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	355044	A. BUILDING _____ B. WING _____	08/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	615 6TH ST SE STANLEY, ND 58784

(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 08/04/14 and completed on 08/06/14, the sample included 2 residents for complete review, 9 residents for focused review, and 1 closed record for review.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Nursing staff were instructed on 8/29/2014 on the policy titled, "Confidentiality, Privacy and Dignity." This instruction was for resident #3, #6, and #9 as well as any other resident who may be affected. 2) Any resident requiring personal privacy has a potential to be affected. All staff that provide care to residents will be educated and evaluated on the importance of providing privacy when caring or giving treatment to a resident and making sure to knock and identify who is at the door prior to entry or allowing entry to others. 3) The QA director or nursing designee will monitor those staff who provide care to residents to ensure that privacy and knocking on door, and/or saying who is at the door prior to entry is occurring. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented.	09/02/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael L Hall	Interim CEO/Administrator	8/29/14

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 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure personal privacy during cares for 3 of 8 sampled residents (Resident #3, #6, and #9) observed receiving incontinence cares. Failure to ensure privacy during cares is an infringement on the residents' rights and may lead to a loss of dignity. Findings include: Review of the facility policy titled "Confidentiality, Privacy, and Dignity" occurred on 08/06/14. This policy, revised in 2012, stated, ". . . All staff will knock before entering a resident/patient's room and allow resident/patient's privacy when receiving treatment and caring for their personal needs. . . ." - Observation on 08/04/14 at 12:50 p.m. showed two certified nursing assistants (CNAs) (#7 and #8) provided incontinence cares for Resident #6. The CNAs failed to pull the privacy curtain, leaving the resident visible from the doorway. During cares, a staff member knocked on the door. Neither of the CNAs responded to the knock, so an unidentified staff member entered the room without announcing herself. The staff member stated "sorry" and pulled the resident's privacy curtain before exiting the room. - Observation on 08/05/14 at 4:40 p.m. showed two CNAs (#6 and #8) provided incontinence cares for Resident #9. During cares, a CNA (#9) knocked and immediately entered without waiting for permission to enter.	F 164	The QA director will submit a report of the monitoring results to the QA committee at each scheduled meeting. 4) The QA director or nursing designee will monitor resident #3, #6 and #9 and any other residents requiring right to privacy during cares monthly x 3, then quarterly for one year. Monitoring to begin 9/2/14.	

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F 164	Continued From page 2 - On 08/06/04 at 10:15 a.m. observation showed two licensed nurses (#2 and #3) changed the wound vacuum dressing on Resident #3's right hip. During the procedure, while the resident lay on her bed with her lower body exposed, there was a knock on the door. The licensed nurses (#2 and #3) made no response to the knock. The staff member (#5 - a CNA) then entered the room without waiting for a response. Several minutes later, while the resident remained in bed wearing a brief and not covered by her bedding, there was another knock on the door. Without covering the resident or asking the person knocking to identify themselves, the licensed nurses (#2 and #3) stated, "come in." A staff member (#6 - a travel CNA) opened the door and asked if the nurses needed any help. During an interview, on 08/06/14 at 10:55 a.m., an administrative nurse (#1) agreed staff should knock and wait for a response prior to entering a resident's room. Failure to cover the residents' exposed body, respond to knocks on the door, and/or identify the person at the door prior to allowing entry violated Resident #3, #6, and #9's right to privacy during cares.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Nursing staff were instructed on 8/29/14 on policy titled, "Abuse, Neglect, and Misappropriation Reporting." This instruction was for resident #6 as well as any other resident who may be affected.	09/02/14

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F 225	Continued From page 3 of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy and procedure, and staff interview, the facility failed to ensure the misappropriation of a resident's property was immediately reported to the administrator of the facility and to other officials in accordance with State law for 1 of 1	F 225	2) Any resident requiring the use of a Fentanyl patch has the potential to be affected. All nursing staff that notice a Fentanyl patch is missing on any resident will follow the "Abuse, Neglect, and Misappropriation Reporting" policy to ensure the proper individuals are notified. 3) Fentanyl patches are checked daily on the MAR for placement. Fentanyl patches are changed every 72 hours and on removal of a Fentanyl patch, a co-signature of a nurse is required to ensure the patch is destroyed properly. The QA director or nursing designee will monitor to ensure staff is following the "Abuse, Neglect and Misappropriation Reporting" policy and that all the correct individuals were notified monthly times 3, then quarterly times one year. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA director will submit a report monitoring the results to the QA committee at each scheduled meeting. 4) The QA director or nursing designee will monitor resident #6 and any other resident requiring the implementation of the "Abuse, Neglect, and Misappropriation Reporting" policy to ensure all the proper individuals are notified monthly x 3, then quarterly times one year. Monitoring will begin 9/2/2014.	

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sampled resident (Resident #6) identified with misappropriation of property. Failure to identify, report, and investigate the misappropriation of property (controlled medication) places all residents at risk of not receiving prescribed medications.

Findings include:

Review of the facility policy titled "ABUSE, NEGLECT, AND MISAPPROPRIATION REPORTING" occurred on 08/06/14. This policy, revised in 2012, stated, "POLICY: . . . All personnel must promptly report and incident of misappropriation of resident property. . . . All alleged violations involving . . . misappropriation of resident property are reported immediately to the administrator of the facility and to local law enforcement, in accordance with State law through established procedures. . . . When an incident of . . . misappropriation is suspected or determined, such incident must be reported to the Charge Nurse, DON [Director of Nursing], LSW [Licensed Social Worker] or Administrator regardless of the time lapse since the incident. . . ."

Review of Resident #6's medical record occurred on all days of survey. Medications included a Fentanyl Patch (an opioid analgesic) 12 micrograms (mcg) with instructions to change every third day.

A nurse's note, dated 10/28/13 at 4:00 p.m., stated, "No fentanyl patch found on upper chest or back - new patch applied."

Review of the October 2013 Medication Administration Record (MAR) identified a nurse

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F 225	Continued From page 5 checked for Resident #6's patch placement on 10/28/13 at 4:00 p.m., discovered the patch missing, and placed a new patch on the resident. The documentation stated, "[no] patch found. Resident had bath et [and] came off [with] bathing." During an interview on 08/06/14 at 12:45 p.m., the nurse (#3) stated Resident #6 had a bath on 10/28/13 and she assumed the patch came off during the bath and did not report it to administration. An administrative nurse (#1) stated the facility failed to investigate the missing Fentanyl patch. The facility failed to conduct a thorough investigation to determine if misappropriation of property occurred and failed to report the missing Fentanyl patch to the state survey and certification agency.	F 225		
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. 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	F 278	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Nursing staff were instructed on 8/29/14 on the importance of making sure they are documenting on the "Turning/ Repositioning Form" every two hours. The RN/MDS Coordinator corrected the MDS on resident #3, #4, #6 and #9 (#12 is deceased) and any other resident who may have been affected. 2) All residents who require to be turned every two hours could potentially be affected. Staff instructed on 8/29/2014 the importance of documenting on the	09/02/14

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F 278	Continued From page 6 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 4 of 4 sampled residents (Resident #3, #4, #6, and #9) and 1 discharged resident (#12) coded with a turning/repositioning program. Failure to code portions of the MDS correctly does not provide an accurate assessment of a resident's current status and needs. Findings include: The Long-Term Care Facility RAI User's Manual, October 2013, page M-38 stated, "M1200C Turning/Repositioning Program: 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. [such as] reposition on side, pillows between knees) and frequency	F 278	"Turning/Repositioning Forms." These forms will be reviewed by Care Coordinator at least monthly for completeness. 3) The Care Coordinator or nursing designee will monitor the "Turning/ Repositioning Forms" to be sure they are filled out accurately. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA director will submit a report of the monitoring results to the QA committee at each scheduled meeting. 4) The Care Coordinator or nursing designee will monitor resident #3, #4, #6, and #9 (#12 is deceased) and any other residents requiring a "Turning/ Repositioning Form" to be completed monthly x 3, then quarterly x 1 year. Monitoring to begin 9/2/2014.	

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(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."

- Resident #3's, medical record reviewed on all days of survey, identified a stage 4 (full thickness tissue loss) pressure ulcer on the right hip. A Significant Change in Status MDS, dated 06/18/14, identified a turning/repositioning program. Resident #3's current care plan, dated 06/30/14, identified a problem: "Risk for pressure ulcer r/t [related to] impaired mobility." An approach to the problem stated,"Change Position frequency [sic] and keep clean and dry." Review of Resident #3's repositioning flowsheets lacked evidence staff implemented an individualized repositioning program for the resident.

- Review of Resident #4's medical record occurred on all days of survey. An Annual MDS, dated 06/04/14, identified one stage 1 and one stage 2 pressure ulcer and a turning/repositioning program. Resident #4's current care plan, dated 06/17/14, identified a problem: "Potential for skin breakdown related to a history of stasis ulcers to her lower legs, peripheral vascular disease, and dependence in ADLs [activities of daily living]." Review of approaches to this problem failed to identify staff implemented a turning/repositioning program for this resident.

- Review of Resident #6's medical record occurred on all days of survey. The quarterly MDS, dated 04/30/14, identified a turning/repositioning program. The current care plan stated, "Problem: Activities of Daily Living: . .

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F 278	Continued From page 8 . At risk for pressure areas . . . Assist resident to lay down after meals . . . Problem: Mobility: . . . Reposition every 2-3 hours and encourage her to reposition as she is able . . ." Resident #6's medical record failed to identify a specific and individualized turning/repositioning program. - Review of Resident #9's medical record occurred on 08/06/14. The quarterly MDS, dated 06/05/14, identified a turning/repositioning program. The current care plan and the medical record failed to identify a specific and individualized turning/repositioning program for Resident #9. - Review of Resident #12's medical record occurred on 08/06/14. A Quarterly MDS, dated 06/30/14, identified two stage 2 (partial thickness tissue loss) pressure ulcers and a turning/repositioning program. Resident #12's care plan, dated 07/07/14, identified a problem: "[Resident #12] has pain related to arthritis, amputation, PVD [peripheral vascular disease], and decreased mobility. An approach to the problem stated, "Assist with repositioning [Resident #12] frequently." When interviewed on 08/06/14 at 10: 35 a.m., an MDS coordinator (#4) agreed the interventions developed for Resident #3, #4, #6, #9, and #12 did not meet the MDS definition of a turning/repositioning program.	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	F 280	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Nursing staff were instructed on 8/29/2014 regarding updating of care	09/02/14

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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.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and staff interview, the facility failed to review and revise the care plans for 4 of 11 sampled residents (Resident #1, #3, #6, and #7). Failure to ensure care plans accurately reflected the residents' current status limited the staff's ability to communicate the care needs and ensure continuity of care for the residents.

Findings include:

- Resident #3's medical record, reviewed on all days of survey, identified diagnoses including constipation and a stage 4 (full thickness tissue loss) pressure area ulcer to the right hip. Resident #3's current care plan, dated 06/30/14, identified a problem, dated 01/11/10: "SKIN: Risk for pressure ulcer r/t [related to] impaired

F 280 plans to ensure they accurately reflect the current status of the resident. Care plans for resident #1, #3, #6 and #7 were corrected to reflect the current status of each resident on 8/18/2014.

2) All residents who have a care plan could potentially be affected. On 8/18/2014, a member of the nursing staff went through all the residents' care plans to ensure they reflect the residents' current status and needs. Nursing staff were instructed on 8/29/2014 on the importance of updating residents' care plans according to their status.

3) The QA director or nursing designee will monitor the care plans for completeness and accuracy monthly x 3, then quarterly times 1 year. Results will be reported to DON. If concerns are identified, immediate corrective action will be implemented. The QA director will submit a report monitoring the results to the QA committee at each scheduled meeting.

4) The QA director or nursing designee will monitor resident #1, #3, #6, and #7 and other residents who have a care plan monthly x 3, then quarterly x 1 year. Monitoring will begin 9/2/2014.

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mobility." The care plan failed to identify Resident #3 had a current stage 4 pressure ulcer and lacked an individualized repositioning schedule and/or other interventions to promote healing and prevent development of future pressure ulcers.

Record review identified Resident #3 required suppositories four to six times each month from April-July 2014. The resident's current care plan lacked dietary and/or other less invasive interventions for Resident #3's constipation.

- Review of Resident #7's medical record occurred on August 4-5, 2014. A Quarterly Minimum Data Set (MDS), dated 05/22/14, identified the resident as cognitively intact and had almost constant pain at a level 8 on a scale of 0 to 10. During an interview with Resident #7 on 08/04/04 at 3:20 p.m. observation showed the resident with a pain patch on his forehead. Resident #7 stated the patch was for his "continuous headaches" and indicated he had an upcoming appointment with a neurologist to evaluate treatment options.

The resident's current care plan, dated 06/27/14, identified a problem, dated 03/11/12: "PAIN: [Resident #7] has frequent pain to back, right shoulder, and arm." The care plan failed to identify the resident's "continuous headaches" or any interventions developed and implemented by staff to help alleviate the headaches.

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included osteoporosis. The MDS, dated 04/30/14, identified extensive assistance of two staff members for transfers. The current care plan stated, ". . . Approaches: . . . Standing lift with

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(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 280	Continued From page 11 assist of 2 . . ." Observations on 08/04/14 at 3:45 p.m., 08/05/14 at 9:20 a.m., 12:50 p.m., and 4:25 p.m., showed six different CNAs (#6, #7, #8, #12, #13, and #14), two with each observation, utilized a hoyer (full body mechanical lift) for all transfers. During an interview on 08/05/14 at 12:50 p.m., a CNA (#8) stated they (the CNAs) occasionally use the standing lift to transfer Resident #6 but the resident's knees have buckled lately so they use the hoyer lift. - Review of Resident #1's medical record occurred on August 4-5, 2014. A Quarterly MDS, dated 05/14/14, identified the resident as independent with ambulation and having two falls during the assessment period. Resident #1's medical record also identified falls on 06/12/14, 06/16/14, 06/27/14, 06/30/14 and 07/02/14. The resident's current care plan, dated 07/03/14, failed to identify the resident's history of falls, and failed to identify interventions to prevent further falls. When interviewed on 08/05/14 at 4:00 p.m., an MDS coordinator (#4) verified the facility failed to address falls in Resident #1's current care plan.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Nursing staff were instructed on 8/29/2014 on the updated policy titled, "Bowel Care." Staff will follow "Bowel	09/02/14

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	355044	A. BUILDING _____ B. WING _____	08/06/2014

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F 309	Continued From page 12 and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide the necessary care and services to manage constipation for 2 of 2 sampled residents (Resident #3 and #9) who required as needed (PRN) medications for constipation. Failure to implement less invasive interventions to manage constipation may have resulted in these residents receiving unnecessary suppositories and has the potential to cause constipation and/or fecal impaction. Findings include: - Resident #3's medical record, reviewed on all days of survey, identified diagnoses including senile dementia and constipation. The record showed the resident received no dietary interventions for the constipation. Resident #3's current physician's order sheet identified the following standing orders for constipation: * 12/22/09: Milk of Magnesia 15 cc [cubic centimeters] (O [orally]) PRN constipation." * 12/22/09: "Glycerin or Bisacodyl suppository q [every] 3-4 days (R [rectal]) PRN constipation." * 12/22/09: "Phosphate enema q 3-4 days PRN (R) for constipation." Additional physician's orders (not standing orders) regarding constipation stated: * 06/21/13: "If no BM in 3 days give MOM 30 cc (O). If no results from MOM on 4th day, give	F 309	Care' policy for resident #3 and #9 as well as any other resident who may be affected. 2) Any resident requiring a bowel aide could potentially be affected. All nursing staff will be educated that if a resident has not had a bowel movement by the third day, the resident will receive a bowel aide. The bowel aide will be milk of magnesia or bowel care of choice as ordered by the provider. 3) The QA director or nursing designee will monitor those staff who give a bowel aide to ensure that either milk of magnesia or a bowel aide of choice is given on day 3 for a resident who has not had a bowel movement. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA director will submit a report of the monitoring results to the QA committee at each scheduled meeting. 4) The QA director or nursing designee will monitor resident #3 and #9 and any other resident requiring a bowel aide monthly times three, then quarterly times one year. Monitoring to begin 9/2/2014.	

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Bisacodyl supp [suppository] PR [rectal]. If no results from supp give phosphate enema PR. Notify MD if indicated." This order failed to identify specifically when staff should notify the physician and conflicted with the standing orders.
* 04/10/14: "Senna Plus 1 tab [tablet] (O) BID [twice a day] - constipation."

The Daily Bowel Tracking form stated, "After 3 days Evening Nurse to give MOM if no BM by day shift then Day Nurse gives Suppository."

Resident #3's Daily Bowel Tracking form showed the resident had a large BM on May 14 and no bowel movement recorded from May 15 - 18 (four days). Staff failed to implement the bowel protocol until May 19 (5th day) when a nurse administered MOM with no results. On May 20 a nurse administered a bisacodyl suppository with no results recorded. Staff failed to administer an enema when the resident had no results from the suppository. The next bowel movement recorded for Resident #3 was a small soft BM on May 23 (eight days later).

After two more days without a BM (May 24 - 25), staff administered MOM on May 26 with no results, a bisacodyl suppository on May 27 with no results, and another bisacodyl suppository on May 30 with no results. Staff took no further action until June 5 when a nurse administered a bisacodyl suppository with large results. The record lacked evidence staff administered an enema when the resident had no results from the suppositories or contacted the physician during the 21 day period (May 15 - June 4) when Resident #3 had only one bowel movement recorded (the small BM on May 23).

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In addition, the resident's Daily Bowel Tracking forms identified staff administered bisacodyl suppositories without first attempting MOM on the following dates:
* 06/17/14 - 3rd day with no BM
* 07/01/14 - 4th day with no BM
* 07/05/14 - 5th day with no BM
* 07/09/14 - 4th day with no BM

The Daily Bowel Tracking forms identified staff administered MOM on May 6, 12 and 26; June 24; and July 16 and 27; and suppositories on May 14 and 27; June 5 and 25; and July 1 and 5 without recording those medication on Resident #3's Medication Administration Records (MARs). Failure to record medications on the MARs could result in staff administering multiple doses of the same medication.

During an interview on 08/06/14 at 10:30 a.m., an administrative nurse (#4) stated staff should follow the bowel protocol as ordered by the physician.

The facility failed to attempt less invasive measures to address Resident #3's constipation, including dietary interventions and administering MOM as ordered on the 3rd day with no BM. In addition, staff failed to consult with the physician during the 21 day period from May 15 - June 4 when the resident had only one small BM recorded.

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- Review of Resident #9's medical record occurred on 08/06/14. Medications to manage constipation included Senna Plus twice daily, Milk of Magnesia (MOM) PRN, glycerin or bisacodyl suppository every three to four days PRN, and a phosphate enema every three to four days PRN. An additional physician's order stated, "If no BM [bowel movement] in 3 days give MOM . . . If no results from MOM on 4th day give bisacodyl supp [suppository] PR [per rectum]. If no results from supp give phosphate enema PR. Notify MD [medical doctor] if indicated." The order failed to identify specifically when staff should notify the physician.

Review of Resident #9's "Daily Bowel Tracking" forms and Medication Administration Record (MAR) identified the following:
*April 2014: No BM April 3, 4, 5, or 6 (four days). Nursing staff administered a suppository on the April 7 with results. Staff failed to administer the MOM after the 3rd day.
*May 2014: No BM May 1, 2, 3, or 4 (four days). Nursing staff administered a suppository on May 5 with results. Staff failed to administer the MOM after the 3rd day.
*June 2014: No BM June 3, 4, 5, 6, 7, 8, or 9 (seven days). Nursing staff administered MOM on June 8 with no results until June 10.Staff failed to administer the MOM after the 3rd day.

The facility failed to provide less invasive interventions (MOM) to manage constipation, including dietary interventions to aid in bowel elimination, prior to a suppository and failed to notify the physician in June when Resident #9

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F 309	Continued From page 16 went seven days without a BM.	F 309		
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 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 procedure, and staff interview, the facility failed to ensure staff developed and implemented a repositioning schedule to promote healing and prevent development of new pressure ulcers for 1 of 2 sampled residents (Resident #3) with a current pressure ulcer. Failure to develop and implement a repositioning schedule may have contributed to the resident's pressure ulcer progressing to a Stage 4 (full thickness tissue loss) and placed the resident at risk of developing a new pressure ulcer. Findings include: Review of the facility policy and procedure, "PREVENTION AND TREATMENT OF PRESSURE SORES" occurred on 08/06/14. The policy and procedure, revised June 2014, stated, "PURPOSE: A program to prevent and treat pressure sores is planned for all clients to prevent	F 314	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Nursing staff were instructed on 8/29/2014 on policy titled,'Prevention and Treatment of Pressure Sores." Staff instructed to reposition resident #3 according to policy as well as any other resident who is at risk for a pressure sore. 2) Any resident who is at risk for developing a pressure sore has the potential to be affected. All"Turning/ Repositioning Forms" of those residents who have them will be reviewed by the Care Coordinator at least monthly for completeness. 3) The Care Coordinator or nursing designees will monitor those residents who are at a high risk for pressure sores to ensure that those residents are being turned/repositioned every two hours and documentation supports it. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA director will submit a report of the monitoring results to the QA committee at each scheduled meeting.	09/02/14

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F 314	Continued From page 17 skin breakdown and promote healing, if breakdown does occur. . . . PRESSURE SORE PREVENTION: . . . 4. Institute a preventative plan for any client who has a potential for developing a pressure sore or whose condition is rapidly deteriorating, including: a. Reevaluation of turning and positioning schedules with readjustment as necessary . . . - Resident #3's medical record, reviewed on all days of survey, identified a Stage 4 pressure ulcer on the right hip, a history of a Stage 1 (redness that does not turn pale when pressed firmly with a finger) pressure ulcer on the left hip, and a history of a Stage 2 (open area or blister) pressure ulcer on her coccyx. A significant change in status Minimum Data Set (MDS), dated 06/18/14, identified total assistance with bed mobility and transfers and a turning/repositioning program. The Pressure Ulcer Care Area Assessment, dated 06/24/14, stated, "Res [resident] has stage IV ulcer to her right hip. Res developed cellulitis along the incision line of hip replacement site in Feb [February]. Res was treated [with] antibiotics and area had healed. In April the area again flared & [and] was treated. Hip had small scab, when scab came off breakdown under skin noted. Res has seen surgeon, is not able to lie flat for [tests] to rule out osteomylitis. Family does not IV [intravenous] antibiotics or frequent trips to Minot. Wound vac [vacuum] has been applied. . . ." An interdisciplinary progress note, dated 04/22/14 at 11:00 a.m., stated, ". . . Has air mattress on bed now et [and] is repositioned et turned q [every] 2 [hours]. . . ." Resident #3's current care plan, dated 06/30/14,	F 314	4) The Care Coordinator will monitor resident #3 and any other resident requiring "Turning/Repositioning Forms" monthly x 3, then quarterly times one year. Monitoring to begin 9/2/2014.	

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identified a problem: "Risk for pressure ulcer r/t [related to] impaired mobility." An approach to the problem stated, "Change Position frequency [sic] and keep clean and dry." The care plan failed to address Resident #3's current pressure ulcer and a specific turning/repositioning schedule.

Observations of Resident #3 throughout the survey showed the following:
* 08/04/14 at 3:12 p.m.: resting in bed on her left side
* 08/05/14:
8: 35 a.m. - in bed lying on her left side
11:50 a.m. - seated in her recliner positioned toward her left side
12:12 p.m. - a Certified Nursing Assistant (CNA) (#10) assisted Resident #3 to eat with the resident positioned on her back in the recliner
1:04 p.m. - two CNAs (#10 and #11) assisted the resident to bed and positioned her on her left side
4:10 p.m. - resting in bed on her left side
* 08/06/14 at 10:15 a.m.: two licensed nurses (#2 and #3) changed the wound vac dressing on Resident #3's right hip. Following the dressing change, the nurses positioned the resident on her left side.

Resident #3's repositioning flowsheets stated, "turn every 2 hrs [hours] & initial." Review of the resident's repositioning flowsheets from 07/05/14 to 08/06/14 showed three days (July 17, 20, and 27) when no repositioning occurred, five days (July 7, 18, 28, 29, and August 5) when staff repositioned the resident once, nine days (July 5, 8, 9, 10, 14, 19, 25, 30, and August 1) when positioning occurred five or less times in 24 hours, and only four days (July 13, 22, 26, and August 1) when staff repositioned the resident every two hours.

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F 314	Continued From page 19 During an interview on the afternoon of 08/06/14 an administrative nurse (#1) agreed staff should not consistently position Resident #3 to her left side. Failure to reposition Resident #3 every two hours and to alternate positions placed the resident at risk of developing a new pressure ulcer.	F 314		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide fluids to maintain adequate hydration for 1 of 3 sampled residents (Resident #6) dependent on staff for fluid needs. Failure to offer fluids during cares increased Resident #6's risk of dehydration, constipation, and urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Hydration and Nutrition Policy and Procedure" occurred on 08/06/14. This policy, revised in 2007, stated, "Policy: 1. The nutrition and hydration status of each resident is maintained as close to optimal levels as possible . . . 7. Water must be available to residents at all times . . ."	F 327	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Nursing staff were instructed on 8/29/2014 on the policy titled, "Hydration and Nutrition." Staff were instructed to offer fluids when providing care to resident #6 and any other resident who needs assistance with fluids. 2) Any resident requiring the assistance of fluids to maintain adequate hydration has the potential to be affected. All staff who provide care to those residents that need assistance with fluids will be educated and evaluated on the importance of offering/assisting residents so the residents maintain adequate hydration. 3) The QA director or nursing designee will monitor those staff who provide care to those residents who need assistance with fluids to ensure fluids are being offered consistently. Results will be	09/02/14

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F 327	Continued From page 20 Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia and a history of constipation and UTIs. The resident's quarterly Minimum Data Set (MDS), dated 04/30/14, identified extensive assistance for eating and all other activities of daily living (ADL). The current care plan stated, "Problem: Elimination: . . . History of constipation & [and] UTI . . . Approaches: . . . Encourage fluids . . ." Observation on 08/04/14 at 3:45 p.m. showed two certified nursing assistants (CNAs) (#12 and #13) provided cares for Resident #6. At the completion of cares, one of the CNAs assisted the resident with a glass of cranberry juice and the resident drank 100 percent of the juice. Observations on 08/05/14 at 8:35 a.m, 9:20 a.m., 12:50 p.m., and 4:25 p.m. showed five different certified nursing assistants (CNAs) (#5, #6, #7, #8, and #14) provided cares for Resident #6 in her room. Observation showed a glass of water on the resident's bedside stand. During each observation, the CNAs exited the room and failed to offer/assist Resident #6 with fluids. During an interview on the afternoon of 08/06/14, an administrative nurse (#1) stated she expected facility staff to offer fluids to dependent residents during cares.	F 327	reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA director will submit a report of the monitoring results to the QA committee at each scheduled meeting. 4) The QA director or nursing designee will monitor resident #6 and any other resident requiring assistance with fluids monthly x 3, then quarterly times one year. Monitoring to begin 9/2/2014.	
F 441 SS=D	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	F 441	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Nursing staff were instructed on 8/29/2014 on the policy titled, "Peri-	09/02/14

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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 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, review of facility policy, and staff interview, the facility failed to follow standard infection control practices for 2 of 4 sampled residents (Resident #6 and #9)

F 441 care." The instruction was for resident #6 and #9 as well as any other resident who may be affected.

2) Any resident requiring peri-care has the potential to be affected. All staff who provide peri-care to residents will be educated and evaluated on the importance of washing hands following bowel incontinence.

3) The QA director or designee will monitor those staff who provide peri-care to residents to ensure that proper hand washing is occurring following bowel incontinence. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA director will submit a report of the monitoring results to the QA committee at each scheduled meeting.

4) The QA director or nursing designee will monitor resident #6 and #9 and any other residents requiring peri-care monthly x 3, then quarterly times one year. Monitoring to begin 9/2/2014.

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observed during incontinence cares. Failure to follow infection control practices related to hand hygiene and glove usage has the potential to cause or spread infection within the facility.

Findings include:

Review of the facility policy titled "PERICARE" occurred on 08/06/14. This policy, dated 2006, stated, ". . . Turn person onto their side . . . Wash and dry rectal area . . . Remove gloves . . . Put on clean gloves. Apply clean incontinent product . . . Apply clean clothing as needed. Remove gloves. Wash hands. . . ."

- Observation on 08/05/14 at 4:25 p.m. showed the certified nursing assistant (CNA) (#8) positioned Resident #6 on her side and another CNA (#6) provided incontinence cares after a bowel movement (BM). With the same gloves, the CNA (#6) assisted the resident with her clean brief, pants, and shoes. The CNA (#6) failed to change gloves after performing incontinence (BM) cares and before providing other cares, and failed to wash her hands before exiting the room.

- Observation on 08/05/14 at 4:40 p.m. showed a CNA (#6) removed Resident #9's brief (soiled with BM) and provided perineal cares. The CNA (#6) failed to wash her hands after performing incontinence (BM) cares and before exiting the room.

During an interview on the afternoon of 08/06/14, an administrative nurse (#1) stated she would expect the CNAs to wash their hands after providing incontinence (BM) cares.