STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. BUILDING _____ B. WING _____	08/15/2013

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 08/12/13 and completed on 08/15/13, the sample included three (3) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included two (2) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Brown
TITLE: Administrator
(X6) DATE: 9/23/13

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 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156		

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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of Medicare billing records, and staff interview, the facility failed to issue a liability notice to 1 of 1 resident (Resident #15) reviewed for termination of Medicare coverage. A liability notice informs a resident why specific services may not be covered by Medicare, the resident's potential liability for payment of noncovered services, and the resident's right to have a claim (demand bill) submitted to Medicare. Failure to issue a liability notice does not ensure residents received the option to request a demand bill, which is an infringement of the resident's rights. Findings include: Review of the facility's Medicare billing records occurred on 08/13/13. The records identified Resident #15's Medicare coverage ended on 08/07/13. On 08/05/13, Resident #15's representative received notification the resident's Medicare	F 156	MBH will meet this requirement by: Provided resident #15's representative a liability notice form. All residents who receive Medicare coverage will be given a liability notice form/denial letter when resident is notified by a "Notice of Medicare Provider Noncoverage (Form CMS-10123) of Medicare coverage ending. Business Office Manager was inserviced on 8/13/13 of the need for both forms to be given to resident or representative of resident. Business Office Manager will monitor monthly through the QA committee.	08/14/13 09/29/13

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F 156	Continued From page 3 would be ending. On 08/06/13, the representative signed a "Notice of Medicare Provider Noncoverage (Form CMS-10123) (informs resident of the right to an immediate, independent medical review from a Quality Improvement Organization of the decision to end Medicare coverage)." Resident #15's record lacked evidence the facility provided him with a liability notice. During an interview on 08/13/13 at 2:00 p.m., an administrative business office staff member (#16) and nursing staff member (#1) stated the facility had discontinued providing resident/resident's representatives with a liability notice form/denial letter.	F 156		
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	F 157		

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F 157	Continued From page 4 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. 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, review of facility policy and procedure, family interview, and staff interview, the facility failed to notify the designated family member of two falls experienced by 1 of 5 sampled residents (Resident #4). Failure to notify the family member of a fall involving a head injury limited the family member's ability to make informed decisions regarding medical care. Findings include: Review of the facility policy and procedure, "Post-Fall Guidelines," occurred on 08/15/13. This document, revised in February 2006, stated "PURPOSE: To provide prompt assessment and treatment following a fall. . . . PROCEDURE: . . . 11. Notify family. . . . DOCUMENTATION: . . . 8. Notification of family." During the initial facility tour, on 08/12/13 at 12:00 p.m., a supervisory nursing staff member (#3) reported Resident #4 fell the previous weekend (August 10-11, 2013) and had a history of falls.	F 157		

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F 157	Continued From page 5 Observation showed the resident sleeping on her bed and a discolored area on her right forehead. Review of Resident #4's medical record occurred on August 12-15, 2013. The facility admitted the resident in December 2009. Current diagnoses included dementia and a history of fractures (2011) related to falls. The resident's quarterly Minimum Data Set (MDS), dated 06/19/13, identified severe cognitive impairment, extensive assistance of two or more persons for transfers, and a fall with injury since the prior assessment in March 2013. Resident #4's medical record identified a family member (A) as her power of attorney. Another family member is identified as "second contact." During interview, on 08/13/13 at 1:45 p.m., Resident #4's family member (A) and spouse reported the facility failed to notify them of an incident approximately one month ago and failed to leave a message regarding the fall over the previous weekend. Regarding the fall over the weekend (August 10-11, 2013) Resident #4's family member (A) and spouse reported observing Resident #4's bruise and finding out about the fall when they visited the resident that weekend. They also reported the facility telephone number appeared on their home telephone caller identification but the facility failed to leave a message. Resident #4's Interdisciplinary Progress Notes included the following: *Physician communication, 07/25/13, untimed - ". . . Unwitnessed fall in bathroom, found @ [at] [8:00 p.m.]. No c/o [complaints of] pain or injury.	F 157	MBH will meet this requirement as evidenced by: Staff will be educated on the deficient practice and POC. MBH falling star policy will be revised to reflect changes to meet F157 requirements. Resident #4's family was notified of falls on 8/13/13. MBH staff will contact or leave message for all families according to policy. DON or designee will monitor notifications of resident or family through the fall committee according to this requirement monthly x 3 then quarterly x 1.	09/26/13 09/29/13

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F 157	Continued From page 6 No bruising noted. . . . Name of Family contacted: [Blank] . . ." *08/11/13, 5:45 p.m. - "Resident was found on floor in bedroom between her bed & [and] table. . . . Son [second contact's name] notified of fall." *Physician communication, 08/11/13, untimed - ". . . Had fall in room resulting in 2 cm [centimeter] cut to (R) [right] [upper] eyebrow. . . . Family contacted: Son . . ." During interview, on 08/14/13 at 5:00 p.m., a supervisory nursing staff member (#3) confirmed the facility staff failed to notify the family member (A) regarding Resident #4's fall on 07/25/13. This staff member also confirmed the facility staff failed to contact family member (A) regarding Resident #4's fall on 08/11/13 and it is unknown why facility staff notified the "second contact."	F 157		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: 1. Based on review of employee files, facility policy, and staff interview, the facility failed to implement established policies and procedures for 3 of 5 recently hired employees (staff member A, B, and C). Failure to check the appropriate boards/registries and references prior to employment placed facility residents at risk of abuse.	F 226		

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F 226	Continued From page 7 Findings include: Review of the facility policy titled "Abuse Prohibition Reporting and Investigation of Allegations" occurred on the morning of 08/15/13. The policy stated, ". . . The facility will . . . check with appropriate licensing boards and registries . . ." Review of the facility policy titled "Abuse Prohibition Reporting and Investigation of Allegations" occurred on the morning of 08/15/13. The policy stated, ". . . The facility will attempt to obtain information from previous employers and current employers (with the applicant's permission). . . ." Review of employee files occurred on the afternoon of 08/13/13 and showed the facility hired the staff member A on 06/11/13 however failed to check with the appropriate licensing board until 08/13/13. Review of the work schedule on 08/13/13 at 2:45 p.m. identified staff member A worked at the facility a total of 154 hours, June 12, 2013-August 13, 2013, before facility staff verified her status with the licensing board. Further review of employee files showed the facility hired the staff member B as a certified nursing assistant (CNA) on 04/12/13 however failed to check with the state registry until 04/19/13. Review of the work schedule on 08/13/13 at 2:45 p.m. identified staff member B worked a total of twenty four hours, April 16, 17, and 18, before facility staff verified her status on the appropriate registry.	F 226	MBH will meet this requirement by: Director of Human Resources will be inserviced on the facilities policy for "Abuse Prohibition Reporting and Investigation of Allegations" and the correct procedure for checking with appropriate licensing boards and registries for all new hires and attempt to obtain information from previous employers and current employers before new hires start work, will be followed. All employee files were reviewed for compliance on 8/15/13. Director of Human Resources or designee will monitor the new hire application process for the above procedures on a monthly basis and will report findings at the quarterly QA committee meeting.	08/15/13 09/29/13

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F 226	Continued From page 8 During an interview on 08/15/13 at 10:15 a.m., an administrative human resources staff member (#17) confirmed the facility should have checked with the appropriate board and registry prior to allowing the employees to work in the facility. Review of employee files showed staff member C terminated employment with the facility on 06/20/12 and the facility rehired staff member C on 07/25/13. The facility failed to attempt to obtain a reference from the employee's previous or current employer.	F 226		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on policy and procedure review, review of Resident Council minutes, and group, resident, and staff interviews, the facility failed to act upon resident grievances; specifically concerns about palatable food for 7 of 10 residents (Resident A, B, C, F, G, H, and I) who attended a group interview and during confidential resident interviews (Resident A, B, D, J, K, L, E). Failure of the facility to act upon the grievances of the residents resulted in continued unpalatable food concerns. Findings include:	F 244		

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Review of the facility policy "Patient/Resident Grievance and Complaint Policy and Procedure" occurred on the morning of 08/15/13. The policy, dated April 2010, stated, ". . . Any grievance/complaint received by a staff member should be addressed at the time of the grievance/complaint by the appropriate staff present (including supervisor). If staff cannot resolve the grievance/complaint, then it should be forwarded to the Risk Manager or the Administrator. Within 7 days of receiving the grievance/complaint, the Risk Manager will notify the patient/resident of the status and/or resolution of the investigation. Notification may be verbally or in writing. . . ."

- During initial tour on the morning of 08/12/13, the following comments were made regarding the facility's food:
* Resident A stated, "the food is not good", "the meat is tough", "the grilled cheese sandwiches are hard", and the "soup tastes like water with vegetables."
* Resident B stated, "the food tastes bad. It has no flavor."
* Resident C stated, "if the food is not burnt, then it's raw." "The noodles in the beef stroganoff were raw, I had a stomachache after eating them. We are served a lot of instant potatoes that taste awful."

Ten residents (identified by the facility as interviewable) attended the group interview on 08/13/13 at 9:30 a.m. Seven residents (Resident A, B, C, F,G, H, and I) voiced concerns regarding "tough, dry, chewy, old" meat. Three residents (Resident B, C, and F) voiced concerns regarding "mushy, flavorless" vegetables. Three residents

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(Resident A, B, and C) voiced concerns regarding "hard, not done" baked potatoes.
- During the survey, an interview occurred with Resident A. During this interview, the resident indicated the food is bland and the meat is tough. The resident talked about a conversation had with a facility staff member about the food. Resident A said during that conversation, the staff member said, "We can't ever seem to please you with the food."

Record review occurred during the survey for Resident A. Resident A's current Minimum Data Set (MDS), identified a Brief Interview for Mental Status (BIMS) score of 15 (indicating the resident is interviewable). The resident record contained information to indicate facility staff were aware of Resident A's concerns of tough meat and not liking the flavor of some foods.

The menu identified lunch on 08/13/13 as meatloaf, mashed potatoes with gravy, and mixed vegetables (carrots and beans). At 12:30 p.m. on 08/13/13, Resident A, when asked about the food, said the vegetables are "mushy" and have "no flavor."

- During the survey, an interview occurred with Resident B. During this interview, the resident stated, "Don't ask me about the food, I can't find anything good to say about it." When asked to elaborate, the resident stated, "The food is terrible and that is all I am going to say about that." When asked about her lunch (meatloaf, mashed potatoes, and mixed vegetables), the resident said the vegetables were "terrible," with "no flavor."

Record review occurred during the survey for

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F 244	Continued From page 11 Resident B. Resident B's current MDS, identified a BIMS score of 15. The resident record contained information to indicate facility staff were aware of Resident B's concerns about the food. - During the survey, an interview occurred with Resident D. This resident reported the pork chops and roast beef are "tough," chicken is "overdone," and vegetables are undercooked and not seasoned. The resident reported if she does not like the food items served or feels they are not palatable, the resident leaves them on the plate. The resident does not ask for substitutes and asks family members to bring food to substitute for food items that are not palatable. Resident D's medical record identified complaints about the food in the facility and family members brought food to the resident. - During an interview, Resident J stated, "meat tastes a little old, chicken is not tender, fixed a hamburger and it was cooked so hard couldn't hardly eat it." - During an interview, Resident K stated, "meat, sometimes think it tastes old." - During an interview, Resident L stated, "hard meatloaf and meatballs." During an interview, Resident E indicated he/she does not care for the food. He/she brings in hamburger, noodles, vegetables, and tomato soup and the activity staff assist in preparing a hot dish. Review of the February, April, June, and August "Resident Council Minutes" failed to indicate discussion of food concerns.	F 244	MBH will meet this requirement by: Staff will be inserviced on facility's "Patient/Resident Grievance and Complaint Policy and Procedure" to ensure staff understand the steps to be taken when residents have a grievance or complaint. Resident Council Meeting was held on 8/23/13 to discuss F244 and to ask residents for permission to add "Food Concerns" as a standing agenda item. A "Dining Satisfaction Survey" was developed for all residents/resident representatives to complete. Surveys were mailed to resident representatives where resident was not able to complete on their own. Families were asked to return survey be 10/1/13. Residents who were able to complete on their own, were given one and asked to return by 10/4/13. Copies of all returned surveys will be given to the Dietary Manager, who will then review with the Administrator. Resident Council meetings will include the "Food Concerns" item and any follow up items not previously addressed to the satisfaction of the residents.	09/26/13 10/06/13

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F 244	Continued From page 12 An interview occurred on 08/14/13 at 3:30 p.m. with two social services staff members (#5 and #6) who conduct the resident council meetings. The staff member (#5) stated she did not include food concerns the residents raised in group interview; rather, she forwarded the concerns in an e-mail to the dietary manager. The staff members (#5 and #6) confirmed they were aware of resident council concerns of "bland" food and individual residents' general concerns with meat, chewy chicken, and undercooked baked potatoes. Refer to F364 for issues with palatable foods.	F 244	Social Services Director will monitor monthly and report findings at the quarterly QA committee meeting.	10/06/13
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions;	F 272		

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	355044	A. BUILDING _____ B. WING _____	08/15/2013

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

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F 272	Continued From page 13 Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. 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) and accompanying Care Area Assessment (CAA) Summary, were completed accurately and in a timely manner for 1 of 1 newly admitted sampled resident (Resident #12) and for 1 newly admitted supplemental sampled resident (Resident #15) who have resided in the facility and met the requirement for completion of the MDS and CAAs. Failure to complete the CAAs for residents in a timely manner may affect accurate development and implementation of a care plan, thus having the potential to negatively affect resident care. Findings include:	F 272		

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F 272	Continued From page 14 Review of the Long Term Care Facility RAI User's Manual, Version 3.0, page 2-15 contained a RAI OBRA (Omnibus Budget Reconciliation Act) - required assessment summary table. This table identified an Admission assessment as a comprehensive (requiring both MDS and CAAs) assessment. The MDS completion date (Item Z0500B) is to be no later than "14th calendar day of the resident's admission. . ." The CAA Completion Date (Item V0200C2) is to be no later than "Same as MDS Completion Date." - A review of Resident #12's record occurred on August 14-15, 2013. The facility admitted Resident #12 on 07/11/13. The record did not contain an admission MDS assessment. An administrative staff nurse (Staff #1), when asked to provide the assessment, provided the MDS and the Nutritional Status CAA. This staff member identified the other CAAs were still being worked on. The Z0500B (MDS completion date) identified was 07/24/13 and the V0200C2 (CAA completion date) was blank. On 08/15/13, the administrative staff nurse (#1) provided all CAAs for Resident #12's admission assessment. Only the CAAs for ADL (Activities of Daily Living) Functional/Rehabilitation Potential and Urinary Incontinence (as well as the Nutritional Status CAA reviewed earlier) had been completed. When asked about completion of these CAAs, this staff member identified she completed them on 08/14/13. Review of these CAAs indicated a date of completion as 07/24/13 (three weeks prior to the actual completion of the forms). The CAAs for Falls, Dental Care, and Pressure Ulcers remained blank; although the "Location and Date of CAA documentation" in Section V is dated as 07/24/13 for all CAAs,	F 272	MBH will meet this requirement as evidenced by: Resident #12: On 8-16-13 CAA summaries were completed for this resident. The date on the CAA resource was changed to reflect completion of 8-16-13. Resident #15: On 8-16-13 CAA summaries were completed for this resident. The date on the CAA resource was changed to reflect the completion date of 8-16-13. For all residents future practice will be to sign the CAA completion date on the MDS on the date it is completed. All admission MDS's and CAA's will be completed within 14 days of resident admission. Nursing staff will be educated on the plan of correction and the RAI OBRA – required assessment summary table located in the Long Term Care Facility RAI User's Manual, Version 3.0., pages 2-15. DON will monitor for timely completion of MDS's on a weekly basis for 1 month, then monthly for 2 months, then quarterly for 1 month. The findings will be reported to the quarterly QA committee.	09/26/13 09/29/13

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F 272	Continued From page 15 including the CAAs left blank. - A review of Resident #15's record occurred on 08/15/13. The facility admitted Resident #15 on 07/18/13. The record did not contain an admission MDS assessment. An administrative nursing staff member (#1) provided the MDS and the CAA Resource Forms for seven CAAs. The Z0500B (MDS completion date) was identified as 07/24/13 and the V0200C2 (CAA completion date) was identified as 07/31/13, one week after the MDS completion date. Review of the seven CAAs provided, found the Urinary Incontinence CAA and the Falls CAA documentation blank. The "Location and Date of CAA documentation" in Section V is dated as 07/24/13 for these blank CAAs, indicating the documentation as completed on that date. During interview on the morning of 08/15/13, an administrative nursing staff member (#1) confirmed the completion of the CAAs for both Resident #12 and #15 is late.	F 272		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		

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F 323	Continued From page 16	F 323		

Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to provide adequate supervision and assistive devices to prevent accidents, for 1 of 5 sampled residents (Resident #4) identified with falls. Failure to supervise Resident #4 in the bathroom placed the resident at risk of recurrent falls and injury.

Findings include:

Review of the facility policy and procedure, "Gait Belts For Transfer," occurred on 08/15/13. This document, revised June 2006, stated "POLICY: . . . 2. Each resident/patient who uses a gait belt will have his/her own belt. . . ."

Review of Resident #4's medical record occurred on August 12-15, 2013. The facility admitted the resident in December 2009. Current diagnoses included dementia, a history of fractures (2011) related to falls, and a history of falls. The resident's quarterly Minimum Data Set (MDS), dated 06/19/13, identified severe cognitive impairment, extensive assistance of two or more persons for transfers, and a fall with injury since the prior assessment in March 2013.

Resident #4's Falls Care Area Assessment, dated 03/27/13, identified the resident was a high falls risk. Resident #4's current care plan, updated on 06/27/13, stated "Problem, Falls: At risk for falls r/t [related to] hx. [history] of falls. . . . Approaches . . . Alarms to bed/chair as indicated. . . .;" and, "Problem, Continence: Continent of bowel and frequently incontinent of bladder . . . Approaches . . . Assist with ADLs [activities of daily living] as needed . . ." Resident #4's CNA (certified nursing assistant) Care Sheet identified

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F 323	Continued From page 17 "ADL Assist, Assist [of] 1 ADLs/transfers . . . Toileting . . . Assist of 1 PRN [as needed] . . ." Observation on 08/13/13 at 8:25 a.m. identified Resident #4 seated in a wheelchair in her pajamas repeatedly calling out, "Got to get to the bathroom, hurry." A CNA (#7) wheeled the wheelchair into the bathroom and searched in the room for a gait belt. The CNA (#7) could not find a gait belt and left the room to find one. Resident #4 remained seated in the wheelchair next to the toilet, repeatedly calling out, "Got to get to the bathroom, hurry." Approximately three minutes later, the CNA (#7) returned to the room with a gait belt. The CNA (#7) applied the gait belt to the resident's waist and the resident stated "too tight" and voiced discomfort. Resident #4 grasped the wall bars and the CNA (#7) assisted Resident #4 to stand by pushing on her buttocks. When seated on the toilet, Resident #4 immediately voided. After toileting, morning cares, and partial dressing while seated on the toilet, the CNA (#7) applied the gait belt to Resident #4's waist to attempt to transfer her to the wheelchair. Resident #4 stated "too tight" and voiced discomfort. The CNA (#7) left Resident #4 seated on the toilet and left the room to find another person to assist with the transfer. The CNA (#7) returned approximately two minutes later with a supervisory nursing staff member (#10). The staff members (#7) and (#10) assisted Resident #4 from the toilet to the wheelchair. Resident #4 experienced six falls in the period	F 323	MBH will meet this requirement by: Resident #4's care plan has been updated to reflect "Do not leave alone in restroom". A fall committee has been formed to discuss all resident falls, interventions and policies regarding falls and fall risk for residents will be reviewed and revised as indicated with care plans updated when risk is identified. Staff was educated on the POC. Fall Committee will monitor care plans for at risk residents monthly x 3, then quarterly x 1. The finding will be reported at the quarterly QA committee meeting.	08/15/13 09/26/13 09/29/13

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F 323	Continued From page 18 June 13, 2013 through August 15, 2013, one with a possible fracture and one with a laceration to the forehead. Two of these falls occurred in the bathroom. CNA (#7) left Resident #4 alone in the bathroom on two occasions during the episode of care on 08/13/13. Resident #4's care plan and CNA Care Sheet fail to include interventions regarding prevention of the resident's falls in the bathroom. During interviews, on 08/14/13 at 4:30 p.m., an administrative nursing staff member (#1) and a supervisory nursing staff member (#3) confirmed the facility staff should not leave Resident #4 alone in the bathroom.	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, record review, and staff interview, the facility failed to prepare food using methods to enhance flavor and texture for 2 of 2 meals (noon meals on 08/13/13 and 08/14/13) assessed with test trays. Failure to ensure foods are prepared to promote palatability and serve foods residents deem palatable may impact food intake by residents. Findings include:	F 364		

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F 364	Continued From page 19	F 364		

Review of the facility's policy titled "Policy of Nutritional Care" occurred on 08/15/13. The policy, dated 12/07/09, stated, "The goals of the food service department are to provide nourishing, palatable, balanced meals that meet the nutritional needs of the residents in accordance with the physicians' orders. . . "

A test tray for the noon meal on 08/13/13 at 12:30 p.m. consisted of the following foods: Cheesy Meatloaf, Mashed Potatoes, Prince Edward Vegetable Blend, and Fruited Gelatin. Four surveyors agreed the meatloaf tasted bland with visible breading and a tough layer of cheddar cheese on top. The surveyors also agreed the vegetable blend, especially the carrots, were watery and mushy with no flavor.

Observation of meal intake in the dining room following this meal revealed 17 out of 54 current residents with 50 percent or more of the meatloaf remaining on their plates and 19 residents with fifty percent or more of the vegetables remaining on their plates.

A test tray for the noon meal on 08/14/13 at 12:25 p.m. consisted of the following foods: Chicken Ala King, Peas and Carrots, Biscuit, Carrot Cake, and Sliced Roast Turkey (substitute meal choice). Four surveyors agreed the chicken had a chewy texture and the turkey tasted bland with a pink and white variegated unappealing appearance. The surveyors also agreed the peas and carrots were watery with no flavor.

Review of the meal intake in the dining room following this meal revealed 16 residents with 50 percent or more of the chicken ala king/biscuit

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F 364	Continued From page 20	F 364		

remaining on their plates and 21 residents with 50 percent or more of the vegetables remaining on their plates.

During an interview on the morning of 08/15/13, the cook (#18) who prepared the observed meals stated vegetables are cooked on the stove and are not drained before they are placed in the steam table. The cook stated she does not usually add butter or seasoning to the vegetables.

Review of the recipe titled "Vegetable Blend, Prince Edward," provided by the cook, occurred on the morning of 08/15/13. The recipe stated, ". . . [Table with vegetables, hot water, and margarine amounts per number of servings] 1. Steam or boil vegetables until tender. Drain off excess liquid. Note: Prince Edward Blend is 33% wax beans, 33% green beans, 33% carrots, 2. Toss lightly with and [sic] margarine. . . . Serve at or above 140 [degrees] F [Fahrenheit]. Note: Recommended seasonings include basil, dill, marjoram, oregano, rosemary, tarragon, thyme, onion powder, herb de provence, salt free herb seasonings. Add 2-1/2 tablespoons of seasoning of choice per 10 pounds." The recipe titled "Peas and Carrots" included the same instructions for draining vegetables and adding margarine and seasoning.

During an interview on the morning of 08/15/13, the cook (#18) who prepared the observed meals stated, she prepared the meatloaf with bread crumbs prepared in a blender using leftover bread loaf ends/heels stored on a shelf in the kitchen. The cook stated she used six to seven cups of bread crumbs in fifteen pounds of ground beef. When asked about other ingredients in the meatloaf, the cook stated she added ketchup to

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F 364	Continued From page 21 the meat mixture and cheese on top after the meatloaf cooked. Review of the recipe titled "Meatloaf, Cheesy," provided by the cook on 08/15/13, occurred on the morning of 08/15/13. The recipe stated, " . . . [Table with ground beef, bread crumbs, diced fresh onions, egg mix, tomato sauce, salt, black pepper and mozzarella cheese amounts per number of servings] . . ." The amount of bread crumbs indicated for the 75 servings was to be 2-1/2 cups in 12-1/2 lbs [pounds] of ground beef. The recipe further stated, ". . . Combine beef, breadcrumbs, diced onion, egg mix, a quarter of tomato sauce, salt, and pepper in a mixing bowl. 2. Place meat mixture into loaf pans. Top with the rest of the tomato sauce. 3 Bake in oven at 350 [degrees] F for 50-60 minutes, or until done. Top meatloaf with shredded cheese and continue cooking for 5-10 minutes or until cheese is melted. . . ." During an interview on the morning of 08/15/13, an administrative dietary staff member (#19) stated she was not sure how foods were cooked as she does not know the recipes. Refer to F244.	F 364	MBH will meet this requirement by: Dietary staff will be educated on the Nutritional Care Policy and on the importance of following recipes to ensure foods, including vegetables, are palatable. The "Cheesy Meatloaf" recipe has been removed from the menu due to the palatability issues with residents and surveyors. The Dietary Manager or designee will be responsible for monitoring, on a weekly basis, to ensure recipes are being followed and will report finding at the quarterly QA committee meeting. In conjunction with F244, the Dietary Manager or designee will attend Resident Council meetings to address resident food concerns. This will be monitored monthly and reported to the quarterly QA committee meeting also.	09/18/13 08/26/13 09/29/13
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		

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F 431	Continued From page 22 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and staff interview, the facility failed to ensure periodic reconciliation (accurate account) of Schedule IV controlled medications for 2 of 2 medication carts. Failure to periodically reconcile controlled medications has the potential for medication errors and loss or diversion of medications. Findings include:	F 431		

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F 431	Continued From page 23 Review of the facility policy titled "ADMINISTRATION OF CONTROLLED SCHEDULED II MEDICATIONS POLICY AND PROCEDURE" occurred on 08/15/13. This policy, dated 02/2006, stated, "Purpose: To administer and monitor controlled schedule II medications. Other scheduled medications maybe counted at the facility's discretion. . . Procedure . . . 4. The controlled medications must be signed for on the MAR [medication administration record] and the Narcotic, Hypnotic, and Controlled Drugs count sheet at the time the drug is taken, . . . A running count of the remaining number of medications left is kept on the Narcotic, Hypnotic, and Controlled Count Sheet and may also be kept on the MAR. . . . 10. Any count deviation is reported upon discovery to the DON [Director of Nursing] who will then notify pharmacy. Observation of the medication cart occurred on 08/14/13 at 3:15 p.m., with a nursing staff member (#15). During reconciliation of controlled medications the staff member identified the lack of monitoring/counting of Ativan (antianxiety medication). On the morning of 08/15/13, an administrative nurse (#1) identified additional Schedule IV medications not counted: diazepam (antianxiety medication) clonazepam (antianxiety medication) During an interview on 08/14/13 at 4:00 p.m., an administrative nurse (#1) stated nursing staff do not reconcile/count for any Schedule IV controlled medications, and the staff need to develop a system.	F 431	MBH will meet this requirement by: Nursing staff will be educated on plan of correction. Facility policy on counting of controlled medications will be reviewed and revised to include all controlled medications. Schedule IV controlled medications will be added to the current list of counted medications and same process of counting will be followed that is currently set up for Schedule II medications. DON or designee will monitor monthly x 3 then quarterly x 1 for compliance and will report findings at the quarterly QA committee meeting.	09/26/13 09/29/13

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F 441	Continued From page 24	F 441		
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 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.	F 441		

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MOUNTRAIL BETHEL HOME	615 6TH ST SE STANLEY, ND 58784

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This REQUIREMENT is not met as evidenced by:
1. Based on observation, review of facility policy and procedure, review of professional literature, and staff interview, the facility failed to properly disinfect the glucometer for 1 of 1 supplemental resident (Resident #16) observed during blood glucose testing. Failure to correctly disinfect glucometers may result in the transmission of organisms and pathogens to other residents, staff, and visitors.

Findings include:

Review of the facility policies titled "Blood Glucose Monitoring" and "Assure Pro Glucose Meter Policy and Procedure" occurred on 08/14/13. These policies, dated 09/2007 and 06/2008, failed to identify a cleaning method for an Assure Glucose Meter.

A Centers for Disease Control and Prevention publication titled "Frequently Asked Questions (FAQs) regarding Assisted Blood Glucose Monitoring and Insulin Administration," dated 03/08/11, stated, ". . . General: . . . Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. . . . Blood Glucose Meters: 1. . . . Infectious agents, such as HBV [hepatitis B Virus] can be transmitted through indirect contact transmission, even in the absence of visible blood. . . . Healthcare personnel hands can become contaminated with blood at various points while performing assisted blood glucose monitoring including pricking the

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F 441	Continued From page 26 patient's finger or handling the test strip. Blood can then be transferred to the meter . . . 2. . . . FDA [Food and Drug Administration] has recently released guidance for manufacturers regarding appropriate products and procedure for cleaning and disinfection of blood glucose meters. . . . 'The disinfection solvent you choose should be effective against HIV [human immunodeficiency virus], Hepatitis C, and Hepatitis B virus. . . . Please note that 70% ethanol (alcohol) solutions are not effective against viral bloodborne pathogens and the use of 10% bleach solutions may lead to physical degradation of your device. . . ." Observation on 08/12/13 at 4:22 p.m. and 08/13/13 at 4:55 p.m., showed a staff nurse (#11) tested Resident #16's blood glucose with a glucometer. After testing the resident's blood glucose, the nurse wiped the glucometer with an alcohol wipe. In an interview, after the second observation, the nurse (#11) stated this glucometer is used for multiple residents, it is cleaned with alcohol between residents and every night it is cleaned with a caviwipe. During an interview on 08/15/13 at 8:45 a.m., an administrative nurse (#1) stated she expected staff to disinfect the glucometer after each use with a caviwipe, not an alcohol wipe. 2. Based on record review, review of facility policy, and staff interview, the facility failed to investigate and document on the facility infection control log for 1 of 1 sampled resident (Resident #2) with a maggot infested wound. Failure to complete an investigation and document on the infection control log regarding a maggot infested wound limited the facility's ability to track and	F 441		

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trend infected wounds, and prevent the potential spread of infection to residents, staff, and visitors.

Findings include:

Review of the facility policy titled "Infection Surveillance" occurred on 08/15/13. This policy, dated 2013, stated, "Purpose: To monitor . . . residents who exhibits sign and symptoms of infection. To prevent the spread of infection to . . . residents. . . . Procedure: . . . 3. The QRM [Quality Risk Manager] department personnel will log all infections of . . . residents on respective log forms . . ."

Review of Resident #2's medical record occurred on all days of survey. Diagnoses include diabetes mellitus, arteriosclerotic vascular disease, and history of below the knee amputation of the right leg. The medical record identified Resident #2 as having a non-healing, worsening ulceration, and a lesion of the left foot.

Review of Resident #2's July treatment record revealed:
07/02/13 - paint foot ulcers with Betadine and leave open to air
07/05/13 - keep left foot wrapped with kerlix and ace wrap, change daily.

Nursing progress notes identified the following:
07/14/13 at 10:15 a.m. "Dressing removed from [left] foot noted large amt [amount] maggots open wound. Dr. [name of Physician] notified - will come to see. Requests ADON [Acting Director of Nursing] [name] be notified to come up as well. [and] notified per phone - will be here."
07/14/13 at 10:30 a.m." [Dr. name] in to see [left] foot, relates [Dr. name of surgeon] here in

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building today [and] will have him come to see."

A Physician Progress Note, dated 07/14/2013, identified the following: ". . . Was seen today per request of nursing staff for [Resident #2]. They were changing his dressing on his left foot. They did note some larva to be crawling in the wound today. Wound was inspected, cleaned and changed yesterday and nothing was noted. Then this morning did note these larva in the wound. . . . ASSESSMENT/PLAN: 1. Left foot ulceration with infestation. Consult to [name of surgeon] who inspected the wound and will schedule him for a left above the knee amputation tomorrow. In the meantime we will place a Decane [sic] [Dankins] solution every 12 hours to the wound. We will thoroughly clean his room. Contact [staff name] Infection Control Officer as well as [staff name], Interim Director of Nursing to address the issue. . . ."

Review of the facility infection control log occurred on 08/14/13. This log showed Resident #2 had a wound infection on 07/05/13. This log failed to identify Resident #2 with a maggot infested wound on 07/14/13.

During an interview on the afternoon of 08/14/13, an administrative staff nurse (#1) stated staff had discussed adding the maggot infestation to the current infection control log, but did not. This staff member reported the facility did not complete an investigation or additional documentation.

During an interview on the morning of 08/15/13, an infection control nurse (#10) stated she did not add this infestation to the infection control log, as she felt it was not an infection and the facility took precautions such as deep cleaning of Resident

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F 441	Continued From page 29 #2's room. During an interview on the morning of 08/15/13, Resident #2's physician (#12) reported Resident #2's foot ulcer was deteriorating rapidly, the toe was painted with betadine and left open to air, the other areas of the foot were wrapped. He stated his wound nurse checked the wound on 07/12/13, and the wound had no sign of infestation. He stated larva can infest a wound in six to eight hours. Failure to investigate and document the source of the maggots in Resident #2's foot placed other residents at risk and limited the facility's ability to implement corrective action. 3. Based on observation, record review, review of facility policy and procedure, and staff interview, the facility failed to ensure handwashing for 1 of 1 sampled resident (Resident #3) with methicillin resistant staphylococcus aureus (MRSA) in the groin who independently toileted on 3 of 3 days of observation (August 12 - 14, 2013) and for 1 of 4 sampled residents (Resident #5) observed during perineal care. Failure to follow infection control practices related to hand hygiene has the potential to cause or spread infection within the facility. Findings include: Review of the facility policy and procedure, "Handwashing/Hygiene," occurred on August 14-15, 2013. This document, revised in June 2006, stated "PURPOSE: To assure compliance with the most important measure to prevent the transmission of disease causing microorganisms.	F 441		

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POLICY: Hand washing has long been considered the most important measure to prevent the transmission of disease causing microorganisms. Hand hygiene refers to the acceptability of waterless hand antiseptics for routine use when hands are not visibly soiled. . . .

Soap and water washing is always required after contact of hands with gross body fluids or substances. . . .

When is hand hygiene required?
Because of the increase [in] incidence of antibiotic resistant organisms in healthcare facilities and more recently in the community, we need to consider that all residents/patients and personnel could be "colonized" and so hand hygiene has become increasingly important to prevent transmission in the facility. . . .
2. After . . .
e. Upon leaving the room after "cares" . . .
f. Upon leaving an isolation room and after all contacts with resident/patient "colonized" with an antibiotic resistant organism or his/her equipment.
g. After contact with a "dirty" body site - before contact with another body site. . . . "

- During the initial facility tour, on 08/12/13 at 11:25 a.m., observation identified a sign "Contact Precautions" on Resident #3's private room door. At this time a supervisory nursing staff member (#3) reported Resident #3 had long standing positive "MRSA" cultures which were recently repeated and tested positive in the groin area. The staff member (#3) reported Resident #3 did not have a wound or drainage and cultures of other body areas were negative. This staff member also reported the resident is continent at

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times and requires cues for activities of daily living (ADLs).

Review of Resident #3's medical record occurred on August 12-15, 2013. The facility admitted the resident in March 2010. Current diagnoses included dementia. The resident's quarterly Minimum Data Set (MDS), dated 05/29/13, identified the resident usually made herself understood and understood others, had short and long term memory problems, had severely impaired daily decision making ability, walked in her room independently with supervision, and required extensive assistance of one person for toileting.

Resident #3's current care plan, updated 06/04/13, stated "Problem, Continence: Continent of bowels. Occasionally incontinent of bladder. . . . Approaches . . . Assist of 1 with toileting, as she needs. . . .;" and "Problem, MRSA in nares/isolated . . . Approaches, Have resident wash her hands with sanitizer before she leaves her room. . . ."

Resident #3's laboratory results, dated June 2013, included cultured swabs of the nares and axilla which were negative and the groin which was positive for MRSA.

Observation on August 12-14, 2013, showed Resident #3 ambulating independently in her room, to her bathroom, to the dining room, to the activity room, and throughout the facility. Observations failed to show the resident washed her hands. Facility staff offered to assist the resident to toilet and the resident declined. Observation failed to show facility staff reminded or offered to assist Resident #3 to sanitize or

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F 441	Continued From page 32 wash her hands. During interview, on 08/14/13 at approximately 10:15 a.m., a certified nursing assistant (CNA) (#4) reported Resident #3 requires assistance for toileting at times and recently has been independent. This staff member reported the facility staff do not offer handwashing for Resident #3. Review of the CNA Care Sheet, provided by CNA (#4), identified Resident #3 as ". . . MRSA+ . . . Toileting, Per Request PRN [as needed] . . ." The CNA Care Sheet failed to identify handwashing before Resident #3 left her room. The facility identified Resident #3 was on contact precautions regarding positive MRSA cultures in the groin, identified the resident had impaired decision making ability, and facility staff were aware the resident toileted herself. Failure to cue or assist Resident #3 to wash her hands after toileting placed facility residents, visitors, and staff at risk of potential exposure to MRSA. - Review of Resident #5's medical record occurred on all days of survey. Resident #5's quarterly MDS, dated 05/01/13, identified the resident required extensive assistance with bed mobility, transfers, toilet use and personal hygiene. Observation on 08/13/13 at 1:45 p.m., showed two CNAs (#8) and (#9) assisted Resident #5 from the wheelchair to the bedside commode. The resident had a small stool, the CNA's donned gloves and one CNA (#8) completed perineal care and removed her gloves. Both CNAs (#8) and (#9) assisted Resident #5 into bed. One CNA (#8) raised the head of the bed, gave the resident	F 441	MBH will meet this requirement by: Nursing staff will be educated regarding the plan of correction. Nursing staff cleaned glucometer with cavi-wipe for Resident #16. All other residents who require accu-check use will have the accu-check machine cleaned after each use with cavi-wipes. Nursing staff will observe CNA's and Residents #3 and #5 for proper hand washing after perineal care. CNA's were educated between 8/15/13 and 9/26/13 on the importance of proper handwashing techniques. Residents requiring perineal will be observed to ensure CNA's use proper hand hygiene to ensure infection control practices related to hand hygiene are being followed to prevent the spread of infection. Resident #3's care plan will be changed to include the use of alcohol sanitizer before leaving room and all other residents who are MRSA positive to prevent spread of infection. Infestation will be added to the infection log for Resident #2 and any future resident who might have infestation. QA Manager or designee will monitor glucometer cleaning, hand washing and infection control log monthly x 3 then	09/26/13 08/15/13 09/26/13

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F 441	Continued From page 33 a drink of water, lowered the head of bed and adjusted the resident's pillow and clothing. The CNA (#8) failed to complete hand hygiene after completing perineal care and before doing other tasks. During an interview on 08/14/13 at 08:45 a.m., an administrative nurse (#1) stated she expected staff to perform hand hygiene immediately after perineal care.	F 441	quarterly x 1. Findings will be reported at the quarterly QA committee meetings.	09/29/13
F 494 SS=D	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.	F 494		

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F 494	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on review of state nurse aide registry files, facility record review, and staff interview, the facility failed to ensure two nurse aides (staff member E and F) working with residents in the facility remained certified. Staff members E and F provided hours of nursing related services without verifying competency through certification. Failure to ensure certification of caregivers has the potential to affect resident care. Findings include: - Staff member E contacted the state nurse aide registry on 02/01/13 to renew the employee's certification. The state nurse aide registry file review identified staff member E's certification expired on 12/25/12. Review of the employee's hours on the afternoon of 08/13/13 verified staff member E worked 13.25 hours (2 shifts) with an expired certificate. - Staff member F contacted the state nurse aide registry on 08/26/13 to renew the employee's certification. The state nurse aide registry filed review identified staff member F's certification expired on 06/21/13. Fax transmissions from the facility verified staff member F worked 360 hours (31 shifts) with an expired certification. During an interview on 08/15/13 at 10:15 a.m., administrative human resources staff member (#17) stated the facility does not have a process for ensuring employees' certifications are not expired.	F 494	MBH will meet this requirement as evidenced by: Nursing Staff and Human Resources will be educated on plan of correction. Form was developed in May 2013 to track travel CNA license expiring, abuse registry and date of checking. New hires will be checked prior to arriving. DON will monitor travel staff, Human Resources will monitor MBH staff, prior to starting work and annually thereafter. Care Coordinator or designee will monitor monthly x 3, then quarterly x 1. Findings will be reported at the quarterly QA meetings.	09/26/13 09/29/13