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 _____	C 09/23/2021

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 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey and complaint survey started on 09/20/21 and concluded 09/23/21.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		10/28/21

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

Electronically Signed | 10/22/2021

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F 580	Continued From page 1 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 11/07/19. Based on record review and staff interview, the facility failed to notify the physician of a change in condition for 2 of 4 sampled residents (Resident #8 and #13) who experienced weight changes. Failure to notify the physician limited the ability to make informed decisions regarding Resident #8 and #13's medical care. Findings include: Upon request, the facility failed to provide a policy regarding physician notification. - Review of Resident #8's medical record occurred on all days of survey. The weight documentation showed:	F 580	1. a. Resident # 8: Provider was notified on 10/18/2021 of resident□s weight loss from 4/23/21 to 8/30/2021. This notification was documented in resident□s progress notes. b. Resident # 13: The weight entered from 6/12/21 was found to be an error in chart entry. This entry was removed from resident□s chart on 10/11/2021. Resident # 13 did have a 10 pound weight loss from 5/29/2021 to 9/25/2021, so provider was notified of this on 10/27/2021 and notification documented in progress notes. c. A policy titled Physician Notification of Weight Changes was added to our Dietary Policy and Procedure book.	

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F 580	Continued From page 2 *04/23/21 194 pounds *05/03/21 192 pounds *05/10/21 189 pounds *05/14/21 190 pounds *05/24/21 192 pounds *05/31/21 195 pounds *06/08/21 192 pounds *06/09/21 187 pounds *06/14/21 187 pounds *06/21/21 189 pounds *06/28/21 186 pounds *07/12/21 173 pounds *07/19/21 185 pounds *08/09/21 181 pounds *08/30/21 176 pounds Resident #8's current care plan stated, "CHF [Congestive Heart Failure]: I am at risk for complications r/t [related to] diagnosis of CHF . . . I want staff to monitor my weight on a weekly basis on my bath day and report concerns to nurse/provider as appropriate." Review of Resident #8's progress notes and physician communication records showed the facility failed to notify the provider of Resident #8's weight fluctuations at any time from 04/23/21 to 08/30/21. - Review of Resident #13's medical record occurred on all days of survey. The weight documentation showed: * 05/29/21 157 pounds * 06/12/21 140 pounds Resident #13's current care plan stated, "DENTAL: I am edentulous and wear upper and	F 580	2. Dietary and Nursing staff will review resident charts and identify any residents who have had a weight change of five (5) or more pounds in the past six (6) months, and will notify physician as appropriate. 3. a. Beginning 10/18/2021 we will have a registered dietician come to our facility on a monthly basis. She will be monitoring residents' weights and providing appropriate documentation/recommendations to our nursing and dietary staff. b. We will have monthly Nutrition Risk Meetings with our registered dietician, dietary manager, nursing staff and administration. c. Weekly Nutrition Reports will be assessed by the CDM and concerns will be sent to the provider immediately as appropriate. Progress notes/supporting documentation will be entered into residents' medical records as appropriate. 4. A QA designee will audit five (5) resident charts weekly for four (4) consecutive weeks, and then monthly for six (6) months. These residents will be newly assessed to ensure that any declines in weight have been identified, evaluated and communicated to the provider. Findings of this audit will be discussed at quarterly QA meetings.	

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F 580	Continued From page 3 lower dentures . . . Monitor for difficulty eating, chewing, swallowing, and for weight loss, as it may indicate improper fitting of dentures. Report to my nurse/MD [medical doctor]/dentist as indicated." Review of progress notes and physician communication records showed the facility failed to notify the provider of Resident #13's 17 pound weight loss. During an interview on 09/23/21 at 9:08 a.m., two administrative nurses (#1 and #4) confirmed they expected staff to notify the physician regarding weight changes.	F 580		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 4 of 12 sampled residents (Resident #5, #15, #28, and #32). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may negatively affect the development of a comprehensive care plan and the care provided to the residents. Findings include:	F 641	Section K: Swallowing/Nutritional Status 1. Resident #5 and Resident #28 were reassessed on October 4, 2021 to correct the MDS in Section K, to determine that weight loss/gain was actual. 2. The facility determined that ALL residents have the potential to be affected. 3. a. An in-service was conducted on October 18, 2021 by the MDS Coordinator addressing the importance of identifying weight loss and the effect on	10/28/21

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F 641	Continued From page 4 Section K: Swallowing/Nutritional Status The Long-Term Care Facility RAI User's Manual, revised October 2019, page K-5 to K-6 stated, ". . . Weight loss . . . From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago. . . . If the current weight is less than the weight in the observation period 30 days ago, calculate the percentage of weight loss . . . Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. . . . Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician. . . ." - Review of Resident #5's medical record occurred on all days of survey. A significant change MDS, dated 06/20/21, identified a weight loss. Review of Resident #5's weight documentation showed a weight of 117 pounds on 12/10/20, 111 pounds on 05/20/21, and 111 pounds on 06/17/21 (0% weight change in 30 days and 5.1% weight change in 180 days). This is not indicative of a significant weight loss in 30 or 180 days. -Review of Resident #28's medical record occurred on all days of survey. A quarterly MDS, dated 05/25/21, showed no weight loss. Review of Resident #28's weights showed a weight of 117 pounds on 05/23/21 and 124 pounds on 04/25/21 (a 5% weight change in 30 days).	F 641	the resident(s). b. The MDS Coordinator will conduct random audits of five (5) residents per week for four (4) weeks. The medical records will be assessed to ensure weight changes are addressed immediately. CDM will complete weight and nutrition reports weekly to ensure all weight changes are addressed immediately. 4. This plan of correction will be monitored monthly at the QA meetings. Section M: Skin Conditions 1. Resident #32 □ The MDS in question from 9/4/21 was corrected with a modification MDS on 10/4/21. No billing adjustment needed, as this resident'□s payment classification did not change because of the error. 2. The MDS Coordinator will review all residents MDS□ with a pressure ulcer to make sure of accurate coding. Any needed corrections will be made immediately. 3. RAI pages; M-7 through M-25 were reviewed by the MDS Coordinator and a Section M Webinar was watched on 10/19/21. The MDS Coordinator will continue to ensure that a Skin Observation Tool is completed within the appropriate timeframe before the MDS. All wounds will be reviewed and	

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F 641	Continued From page 5 During an interview on 09/22/21 at 4:25 p.m., an administrative dietary staff member (#2) confirmed the facility staff inaccurately coded the MDSs for weight loss. Section M: Skin Conditions The Long-Term Care Facility RAI User's Manual, revised October 2019, page M-7 stated, "M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. Steps for completing M0300A-G . . . For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. . . ." Review of Resident #32's medical record occurred on all days of survey. A quarterly MDS, dated 09/04/21, showed two stage 2 pressure ulcers with one present on admit. Review of Nursing Skin Observation Tool Documentation showed: 02/23/21, ". . . Resident has unstageable pressure ulcer to (L) [left] heel that was present on admission to facility. Wound has yellowish, boggy scab. Skin is moist. New wound noted superior to scab. Wound measures 1 cm [centimeter] x 0.5 cm. Wound base is smooth, tissue bright pinks, edges are irregular. No drainage of [sic] s/s [signs or symptoms] of infection noted." During an interview on 09/23/21 at 10:10 a.m., the administrative nurse (#9) agreed she miscoded the MDS for staging of the left heel ulcer. Section N: Medications	F 641	measured at least monthly by a wound care nurse and weekly by floor nurses 4. QA□s of wound staging accuracy on the MDS will be conducted by an administrative nurse, other than the MDS Coordinator, quarterly to ensure the quality of the MDS□. Section N: Medications 1. Resident #15 □ The MDS in question from 7/13/21 was corrected with a modification MDS on 10/4/21. No billing adjustment needed, as this resident'□s payment classification did not change because of the error. 2. The MDS Coordinator will review the MDS□ of all other resident□s in the facility to make sure their most recent MDS is coded correctly for all active medications. Any needed corrections will be made immediately. 3. RAI pages; N-1 through N-7 were reviewed by the MDS Coordinator and a Section N Webinar was watched on 10/20/21. The MDS Coordinator will continue to review all active medications on the MAR for coding of the MDS. A MDS 3.0 Drug Class Index was obtained online and will be used to cross-reference medications from now on. 4. QA□s of drug coding accuracy on the MDS will be conducted by an	

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F 641	Continued From page 6 The Long-Term Care Facility RAI User's Manual, revised October 2019, page N-7 stated, ". . . N0410E, Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period . . ." Review of Resident #15's medical record occurred on all days of survey. A physician's order, dated 01/15/20, included an anticoagulant, "Eliquis Tablet 5 MG [milligram] (Apixaban) Give 1 tablet by mouth two times a day for A. Fib [atrial fibrillation]." Resident #15's quarterly MDS, dated 07/13/21, showed the facility failed to code the use of an anticoagulant. During an interview on 09/23/21 at 10:05 a.m., an administrative nurse (#9) stated she should have coded for 7 days for anticoagulant use.	F 641	administrative nurse, other than the MDS Coordinator, quarterly to ensure the quality of the MDS□.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		10/28/21

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F 656	Continued From page 7 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a comprehensive care plan for 1 of 12 sampled residents (Resident #8). Failure to develop a care plan that includes the care and services the facility provides to the resident may result in inconsistent care delivery. Findings include:	F 656	1. Resident # 8 was prescribed vancomycin for c-diff prophylaxis, but the antibiotic was not in the resident□s care plan. The deficiency has been corrected, as the antibiotic usage and diagnosis were both added to the resident□s care plan.	

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F 656	Continued From page 8 Review of Resident #8's medical record occurred on all days of survey. Diagnoses included Clostridium difficile (C. diff). Resident #8's physician's orders showed, "Vancomycin HCl [an antibiotic] Capsule 125 MG [milligram] Give 1 capsule by mouth one time a day every 3 day(s) for C-Diff prophylaxis." Review of Resident #8's care plan occurred on 09/23/21. The care plan failed to address the resident's C. diff prophylaxis and provide associated goals and interventions. During an interview on 09/23/21 at 10:15 a.m., an administrative nurse (#1) agreed staff failed to care plan C. diff. goals and interventions.	F 656	2. The ADON and MDS Coordinator will review residents' care plans and ensure that everyone who is on an antibiotic has an updated care plan stating so. 3. Floor nurses will be educated that any time a resident is started on an antibiotic, their care plan needs to be updated to reflect such. The IP will be notified when a resident is started on an antibiotic, and she will check the care plan to verify that it has been updated. If it has not been updated, she will update at that time. 4. IP will audit by seeing who has been started on an antibiotic, and checking their care plan to ensure it is up-to-date. This auditing will be done on a weekly basis x 12 weeks, then monthly x 3 months, then quarterly x 2 quarters. This information will be shared with the QA team and quarterly QA meetings.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		10/28/21

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F 657	Continued From page 9 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 11/07/19. Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the care plan in response to changes in resident condition for 2 of 12 sampled residents (Resident #8 and #13) with weight changes. Failure to update the care plan as needed may result in delayed treatment interventions and inadequate/inconsistent care delivery. Findings include: Review of the facility policy titled "Significant Weight Loss" occurred on 09/23/21. This undated policy, stated, ". . . The goal of medical nutrition therapy (MNT) is to identify underlying causes or factors contributing to the significant unplanned weight loss, and intervene as appropriate to resolve the problem and stabilize the weight . . . Severe Weight Loss > [greater than] 1-2% weight	F 657	1. a. Resident # 8: Care plan was updated on 10/27/2021 to reflect history of significant weight loss, and identify interventions such as assistance with feeding and supplement use. b. Resident # 13: Care plan was updated on 10/27/2021 to reflect history of significant weight loss, and identify interventions such as assistance with feeding, fortified foods and supplement use. 2. Dietary and Nursing staff will identify residents who have had a history of significant weight change and review their care plans to ensure they are up-to-date and reflect the significant weight changes and interventions being implemented. 3. a. Beginning 10/18/2021 we will have a registered dietician come to our	

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F 657	Continued From page 10 loss in 1 week, > 5% weight loss in 30 days . . . >7.5% weight loss in 3 months . . . >10% weight loss in 6 months . . . Document findings, assessment of nutritional status, and nutritional intervention in the medical record (including the care plan). . . ." Review of the facility policy titled "Significant Weight Gain" occurred on 09/23/21. This undated policy, stated, ". . . Review for positive or negative outcome of the weight gain . . . Document all information and recommendations accordingly . . ." - Review of Resident #8's medical record occurred on all days of survey. Review of the weight documentation showed severe weight changes from 06/09/21 to 07/12/21, 06/28/21 to 07/12/21, and 07/12/21 to 07/19/21. - Review of Resident #13's medical record occurred on all days of survey. The weight documentation showed severe weight changes from 10/24/20 to 11/21/21, 10/24/20 to 01/23/21, 01/16/21 to 01/23/21, 02/22/21 to 03/27/21, and 06/12/21 to 07/09/21. Resident #8 and #13's current care plans failed to identify weight loss/gain and interventions to prevent further weight changes and ensure adequate nutrition. During an interview on 09/22/21 at 5:13 p.m., a managerial dietary staff member (#2) acknowledged the facility failed to update the care plans related to weight changes.	F 657	facility on a monthly basis. She will be monitoring residents' weights and providing appropriate documentation/recommendations to our nursing and dietary staff. b. We will have monthly Nutrition Risk Meetings with our registered dietician, dietary manager, nursing staff and administration. c. CDM will ensure all residents who are experiencing significant weight changes will have proper documentation to reflect this in their care plans. 4. MDS Coordinator will audit by seeing who had a significant weight change, and checking their care plan to ensure it has been updated. Auditing will be done on a weekly basis x 12 weeks, monthly x 3 months and then quarterly x 2 quarters. Audit findings will be reviewed at quarterly QA meetings.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		10/28/21

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	355044	A. BUILDING _____ B. WING _____	C 09/23/2021

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 658	Continued From page 11 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 2 of 2 sampled residents (Resident #25 and #31) reviewed for insulin use. Failure to keep the physician informed of insulin refusal, carry out physician's orders, and notify the physician of blood sugars greater than 450 milligram/deciliter (mg/dL) may result in adverse health effects. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 10th ed., Pearson Education, Inc., Massachusetts, page 68, stated, ". . . It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber. . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." Review of the facility policy titled "Medication Monitoring" occurred on 09/23/21. This policy, dated December 2020, stated, ". . . Licensed nurses, with periodic oversight by nurse managers, shall: . . . Report refusals of medications . . . to the physician. . . ."	F 658	1. a. Resident #31: Dr. Longmuir was notified that resident has been refusing most of her Novolog Insulin order□s for the past few months. Dr. Longmuir ordered to continue with current orders for resident□s insulin, and this has been documented in her chart. b. Resident #25: Nursing staff have been educated on the importance of contacting the provider when the resident□s blood sugar is >450, even if he is asymptomatic. 2. a. Administrative nursing staff will review residents' MARs to identify if there are any other residents who are frequently refusing ordered medications. If this is observed, we will notify the provider for their recommendations. b. Administrative nursing staff will review other diabetic charts to ensure providers are being notified of any blood sugars above ordered parameters, and that notification of the provider is being documented. 3. a. Nursing staff will be educated at an in-service on 10/26/2021 that if a resident	

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F 658	Continued From page 12 - Review of Resident #25's medical record occurred on all days of survey. Diagnoses included diabetes mellitus type 2. A physician's order, dated 01/20/21, stated, ". . . call provider if Blood Glucose is over 450 . . ." Review of Resident #25's blood glucoses showed the following: * 09/06/21 at 8:00 p.m., 473 mg/dl * 09/08/21 at 8:00 p.m., 489 mg/dl * 09/11/21 at 5:00 p.m., 496 mg/dl * 09/11/21 at 8:00 p.m., 513 mg/dl * 09/17/21 at 8:00 p.m., 487 mg/dl The medical record lacked documentation of physician notification of elevated blood glucose. During an interview on 09/23/21 at 9:30 a.m., an administrative nurse (#4) agreed the medical record lacked documentation of physician notification and stated she expected nursing staff to contact the physician when Resident #25's blood glucose was higher than 450 mg/dl. - Review of Resident #31's medical record occurred on all days of survey. Diagnoses included type 2 diabetes mellitus with diabetic chronic kidney disease. The quarterly Minimum Data Set (MDS), dated 09/03/21, identified intact cognition. The current care plan stated, ". . . I am at risk for uncontrolled blood sugars r/t [related to] diagnosis of Diabetes and use of Insulin. . . . Administer insulin as ordered by provider and monitor for effectiveness/side effects and report concerns to nurse/provider as appropriate. . . ." A physician's order, dated 06/16/20, included a short-acting insulin, "NovoLOG Solution (Insulin	F 658	is refusing a medication on a consistent basis, the doctor needs to be notified. Administrative nursing staff will monitor weekly report sheets and if it is noticed that any residents are consistently refusing medications, they will check to see if the provider has been notified. b. Nursing staff will be educated at an in-service on 10/26/2021 on the importance of notifying providers when a resident□s blood sugar is above the order parameters. Nursing staff will also be educated on the importance of documenting this notification. 4. a. Administrative nursing staff will complete audits by monitoring residents' MARs for medications which are frequently refused. If there are meds which are being frequently refused, they will audit to ensure the provider has been notified. Auditing will be done weekly x 12 weeks, monthly x 3 months and quarterly x 2 quarters. This information will be shared with the QA team and quarterly QA meetings. b. Administrative nursing staff will complete audits of diabetic residents' charts to ensure documentation is completed about provider notification of blood sugars over ordered parameters. Auditing will be done weekly x 12 weeks, monthly x 3 months and quarterly x 2 quarters. This information will be shared with the QA team and quarterly QA meetings.	

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F 658	Continued From page 13 Aspart) Inject as per sliding scale [based on Resident #31's blood sugar level at 7 a.m. and 11 a.m.] . . ." The orders also included the long-acting insulin Levemir once daily. Resident #31's July-September 2021 Medication Administration Records (MARs) showed the resident refused every NovoLog insulin dose required for high blood sugars before breakfast and lunch, except on two occasions in July. The record lacked evidence staff notified the physician of Resident #31's consistent refusal of NovoLog insulin at 8 a.m. and 12 p.m. During an interview on 09/22/21 at 3:40 p.m., an administrative nurse (#1) stated she was unaware if staff informed Resident #31's physician of the resident's refusal of the NovoLog insulin. The nurse stated staff should notify the doctor when residents refuse medications consistently.	F 658		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident	F 692		10/28/21

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F 692	Continued From page 14 preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure acceptable parameters of nutritional status for 3 of 5 sampled residents with weight loss (Resident #8, #13, and #16). Failure to adequately monitor and evaluate weights, complete nutritional assessments, assess the effectiveness of existing interventions, and re-evaluate the need for updated or additional interventions may result in weight loss, inadequate nutrition, delayed wound healing, and/or dehydration. Findings include: Review of the facility policy titled "Accurate Weights Policy at Mountrail Bethel Home" occurred on 09/23/21. This policy, revised December 2020, stated, ". . . Clients are weighed weekly . . . Re-weighs will be done if the weight varies 5# [pounds] or more, up or down . . .Weights will not be transferred to the medical record until confirmed accurate . . ." Review of the facility policy titled "Significant Weight Loss" occurred on 09/23/21. This undated policy stated, ". . . The goal of medical nutrition therapy (MNT) is to identify underlying causes or factors contributing to the significant unplanned	F 692	1. a. Resident # 8: Moving forward, any time a five (5) pound weight loss/gain is identified during weekly weights, the resident will be reweighed and provider will be notified. Provider was notified on 10/18/2021 of progressive weight loss since 4/23/21, and LRD has been consulted for recommendations. This has been documented in resident□s progress notes. b. Resident #13: Provider was notified of frequent weight fluctuations since 10/24/20 on 10/27/2021. LRD was consulted in resident care for recommendations and this has been documented in resident□s progress notes. c. Resident #16: Paper documentation found of weight on 8/13/2021 and entered into resident□s chart appropriately. LRD has been consulted regarding resident□s care and this has been documented in resident□s chart. CNAs have been educated on the importance of documenting administration of supplements. Nursing staff is	

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F 692	Continued From page 15 weight loss, and intervene as appropriate to resolve the problem and stabilize the weight. . . . Severe Weight Loss > [greater than] 1-2% [percent] weight loss in 1 week, >5% weight loss in 30 days . . . >7.5% weight loss in 3 months . . . >10% weight loss in 6 months . . .Re-weigh the individual to assure an accurate weight . . . Assess the risk of undernutrition and protein-energy malnutrition . . . Document findings in the medical record . . . Request/implement nutrition interventions based on the individual case . . . Complete follow up documentation as needed . . . Document possible reasons why the initial nutrition intervention was not successful . . . Document findings, assessment of nutritional status, and nutritional intervention in the medical record (including the care plan). . . ." Review of the facility policy titled "Medical Nutrition Therapy Documentation" occurred on 09/23/21. This undated policy stated, ". . . The focus of the Comprehensive Nutrition (MNT) Assessment is to identify risk factors that may contribute to under nutrition, protein energy malnutrition, dehydration, unintended weight loss, pressure ulcers and other nutrition problems, as well as identifying other nutrition needs. . . . For Medicare, the initial MNT assessment is generally initiated or completed within 5 days of the admission. Re-assessments and/or progress notes are then completed at 14, 30, 60, 90 days and a minimum of every quarter . . . For non-Medicare individuals, . . . are completed a minimum of every quarter or more often as needed . . . The assessment includes information on weight status, acute and chronic health status, calculation of nutritional needs,	F 692	documenting the administration of Pro-Stat supplement BID in MAR. 2. Dietary and Nursing staff will review residents' charts to ensure anyone who has been experiencing weight fluctuations is being referred to the LDR, and review the documentation to see if supplements are being offered. 3. a. Beginning 10/18/2021 we will have a registered dietician come to our facility on a monthly basis. She will be monitoring residents' weights and providing appropriate documentation/recommendations to our nursing and dietary staff. b. We will have monthly Nutrition Risk Meetings with our registered dietician, dietary manager, nursing staff and administration. c. ADON will review all weights collected before they are entered into the computer, and any residents experiencing a five (5) pound weight change from the week before will be ordered a reweight before they are entered into the computer. If the five (5) pound weight change still occurred, then the ADON will notify dietary and provider. 4. DON will audit by seeing how many residents had a five (5) pound weight change, and ensure reweighs were done on these residents and that the provider and CDM were notified. Audits will be	

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F 692	Continued From page 16 adequacy of nutrient intake, diet and appropriateness, feeding ability, skin condition, bowel and bladder, laboratory data, potential food-medication interactions, food preferences, dental status, chewing/swallowing ability, food allergies and intolerances, need for and response to nutrient or texture modifications . . ." - Review of Resident #8's medical record occurred on all days of survey. Resident #8's current physician's orders stated, ". . . Lasix Tablet 20 MG [milligram] (Furosemide) Give 1 tablet by mouth one time a day . . . May have supplement of choice prn [as needed] . . . Obtain weight and vitals weekly . . ." Resident #8's current care plan stated, "NUTRITION: I want to maintain a stable weight through next review . . . Refer me to a LRD [licensed registered dietitian]. PRN . . . CHF [congestive heart failure]: . . . I want my fluid balance to be maintained through review date . . . I want staff to monitor my weight on a weekly basis . . . and report concerns to nurse/provider as appropriate . . ." A nurse's progress noted, dated 06/24/21, stated, "Talked to [name], NP [nurse practitioner] in regards to blood work that was drawn on resident today. He stated that she was dehydrated and we could give her a litter [sic] of fluids if her family wanted. I called Daughter, [name], and explained this to her and she would like for [name] to get a litter [sic] of fluids." Resident #8's record lacked nutrition assessments or progress notes.	F 692	done on a weekly basis x 12 weeks, monthly x 3 months and quarterly x 2 quarters.	

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F 692	Continued From page 17 The weight documentation showed the following: *04/23/21 194 pounds *05/03/21 192 pounds *05/10/21 189 pounds *05/14/21 190 pounds *05/24/21 192 pounds *05/31/21 195 pounds *06/08/21 192 pounds *06/09/21 187 pounds *06/14/21 187 pounds *06/21/21 189 pounds *06/28/21 186 pounds *07/12/21 173 pounds *07/19/21 185 pounds *08/09/21 181 pounds *08/30/21 176 pounds The facility failed to follow up when severe weight changes occurred on 07/12/21, 07/19/21, and 08/30/21. Resident #8's record showed the facility failed to complete nutritional assessments as required per their policy, re-weigh when five pound weight changes occurred, follow up with the LRD as needed, offer/document supplement of choice for weight loss, and update the provider with weight changes which resulted in continued weight loss and potentially contributed to dehydration. - Review of Resident #13's medical record occurred on all days of survey. Resident #13's current physician's orders stated, ". . . May have supplement of choice prn . . ." Resident #13's current care plan stated,	F 692		

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F 692	Continued From page 18 "NUTRITION: . . . I am at risk for weight loss, due to my DX [diagnosis] of Parkinson's and dependency on staff for nutrition and hydration . . . I want to maintain a stable weight through the review . . . Offer a snack TID [three times daily]-I like Strawberry [diabetic supplement], Strawberry Ice Cream . . . Refer me to a dietitian as needed . . ." Resident #13's nutrition assessments/progress notes identified the following: *01/21/21, ". . . Likes Strawberry [diabetic supplement] and ice cream for snack . . . Continue current nutrition intervention at this time. RD available for any diet/nutrition needs." This is the last nutrition assessment staff completed. *02/05/21, "Weight loss potential, due to sleeping at meals and varied intakes. He is served fortified foods and supplements when he experiences weight loss." The record lacked evidence staff provided supplements when weight loss occurred. *07/16/2021, "Nutrition consult r/t [related to] poor oral intakes and diet change . . . Foods are fortified. Offered high calorie snacks . . . Continue providing feeding assistance as needed and providing supplements often . . . RD [registered dietitian] follows PRN." The record lacked evidence of assessments/interventions by the RD. The weight documentation showed the following: *10/24/20 123 pounds *11/21/20 146 pounds *12/05/20 145 pounds *01/02/21 152 pounds	F 692		

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F 692	Continued From page 19 *01/16/21 149 pounds *01/23/21 140 pounds *02/22/21 140 pounds *03/27/21 153 pounds *04/09/21 155 pounds *04/24/21 152 pounds *05/01/21 153 pounds *05/08/21 150 pounds *05/29/21 157 pounds *06/12/21 140 pounds *07/09/21 155 pounds *08/07/21 154 pounds *08/21/21 147 pounds *09/04/21 150 pounds *09/11/21 148 pounds The facility failed to follow up when severe weight changes occurred on 11/21/20, 01/23/21, 03/27/21, 05/29/21, 06/12/21, and 07/09/21. Resident #13's record identified the facility failed to complete nutritional assessments at a minimum of quarterly as per their policy, consistently obtain weekly weights, re-weigh when five pound changes occurred, offer/document supplements, and refer to a LRD when needed which resulted in continued weight fluctuations. - Review of Resident #16's medical record occurred on all days of survey. Residents #16's physician's orders stated, ". . . May have supplement of choice prn . . . Obtain weight and vitals weekly . . ." Resident #16's current care plan stated, ". . . NUTRITION: . . . Offer me supplements PRN for weight loss . . ."	F 692		

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F 692	Continued From page 20 A nutrition assessment dated, 08/24/21, stated, ". . . Pressure ulcers . . . Offered Prot-Stat [sic] Liquid protein supplement BID [twice daily] . . . Resident has increased caloric and protein needs r/t increased metabolic demands for wound healing. Encourage adequate caloric and protein intakes. Offer high calorie supplement once daily . . . RD will update nutrition services." The record lacked evidence staff offered the high calorie supplement per the RD's recommendation. The weight documentation showed the following: *07/07/21 183 pounds *07/08/21 179.8 pounds *07/09/21 176 pounds *07/23/21 173 pounds *07/23/21 172 pounds *07/30/21 173 pounds *08/06/21 157 pounds *08/13/21 Wrong Chart (referring to 08/06/21 weight but no re-weigh documented) *09/17/21 173 pounds The facility failed to consistently obtain weekly weights and re-weights when a five pound change occurred, follow up with the LRD or Certified Dietary Manager (CDM) when needed, and offer high calorie supplements per the LRD's recommendations which may result in delayed wound healing and inadequate nutrition for Resident #16. During an interview on 09/22/21 at 5:13 p.m., a managerial dietary staff member (#2) confirmed the facility failed to adequately monitor weights and perform appropriate follow up.	F 692		

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 11/07/19. Based on observation, record review, review of the facility policy, and staff interview, the facility failed to ensure proper respiratory care for 2 of 2 sampled residents (Resident #8 and #15) and 1 supplemental resident (Resident #1) with orders for oxygen (O2) therapy. Failure to provide oxygen as ordered may complicate the residents' respiratory status. Findings included: Review of the facility policy titled "Oxygen Therapy" occurred on 09/23/21. This policy, dated December 2020, stated, ". . . Oxygen is administered under orders of the attending physician . . ." - Review of Resident #1's medical record occurred on September 20-21, 2021. A current physician's order stated, "Oxygen per nasal cannula at 2 liters/min [minute] PRN [as needed] for acute respiratory distress or saturations <	F 695	1. a. Resident #1: Resident had a prn order for oxygen at 2.5 liters/min, but her oxygen concentrator was set at 2 liters/min. We corrected by turning back down to 2 liters/min on 9/21/2021. b. Resident #8: Resident had a prn order for oxygen at 2 liters/min, but her oxygen concentrator was set at 3 liters/min. We corrected by turning back down to 2 liters/min on 9/21/2021. c. Resident #15: Resident had an order for prn oxygen, but had oxygen every day during the survey window. Staff did not notify provider that resident was on prn oxygen that long. Concentrator was also found to be set at 4 liters/min vs. 2 liters/min. This was corrected on 9/23/2021 by turning back down to 2 liters/min and resident□'s provider was notified; also on 9/23/2021 the order was updated in the resident's chart stating: Check oxygen saturations every shift, if oxygen is <90% administer Oxygen per	10/28/21

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	355044	A. BUILDING _____ B. WING _____	C 09/23/2021

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F 695	Continued From page 22 [less than] 90% [percent]. Notify provider and obtain order for oxygen, liters of flow, duration, and parameters for weaning off oxygen. Monitor oxygen saturation Q [every] shift while on oxygen . . ." Observation on 09/20/21 at 11:24 a.m. showed Resident #1's oxygen concentrator at 2.5 liters. - Review of Resident #8's medical record occurred on all days of survey. A current physician's order stated, "Oxygen per nasal cannula at 2 liters/min PRN for acute respiratory distress or saturations <90%. Notify provider and obtain order for oxygen, liters of flow, duration, and parameters for weaning off oxygen. Monitor oxygen saturation Q shift while on oxygen . . ." Observation on 09/20/21 at 11:35 a.m. showed Resident #8's oxygen concentrator at 3 liters. - Review of Resident #15's medical record occurred on all days of survey. A physician's order, dated 04/28/21, stated, "Oxygen per nasal cannula at 2 liters/min PRN for acute respiratory distress or saturations < 90%. Notify provider and obtain order for oxygen, liters of flow, duration, and parameters for weaning off oxygen. . . ." The September 2021 vital sign record identified Resident #15 used oxygen daily and her oxygen saturation ranged from 90-100%. The September 2021 Treatment Administration Record (TAR) matched the order for 2 liters of oxygen and showed the nurses initialed the TAR every shift except on one occasion. Observations on 09/20/21 at 2:35 p.m. and 09/22/21 at 8:55 a.m. showed Resident #15 in	F 695	nasal cannula at 2 liters/min. Notify provider if resident is requiring more than 2L/min of oxygen. 2. a. Administrative nursing staff will review residents' charts and perform staff interviews to see if there are any other residents who are requiring oxygen. If other residents are on oxygen, we will ensure their concentrators are set at the ordered level. b. Administrative nursing staff will review residents' charts by 10/28/2021 and if any residents have been on prn oxygen for an extended period of time, we will notify the provider for an official order. 3. a. Education will be provided to staff to ensure they understand the importance of having oxygen concentrators set at the ordered levels at an in-service on 10/26/2021. b. Education will be provided to nursing staff at an in-service on 10/26/2021 stating that if a resident is on PRN oxygen for an extended period of time, the provider needs to be notified for an official order. c. A nursing task will be added to the TAR which will require nurses to verify resident oxygen concentrators are set to the ordered level each shift by 10/28/2021. 4. a. Administrative nursing will	

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F 695	Continued From page 23 her room wearing a nasal cannula with the oxygen flow set at 4 liters. During an interview on 09/23/21 at 10:08 a.m., an administrative nurse (#1) identified the nurses' initials on the Treatment Administration Record's oxygen order meant Resident #15 wore oxygen at 2 liters that shift. The nurse (#1) stated the resident had been on continuous oxygen at 2 liters for a while as she had worsening health problems and they probably should contact the doctor to change the oxygen order to continuous. The nurse (#1) stated the nurses are responsible for setting the oxygen flow meter on the concentrator. The facility failed to ensure the correct oxygen flow rate and notify the physician of Resident #15's continuous use of oxygen.	F 695	perform auditing to ensure the provider has been notified of any residents who are using prn oxygen for an extended period of time. b. Administrative nursing will perform auditing to ensure oxygen concentrators are set to their ordered levels. c. Auditing will be done weekly x 12 weeks, monthly x 3 months and quarterly x 2 quarters. This information will be shared with the QA team and quarterly QA meetings.	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide	F 725		10/28/21

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F 725	Continued From page 24 nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on staffing reports, record review, and staff interview, the facility failed to designate a licensed nurse to serve as a charge nurse on each tour of duty (shift) for 4 of 4 days of survey (September 20-23, 2021). Failure to designate a charge nurse on each shift may result in inefficient or lack of coordination of care/services, and could lead to confusion in an emergency. Findings include: During an interview on 09/21/21 at 2:58 p.m., a staff nurse (#10) stated the facility has no designated charge nurse on any shift. Review of the facility staffing reports and schedule showed two nurses scheduled, one on each unit for both the day and evening shift, and one nurse scheduled for the night shift. Neither the staffing report nor the schedule identified a charge nurse. During an interview on 09/23/21 at 9:50 a.m., two administrative nurses (#1 and #4) agreed the facility failed to designate a charge nurse on	F 725	1. n/a 2. n/a 3. A charge nurse has been indicated on every shift by placing a (*) next to their scheduled shift on the nurses' schedule. Whichever nurse has a (*) on their schedule for that day is the designated charge nurse for that shift. This will be done for all shifts on all schedules moving forward. 4. a. Administrative nursing will audit the nursing schedule to ensure that every shift for that time period has a designated charge nurse. b. Auditing will be done weekly x 12 weeks, monthly x 3 months and quarterly x 2 quarters. This information will be shared with the QA team and quarterly QA meetings.	

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F 725	Continued From page 25 every tour of duty.	F 725		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the facility's nursing staff schedule and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day, seven days a week, for two days of the 47-day period from 08/08/21 to 09/23/21. Failure to ensure the availability of sufficient, qualified nursing staff daily has the potential to affect all the residents residing in the facility. Findings Include: The facility provided a copy of the nurse's schedule from 08/08/21 to 09/23/21. Review of the schedule showed the facility lacked the required RN coverage for August 8th and September 18th.	F 727	1. n/a 2. n/a 3. Administrative nursing is responsible for ensuring there is an RN in the building for 8 hours every day of the week. If we are unable to schedule an RN for any particular shift, Administrative nursing will need to be here to cover those 8 hours. 4. Administrative nursing will audit the nursing schedule to ensure that every day for that time period has RN coverage for 8 consecutive hours.	10/28/21