DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	12/18/2014

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 and complaint survey started on 12/15/14 and completed on 12/18/14, the sample included five (5) residents for complete review, 15 residents for focused review and three (3) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000	**This plan of correction is our allegation of compliance.** **Submission of this Plan of Correction is not an admission by Bethany that the Statement of Deficiencies cited are accurate in any respect.**	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	1. Resident #21 is no longer a resident at this facility so corrective action was unable to be accomplished. 2. Residents who have a change in condition, accident with injury or change in treatment have the potential to be affected. 3. The following measures were put into place: a) Education (Attachment A) provided on 12/18/2014 via shift report x 14 days. b) Education provided to nurses at Plan of Correction Meeting on 1/12/2015 (Attachment B) c) Healthcare Academy session "When to Update a Provider and Families" created and assigned to nurses (Attachment C) d) Revision of Physician Notification Tool and Blue Note Non-Emergent Provider Communication Tool (Attachment D&E) e) Educational Poster sent out weekly via email to nursing staff (Attachment F) 4. Change in Condition Audits (Attachment G) will be completed by the Nurse Manager Team daily for 8 weeks and then reviewed quarterly for one year at Quality Meeting. 5. January 19th, 2015.	1/19/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	President/CEO	01/08/2015

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 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policy and procedure, the facility failed to notify the physician for 1 of 1 closed resident record (Resident #21) who sustained a fall with a head injury. Failure to notify Resident #21's physician of a fall with injury did not allow the physician to make informed decisions regarding medical care. Findings include: Review of the facility policy titled "Physician Notification" occurred on 12/18/14. This policy, dated 09/2011, stated, ". . . Purpose: 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 [medical doctor]/Mid-level is immediate or non-emergent 2. Complete Physician Notification Tool or Blue Non-Emergent Provider Communication Note. . . . 4. Notify MD/Mid-level if appropriate. 5. Upon completion of the Physician Notification Tool or Blue Non-Emergent Provider Communication Note, document results in PCC [point click care] under "Physician Update" progress note. . . " The facility form tiled "Practitioner Notification Tool" stated, "Before calling provider assess if the resident has a change in the following areas: . . . Fall With Significant Injury - Obvious or	F 157		

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F 157	Continued From page 2 suspected fracture, Head Injury (with change in LOC [loss of consciousness] or change in Neuro Checks), Excess bleeding/laceration or wound, Nausea/vomiting . . . If the resident is experiencing any of these issues, complete page 2 BEFORE contacting the provider. If the resident is NOT experiencing any of the above issues, please leave a blue 'Non-Emergent Practioner Communication' note in the provider's folder." The facility failed to provide page 2 of this form. Review of Resident #21's medical record occurred on December 17-18, 2014. Diagnoses included atrial fibrillation. Medications included Coumadin (blood thinner) 2.5 milligram (mg) every Monday, Wednesday, Friday, and 5 mg every Sunday, Tuesday, Thursday and Saturday. The quarterly Minimum Data Set (MDS), dated 08/16/14, identified Resident #21 as cognitively intact and required extensive assistance for bed mobility. Resident #21's nursing progress notes identified the following: * 10/15/14 Fall - "Type of Fall: Alleged fall; unattended; from bed Time of Fall 17:30 [5:30 p.m.] Location of Fall: Resident room Position when found: face down/right side; right arm behind pt [patient] back Describe range of motion to upper and lower extremities: ROM [range of motion] is normal for resident; no complaint at time of assessment Injuries: . . . bruising to left and right dorsel [sic] sides of hands; skin tear to left dorsel [sic] hand between pointer and middle finger 2 in [inch] by 2 in. Laceration left cheek; hematoma and swelling present to cheek and lower orbital region. Vitals: bp [blood pressure] 115/56 p [pulse] 74 r	F 157		

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F 157	Continued From page 3 [respirations] 20 t [temperature] 98.6 0/10 pain neuro [neurological checks] completed; . . . Additional Interventions . . . : Ice to swelling left cheek 20 minutes per hour; dressing applied to wound areas. Provider Notified . . .: No; day shift to follow-up Family contacted . . .: Attempted to contact daughter; message left to return call to facility." * 10/15/14 21:30 (9:30 p.m.) - "Skin Integrity . . . Size bruise/hematoma 5 inches; skin tear 2 in by 2 in; laceration 2 inches . . . Resident description of cause of injury: Resident states that he may have fallen asleep while reading through information at bedside and fell forward from bed to floor. Additional interventions Added: dressing applied to left hand and left cheek ice applied 20 minutes hourly to bruised area . . ." * Late Entry 10/15/14 22:30 (10:30 p.m.) "Fall Date: 10/15/14 . . .Pain assessment: Resident reports pain with weight bearing to left foot. Wincing noted 5/10 pain . . . Injuries: bruising left cheek/orbital has increased to > [greater than] 50% of left side of face. Swelling of hematoma decrease with use of ice pack. bleeding stopped in both hand and cheek laceration . . ." * 10/16/14 09:00 "BP 86/53" (documented BPs from 10/15/14 at 5:30 p.m. to 10/16/14 at 5:00 a.m. ranged from 106/69 to 125/81) * 10/16/14 14:33 (2:33 p.m.) "Type: Out of Building . . . Reason . . .: daughter brought patient to hospital . . . Time left facility: 1030" * 10/16/14 14:40 (2:40 p.m.) "Phone call received from [hospital name] ER nurse stating [resident name] will be admitted for Pneumonia symptoms. . . ." During an interview on 12/18/14 at 11:05 a.m.,	F 157		

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F 157	Continued From page 4 administrative nursing staff members (#18, #19, and #20) confirmed Resident #21's physician had not been notified of the resident's fall on 10/15/14 at 5:30 p.m. Resident #21 sustained a head injury and was receiving coumadin at the time of the fall, which increased the resident's risk of bleeding. Resident #21 also complained of pain with weight bearing on 10/15/14 and had a drop in his BP on 10/16/14 at 9:00 a.m. and the facility failed to notify the physician of these as well. Resident #21 was admitted to the hospital on 10/16/14 and expired on 10/20/2014.	F 157		
F 241 SS=E	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, record review, review of facility policy, resident interview, and staff interview, the facility failed to provide care in a manner that enhanced dignity/self-esteem for 5 of 20 sampled residents (Resident #1, #4, #7, #16, and #24) observed during personal cares and/or medication administration. Failure to ensure dignity and respect during personal cares and medication administration does not recognize the individuality of each resident or enhance the quality of life for each resident. Findings include: Review of the facility policy titled "Dignity"	F 241	1. Staff working with Residents #1, #4, #7, #16 and #24 were provided education at shift report as soon as facility was aware of concerns. Facility was not able to identify all individual staff so 1:1 education and/or coaching was provided when able. 2. Residents residing at this facility have the potential to be affected. 3. The following measures were put into place: a) Education provided to staff at Plan of Correction Meeting on 1/12/2015 (Attachment B) b) Dignity and Standards of Care policies reviewed with staff. (Attachment H&I) 4. The Social Services team will audit dignity and respect for the following residents #1, #4, #7, #16 and #24 daily for 2 weeks, 3x/week for 2 weeks; then 2x/week for 4 weeks; then quarterly for one year. Results will then be reviewed quarterly at the Quality Meeting for one year. (Attachment J). 5. January 19th, 2015.	1/19/15

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F 241	Continued From page 5 occurred on 12/18/14. This policy, revised 09/10/09, stated, ". . . staff shall afford resident with as much privacy as is possible during activities requiring personal assistance to the resident . . . Staff will speak with courtesy . . . and treat residents with respect. . . . Staff will knock on resident door and wait for affirmative response prior to entering resident's room . . ." Review of the facility policy titled "Personal Privacy and Confidentiality" occurred on 12/18/14. This policy, revised 08/01/14, stated, ". . . Staff will not enter or exit resident's room(s) when medical treatment and/or personal cares are being provided. . . ." - Observation on 12/16/14 at 9:05 a.m. showed two certified nursing assistants (CNAs) (#1 and #2) transferring Resident #1 to the bathroom using a front wheeled walker and gait belt. After assisting Resident #1 to sit on the toilet, the CNA (#1) stated, "[CNA #2] is going to watch you go potty, okay? Go ahead and tinkle-toe." After Resident #1 voided, the CNA (#1) cued her to wash her hands, stating, "Scrub, scrub, scrub, get 'em good and clean" using a child-like intonation pattern. - During a resident interview on 12/17/14 at 5:00 p.m., Resident #16, identified as interviewable by the facility, stated, "Staff have a tendency to knock and walk right in. Quite a few times. Once a CNA caught me in the bathroom and walked right in. That annoyed me." - Observations showed the following: * On 12/16/14 at 8:05 a.m., two CNAs (#3 and #4) provided pericares for Resident #4. A nurse (#5) knocked and immediately entered the room	F 241		

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F 241	Continued From page 6 as Resident #4 laid exposed on the bed. The nurse (#5) failed to announce herself and/or request permission prior to entering his room. * On 12/16/14 at 1:06 p.m., a CNA (#3) fed Resident #4 heaping teaspoons of pureed foods and drool formed at the corners of Resident #4's mouth. The CNA (#3) used the teaspoon to scrap the food residue from his lip/chin, mixed the residue back into the food on his plate, and eventually fed it to him. - Observation on 12/16/14 at 10:05 a.m. showed two CNAs (#15 and #16) provided morning cares for Resident #7. As Resident #7 laid in bed with a bra on, the CNA (#15) opened the door and exited the room to obtain a mechanical lift. Resident #7's upper body remained exposed as the CNA (#15) opened the door and returned to the room with the lift. During an interview on 12/18/14 at 11:30 a.m., a managerial nurse (#6) confirmed staff should speak to all residents in a courteous and respectful regardless of his/her cognitive abilities, wait for affirmation prior to entering a resident's room, and use a napkin to clean any excess food from a resident's face. - Observation on 12/17/14 at 8:35 a.m. showed Resident #24 and two other residents seated at the dining room table eating breakfast. A licensed nurse (#24) approached the resident, stated it was time for her medicine, and handed her an inhaler. The nurse failed to offer Resident #24 a private location or ask if she objected to receiving her inhaler at the dining room table.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246	1. Immediate PT/OT screens completed for resident #4 to assess positioning.	

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F 246	Continued From page 7 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family interview, and staff interview, the facility failed to ensure proper positioning for 1 of 1 sampled resident (Resident #4) observed sitting in a recliner leaning heavily to the side. Failure to ensure proper positioning resulted in the resident requiring a clothing protector secondary to excessive drooling. Findings include: Review of the facility policy titled "Routine Care" occurred on 12/18/14. This policy, revised November 1013, stated, ". . . Residents will be maintained upright and in good body alignment while in chair. . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, Parkinson's disease, and weakness. The significant change Minimum Data Set (MDS), dated 12/02/14, identified severely impaired cognitive skills and extensive assistance required for Activities of Daily Living (ADLs). Observation on 12/16/14 at 9:35 a.m. showed Resident #4 leaning to the left and drooling after	F 246	2. Residents requiring assistance with ADL's have the potential to be affected. 3. The following measures were put into place: a) Reeducation was provided to staff regarding the importance of proper positioning during the Plan of Correction Meeting on 1/12/2015 (Attachment B) b) Routine Care Policy was reviewed with staff. (Attachment H) c) The Therapy Department will continue to meet with Nurse Manager Team and Restorative Therapy Team to assess resident positioning needs. d) Facility will continue auditing of positioning at mealtimes (Attachment K & L) e) Additional Healthcare Academy session titled; "Importance of Proper Positioning" was assigned to all Bethany staff(Attachment M) 4. The care review team will conduct audits on current residents to assess position when in resident rooms. (Attachment K & L). Audits of resident positioning in rooms will be done 1x/2 weeks for 1 month. The Quality and Education Department will carry on with audits to be done 1x/month (Attachment N). Results will be reviewed quarterly at the Quality Meeting for one year. 5. January 19th, 2015	1/19/15

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F 246	Continued From page 8 two certified nursing assistants (CNAs) (#4 and #14) transferred him into his recliner with a Hoyer lift. Prior to exiting the room, one of the CNAs (#14) wiped Resident #4's lip/chin and placed a small towel over his left shoulder. The CNAs failed to reposition and/or place an assistive device (pillow/wedge) in the recliner, ensuring Resident #4 was positioned as close to midline as possible. During an interview on 12/16/14 at 9:45 a.m., Resident #4's family member stated, "He leans so bad. I wish they would put a pillow under his [left] arm. I asked them to put a cloth on him because his shirt gets wet [from his drooling]." Observation on 12/16/14 at 10:10 a.m. showed Resident #4 sitting in his recliner, leaning heavily to the left and drooling onto his clothing protector. Observation on 12/17/14 at 9:02 a.m. showed Resident #4 sitting in his recliner, leaning to the left with a small amount of drool on his chin. During an interview on 12/18/14 at 11:30 a.m., a managerial nurse (#6) confirmed staff should ensure Resident #4 is positioned as close to midline as possible.	F 246		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F 278	1. When notification of residents involved in this practice was obtained; a modification assessment was completed for residents #4, #5, #7, #9, #11, #12, #13, #15, #19, #20. 2. Residents having an MDS completed could be affected by this practice.	

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F 278	Continued From page 9 A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 10 of 20 sampled residents (Resident #4, #5, #7, #9, #11, #12, #13, #15, #19, and #20) coded incorrectly on the MDS. Failure to code portions of the MDS correctly does not provide an accurate assessment of the resident's current status and needs and may prevent staff from developing an effective comprehensive care plan that meets the needs of the residents. Findings include:	F 278	3. The following measures were put into place: a) Reeducation to MDS Coordinators was provided on 1/14/2015. (Attachment O) b) Reeducation to Social Services department was provided on 1/14/2015. (Attachment O) 4. The MDS Coordinators and Social Services Department will audit 4 MDS'/month for one year. These results will be shared quarterly at the Quality Meeting for one year. (Attachment Q) 5. January 19th, 2015.	1/19/15

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F 278	Continued From page 10 The Long-Term Care Facility RAI User's Manual, October 2013, stated the following: * Section M1200C (Turning/Repositioning Program), page M-38, stated, "The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. [exampli gratia] reposition on side, pillows between knees) and frequency (e.g. every 2 hours). Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention." Review of the medical record for Resident #4, #5, #7, #9, #11, #12, #13, #15, #19, and #20 occurred December 15-18, 2014. - Resident #5's annual MDS, dated 10/02/14, identified a turning/repositioning program present during the seven day assessment period. The current care plan stated, "PRESSURE ULCER - RISK: . . . Turn and reposition every 2 hours and PRN [as needed] . . . At risk for pressure ulcer: turning/repositioning/program determined by tissue tolerance assessment . . ." - Resident #9's quarterly MDS, dated 12/01/14, identified a turning/repositioning program present during the seven day assessment period. The current care plan stated, "RISK FOR PRESSURE ULCER . . . [name] is currently on Turn and Reposition every 2 hour [sic] and PRN program. [name] refused to be turned and repositioned at times. She is aware of the risks of refusing repositioning . . ."	F 278		

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F 278	Continued From page 11 - Resident #20's annual MDS, dated 10/09/14, identified a turning/repositioning program present during the seven day assessment period. The current care plan stated, "PRESSURE ULCER - HIGH RISK . . . At risk for pressure ulcer: turning/repositioning/program determined by tissue tolerance assessment - every 2 hours . . ." - Resident #12's annual MDS, dated 11/07/14, identified a turning/repositioning program present during the seven day assessment period. The current care plan stated, ". . . At risk pressure ulcer . . . turn and reposition every two hours. . ." - Resident #4's significant change MDS, dated 12/02/14, identified a turning/repositioning program present during the seven day assessment period. The current care plan stated, ". . . Pressure Ulcer - High Risk . . . T/R [turn/reposition] every 2 hours . . ." - Resident #19's quarterly MDS, dated 11/12/14, identified a turning/repositioning program present during the seven day assessment period. The current care plan and CNA worksheet stated, ". . . Pressure Ulcer . . . high risk . . . turn every hour . . ." - Resident #7's quarterly MDS, dated 10/28/14, identified a turning/repositioning program present during the seven day assessment period. The current care plan stated, "PRESSURE ULCER - RISK: . . . Turn and reposition every 2 hours and PRN [as needed] . . . At risk for pressure ulcer: turning/repositioning/program determined by tissue tolerance assessment . . ." - Resident #11's annual MDS, dated 10/29/14,	F 278		

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F 278	Continued From page 12 identified a turning/repositioning program. The facility failed to identify any skin issues or rationale for the turning and repositioning program. - Resident #13's quarterly MDS, dated 10/29/14, identified a turning/repositioning program. The resident's current care plan stated, "PRESSURE ULCER - RISK . . . T/R Q [every] 2 hours . . ." - Resident #15's quarterly MDS, dated 12/06/14, identified a turning/repositioning program. The resident's current care plan stated, "PRESSURE ULCER - RISK . . . TTA completed. T/R every 2 hours and PRN . . ." The facility failed to provide evidence of specific and individualized repositioning programs (e.g. reposition on side, pillows, between knees, etc.) based on Resident #4, #5, #7, #9, #11, #12, #13, #15, #19, and #20's assessments, document the program's implementation, and monitor/reassess the effectiveness of the programs. The Long-Term Care Facility RAI User's Manual, October 2013, stated the following: * Section E0100 (Potential Indicators of Psychosis), pages E-1 and E-2, stated, "Definitions: Delusion: A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. . . . Steps for Assessment: . . . When a resident expresses a clearly false belief, determine if it can be readily corrected by a simple explanation of verifiable (real) facts (which may only require a simple reminder or reorientation) . . . The resident's response to the offering of a potential alternative explanation is often helpful in determining whether the false belief is held strongly enough to	F 278		

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F 278	Continued From page 13 be considered fixed." Resident #13's quarterly MDS, dated 10/29/14, identified the resident experienced delusions. Review of the medical record during the assessment period 10/23/14 through 10/29/14 showed Resident #13 told staff he was flying in a plane. The progress note failed to show the staff member attempted to determine if his thoughts were delusional. The note failed to support coding the MDS for delusions. During an interview on 12/18/14 at 1:50 p.m., two social service staff members (#12 and #13) confirmed the documentation failed to demonstrate the staff attempted to correct Resident #13's false belief of flying in a plane.	F 278		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	1. Residents #1, #6, #7, #19 had their careplans reviewed and modified when appropriate to reflect individualized interventions as well as current resident status. 2. Residents residing at this facility have the potential to be affected. 3. The following measures were put into place: a) Reeducation to nurses will be conducted at the Plan of Correction Meeting on 1/12/2015 (Attachment B). 4. Audits of resident ADL sheets, careplans, orders, and medications will be conducted by Care Review Team. The Quality and Education Department will review 8 records/month for one year. (Attachment R). Results of audits will be reviewed quarterly at the Quality Meeting for one year. 5. January 19th, 2015.	1/19/15

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F 280	Continued From page 14	F 280		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' status for 4 of 20 sampled residents (Resident #1, #6, #7, and #19). Failure to develop, review, and revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for each resident.

Findings include:

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included constipation. Medication to aid in bowel elimination included Senna S twice daily and Milk of Magnesia (MOM), bisacodyl suppository, and Fleets enema as needed (PRN). Dietary interventions to aid in bowel elimination included prune juice PRN.

Review of the medication administration record (MAR) from October through December 17, 2014 identified facility staff offered Resident #6 PRN medications or prune juice to aid in bowel elimination eight times in October, 11 times in November, and 14 times in December.

The facility failed to develop a comprehensive care plan related to Resident #6's constipation.

- Review of Resident #1's medical record

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F 280	Continued From page 15 occurred on all days of survey. Diagnoses included constipation. The progress note, dated 05/15/14, identified, ". . . day 9 of no BM . . . poor appetite . . ." The physician's orders identified the following constipation medications/interventions: * 12/10/11, Fleet enema as needed (prn) * 03/11/14, Dulcolax suppository 10 micrograms (mg) prn, Milk of Magnesia 30 milligrams (ml) prn, Prune juice/Natural fiber option 4 ounces (oz) prn * 05/15/14, Senna S 1 tablet (tab) twice daily (bid) prn * 08/04/14, Lactulose 30 ml daily prn * 10/20/14, Senna 1 tab bid The current care plan failed to address Resident #1's constipation. - Review of Resident #19's medical record occurred on December 17-18, 2014. Diagnoses included dementia and visual impairment. The quarterly MDS, dated 11/12/14, identified severely impaired cognitive skills and extensive assistance required for eating. The CNA worksheet identified, ". . . RED Divided plate/1-2 items at a time. . . ." The current care plan failed to address Resident #19's need for colored dishware. During an interview on 12/18/14 at 11:30 a.m., a managerial nurse (#6) confirmed Resident #1's care plan failed to address her episodes of constipation and Resident #19's care plan failed to address his need for colored dishware.	F 280		

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F 280	Continued From page 16 - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included multiple sclerosis and constipation. The quarterly Minimum Data Set (MDS), dated 10/28/14, identified Resident #7 as cognitively intact and required total assistance for toileting. Resident #7's care plan stated, " . . . Focus - Bowel: Resident is at risk for constipation r/t [related to] non-ambulatory status and dx [diagnosis of] MS [multiple sclerosis] . . . Interventions/Tasks: . . . Refer to MAR [medication administration record] for bowel medications ordered. Administer all meds [medications] as ordered. Alert provider to changes to bowel pattern. . ." During an interview on 12/16/14 at 10:30 a.m., an administrative nurse (#6) stated Resident #7 receives bisacodyl suppository every Monday Wednesday, and Friday with digital stimulation per the resident's request. Resident #7's care plan failed to identify the resident required digital stimulation with each suppository.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure staff	F 281	1. Corrective action for resident #1 and #7 involved clarification of orders with their medical providers. 2. Residents who receive orders from a medical provider have the potential to be affected. 3. The following measures were put into place: a) Reeducation to nurses will be conducted at the Plan of Correction Meeting on 1/12/2015 (Attachment B).	

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F 281	Continued From page 17 followed and/or clarified physicians' orders for 2 of 20 sampled residents (Resident #1 and #7). Failure of staff to follow and/or clarify physicians' orders resulted in Resident #7 receiving an as needed (PRN) medication on a routine basis and Resident #1 not receiving oxygen as ordered. Findings included: Review of Resident #7's medical record occurred on all days of survey. Diagnoses included multiple sclerosis and constipation. The quarterly Minimum Data Set (MDS), dated 10/28/14, identified Resident #7 as cognitively intact and required total assistance for toileting. Resident #7's care plan stated, " . . . Focus - Bowel: Resident is at risk for constipation r/t [related to] non-ambulatory status and dx [diagnosis of] MS [multiple sclerosis] . . . Interventions/Tasks: . . . Refer to MAR [medication administration record] for bowel medications ordered. Administer all meds [medications] as ordered. Alert provider to changes to bowel pattern. . ." Resident #7's MAR identified a biscadoyl suppository administered every Monday, Wednesday, and Friday in the months of October, November, and December. During an interview on 12/16/14 at 10:30 a.m., an administrative nurse (#6) confirmed Resident #7 receives a bisacodyl suppository every Monday, Wednesday, and Friday per the resident's request. During an interview on 12/18/14 at 12:30 p.m., an administrative nurse (#18) confirmed staff failed	F 281	4. Audits of resident ADL sheets, careplans, orders, and medications will be conducted by Care Review Team. The Quality and Education Department will review 8 records/month for one year. (Attachment R). Results of audits will be reviewed quarterly at the Quality Meeting for one year. 5. January 19th, 2015.	1/19/15

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F 281	Continued From page 18 to follow Resident #7's order for administation of the bisacodyl suppositories. - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included chronic obstructive pulmonary disease (COPD), asthma, shortness of breath, and occasional acute anxiety. The physician's order, dated 06/05/14, stated, "Oxygen 2-5 L [liter] via nasal cannula continously [sic] . . . to maintain O2 [oxygen] stats [saturations] > [greater than] 90% [percent]." Observations on all days of survey showed staff failed to apply Resident #1's nasal cannula/oxygen. During an interview on 12/18/14 at 11:30 a.m., a managerial nurse (#6) indicated Resident #1 had an order for "oxygen as needed." When shown the order for continuous oxygen, she agreed the order should have been clarified.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review, group interview, resident interview, and staff interview, the facility facility failed to provide necessary	F 312	1. Resident #17 is being offered assistance at mealtimes as she will allow. 2. Residents requiring assistance at meals could potentially be affected. 3. The following measures were put into place to ensure this practice will not recur: a. Reeducation to staff will be conducted at the Plan of Correction Meeting on 1/12/2015. (Attachment B). 4. Dining room audits will be done 3 times/week for 4 weeks, and then monthly. (Attachment K & L). Audit results will be reviewed by Care Delivery Team and results will be shared quarterly at the Quality Meeting for one year. 5. January 19th, 2015.	1/19/15

conducted by the Care delivery team per phone call on 1/29/15 @ 2:35 pm KB

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F 312	Continued From page 19 assistance to meet the needs of 1 of 1 resident (Resident #17) observed eating with her fingers. Failure to provide assistance to residents who cannot independently carry out activities of daily living such as eating places them at risk for weight loss and malnutrition. Findings include: - Review of Resident #17's record occurred on December 15-18, 2014. The resident's diagnoses included degenerative diseases of the basal ganglia and dysphagia. The most current Miminum Data Set (MDS), dated 10/27/14, identified the resident as cognitively intact and requiring limited assistance of one with eating. During the group interview on 12/16/14 at 4:00 p.m., eight interviewable residents (Resident A, B, C, D, E, F, G, H) reported observing staff passing trays to the dependent residents prior to being able to provide them with feeding assistance. They also stated the staff members often have to microwave the residents' meals due to their food getting cold. Observation of the evening meal on 12/17/14 at 5:58 p.m. showed an unidentified certified nursing assistant (CNA) feeding Resident #17 her meal. The CNA stated, "You do much better when you're fed." Observation of breakfast on 12/18/14 at 7:45 a.m. showed Resident #17 placed a cut up piece of caramel roll into her mouth using her fingers. Observation showed food on her plate included a slice of toast, a cut up sausage patty, and a few remaining pieces of scrambled egg.	F 312		

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F 312	Continued From page 20 During an interview on 12/18/14 at 7:50 a.m., a dining services assistant (#7) stated she served Resident #17 her food at approximately 7:10 a.m. During an interview on 12/18/14 at 7:55 a.m., a certified nursing assistant (CNA) (#8) stated she started feeding Resident #17 at approximately 7:40 a.m. and another CNA (#9) fed the resident before then. During an interview on 12/18/14 at 8:00 a.m., a CNA (#9) stated she brought Resident #17 into the dining room at 7:00 a.m. and had not fed her today. The CNA stated, "She's not a big fan of her utensils. She uses her fingers more than anything I think." During a resident interview on 12/18/14 at 9:30 a.m., Resident #17 stated, "I have to use my fingers. I eat larger pieces of food. I use my hands because it's easier than if I use a fork. The fork jams into the roof of my mouth and food falls off it. It's better when they feed me." Resident confirmed at breakfast today, she ate with her fingers and the meal included scrambled eggs. Resident #17 further stated, "It doesn't bother me. When I first started eating with my fingers people [staff and other residents] looked at me funny. Now they don't." Resident #17 confirmed she preferred to be fed by staff as otherwise her food becomes "lukewarm." During an interview on 12/18/14 at 12:10 p.m., a charge nurse (#11) (for the resident care area in which Resident #17 resides) stated, Resident #17 received her meal approximately between 7:00 a.m. and 7:15 a.m. Based on these interviews, it can be determined	F 312		

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F 312	Continued From page 21 that Resident #17 received no assistance with her meal for approximately 30 minutes. Resident #17's care plan, not dated, identified, ". . . More assistance needed at meals, would benefit from being fed most days . . . offer finger foods if available, however [resident's name] may refuse. Prefers to eat with her hands (05/01/14) . . . help with feeding as needed . . . d/c [discontinue] use of finger food as [resident's name] prefers to eat meal with her fingers and is comfortable with this, provide assistance at meals (11/07/14). Review of a nurse's progress note, dated 11/13/14 at 11:16 a.m., identified, "Stop and watch tool received stating that [resident's name] is requesting more assistance at breakfast with eating and drinking . . . Will pass along that staff should pay extra close attention to her during meals." The CNA activities of daily living sheet for Resident #17 identified, ". . . Assist with meals . . ." Failure to provide the assistance with the breakfast meal resulted in Resident #17 eating for approximately 30 minutes without assistance.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	1. Resident #4 has had his plan of care revised to accurately assess his risk for pressure ulcer development. 2. Residents who are at risk for pressure ulcer development could be potentially affected. 3. The following measures were put into place: a) Reeducation to nurses will be conducted at the Plan of Correction Meeting on 1/21/15 (Attachment B).	

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F 314	Continued From page 22 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to consistently implement pressure-relieving interventions for 1 of 1 sampled resident (Resident #4) dependent on staff to provide these interventions. Failure to float the resident's heels as ordered may result in the development of avoidable, facility-acquired pressure ulcers. Findings include: Review of the facility policy titled "Pressure Ulcer (Skin), Risk Assessment, Care and Prevention" occurred on 12/18/14. This policy, revised March 2013, stated, ". . . Position with . . . pillows to protect bony prominences; off-load . . . residents at risk of developing a pressure ulcer according to CNA [certified nursing assistant]'s Worksheet. . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia, Parkinson's disease, weakness, and history of pressure ulcers. The significant change Minimum Data Set (MDS), dated 12/02/14, identified severely impaired cognitive skills and extensive assistance required for Activities of Daily Living (ADLs). The current care plan stated, "Problem . . . Pressure Ulcer - High Risk. . . Approach . . . Float heels . . ." The CNA worksheet failed to identify Resident #4's needed to have his heels floated.	F 314	4. Audits of resident ADL sheets, careplans, orders, and medications will be conducted by Care Review Team. The Quality and Education Department will review 8 records/month for one year. (Attachment R). Results of audits will be reviewed quarterly at the Quality Meeting for one year. 5. January 19th, 2015.	1/19/15

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F 314	Continued From page 23 Observations on 12/16/14 at 8:05 a.m. and 1:50 p.m. and on 12/17/14 at 1:25 p.m. showed Resident #4 lying in bed with a pillow tucked under his knees and his heels directly on the mattress. During an interview on 12/18/14 at 11:30 a.m., a managerial nurse (#6) confirmed staff should ensure Resident #4 heels are floated when lying in bed.	F 314		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. 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 the appropriate use of assistive devices during meals for 2 of 2 sampled residents (Resident #1 and #19) who required colored dishware. Failure to ensure colored dishware was available placed Resident #1 and #19 at risk for decreased meal intakes and a loss of dignity related to food spillage. Findings include: Review of the facility policy titled "Adaptive Eating Equipment" occurred on 12/18/14. This policy, revised November 2019 [sic], stated, ". . . Adaptive eating equipment is designed to enhance the ability of residents to eat per self. . . . When the Dining Services Assistant sets the	F 369	1. Corrective action for residents #1 and #19 was provided immediately by educating staff working on the importance of using adaptive equipment at mealtimes. 2. Residents requiring adaptive equipment at mealtimes have the potential to be affected. 3. The following measures were put into place: a) Education to staff will be conducted at the Plan of Correction Meeting on 1/12/2015. (Attachment B) b) Education via iPod messaging conducted (Attachment S) c) Healthcare Academy session created for Dining Services and Nursing staff—What is Adaptive Equipment and Why is this important" (Attachment T) 4. Dining room audits will be done 3 times/week for 4 weeks, and then monthly. (Attachment K & L). Shift report audits will be done weekly times 4 weeks and then monthly. Results will be reviewed quarterly at Quality Meeting for one year. 5. January 19th, 2015. conducted by the care delivery team per phone call on 1/19/15 @ 2:35pm KB	1/19/15

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 _____	12/18/2014

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 369	Continued From page 24 table, the equipment will be placed at the resident's dining spot. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included memory loss and weight loss. The quarterly Minimum Data Set (MDS), dated 12/11/14, identified severely impaired cognitive skills and extensive assistance required for eating. The dietary progress note, dated 09/22/14, identified, ". . . Will trial a red divided plate instead of a white divided plate as [Resident #1] seems to do well with color, which may help her to locate items on her plate much easier. . . ." The current plan of care stated, ". . . Focus: Nutrition . . . Interventions: . . . Provide adaptive equipment at meals such as: red divided plate at meals. . . ." The CNA (certified nursing assistant) worksheet failed to identify Resident #1's need for colored dishware. Observations revealed the following: * On 12/16/14 at 9:05 a.m. and 12:17 p.m. and on 12/18/14 at 8:40 a.m., Resident #1 sat at an assisted table in the dining room, attempting to feed herself. During all three observations, staff failed to ensure her tray contained colored dishware. * On 12/17/14 at 8:00 a.m., Resident #1 sat at an assisted table in the dining room, and attempted to feed herself. Staff failed to ensure her tray contained colored dishware. On seven occasions, Resident #1 dipped her spoon towards her plate, and took a "bite" from her empty spoon. An unidentified CNA walked over to her table and stated, "Can't you see, the food is right in front of	F 369		

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 _____	12/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON 42ND	4255 30TH AVE S FARGO, ND 58104

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F 369	Continued From page 25 you . . . Go ahead and eat." - Review of Resident #19's medical record occurred on December 17-18, 2014. Diagnoses included dementia and pharyngitis. The quarterly MDS, dated 11/12/14, identified severely impaired cognitive skills and extensive assistance required for eating. The current plan of care stated, ". . . Focus: Impaired visual function . . ." The current care plan failed to address Resident #19's need for colored dishware. The CNA worksheet identified, ". . . RED Divided plate/1-2 items at a time. . . . divided plate [and] plastic handled spoon and fork. . . ." Observation on 12/18/14 at 8:45 a.m. showed Resident #19 sitting at an assisted table in the dining room, attempting to feed himself. Staff failed to ensure his tray contained colored dishware. During an interview on 12/18/14 at 2:10 p.m., a dietary staff member (#17) reported the facility only uses colored plates during the noon and evening meals, "not during [the] breakfast" meal. She explained, "We wouldn't put hot cereal on a plate." When asked why the facility wouldn't put the cereal into a colored bowl, she responded, "That's a good idea." During an interview on 12/18/14 at 11:30 a.m., a managerial nurse (#6) confirmed staff should ensure residents receive colored dishware as per their care plan/CNA worksheet.	F 369		