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 _____	09/08/2016

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 September 6, 2016 and completed on September 8, 2016, the sample included two (2) residents for complete review, nine (9) residents for focused review, and one (1) closed record for review.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) 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 complete a significant change status assessment (SCSA) for 1 of 11 sampled residents (Resident #7). This failure limited the facility's ability to accurately assess the resident's status and identify and implement appropriate care approaches.	F 274	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) MDS Coordinator will be instructed on 10/06/2016 on the importance of doing a significant change status assessment on Resident #7 and any other resident who has a significant decline or improvement. This will be completed for Resident #7.	10/6/16

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

Electronically Signed | 09/29/2016

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F 274	Continued From page 1 Findings include: The Long-term Care Facility RAI Manual, revised October 2015, page 2-23 stated, ". . . A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement). . . ." Review of Resident #7's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 02/02/16, identified supervision of one person with transfers, locomotion off unit, and toilet use. A quarterly MDS, dated 04/26/16, identified extensive assistance of two people with transfers and extensive assistance of one person with locomotion off the unit and toilet use. Resident #7 showed a decline in three areas of functional status. The facility failed to complete a SCSA MDS. During an interview on 09/07/16 at 4:10 p.m., an administrative nurse (#3) confirmed staff should have completed a SCSA.	F 274	2) Any resident requiring a MDS has the potential to be affected. MDS Coordinator will evaluate each resident that is noted to have a decline or improvement within two weeks to see if a significant change status assessment is needed. Also, with each MDS completed, MDS Coordinator will evaluate any change resulting in significant improvement or significant decline by comparing to previous MDS assessments. 3) MDS Coordinator will change her data collection form to note any significant decline or improvement with each scheduled MDS. A form will be developed to identify residents noted to have a change in status to reevaluate in two weeks. 4) The MDS Coordinator or nursing designee will monitor Resident #7 and any other resident who may require a significant change status assessment monthly x 3, then quarterly for one year. Monitoring will begin 10/06/2016. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The MDS Coordinator or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		10/6/16

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F 278	Continued From page 2 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 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 accurate coding of Minimum Data Sets (MDSs) for 4 of 11 sampled residents (Resident #2, #4, #5, and #7). Failure to complete the correct MDSs after being discharged from the facility with return anticipated (Resident #2, #4, and #5) and failure to accurately complete portions of the	F 278	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) MDS Coordinator was instructed on correcting the inaccurate MDS identified for Residents #2, #4, #5, #7 or any other resident affected. This will be completed for Residents #2, #4, #5, and #7 so the MDS is accurately coded.	

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F 278	Continued From page 3 MDS, Section E (behaviors) (Resident #7), does not allow each resident's assessment to reflect the resident's current status/needs and may result in the inaccuracy of the facility's Resident Level Quality Measure Reports. Findings include: The Long-Term Care Facility RAI Manual, revised October 2015, page 2-8 stated, "Admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m. . . . this date is considered the 1st day of admission. Completion of an OBRA (Omnibus Budget Reconciliation Act) Admission assessment must occur in any of the following admission situations: * when the resident has never been admitted to this facility before; OR * when the resident has been in this facility previously and was discharged return not anticipated; OR * when the resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge . . ." - Review of Resident #2's medical record occurred on all days of survey. Resident #2's record identified a hospital stay from March 29 through April 04, 2016. The facility completed a discharge return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS. - Review of Resident #5's medical record occurred on all days of survey. Resident #5's record identified a hospital stay from October	F 278	2) Any resident who has been discharged with return anticipated or having been coded with delusions has the potential to be affected. 3) Admission assessment will only be completed at initial entry to facility (never been admitted before), following a discharge return not anticipated, or following a discharge return anticipated but did not return until after 30 days of discharge. Will educate Social Workers on what is a delusion and how to accurately code on MDS. 4) MDS Coordinator and Social Worker will monitor Resident #2, #4, #5, #7 and any other resident requiring a discharge return anticipated and coding of Section E monthly x 3, then quarterly for 1 year. Monitoring will begin 10/06/2016. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The MDS Coordinator or Social Worker 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 4	F 278		

02-07, 2015. The facility completed a discharge return anticipated MDS and upon return from the hospital, incorrectly completed an admission MDS.

- Review of Resident #4's medical record occurred on all days of survey. Resident #4's record identified a hospital stay from May 31 to June 03, 2016. The facility completed a discharge return anticipated MDS and upon return, incorrectly completed an admission MDS.

Resident #2, #4, and #5, all returned to the facility within 30 days of discharge.

During an interview on 09/07/16 at 4:10 p.m. an administrative nurse (#3) confirmed she incorrectly completed admission MDSs.

The Long-Term Care Facility RAI User's Manual, October 2015, Chapter 3 Page E-2 and E-3 stated, "E0100: Potential Indicators of Psychosis . . . Coding Instructions . . . Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis. . . . Check E0100B, delusions: if delusions were present in the last 7 days. A delusion is a fixed, false belief not shared by others that the resident holds true even in the face of evidence to the contrary. . . . Coding Tips and Special Populations . . . If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code it as a delusion. . . ."

- Review of Resident #7's medical record occurred on all days of survey. The quarterly MDS, dated 04/26/16, indicated the resident

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F 278	Continued From page 5 experienced delusions. The medical record lacked evidence Resident #7 had a delusion in the seven day look back period. During an interview on 09/07/16 at 4:15 p.m., a staff member (#2) confirmed the incorrect coding of delusions.	F 278		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, the facility failed to review and revise the care plan for 6 of 11 sampled residents (Resident #1, #2,	F 280	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Nursing staff will be instructed on	10/6/16

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F 280	Continued From page 6 #3, #4, #5 and #7). Failure to revise the care plan as each resident's status changed limited the staff's ability to communicate treatment approaches and interventions to ensure continuity of care. Findings include: Review of the facility policy titled "RESIDENT CARE PLANNING POLICY AND PROCEDURE" occurred on 09/08/16. This policy, revised June 2016, stated, "POLICY . . . The care plan will be reviewed and revised by the Interdisciplinary Team after each assessment and as needed. . . ." - Review of Resident #2's medical record occurred on all days of survey. The "Consultant Dietitian Report" dated 08/12/16 stated ". . . Stop arginaid . . ." The current care plan stated, "Focus: NUTRITIONAL: [Resident #2] usually eats a good breakfast--he is obese per BMI [body mass index]--diagnosis of diabetes . . . Interventions/Tasks . . . Offer an Arginaid daily . . ." The facility failed to update the care plan to reflect Resident #2's current interventions. - Review of Resident #5's medical record occurred on all days of survey. During an interview on 09/06/16 at 5:29 p.m., Resident #5 stated she takes herself to the bathroom. During an interview on 09/07/16 at 9:30 a.m., a certified nursing assistant (CNA) (#4) stated Resident #5 needs assistance applying TED (antiembolism) stockings; otherwise, she is	F 280	10/06/2016 on the policy entitled "Resident Care Planning Policy and Procedure." This instruction will be for Resident #1, #2, #3, #4, #5 and #7 as well as any other resident who may be affected. The above residents' care plans will be updated to reflect their current status. 2) Any resident requiring a care plan review has the potential to be affected. All staff who review or update care plans will be educated on the importance of updating the care plan to reflect the current status of the resident. 3) All care plans will be updated quarterly and as needed for any change in resident's condition by the charge nurses and reviewed by the MDS Coordinator to ensure the care plan is current and the deficient practice will not recur. 4) The QA Coordinator or nursing designee will monitor Resident #1, #2, #3, #4, #5, #7 and other residents requiring updates to care plans monthly x 3, then quarterly for one year. Monitoring will begin 10/06/2016. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA Coordinator or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 280	Continued From page 7 "pretty independent." During an interview on 09/07/16 at 1:50 p.m., a CNA (#5) stated Resident #5 is independent. During an interview on 09/07/16 at 3:20 p.m., an administrative nurse (#1) confirmed Resident #5 is independent with transfers and toileting. The current care plan stated, "PT [physical therapy]: Resident will have improved functional mobility and independence with transfers and ambulation. . . . Interventions/Tasks: Resident will transfer and ambulate with assist x1 . . . Focus: FALLS: [Resident #5] is at risk for falls. . . . Interventions/Tasks . . . [Resident #5] will transfer and ambulate with assistance of one. She will at times self transfer and self toilet. Remind her and encourage her to ask for assistance and wait for assistance to arrive. . . . Focus: ADLs [Activities of Daily Living]: [Resident #5] requires assistance with some ADL care. . . . Interventions/Tasks . . . [Resident #5] requires assistance of one with cares like dressing, transferring, toileting and locomotion on and off the unit. She is independent with eating and some grooming, but may need set up assistance. . . ." The facility failed to update the care plan to reflect Resident #5's current abilities. - Review of Resident #3's medical record occurred on all days of survey. The current care plan stated, ". . . BOWEL: [Name of resident] is continent of bowel . . . will frequently refuse help with toileting. Staff will assist when tolerated by resident. . . . ADL: . . . uses an electric wheelchair for locomotion . . . FALLS: . . . Electric	F 280		

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wheelchair to be taken out of room at HS [bedtime]. . . ."

Resident #3's quarterly Minimum Data Set (MDS), dated 08/27/16, indicated extensive assistance of two staff for toileting and occasional bowel incontinence.

Observation throughout the survey showed the resident used a manual wheelchair, had a splint to her right lower extremity (RLE), and was dependent on and accepting of staff assistance for toileting.

On the afternoon of 09/07/16, an administrative nurse (#3) stated the facility switched Resident #3 from an electric to a manual wheelchair after her fall and right ankle fracture in June. This nurse verified the facility failed to update the care plan to reflect the resident's current status regarding bowel continence, staff assistance, splinted RLE, and type of wheelchair.

- Review of Resident #4's medical record occurred on all days of survey. The current care plan stated, ". . . ADL: . . . uses continual oxygen at 2L [liters (per minute)]. . . ."

Physician orders stated the following:
* 07/19/16, "Oxygen 3L/NC [liters per nasal cannula] continuous every shift for hypoxia. Keep SATS [saturation level] above 90% [percent]"

Observation throughout the survey showed the resident utilized oxygen continuously at 3L or greater.

During an interview on 09/08/16 at 10:05 a.m., an

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administrative nurse (#3) verified Resident #3's care plan failed to reflect her current status related to oxygen use.

- Review of Resident #1's medical record occurred on all days of survey. The current care plan stated, ". . . at risk for falls . . . has a chair alarm in place . . ."

Observations on September 06-07, 2016 showed no chair alarm present for Resident #1.

During an interview on 09/07/16 at 10:15 a.m. a CNA (#6) confirmed Resident #1 does not use a chair alarm.

During an interview on 09/08/16 at 8:05 a.m., an administrative nurse (#1) confirmed staff should have discontinued the chair alarm on the careplan.

- Review of Resident #7's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 07/26/16, identified current risk for pressure ulcers (skin breakdown) with one unhealed stage two pressure ulcer. The wound record, dated 08/29/16, identified the ulcer healed.

Review of Resident #7's current care plan, dated 05/25/16, stated, ". . . is not at risk for skin breakdown. . ."

The facility failed to update the care plan to reflect Resident #7's current status.

During an interview on 09/08/16 at 8:10 a.m., an administrative nurse (#1) confirmed staff failed to

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F 280	Continued From page 10 update Resident #7's careplan.	F 280		
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: Based on record review, review of facility policy, and staff interview, the facility failed to ensure the safety for 1 of 2 sampled residents (Resident #9) identified at risk for elopement. Failure to identify, report, and investigate an elopement could result in the resident leaving the facility unsupervised. Findings: Review of the facility procedure titled, "CODE E (ELOPEMENT) MISSING RESIDENT PROCEDURE" occurred on 09/08/16. This policy, revised March 2005, stated, "To assure the safety and welfare of residents . . . 10. If the resident is found to have wandered out of facility or was found to have fallen, or in any way looks to have had an adverse event, Charge nurse will: *Examine the resident for injuries, low temperature, etc. [etcetera] and treat accordingly. If resident is suspected to have adverse medical condition resident should be seen in ER [emergency room]. *Complete an incident report. *Document the occurrence in the medical record.	F 323	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Nursing staff will be instructed on 10/06/2016 on the policy entitled "Code E (Elopement) Missing Resident Procedure." This instruction was for Resident #9 as well as any other resident who may be affected. An incident report and thorough investigation will be completed for this resident and noted in the resident's care plan. 2) Any resident who may elope has the potential to be affected. All staff who might see that a resident has eloped will be educated on the importance of filling out an incident report and completing a thorough investigation. 3) During Resident Review Committee which meets every Monday, for any resident who is reported to have eloped	10/6/16

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F 323	Continued From page 11 *Notify family" Review of Resident #9's medical record occurred on September 07-08, 2016. Admission occurred on 12/09/15. Current diagnosis included dementia with behaviors. Resident #9's "ELOPEMENT RISK ASSESSMENT," dated 12/09/15, stated an elopement risk as "Resident has demonstrated previous behaviors prior to admission that identifies them at risk for wandering or elopement." A progress note dated 12/09/15 at 10:00 a.m. stated, ". . . Will put secure care bracelet on to monitor any wandering for a few days. . . ." The current care plan identified a focus and intervention initiated on 03/10/16 and stated, ". . . Focus: Elopement: [Resident #9] continues to be an elopement risk, she enjoys walking all over the building. . . . Interventions/Tasks: [Resident #9] will continue to wear a secure care bracelet to help monitor for any elopement attempts. Staff will observe for any changes in [Resident #9's] elopement status and report them to the charge nurse or social worker. . . ." Review of the August 2016 "BEHAVIOR LOG" identified a note written by a certified nursing assistant (CNA), dated 08/18/16. The note stated, "Around 10:45 am [Resident #9] went through those two doors by the conference room doors and made her way outside. We were able to catch her right away." The medical record lacked further information on	F 323	or attempted to elope, the QA Coordinator will make sure that an incident report was completed along with a thorough investigation and that such was recorded in the resident's care plan so that the deficient practice will not recur. 4) The QA Coordinator or nursing designee will monitor Resident #9 and any other resident who may require an incident report/investigation to be completed monthly x 3, then quarterly for one year. Monitoring will begin on 10/06/2016. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The QA Coordinator or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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	355044	A. BUILDING _____ B. WING _____	09/08/2016

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 12 Resident #9's elopement. The care plan failed to identify Resident #9's elopement. During an interview on 09/08/16 at 12:12 p.m., an administrative nurse (#1) stated facility staff failed to complete an incident report. Facility staff failed to complete an incident report and failed to complete a thorough investigation of how the resident exited the building, including contributing factors. These failures limited the facility's ability to implement the necessary measures to prevent further elopements.	F 323		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 4 of 5 sampled residents (Resident #2, #4, #8, and #11) with orders for oxygen. Failure to provide oxygen as ordered has the potential for residents to	F 328	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Nursing staff will be instructed on 10/06/2016 on the following policies: "Oxygen Therapy - Oxygen Concentrator Policy and Procedure" and "Oxygen	10/6/16

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F 328	Continued From page 13 experience complications and/or hospitalization related to inadequate oxygen saturation levels. Findings include: Berman and Synder, S., "Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 1397, stated, "OXYGEN THERAPY . . . Like many medication, oxygen is not completely harmless to the client. Clients receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. . . ." Review of the facility policy titled "OXYGEN THERAPY-OXYGEN CONCENTRATOR POLICY AND PROCEDURE" occurred on 09/08/16. This policy, revised February 2006, stated, ". . . PROCEDURE . . . 11. Regulate oxygen flow via meter on front of machine according to Doctor's orders. . . ." Review of the facility policy titled "OXYGEN THERAPY BY NASAL CANNULA OR FACE MASK PER PORTABLE TANK POLICY AND PROCEDURE" occurred on 09/08/16. This policy, revised June 2006, stated, ". . . PROCEDURE . . . 13. Record oxygen therapy on treatment and nurses notes. 14. Record: a. Liter flow b. Time started c. Time discontinued d. Pertinent observations e. Signature" - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included dementia and anxiety. The physician	F 328	Therapy by Nasal Cannula or Face Mask Per Portable Tank Policy and Procedure." These instructions were for Resident #2, #4, #8, #11 as well as any other resident who may be affected. Quality Coordinator or DON will put a sign on the oxygen concentrator as to the proper setting for the oxygen and update care plans on the above residents who are on oxygen as to the proper setting for the oxygen and titrating to proper saturation levels. Care plans for the above residents will be updated to reflect the MD orders including oxygen saturation levels. 2) Any resident who requires oxygen administration has the potential to be affected. 3) All staff who provide care related to oxygen administration will be educated and evaluated on the importance of setting oxygen at the flow rate as ordered by the MD and of making sure to document oxygen saturation when oxygen levels decrease and titrate oxygen as ordered by MD so that the deficient practice will not recur. 4) The Quality Coordinator or nursing designee will monitor Resident #2, #4, #8, #11 and any other resident who may require oxygen to make sure the oxygen and saturation levels are on the correct setting monthly x 3, then quarterly for one year. Monitoring will begin 10/06/2016. Results will be reported to the DON. If	

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F 328	Continued From page 14 orders, dated 08/29/16, stated, ". . . Continual O2 [oxygen] via NC [nasal cannula] @ 2L [two liters] at all times. . . ." The current care plan stated, ". . . Focus: ADL [activities of daily living]: [Resident #2] is dependent on staff for ADL cares . . . Interventions/Tasks . . . [Resident #2] is to be on oxygen continuous 2L per NC . . . wears O2 via NC @ 2L at all times . . ." Observations showed the following: * 09/06/16 from 3:22 p.m. to 5:26 p.m.: Resident #2 lying in bed wearing a nasal cannula connected to an oxygen concentrator set at 3 liters per minute (LPM). * 09/07/16 at 7:43 a.m.: Resident #2 seated in the dining room wearing a nasal cannula connected to a Helios (type of portable liquid oxygen) tank set at 2 LPM. * 09/07/16 at 9:20 a.m.: Two certified nursing assistants (CNAs) (#4 and #6) assisted Resident #2 into bed and applied the oxygen nasal cannula connected to an oxygen concentrator set at 2.5 LPM. * 09/07/16 at 11:22 a.m.: Two CNAs (#4 and #6) transferred Resident #2 from the bed to the wheelchair and applied the oxygen nasal cannula connected to a Helios oxygen tank set at 2.5 LPM. * 09/07/16 at 2:02 p.m.: Resident #2 lying in bed wearing a nasal cannula connected to an oxygen concentrator set at 2.5 LPM. * 09/07/16 at 6:04 p.m.: Resident #2 seated in the lounge wearing a nasal cannula connected to a Helios oxygen tank set at 2.5 LPM. * 09/08/16 at 7:48 a.m.: Resident #2 seated in the lounge wearing a nasal cannula connected to a Helios oxygen tank set at 2.5 LPM. * 09/08/16 at 9:36 a.m.: Resident #2 lying in bed	F 328	concerns are identified, immediate corrective action will be implemented. The QA Coordinator or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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wearing a nasal cannula connected to an oxygen concentrator set at 3 LPM.

The facility failed to consistently provide Resident #2's oxygen at the ordered flow rate, and the record lacked evidence to support an oxygen flow rate above 2 LPM on the days of observation.

- Review of Resident #4's medical record occurred on all days of survey. Diagnoses included heart failure, unspecified abnormalities of breathing, shortness of breath, and history of upper respiratory infection. The current care plan stated, ". . . ADL: . . . uses continual oxygen at 2L. Staff should ensure [Resident #4] is wearing O2 properly and portable tank full. . . ." (The facility failed to update the care plan with Resident #4's current oxygen status. See F280)

Physician orders stated the following:
* 07/19/16: "Oxygen 3L/NC [liters per nasal cannula] continuous every shift for hypoxia. Keep SATS [saturation level] above 90% [percent]"
* 12/14/15: "Oxygen up to 5L/nasal cannula or mask. Titrate oxygen down to keep O2 sat > [greater than] 90%. Notify the provider as needed for Shortness of breath or respiratory distress/ SO [per standing order]"

Observation throughout the survey showed Resident #4 received oxygen continuously through a nasal cannula. The oxygen flow rate varied as follows:
* 09/06/16 at 4:10 p.m.: Resident #4 in bed with the oxygen concentrator flow rate between 3.5 to 4 LPM. Two CNAs (#7 and #8) transferred the resident from the bed to her wheelchair. A CNA

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F 328	Continued From page 16 (#8) refilled the Helios unit on the wheelchair and set the oxygen flow rate at 3 LPM. * 09/07/16 at 9:16 a.m.: Resident #4 in her wheelchair with the Helios unit flow rate at 3 LPM. Two CNAs (#5 and #10) transferred the resident to her bed and placed her on oxygen per the concentrator, with the flow rate at 3.5 LPM. * 09/08/16 at 9:51 a.m.: Resident #4 in bed with the oxygen concentrator flow rate between 3.5 to 4 LPM. At 9:58 a.m., an administrative nurse (#10) verified the incorrect setting and reduced the oxygen flow rate to 3 LPM. A progress note, dated 08/23/16 at 10:53 a.m., stated, ". . . [O2 sat] 96-97% on RA [room air] . . . not currently using O2 . . ." and at 1:00 p.m., ". . . back on 3L - O2 sat 83% on RA." The staff failed to follow the order for oxygen at 3L continuous. Review of Resident #4's treatment administration record from 08/01/16 to 09/08/16 showed the resident received "Oxygen 3L/NC continuous." The vital sign record during the same time frame showed staff checked the O2 sat daily with oxygen on. On 38 of 39 days staff recorded the resident's O2 sat between 90-98%, with the O2 sat 95-96% on September 6-8, 2016. During an interview on 09/08/16 at 10:05 a.m., an administrative nurse (#3) stated a nurse could titrate Resident #4's oxygen flow rate to keep the O2 sat greater than 90%, but should not decrease the oxygen below 3 LPM per the order. The facility failed to consistently provide Resident #4's oxygen at the ordered flow rate, and the record lacked evidence to support an oxygen flow rate above 3 LPM on the days of	F 328		

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F 328	Continued From page 17 observation. - Review of Resident #11's medical record occurred on September 7-8, 2016. Diagnoses included unspecified heart failure. The current care plan stated, ". . . ADL: . . . use continual oxygen via nasal cannula at 3L to keep O2 sats above 90%. . . ." Physician orders stated the following: * 02/24/16: "Titrate O2 to keep sats greater than 90% use N/C up to 6L. one time a day for O2 Sats" * 02/17/16: "Continuous O2 @ 3L every shift for keep O@ [sic] sat above 88%" * 12/14/15: "Oxygen up to 5L/nasal cannula or mask. Titrate oxygen down to keep O2 sat > 90%. Notify the provider as needed for Shortness of breath or respiratory distress/ SO" Observation throughout the survey showed Resident #11 received oxygen continuously through a nasal cannula. The oxygen flow rate varied as follows: * 09/07/16 at 6:45 p.m.: A CNA (#11) assisted Resident #11 to her room and switched the resident from her Helios oxygen unit to the oxygen concentrator, which was already turned on to 4 LPM. When asked what flow rate was ordered for Resident #11, the CNA stated she "wasn't sure." * 09/08/16 at 7:55 a.m.: Resident #11 in the dining room with O2 on at 3 LPM per her Helios unit. At 9:49 a.m., observation showed Resident #11 laying on her bed with O2 on at 4 LPM per the concentrator. The resident stated, "I think I'm supposed to be at 3L." At 9:50 a.m., an administrative nurse (#10) verified the oxygen	F 328		

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concentrator was set at 4 LPM, and stated the oxygen flow rate should be the same as the Helios unit. The nurse decreased the concentrator flow rate to 3 LPM.

Review of Resident #11's treatment administration record from 08/01/16 to 09/08/16 showed the resident received "Continuous O2 @ 3L." The vital sign record during the same time frame showed staff checked the O2 sat daily with oxygen on. On all 39 days, staff recorded the resident's O2 sat between 90-98%, with the O2 sat 96-98% on September 7-8, 2016.

The facility failed to consistently provide Resident #11's oxygen at the ordered flow rate, and the record lacked evidence to support an oxygen flow rate above 3 LPM on the days of observation.

-Review of Resident #8's medical record occurred on September 07-08, 2016. Diagnose included anemia (decreased ability to carry oxygen in blood). The physician orders, dated 05/01/15, stated, " . . . Check oxygen saturation every day shift for Hypoxia . . . Oxygen up to 5L/nasal cannula or mask. Titrate oxygen down to keep O2 sat > 90% . . ."

Review of O2 sats identified the following:
* 08/24/16: O2 sat 87% on RA
* 08/23/16: O2 sat 89% on RA
* 08/10/16: O2 sat 87% on RA
* 08/09/16: O2 sat 89% on RA
* 08/06/16: O2 sat 85% on RA

The medical record lacked evidence staff intervened when oxygen levels were below 90%.

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F 328	Continued From page 19 During an interview on 09/08/16 at 9:55 a.m., an administrative nurse (#1) confirmed staff should apply oxygen when Resident #8's O2 sats are below 90%.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to complete	F 329	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by:	10/6/16

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F 329	Continued From page 20 an Abnormal Involuntary Movement Scale (AIMS) for 1 of 2 sampled residents (Resident #6) on an anti-psychotic medication. Failure to assess and monitor for potential side effects of psychoactive medications may result in residents experiencing adverse consequences. Findings include: Review of the policy titled "Abnormal Involuntary Movement Scale" occurred on 09/08/16. this policy, dated July 2012, stated, "Policy: Psychoactive drugs may be prescribed for the management of psychotic disorders and/or behaviors of an aggressive nature. These drugs are approved treatment for these disorders, but are capable of causing profound effects. Most neuroleptic medications are anti-psychotics. . . Procedure: 1. Residents shall be assessed for abnormal movement disorders as follows . . . c) every six months while taking the medication, or more frequently if deemed necessary by symptom assessment or by the prescribing practitioner . . . " Review of Resident #6's medical record occurred on all days of survey. Diagnoses included psychosis. Medications included Risperdal (anti-psychotic medication) 0.5 milligrams twice a day. Review of an AIMS completed for Resident #6's showed a date of 06/17/2015 (14 months ago). During an interview at 1:30 p.m., an administrative staff (#1) confirmed an AIMS had not been completed for Resident #6 since 06/17/15.	F 329	1) Nursing administrative staff will be educated on the policy entitled "Abnormal Involuntary Movement Scale" (AIMS). This instruction was for Resident #6 and any other resident who needs an AIMS. An AIMS will be performed on Resident #6. 2) Any resident who is receiving an anti-psychotic medication has the potential to be affected. Nursing staff were educated on the importance of doing an AIMS every six months for those residents receiving an anti-psychotic medication. 3) The DON will compile a list of all residents on an anti-psychotic medication and track when the last AIMS was done so the deficient practice will not recur. 4) The DON or nursing designee will monitor Resident #6 and any other resident receiving an anti-psychotic medication to ensure that the AIMS is completed every six months, monthly x 3, then quarterly for one year. If any concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of manufacturer guidelines, and staff interview, the facility failed to prepare and serve food under sanitary conditions in 1 of 1 kitchen. Failure to ensure staff use quaternary (i.e., quat, a chemical sanitizer) solution appropriately and improper glove usage during preparation of food may result in unsanitary dietary conditions and contribute to foodborne illness outbreak. Findings include: Review of the facility policy titled "Policy for the Preparation, Distribution, and Storage of Food" occurred on 09/08/16. This policy, revised October 2015, stated, ". . . 11. All work and eating surfaces shall be sanitized after each use with measures taken to prevent cross-contamination. . . ." Review of the facility policy titled "Policy of General Cleaning and Sanitation" occurred on 09/08/16. This policy, revised October 2015,	F 371	Mountrail Bethel Home (MBH) will meet this requirement as evidenced by: 1) Dietary staff were instructed on the policies entitled: "Policy of General Cleaning and Sanitation", "Policy for the Preparation, Distribution, and Storage of Food", and "Procedure for Cleaning and Sanitation of Tables." This instruction was for the Dietary Cook (#12), Dietary Manager (#13), Dietary Staff member (#14) and all other Dietary staff who sanitize tables and prepare food. Infection Control Nurse or DON will evaluate all Dietary staff to ensure that food is being prepared and served under sanitary conditions. 2) Any resident who eats the food has the potential to be affected. 3) Infection Control Nurse or DON will randomly test the sanitizer and monitor	10/6/16

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F 371	Continued From page 22 stated, ". . . 1. At the beginning of each shift fill sink or pail with hot sanitizing solution mixing per label instructions. . . . 3. Change sanitizing solution and cloth as it becomes visibly soiled. . . . Procedure for Testing Sanitizer Concentration 1. Prepare or dispense solution as directed. 2. Use test strips per container instructions and compare results." Review of the facility procedure titled "Procedure for Clearing and Sanitation of Tables" occurred on 09/08/16. This policy, revised October 2015, stated, ". . . 5. Wet entire table surface thoroughly with sanitizing solution. . . ." Review of the Sani-Q [quat, a chemical sanitizer] manufacturer guidelines stated, ". . . Sani-Q can be used on food contact surfaces in a concentration range of . . . 150-400 ppm . . ." - Observation on 09/06/16 at 5:45 p.m. during tray line showed a dietary cook (#12) donned gloves, made sandwiches (a ready-to-eat food), entered the walk-in cooler, removed various food items, and resumed making sandwiches without changing gloves. During an interview on 09/08/16 at 10:30 a.m., the dietary manager (#13) stated she would expect staff to change gloves and perform handwashing prior to preparing food. - Observation during the final kitchen tour on 09/08/16 at 10:30 a.m. showed a green bucket (usually used for washing) and a red (usually used for sanitizing) bucket sat on a cart in the dining room. When asked to test the concentration of the sanitizer in the red bucket,	F 371	glove use when food is being prepared to ensure the deficient practice will not recur. 4) Infection Control Nurse or DON will monitor Dietary Cook (#12), Dietary Manager (#13), Dietary Staff member (#14) and any other Dietary Staff who are preparing food or sanitizing tables monthly x 3, then quarterly for one year. Monitoring will begin on 10/06/2016. Results will be reported to the DON. If concerns are identified, immediate corrective action will be implemented. The Infection Control Nurse or DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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 _____	09/08/2016

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 371	Continued From page 23 the dietary manager (#13) stated she thought the bucket contained water with soap. She checked with a dietary staff member (#14) who stated the green bucket had Sani-Q sanitizer in it. The dietary manager (#13) used a test strip to check the concentration of the sanitizer and the strip did not react (indicating an ineffective concentration). When asked, the dietary staff member (#14) stated she made the sanitizer an hour prior and did not test the concentration before sanitizing the dining room tables. The dietary manager (#13) verified staff do not test the concentration of the sanitizer prior to wiping down dining room tables. Failure to test the concentration of the sanitizer prior to sanitizing the dining room tables and wear clean gloves when preparing ready to eat food may result in unsanitary dietary conditions and contribute to foodborne illness outbreak.	F 371		