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 _____	09/06/2017

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 09/05/17 and completed on 09/06/17, the sample included two (2) residents for complete review, seven (7) residents for focused review, and one (1) closed record for review. The sample included four (4) additional residents to verify specific concerns during the survey.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for	F 156		9/22/17

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

Electronically Signed | 09/20/2017

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F 156	Continued From page 1 Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)	F 156		

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F 156	Continued From page 2 [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office,	F 156		

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F 156	Continued From page 3 adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must 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. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) 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. (ii) The facility must also provide the resident with	F 156		

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F 156	Continued From page 4 the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) 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 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) 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/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 156		

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F 156	Continued From page 5 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: MEDICARE BILLING 1. Based on review of Medicare Part A notices/files, the facility failed to provide adequate written notices for 3 of 3 residents (Resident #12, #13, and #14) reviewed for termination of Medicare coverage. Failure of the facility to provide notices that contained the	F 156	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) The Nursing Home Biller will change Medicare forms to include the correct contact information so all residents, including resident #12, #13 and #14, are able to exercise their rights related to	

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F 156	Continued From page 6 correct contact information for the intermediary review agency limits the residents' ability to exercise their rights related to Medicare Part A. Findings include: Review of Medicare billing records occurred on 09/06/17 at 11:10 a.m. The facility provided Resident #12, #13, and #14 with a demand bill form. These forms lacked the correct contact information for the intermediary review agency. POSTING OF INFORMATION 2. Based on observation, the facility failed to post the correct addresses and/or telephone numbers of State advocacy groups including the State Survey Agency and the State Ombudsman on 2 of 2 days of survey (September 05-06, 2017). Failure to provide this information has the potential to limit all residents and their families access to these agencies. Findings include: Observations on September 05-06, 2017, showed advocacy groups contact information displayed on a wall near the activity room. The facility failed to post the correct address for the State Survey Agency and the correct telephone number for the State Ombudsman.	F 156	Medicare Part A if they choose to do so. The Social Worker corrected the telephone number of the State Ombudsman and corrected the address of the State Health Survey Agency on 9/7/2017. 2) Any resident who uses their Medicare Part A benefit or who would like to contact the State Ombudsman or State Survey Agency has the potential to be affected. 3) Social Worker, Business Office, DON and ADON will be instructed on 9/22/2017 on the importance of providing correct contact information in regards to Medicare Part A billing for resident #12, #13, #14 and any other resident who may use their Part A Medicare benefit. Also will instruct Social Worker on making sure we are providing the correct information for the State Survey Agency and State Ombudsman. 4) The Nursing Home Biller or designee will monitor resident #12, #13, #14 and any other resident who may require using Medicare Part A monthly x 3, then quarterly for one year. Social Worker or designee will monitor state advocacy groups to ensure the correct phone number and correct address are listed monthly x 3, then quarterly x one year. If concerns are identified, immediate corrective action will be implemented. Social Worker and Nursing Home Biller will submit a report of the monitoring results to the QA committee at	

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F 156	Continued From page 7	F 156	scheduled meeting.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278		9/22/17

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F 278	Continued From page 8 by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the residents' status for 2 of 9 sampled residents (Resident #2 and #5). Failure to code the MDS correctly related to non-medication intervention for pain 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, revised October 2016, page J-3 stated, "Coding instructions for J0100C, Received Non-medication Intervention for Pain. Code 0, no: if the medical record does not contain documentation that a non-medication pain intervention was received. Code 1, yes: if the medical record contains documentation that a non-medication intervention was scheduled as part of the care plan and it is documented that the intervention was actually received and assessed for efficacy. . . ." - Review of Resident #2's medical record occurred on all days of survey. The quarterly MDS dated 07/08/17, and the significant change MDS dated 01/07/17 identified non-medication intervention used during the assessment period. The medical record failed to identify the non-medication interventions used during the assessment period. - Review of Resident #5's medical record	F 278	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) MDS Coordinator will be instructed on 9/22/2017 on the importance of not marking non-medication intervention unless the resident's chart identifies that there was non-medication interventions done during the assessment period on Resident #2 and #5 and any other resident who has non-medication intervention marked incorrectly. 2) Any resident requiring a MDS has the potential to be affected. 3) MDS Coordinator will change her practice and make sure to not code non-medication intervention unless it is documented during a resident's assessment period so that the MDS accurately assesses the resident's current status. 4) The MDS Coordinator or designee will monitor Resident #2 and #5 and any other residents to make sure that a non-medication intervention is documented prior to coding it, along with monitoring the entire MDS for accuracy, monthly x 3, then quarterly for one year. Monitoring will begin on 9/22/2017. If concerns are identified, immediate corrective action will be implemented. MDS Coordinator will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 278	Continued From page 9 occurred on all days of survey. The annual MDS, dated 06/03/17, identified non-medication intervention used for pain during the assessment period. The medical record failed to identify the non-medication intervention used during the assessment period. During an interview on 09/06/17 at 2:06 p.m., an administrative nurse (#3) confirmed she was unable to identify Resident #2 and Resident #5 received any non-medication interventions used for pain during their assessment periods, and confirmed J0100C (non-medication intervention) should not have been coded for the assessments identified above.	F 278		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with	F 323		9/22/17

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F 323	Continued From page 10 the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: ELOPEMENT 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure adequate supervision to prevent elopements for 1 of 1 sampled resident (Resident #1) who eloped from the facility. Failure to evaluate the effectiveness of current interventions and implement additional interventions may have resulted in Resident #1's elopements and may result in additional elopements and harm. Findings include: Review of the facility policy titled "DAILY SECURE CARE TRANSMITTER/EXIT TESTING POLICY AND PROCEDURE" occurred on 09/06/17. This policy, dated 2007, stated, "MBH [Mountrail Bethel Home] staff will ensure that the Secure Care transmitter worn by residents as per their plan of care, is in place and functioning. Each transmitter will be tested daily using the #707 tester. MBH will ensure that each exit antenna for the Secure Care system is functioning properly. Each exit will be tested daily using the #707 tester. Documentation of this check will be made daily on a transmitter log. . . ." Review of Resident #1's medical record occurred	F 323	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) The cabinets were locked on 9-7-2017 and the secure care bracelets and door transmitters are checked daily. Plant Operations/Environmental Services and nursing staff will be instructed on 9/22/2017 on the policy entitled "Daily Secure Care Transmitter Exit Testing" and the importance of checking secure care bracelets on residents and the door transmitters daily, which includes week-ends, on resident #1 and any other resident who wears a secure care bracelet due to elopement risk. Environmental Services was also instructed on the importance of making sure Non-Acid Disinfectant Bathroom Cleaner, Ace 256 Neutral Disinfectant and Detergent and all other chemicals are in a locked cabinet. 2) Any resident who is an elopement risk or any resident who comes in contact with Non-Acid Disinfectant Bathroom Cleaner and Ace 256 Neutral Disinfectant and Detergent has the potential to be affected. 3) Plant Operations/Environmental Services will ensure the door transmitters	

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F 323	Continued From page 11 on all days of survey. The facility identified cognitive loss and confusion. The care plan stated, ". . . Elopement: [Resident #1's name] is currently an elopement risk . . . Interventions/Tasks: . . . will wear a Secure care bracelet to help monitor any elopement attempts. . . ." Review of Resident #1's progress notes identified the following: * 06/25/17 at 8:30 p.m. - "Resident was missing. Was found within the reception area of the aquatic center. . . . The alarm bracelet did not sound and neither door alarm [sic]. Maintenance to be requested to check the ankle bracelet if it is functional." * 07/17/17 at 9:15 a.m. - "Receptionist over at the clinic [attached to the nursing home] called the social worker [name] and said resident was sitting in the lobby watching TV. . . ." * 07/20/17 at 3:59 p.m. - "At 3:40 pm, the resident escaped and went to the hospital corridor through the main lobby door and was found there by a staff member who informed the Bethel home nursing staff. . . ." The "Resident/Patient Incident/Near Miss" report, dated 06/25/17, identified facility staff could not locate Resident #1 from 8:30 to 8:45 p.m. This report stated, "The secure alarm on the resident's rt [right] leg did not sound, neither did the door bell of the door he passed through. The resident said he was comfortable sleeping on the floor since he'd done that in the past a couple of times. Asked what he wanted to do at pool area he said 'don't know'" An additional note on the report, dated 06/27/17, stated, "Administrator is working [with] [name of company] to replace secure care	F 323	are checked daily and nursing staff will ensure the residents' secure care bracelets are checked daily so staff are alerted if a resident is trying to elope. MBH is currently undergoing installation of a new roam alert GPS monitoring system; it is scheduled for completion in the next couple of weeks. The system was wired the week of Sept. 11 - 15, 2017; the system should be complete by Sept. 29, 2017. Will do every two hour safety checks on resident #1 and all other residents who are an elopement risk. Plant Operations/Environmental Services will make sure all chemicals are in a locked cabinet at all times. 4) Environmental Services/Plant Operations and the QA Coordinator will monitor secure care bracelet tracking and daily secure care testing reports and will monitor two hour safety checks for resident #1 and any other resident who is an elopement risk until the new roam alert system is in place, monthly x 3, then quarterly times one year. Environmental Services/Plant Operations will monitor all chemicals to ensure they are stored in a locked cabinet monthly x 3, then quarterly times one year. If concerns are identified, immediate corrective action will be implemented. Environmental Services/Plant Operations and QA Coordinator will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 323	Continued From page 12 system." Review of the "Secure Care Bracelet Tracking" reports, dated June 01 2017 through September 06, 2017, showed facility staff failed to check Resident #1's Secure Care bracelet on the following days: * June: Every weekend (8 days), June 02 and June 26 (refused). * July: Every weekend (10 days), and July 04. * August: Every weekend (8 days), August 02, 03, 04, 17, 18, 21, and 22. * September: The weekend (2 days), and September 04. Review of the "Daily Secure Care Testing" reports identified 12 areas in the facility with Secure Care alarms. These reports, dated June 01, 2017 through August 31, 2017, showed maintenance failed to check the alarms on the following days: * June: Every weekend (8 days), and June 30. * July: Every weekend (10 days), July 03, 04, 05, 27, and 31. * August: Every weekend (8 days), August 21, and 22. During an interview on 09/06/17 at 1:55 p.m., an administrative nurse (#1) confirmed the Secure Care bracelets worn by residents are checked by the certified nursing assistants (CNAs) and the maintenance department checks the alarm system. The nurse (#1) also confirmed the installment of a new alarm system the week of September 10-14, 2017. A tour of the aquatic center, attached to the facility and accessed through the south door	F 323		

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 _____	09/06/2017

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 323	Continued From page 13	F 323		

(Secure Care door), occurred on 09/06/17 at 2:11 p.m. with a maintenance staff member (#2). The door (locked) led to the reception area. Observation showed the pool in a locked room separate from the reception area. The staff member (#2) stated the Secure Care system is checked daily and, "for the most part," works correctly. This staff member could not explain how Resident #1 eloped past the system and into the reception area of the aquatic center.

Resident #1's first elopement occurred on Sunday, June 25, 2017. Facility staff had failed to check the Secure Care alarm system June 24 or 25 and failed to check Resident #1's Secure Care bracelet June 24, 25, and 26. Resident #1 eloped twice more, July 17 and 20. The facility failed to ensure staff checked the alarm system daily and failed to ensure Resident #1 did not elope from the facility again.

STORAGE OF CHEMICALS

2. Based on observation, review of Material Safety Data Sheets (MSDS), and staff interview, the facility failed to ensure the residents' environment remained as free of accident hazards as possible on 1 of 2 resident units (South Unit). Failure to safely store hazardous chemicals placed cognitively impaired/wandering residents at risk for accidents and injury.

Findings include:

During initial tour on 09/05/17 at 11:30 a.m., observation of an unlocked soiled utility room on the South Unit showed two bottles of NABC Non-Acid Disinfectant Bathroom Cleaner in an

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 _____	09/06/2017

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F 323	Continued From page 14 unlocked cabinet. The chemicals remained unlocked throughout the survey. During the environmental tour on 09/06/17 at 11:00 a.m. and 2:11 p.m., observations of a second unlocked soiled utility room and unlocked bathing room on the South Unit showed a spray bottle of Ace 256 Neutral Disinfectant and Detergent. Review of the MSDS's occurred on 09/06/17 and showed the following: *NABC Non-Acid Disinfectant Bathroom Cleaner: ". . . May be harmful if swallowed. May cause skin irritation. Inhalation of vapors or mist may cause respiratory irritation. Keep out of reach of children. . . ." *Ace 256 Neutral Disinfectant and Detergent: ". . . Causes serious eye irritation. Causes mild skin irritation. May be harmful if swallowed. . . . Keep out of reach of children. . . ." During the environment tour on 09/06/17 at 2:11 p.m., an environmental services staff member (#2) stated he expected all chemicals to be locked.	F 323		