to stand and the gait belt slid upward into Resident #4's axilla. The staff members assisted Resident #4 to walk to the bathroom with one of the CNAs gripping the back of the resident's pants at the waist. When the staff members assisted Resident #4 to transfer from the bathroom back to his loveseat, the gait belt again slid upward into Resident #4's axilla. - Review of Resident #5's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance. The current MDS, dated 11/12/12, identified extensive assistance from two or more people for transfers and no ambulation occurred. Resident	F 323	• Then 1 audit per floor/unit for 2 weeks. See **Attachment L, M, N.** Based on compliance, the audits would then be turned over to our Quality Program for monitoring and review at our monthly Quality Meeting.	

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F 323	Continued From page 4 #5's current care plan identified the use of a sit-to-stand mechanical lift for transfers, and a full-body mechanical lift for transfers, if needed. Observation on 11/20/12 at 11:32 a.m. showed a CNA (#1) assisted Resident #5 to transfer from his wheelchair to his bed using a sit-to-stand lift. During the transfer, the resident's knees were bent at a 90 degree angle, and the lift strap around his chest slipped upward into his axilla which caused his shoulders to shrug upward and his elbows to extend upward above his head. The resident stated, "Hurry up," and the CNA replied, "I'm sorry." The CNA then raised the lift higher as the resident was unable to stand straight enough to clear the edge of the bed. Observation on 11/20/12 at 2:00 p.m. showed the CNA (#1) assisted Resident #5 to transfer from his wheelchair to his bed using a sit-to-stand lift. During the transfer, the resident's knees were bent at a 90 degree angle, and the lift strap around his chest slipped upward into his axilla, which caused his shoulders to shrug upward and his elbows to extend upward above his head. The CNA (#1) attempted to place Resident #5 on his bed but needed to stop and lower the bed because the resident could not clear the edge of the bed. - Review of Resident #11's medical record occurred on November 21, 2012. Diagnoses included anxiety and chronic pain. The most current MDS, dated 11/02/12, identified extensive assistance from two or more people for transfers. Resident #11's current care plan identified the use of a sit-to-stand mechanical lift for transfers.	F 323		

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F 323	Continued From page 5 Observation on 11/21/12 at 8:20 a.m. showed a CNA (#3) assisted Resident #11 to transfer from her wheelchair to a bedside commode using a sit-to-stand lift. During the transfer, the lift strap around the resident's waist slipped upward into her axilla which caused her shoulders to shrug upward and her elbows to extend upward. The CNA (#3) failed to adjust or tighten the strap around the Resident #11's waist. The CNA transferred the resident from the commode to her bed and observation showed Resident #11's shoulders shrugged upward and elbows bowed outward.	F 323		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	1. Corrective actions for residents #5, #6, #7, and #12 involved immediate coaching and reeducation for staff identified by the Survey Team. Education was also provided to all staff working during the survey as concerns were identified. 2. Residents requiring assistance with toileting and/or cueing for hand washing would have the potential to be affected. 3. Bethany on 42nd will initiate the following education to assist staff on the importance of correct execution of perineal cares, and the importance of hand washing for both resident sand staff after toileting. This education is also currently part of our orientation curriculum for newly hired nursing staff and will continue. a) Did You Know educational posters to be emailed and displayed throughout the facility for nursing staff to review. See **Attachment O.**	

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F 441	Continued From page 6 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and policy and procedure review, the facility failed to follow standards of practice to prevent the transmission of infections for 4 of 9 residents (Resident #5, #6, #7, and #12) observed during perineal cares. Failure to follow infection control practices has the potential to spread infection within the facility. Findings include: Review of the facility's policies titled "Hand Washing" and "Perineal Care" occurred on the afternoon of 11/21/12. The policy, "Hand Washing," dated April 2012, stated, ". . . Note: Hand washing using soap and water is required when hands are visibly soiled, before and after eating or handling food, after personal use of the toilet, after performing own personal hygiene, before and after assisting a	F 441	b) Bethany on 42nd's policy on Standards of Care has been updated. See **Attachment P.** c) Education on perineal cares and hand washing to be provided at Plan of Correction Staff Meeting on 12/20/12 for nursing staff. See **Attachment C, J.** d) Health Care Academy online education "ADL's" for nurses and CNA's will be added in December and then annually. See **Attachment Q.** 4. 12/26/12 5. Quality Audits will be completed for residents that need perianal cares and for staff and resident hand washing associated with completion of these cares. Audits will be completed by the Nurse Manager Team as follows: • 10 audits/floor or unit for 2 weeks; • Then 5 audits/floor or unit for 2 weeks; • Then 3 audits/floor or unit for 2 weeks. Based on compliance, the audits would then be turned over to our Quality Program for monitoring and review at our Monthly Quality Meeting. See **Attachment R, S.**	

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F 441	Continued From page 7 resident with toileting (cleansing/wiping perineal area or providing incontinent cares) . . ." The policy, "Perineal Care," dated January 2010, stated, ". . . 10. Female Perineal Care: a) Separate the labia and wash with soap and water or disposable wipes starting at urethral area wiping downward using the front to back technique. b) Move from front to back and side to side using a different section of the washcloth or disposable wipe avoiding the rectal area. . . ." - Review of Resident #7's medical record occurred on 11/19-21/12. The current Minimum Data Set (MDS), dated 09/22/12, identified the resident as cognitively intact and requiring extensive assistance of one with toilet use and personal hygiene. Observation on 11/20/12 at 8:30 a.m., showed a certified nursing assistant (CNA) (#4) assisted Resident #7 to transfer from her bed to the bathroom. The staff member assisted the resident to complete morning cares and Resident #7 participated by cleansing her perineal area. The CNA (#4) failed to cue Resident #7 to wash her hands before Resident #7 walked to the dining area for the breakfast meal. - Review of Resident #6's medical record occurred on 11/19-21/12. Diagnoses included vascular dementia. The current MDS, dated 08/25/12, identified the resident as cognitively intact and requiring extensive assistance of two persons with toilet use and supervision of one person with personal hygiene. Observations showed the CNAs (#4 and #5)	F 441		

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F 441	Continued From page 8 assisted the resident to transfer from her electric wheelchair to the bathroom. During these observations, Resident #6 cleansed her perineal area. The CNAs (#4 and #5) failed to cue Resident #6 to wash her hands as follows: *11/20/12 at 7:55 a.m. *11/20/12 at 10:30 a.m. *11/20/12 at 1:55 p.m. During an interview on 11/20/12 at 11:00 a.m., a CNA (#4) stated Resident #6 "Does most pericare herself." - Review of Resident #12's medical record occurred on 11/21/12. Diagnoses included a history of urinary tract infections (UTIs). Current medications included Bactrim (an antibiotic) daily for "UTI, site not specified." An MDS summary, dated 10/05/12, stated, ". . . She [Resident #12] is on Bactrim prophalactically for UTI's . . ." Observation on 11/21/12 at 8:34 a.m. showed a CNA (#2) assisted Resident #12 with morning cares. The resident was incontinent of urine and a small amount of stool. The CNA used a washcloth to clean the resident's perineal area. As the CNA wiped the resident's rectal area, the washcloth became soiled with stool. The CNA then placed the washcloth into the wash basin, wrung it out, and used it to wash the resident's front perineal area. The CNA used a soiled washcloth/water to wash the resident's front perineal area, which placed her at risk for a UTI. - Observation on 11/20/12 at 11:32 a.m. showed a CNA (#1) assisted Resident #5 to bed and checked his brief. The resident was incontinent of urine and stool. The CNA donned gloves and	F 441		

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F 441	Continued From page 9 performed perineal care. Wearing the soiled gloves, the CNA removed moisture barrier cream from the resident's drawer and applied it to his perineal area. The CNA then removed her gloves, placed a clean brief on Resident #5, pulled up his pants, covered him with a blanket, lowered his bed, and brought the mechanical lift out of the room without performing hand hygiene.	F 441		