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 11/16/2023

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 The Standard Medicare/Medicaid recertification and complaint survey started on 11/13/23 and concluded on 11/16/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		12/5/23

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

Electronically Signed | 12/12/2023

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F 550	Continued From page 1 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide care for 1 of 10 sampled residents (Resident #13) and 1 supplemental resident (#17) in a manner and environment that maintained, enhanced, and respected each resident's dignity. Failure to wait for permission prior to entering a resident's room and ensure a resident's private body parts are not exposed does not preserve the resident's personal dignity and/or enhance their quality of life and placed them at risk of embarrassment and/or emotional harm. Findings include: Review of the facility policy titled, "Confidentiality, Privacy, and Dignity," occurred on 11/16/23. This policy, revised 07/19/16, stated, ". . . All staff will knock before entering a resident/patient's room and allow resident/patient's privacy when receiving treatment and caring for their personal needs. . . ." - During an observation on 11/14/23 at 4:06 p.m., two certified nurse aides (CNAs) (#3 and #4) transferred Resident #13 into bed before providing toileting cares. Resident #13 indicated he scratched his lower stomach and voiced	F 550	What corrective action will be accomplished for those residents/patients affected by the deficient practice? Education has been provided to staff about ensuring dignity to residents which includes, but is not limited to, waiting for permission before entering a resident's room. How will you identify other residents having the potential to be affected by the same deficient practice? All other residents in the facility have the potential to be affected by this deficiency. How will the deficiency be corrected? Education provided to nursing and CNA staff. How will we monitor our performance to ensure solutions are permanent? Visual audits will be completed by the Director of Nursing or Assistant Director of Nursing on nursing and CNA staff to ensure they are waiting for permission before entering a resident's room. Social Worker will also monitor residents in the	

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F 550	Continued From page 2 pain/discomfort when the CNAs (#3 and #4) cleansed the area. Resident #13 laid on the bed, exposed from mid-chest to knees, when one of the CNAs (#4) exited the room to find the nurse. A few minutes later, the nurse (#2) knocked, announced herself, and entered the room without waiting for permission to enter. The other CNA (#3) covered Resident #13's groin with a towel after the nurse entered the room. During an interview on 11/18/23 at 12:55 p.m., an administrative nurse (#1) indicated she expects staff to ensure the resident's dignity while providing personal cares. Review of the facility policy titled, "Helping a resident with Toileting Policy and Procedure" occurred on 11/16/23. This policy, dated December 2020, stated, ". . . It is the practice of this facility to assist residents with toileting needs to maintain the resident's dignity. . . help the resident to the bathroom . . . assist resident with clothing and assist them back to their chair . . ." Observations of Resident #17 showed the following: - 11/13/23 at 3:02 p.m., the resident sitting in a chair in the lobby with urine soaked pants during a visit with a staff member. A nurse, (#2) assisted the resident to the bathroom and changed the soiled pants. -11/14/23 at 3:25 p.m., the resident sitting in a chair in the lobby with urine soaked pants while other residents, staff, and visitors walked by. A nurse (#2) assisted the resident to the bathroom and changed the soiled pants. -11/15/23 at 3:05 p.m., the resident sitting in a chair in the lobby with urine soaked pants while	F 550	lobby and common areas to include any incidents of incontinence. Auditing for both of these areas began on 12/4/2023 and will be completed monthly X 3 months and quarterly thereafter for one year. Results of auditing will be presented to the QA committee on a quarterly basis. When will the deficiency be corrected? Deficiency was corrected at CNA/Nurses' Meeting on 12/05/2023.	

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F 550	Continued From page 3 other residents, staff, and visitors walked by. A nurse, (#2) assisted the resident to the bathroom and changed the soiled pants. During an interview on 11/16/23 at 9:47 a.m., an administrative nurse (#1) indicated she expected staff to toilet the resident timely.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to assess residents for self-administer of medications for 1 of 1 sampled residents (Resident #30) observed with medications in the dining room. Failure to evaluate residents' ability to safely self-administer medications may result in medication errors and/or harm to the residents. Findings include: Review of the policy titled, "Self-Administered Medications" occurred on 11/16/23. This policy, implemented November 2020, stated, ". . . It is the policy of Mountrail Bethel Home to evaluate and allow a resident to self-administer medications after the interdisciplinary team has determined which medications may be self-administered safely. . . According to the self-administer medications assessment, a decision to allow the resident to self-administer medications or to discontinue self-administration	F 554	What corrective action will be accomplished for those residents/patients affected by the deficient practice? Nursing staff will be educated that none of our residents here at MBH should be allowed to self-administer medications. Nursing staff will be educated that they must observe residents taking all of their medications. Nursing staff will be educated that if any residents are able to self-administer, an assessment will first be completed by administrative nursing staff and they will be educated as such if this comes up. How will you identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by this deficiency. How will the deficiency be corrected?	12/5/23

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F 554	Continued From page 4 of medications will be determined. . . ." Review of Resident #30's medical record occurred on all days of survey. The record lacked an assessment for self-administration of medications and/or a physician's order permitting the resident to do so. The quarterly Minimum Data Set (MDS), dated 08/22/23, identified severe cognitive deficits. Observation showed the following: - 11/14/23 at 7:57 a.m., a licensed nurse (#2) stated, "(Resident #30) here are your meds [medication]." The nurse (#2) set the medication cup on the table and left the dining room before the resident took the medications. * 11/14/23 at 8:12 a.m., Resident #30 ate breakfast in the dining room with an empty medication cup next to her plate. * 11/15/23 at 7:50 a.m., Resident #30 ate breakfast in the dining room. The cup next to her plate still contained medications. The nurse (#2) stood next to her medication cart in the next room, out of sight of the resident. During an interview on 11/15/23 at 8:55 a.m., a nurse (#2) indicated she left medications on the table for Resident #30 as "they can self-administer [their medications]." During an interview on 11/15/23 at 2:20 p.m., an administrative nurse (#1) confirmed, "[Resident #30] cannot self-administer their medication." - Observation on 11/14/23 at 7:57 a.m. showed a licensed nurse (#2) stated, "(Resident #30) here are your meds [medication]" the nurse (#2) set	F 554	Nursing staff will be educated on policy and proper practice. How will we monitor our performance to ensure solutions are permanent? The Director of Nursing or Assistant Director of Nursing will complete visual auditing to ensure nursing staff are not allowing residents to self-administer medications. Auditing began on 12/4/2023 and will be completed monthly X 3 months and then quarterly X 3 quarters. Auditing will be reported to QA Committee during QA meetings. When will the deficiency be corrected? The deficiency was corrected at a CNA/Nurses' meeting on 12/05/2023.	

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F 554	Continued From page 5 the medication cup on the table and left the dining room.	F 554		
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 State law or regulations as specified in paragraph (e)(10) of this section.	F 580		12/20/23

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F 580	Continued From page 6 (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: Based on observation, record review, review of facility policy, and staff interview, the facility failed to notify the physician of a change of condition for 1 of 1 sampled resident (Resident #16) with a new pressure ulcer. Failure to promptly notify the physician of the pressure ulcer limited their ability to make informed decisions regarding the resident's medical care. Findings include: Review of the facility policy titled "Wound Treatment Management" occurred on 11/15/23. This policy, dated December 2020, stated, "To promote wound healing . . . provide evidence-based treatments in accordance with current standards of practice and provider orders . . . in the absence of treatment orders, the licensed nurse will notify the physician next business day to obtain treatment orders . . ." Findings include:	F 580	What corrective action will be accomplished for those residents/patients affected by the deficient practice? An order was obtained for dressing changes on resident #16 on 11/15/2023. How will you identify other residents having the potential to be affected by the same deficient practice? All residents with skin concerns have the potential to be affected by this deficiency. The charts of all residents with skin concerns were audited to ensure they have appropriate wound orders, and they do. How will the deficiency be corrected? We will be implementing a new "Wound Care Standing Orders Policy" which will outline standing order criteria for different skin conditions including: skin tears; Stage 1, Stage II, Stage III and	

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F 580	Continued From page 7 Review of Resident #16's medical record occurred on all days of survey. A progress note, dated 11/13/23 at 8:18 p.m., identified, ". . . CNA [certified nurse aide] to nurse 6 a.m. - 6 p.m. shift on Friday, 11/10/23, that resident has a sore to right buttocks . . . this nurse assessed area now, 3 x [times] 3 cm [centimeter] sore (Lshaped) to right buttocks. . . skin has sheared away . . . calmoseptine [a skin protectant] seems to have minimal affect . . . concern note sent to physician . . ." During an interview on 11/15/23 at 10:22 a.m., an administrative nurse (#1) reported staff wrote a concern note for the physician on Friday 11/10/23 addressing Resident #16's pressure ulcer and put it in his in-box, but the physician did not receive the note until Monday 11/13/23. During an interview on 11/16/23 at 9:47 a.m., an administrative nurse (#1) reported the facility is re-evaluating the current process for physician notification. The nurse (#1) stated she expected staff to evaluate/treat Resident #16's pressure ulcer in a timely manner.	F 580	Stage IV pressure ulcers; dry skin, etc. The policy will provide orders for the nurse to implement for different skin conditions and will allow care of the wound to start immediately. We will also be implementing a new policy titled, "After Hours Notification of On-Call Provider Policy". This policy will explain situations when the nurse will be required to notify the on-call provider of change in residents' conditions including: elevated blood sugars, development of new pressure ulcer, change in condition, falls with injury and head injuries. This policy will be approved at the Medical Staff Meeting and put into effect on 12/20/2023. Nursing staff will be educated on these two policy changes via in-person notification, email notification, and Nursing Communication Book Log notification after approval of the policies on 12/20/2023. How will we monitor our performance to ensure solutions are permanent? Our QA Director will audit all new pressure ulcers to ensure the provider was notified at the time of pressure ulcer discovery. The QA Director will audit to ensure the wound-care standing orders were implemented and treatment was provided at the time of discovery. The QA Director will audit this on a weekly basis by determining all new pressure ulcers and auditing the resident's chart to ensure there is documentation regarding notification of provider and new order implementation. Audit findings will be	

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F 580	Continued From page 8	F 580	reported to the QA committee on a quarterly basis. When will the deficiency be corrected? The deficiency will be corrected on 12/20/2023 when the "Wound Care Standing Orders" and "After Hours Notification of On-Call Provider Policy" are approved by our Medical Staff.	
F 582 SS=C	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 582		12/18/23

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F 582	Continued From page 9 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on review of Medicare Part A letters/notices and staff interview, the facility failed to complete the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNFABN) and ensure the Notice of Medicare Non-Coverage (NOMNC) contained updated contact information for the Quality Improvement Organization (QIO) for 1 of 1 supplemental resident (Resident #27) who remained in the facility and 1 discharged resident (Resident #37). Failure to ensure the resident and/or resident representative received all available options for	F 582	What corrective action will be accomplished for those residents/patients affected by the deficient practice? Families were educated at the time of receiving the form that they would no longer be able to stay at the facility with continued Medicare coverage, and they did voice verbal understanding of this so no further action needs to be taken. Both residents/residents' representatives have been mailed written notifications with accurate QIO information. There is	

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F 582	Continued From page 10 care and the option to appeal the termination of coverage has the potential to hinder the residents' right to an expedited review of a service termination. Findings include: - Review of the Medicare Part A letters/notices for Resident #27 occurred on the afternoon of 11/15/23 and identified the facility provided the SNFABN and NOMNC form to Resident #27's representative on 07/03/23. The facility failed to obtain documentation of the resident's wishes for continued services and/or the option to appeal the termination of Medicare Part A coverage prior to termination and failed to include updated QIO contact information. - Review of the Medicare Part A letters/notices for Resident #37 occurred on the afternoon of 11/15/23. The NOMNC failed to include updated QIO contact information. During an interview on 11/16/23 at 10:00 a.m., an administrative nurse (#1) and a staff member (#5) confirmed staff failed to obtain the resident/resident representative option on the SNFABN and failed to provide the QIO contact information.	F 582	Documentation in their charts of these notifications. There is written documentation in both of their charts regarding conversations about notification of Medicare non-coverage as well. How will you identify other residents having the potential to be affected by the same deficient practice? Two other residents had Medicare A stays at our facility this year. Their forms did not have the correct option marked stating whether or not they wanted to continue services. However, there are progress notes stating conversations were had with family and they wanted to continue with long-term placement without Medicare coverage. How will the deficiency be corrected? We have updated our Notice of Medicare Non-Coverage forms to indicate the appropriate QIO phone number, as well as make it more clear that an option needs to be selected on the form. Staff members who complete these forms with family members have also been educated on how to complete the form. How will we monitor our performance to ensure solutions are permanent? Beginning on 12/1/2023 the Social Worker will audit all Medicare discharge forms to ensure these forms are completed appropriately for the next year and that they include all accurate QIO contact information. The monitoring will be completed routinely upon all Medicare	

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F 582	Continued From page 11	F 582	discharges and will be reported to the QA committee on a quarterly basis. When will the deficiency be corrected? The deficiency was corrected on 12/18/2023.	
F 641 SS=D	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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/08/22. Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 13 sampled residents (Resident #9 and #13). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2023, pages K-10 and K-12 stated, ". . . FEEDING TUBE Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but	F 641	What corrective action will be accomplished for those residents/patients affected by the deficient practice? The MDSs for Resident #9 and Resident #13 have been corrected to have accurate coding and have been re-submitted to CMS. How will you identify other residents having the potential to be affected by the same deficient practice? All residents' most recent MDSs have been audited to ensure accurate coding in this section. How will the deficiency be corrected? The Dietary Manager has been educated on the tag and understands that she will have to double check her section of the MDS before she submits it to ensure accurate coding on her section. The Dietary Manager states that she understands neither of these residents were on feeding tubes, and it was a	11/17/23

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	355044	A. BUILDING _____ B. WING _____	C 11/16/2023

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 641	Continued From page 12 are not limited to, Asiatic tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tubes. . . . Coding Tips for K0520B Only feeding tubes that are used to deliver nutritive substances and/or hydration during the assessment period are coded in K0520B. . . ." - Review of Resident #9's medical record occurred on all days of survey. The quarterly MDS, dated 10/23/23, identified the presence of a feeding tube. During an observation on 11/13/23 at 2:06 p.m., two certified nurse aides (CNAs) (#4 and #16) transferred Resident #9 on and off the toilet. Observation showed Resident #9 did not have a feeding tube in place. During an interview on 11/13/23 at 3:27 p.m., an administrative nurse (#1) confirmed staff marked the tube feeding in error. - Review of Resident #13's medical record occurred on all days of survey. The quarterly MDS, dated 10/27/23, identified the presence of a feeding tube. During an observation on 11/14/23 at 4:06 p.m., two CNAs (#3 and #4) transferred Resident #13 into bed before providing toileting cares. Observation showed Resident #13 did not have a feeding tube in place. During an interview on 11/15/23 at 11:45 a.m., a licensed staff member (#8) confirmed staff marked the tube feeding in error.	F 641	technical error on her part. She has been educated on the issue and understands the need to be thorough moving forward.. How will we monitor our performance to ensure solutions are permanent? The MDS Coordinator will complete auditing on all MDSs submitted X 3 months to ensure appropriate coding. After that, a sample of MDSs will be audited quarterly X 3 quarters to ensure appropriate coding. Auditing started on 12/1/2023. All findings will be reported to the QA committee quarterly. When will the deficiency be corrected? The deficiency was corrected on 11/17/2023.	
F 679	Activities Meet Interest/Needs Each Resident	F 679		11/17/23

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F 679 SS=D	Continued From page 13 CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide an ongoing program of meaningful activities designed to meet the interests and physical, mental, and psychosocial well-being for 1 of 13 sampled residents (Resident #26) dependent on staff for activities. Failure to provide meaningful activities for residents limited Resident #26's ability to reach his highest practicable level of physical, mental, and psychosocial well-being. Findings include: Review of the facility policy titled "Activity Program" occurred on 11/16/23. This policy, revised April 2023, stated, ". . . It is the policy of Mountrail Bethel Home to have a planned and meaningful activity program which meets the needs and interests of the residents. . . . Assessment will be completed . . . upon admit to facility, and on an ongoing basis thereafter to identify their activity needs and interests. Activity	F 679	What corrective action will be accomplished for those residents/patients affected by the deficient practice? The Activities Director provided education to Activities staff on 11/17/2023 informing them that all residents of the facility need to be offered/encouraged activities daily. Education also included that the staff need to provide documentation on all residents daily stating whether they participated in an activity, or whether they refused to participate in the activity. Staff have also been educated on the importance of providing one-to-one activities to residents who do not like to participate in group activities. How will you identify other residents having the potential to be affected by the same deficient practice? Charts were audited for residents who do not participate in many activities to	

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F 679	Continued From page 14 program will be developed based off these assessment findings. . . . Activities will be available during the day, in the evenings and on the weekends. . . ." Review of Resident #26's medical record occurred on all days of survey. The current care plan stated, ". . . I . . . enjoyed . . . farming . . . visiting about flight. Baseball . . . . archery and gardening . . . carpentry work . . . When there are programs about farming, invite me. . . . When there are programs about flying, invite me. . . . I maybe open to playing cards and maybe bingo. . . . I like music, especially gospel. Please invite me to listen. . . . I enjoy most programs on METV and I especially like shows such as Gunsmoke. . . . I enjoy going outside for fresh air when the weather permits. . . ." Observations throughout the survey showed Resident #26 sitting/dozing in a recliner in the lounge with the tv on in the background and not participating in any individual or group activities. The activity log, date October 1-November 14, 2023, showed Resident #26 sat in the lounge with the tv on on 36 occasions. Resident #26 participated in three one-on-one activities and 11 group activities within the 45 day period. During an interview on 11/16/23 at 12:12 p.m., an activities staff member (#9) agreed staff failed to engage Resident #26 in a meaningful activity program which met his needs/interests.	F 679	ensure they were offered sufficient activities and/or documentation was appropriate for any refusals. How will the deficiency be corrected? By ensuring that all residents participate in at last one activity every day, and that it is documented as such. Also, if the resident refuses to participate, then ensuring that the refusal is documented on the activities log for that resident. How will we monitor our performance to ensure solutions are permanent? Auditing will begin on 12/19/2023 and will continue weekly X 2 months, monthly X 3 months and then quarterly X 2 quarters. The Activities Director will audit at least 10 residents' charts to ensure they have daily documentation stating they were at an activity or they refused. Priority for which residents' charts will be reviewed will be placed with residents who do not often participate in activities. If a resident is found to be refusing frequently, they will be offered other activities to fit their desires. All auditing will be presented to the QA committee on a quarterly basis. When will the deficiency be corrected? The deficiency was corrected on 11/17/2023.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		12/20/23

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F 686	Continued From page 15 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide appropriate care and services for 2 of 4 sampled residents (Resident #16 and #24) who had a pressure ulcer. Failure to obtain and implement orders for treatment may result in the worsening of the pressure ulcer. Findings include: Review of the facility policy titled "Pressure injury Prevention Guidelines" occurred on 11/15/23. This policy, dated December 2020, stated, ". . . To prevent the formation of avoidable pressure injuries . . . implement interventions for all residents who are assessed at risk or who have a pressure injury present . . . individualized interventions will address specific factors identified in the resident's risk and skin assessment and any pressure injury assessment . . . interventions will be documented in the care plan and communicated to all relevant staff . . . interventions will be documented in the treatment	F 686	What corrective action will be accomplished for those residents/patients affected by the deficient practice? For resident #24, the deficiency was corrected by applying a dressing to the resident's wound on 11/15/2023 when it was determined by administrative nursing staff that the wound did not have a dressing on it. For resident #16, the deficiency was corrected by applying a dressing to the wound per TAR orders on 11/15/2023 when it was determined that the wound did not have a dressing on it. How will you identify other residents having the potential to be affected by the same deficient practice? All residents with dressing change orders have the ability to be affected by this deficiency. All residents who have wound dressing orders were assessed to ensure they have proper wound dressing placement, and they did have proper	

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F 686	Continued From page 16 administration record [TAR] . . ." -Review of Resident #16's medical record occurred on all days of survey. The admission Minimum Data Set (MDS), dated 10/22/23, identified dependence on two or more staff members with bed mobility, one assist with transfers, and history of pressure ulcers in the sacral region. Observation on 11/13/23 at 4:32 p.m. showed Resident #16's right buttocks with an open area during toileting cares, approximately 3 centimeters in size. When asked the CNA (certified nursing aide), (#3 and #4) how they are treating the open skin area, they stated, "we are not sure." The progress notes identified the following: * 11/11/23 at 08:00 a.m., "LATE ENTRY. . . certified nursing assistant reported that resident has an open area on her right buttock during shift change yesterday . . . and the report was passed on to the night shift nurse . . . resident was assessed this morning with the charge nurse . . . has an L-shaped pressure ulcer on her right buttock with a total length of 3.5 cm [centimeters] . . . bilateral groins are also reddened . . . calmoseptine [a skin barrier cream] is applied to her buttocks . . ." *11/13/23 at 8:18 p.m., ". . . CNA to nurse 6 a.m. - 6 p.m. shift on Friday, 11/10/23, that resident has a sore to right buttocks . . . this nurse assessed area now, 3 x 3 cm sore (T-shaped) to right buttocks . . . skin has sheared away . . . calmoseptine seems to have minimal affect . . . concern note sent to physician . . ."	F 686	placement at the time of audit on 11/17/2023. How will the deficiency be corrected? We have updated our "Wound Treatment Management Policy" to include a set of "Wound Care Standing Orders." These orders will include treatments for various different wounds including: skin tears and Stage I, II, III and IV pressure ulcers. With the use of this policy, staff will be able to initiate wound orders per the Wound Care Standing Orders upon identification of new skin issues. We will also be having a new policy approved on 12/20/2023 titled, "After House Notification of On-Call Provider Policy" which will outline instances when nursing staff should notify our on-call providers, to include that they should notify the provider when there is a new pressure ulcer identified. Staff have received education that any residents who have an active wound dressing order need to have a dressing placed at all times. CNA pocket care plans have been updated to list all residents who have wound dressings, so they are aware of which residents should have dressings in place. All residents with wounds have also had new orders added into their TAR so the nurses need to document verification of wound dressing placement every 12 hours while the resident has active wound dressing orders. How will we monitor our performance to ensure solutions are permanent?	

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F 686	Continued From page 17 The (TAR) dated 11/15/23 at 1:00 p.m., identified, ". . . Allevyn dressing [wound dressing] to right buttocks open area . . . change every three days and PRN [as needed]. Monitor and document, start 11/14/23 at 2:42 p.m." Staff failed to apply an Allevyn dressing per physicians order on 11/14/23. During an interview on 11/15/23 at 10:22 a.m., an administrative nurse (#1) reported staff wrote a concern note to the physician on Friday 11/10/23 addressing Resident #16's pressure ulcer, which he received on Monday 11/13/23. -Review of Resident #24's medical record occurred on all days of survey. Diagnoses included a pressure ulcer to the sacral region. The physician's orders, dated 08/08/23, stated, "Wound care: Cleanse with house wound wash, mix collagen powder with NS [normal saline] to make a paste, apply paste to wound bed, cover with secondary dressing, change every other day and prn." Observation on 11/14/23 at 1:30 p.m., showed two CNAs (#4 and #6) transferred Resident #24 into bed and performed perineal care. The resident's sacral region did not have a dressing in place. When asked about a dressing, the CNA (#4) stated, "We are using a barrier cream to the area." She then applied the barrier cream. During an interview on 11/15/23 at 2:40 p.m., an administrative nurse (#1) stated she expected staff to continue the wound dressings as per physician's orders.	F 686	The QA Director will audit residents' charts on a weekly basis to ensure that all residents who have new skin issues have documentation to include: notification of the on-call provider at time of new pressure ulcer discovery, activation of Wound Care Standing Orders at time of new pressure ulcer discovery, and documentation of wound dressing placement at time of pressure ulcer discovery. Auditing began on 12/15/2023, will be done on a weekly basis, and will be reported to the QA committee on a quarterly basis. The Director of Nursing or Assistant Director of Nursing will also complete visual auditing on residents with wound dressing orders to ensure that the dressings are in-place as ordered on current wound-dressing orders. Auditing will begin on 12/19/2023 and will occur weekly X 2 months, monthly X 3 months and then quarterly X 3 quarters. Results will be presented to the QA committee on a quarterly basis. When will the deficiency be corrected? The deficiency will be corrected on 12/20/2023 when the Wound Care Standing Orders and After Hours Notification of On-Call Provider Policy are approved at the Medical Staff meeting. Education was provided to CNA/Nursing Staff regarding the requirement for all residents with wound dressing orders to have proper wound dressings placed at all times during the CNA/Nursing in-service meeting on 12/5/2023.	
F 690	Bowel/Bladder Incontinence, Catheter, UTI	F 690		11/17/23

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F 690 SS=D	Continued From page 18 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		

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F 690	Continued From page 19 Based on information provided by complainants, observation, record review, review of facility policy, and staff interview, the facility failed to provide appropriate services and assistance to maintain bowel /bladder continence for 1 supplemental resident (#17) observed. Failure to provide toileting assistance may result in unnecessary incontinence and a loss of dignity. Findings include: Information received from the complainant identified concerns with inadequate toileting assistance. Review of the facility policy titled, "Helping a resident with Toileting Policy and Procedure" occurred on 11/16/23. This policy, dated December 2020, stated, ". . . It is the practice of this facility to assist residents with toileting needs to maintain the resident's dignity. . . help the resident to the bathroom . . . assist resident with clothing and assist them back to their chair . . ." Review of Resident # 17's medical record occurred on all days of survey. Diagnoses included dementia, renal insufficiency and at risk for urinary tract infections related to intermittent incontinence. The quarterly Minimum Data Set (MDS), dated 08/23/23, identified, ". . . staff to remind and assist for toileting cares . . . no trial of toileting program has been attempted . . ." The current care plan identified, ". . . I need help with peri-cares . . . I can take myself to bathroom at times . . . I want them to offer assist frequently as I am incontinent of bowel and bladder frequently . . . I wear a brief for incontinence	F 690	What corrective action will be accomplished for those residents/patients affected by the deficient practice? Resident #17 was placed on an every 2 hour toileting schedule on 11/15/2023. How will you identify other residents having the potential to be affected by the same deficient practice? All residents who are incontinent have the ability to be affected by this deficiency. How will the deficiency be corrected? All residents were placed on an every 2 hour toileting schedule. How will we monitor our performance to ensure solutions are permanent? The Social Worker will complete visual auditing on the occurrence of any residents observed to be incontinent. Auditing started on 12/17/2023 and will be completed weekly X 2 months, monthly X 3 months and then quarterly X 3 quarters. These findings will be reported to the QA committee quarterly at QA meetings. When will the deficiency be corrected? The deficiency was corrected on 11/17/2023.	

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F 690	Continued From page 20 protection . . . staff to monitor for signs and symptoms for a urinary tract infection and report concerns." Review of Resident #17's individual toileting record dated October 16-November 15, 2023 identified 37 incontinent episodes with a range of five to nine hours between assisting the resident with toileting cares. Observations of Resident #17 showed the following: * 11/13/23 at 3:02 p.m., the resident sitting in a chair in the lobby with urine soaked pants and urine on the floor. *11/14/23 at 3:25 p.m., the resident sitting in a chair in the lobby with urine soaked pants while other residents, staff, and visitors walked by. *11/15/23 at 3:05 p.m., the resident sitting in a chair in the lobby with urine soaked pants while other residents, staff, and visitors walked by. During an interview on 11/16/23 at 9:47 a.m., an administrative nurse (#1) stated she expected staff to toilet the resident timely.	F 690		
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	F 692		12/5/23

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F 692	Continued From page 21 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident 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 maintain acceptable parameters of nutritional status or 1 of 1 sampled resident (Resident #14) with significant weight loss. Failure to reassess/monitor weight variances may delay needed treatment for weight loss and alter the resident's ability to maintain sufficient nutritional status. Findings include: Review of the policy titled, "Physician Notification of Weight Change" occurred on 11/16/23. This policy, implemented October 2021, stated, ". . . the Physician will be notified of significant weight changes in residents to ensure we are doing all things possible. All residents will be weighed on a monthly basis, unless ordered otherwise by provider. The DON [Director of Nursing] and ADON [Assistant Director of Nursing] will monitor and enter the weights into the resident's chart. . . ." The policy failed to address more frequent monitoring for residents who experience significant weight loss.	F 692	What corrective action will be accomplished for those residents/patients affected by the deficient practice? Resident #14's weight was obtained and she was placed on a strict weekly weighing schedule. How will you identify other residents having the potential to be affected by the same deficient practice? Charts of residents with significant weight loss and/or gain were audited to ensure their weights were being obtained on a weekly schedule, and they were. How will the deficiency be corrected? Staff have been educated that they need to complete weekly weights on all residents. Staff have been educated that if a resident is refusing to be weighed, then they need to document as such. How will we monitor our performance to ensure solutions are permanent? The QA Director will complete auditing	

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	355044	A. BUILDING _____ B. WING _____	C 11/16/2023

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

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F 692	Continued From page 22 Review of Resident #14's medical record occurred on all days of survey. Diagnoses included chronic kidney disease and dementia. The significant change Minimum Data Set (MDS), dated 08/10/23, identified weight loss. The physician's orders identified, "Obtain weight and vitals weekly. per SO start date 11/01/23." Review of Resident #14's weight log, dated October 5-November 8, 2023, showed the following: * 05/18/23, 123 lbs * 08/10/23, 116 lbs * 09/28/23, 110 lbs * 10/05/23, 110 lbs * 11/08/23, 103 lbs Facility staff failed to weigh the resident on 11/01/23 as ordered. The progress notes identified the following: * 10/26/23 at 12:49 p.m., "No weights have been taken for [Resident #14] in 21 days. . . . provider notified of possible weight loss and having no current weight to calculate." * 10/30/23 at 2:38 p.m., "[Resident #14] continues to lose weight , , . Interventions are not producing weight gain at this time." * 11/03/23 at 12:56 p.m., "[Resident #14] has had a significant weight loss. 10% past 180 days, 5% past 30 days. . . . She is at Nutrition Risk. . . ." * 11/13/2023 at 3:58 p.m., "[Resident #14] has had a sig [significant] weight loss of 10% past 180 days . . . Will cont [continue] to monitor . . ." During an interview on the afternoon of 11/15/23, when asked how staff monitor residents with	F 692	on a sample of resident charts to ensure weekly weights are being obtained. Auditing will be completed weekly X 2 months, monthly X 3 months, and then quarterly X 3 quarters. Auditing will start on 12/19/2023 and all findings will be reported to the QA committee on a quarterly basis. When will the deficiency be corrected? The deficiency was corrected on 11/17/2023 when the weight of the resident cited in the deficiency was obtained. Furthermore, staff education was completed on 12/05/2023 informing staff on the importance of documenting weekly weights on all residents.	

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F 692	Continued From page 23 significant weight loss, a dietary staff member (#10) stated, "They [the residents] should be weighed weekly if they are a nutrition risk." During an interview on 11/15/23 at 2:20 p.m., when asked how staff monitor residents with significant weight loss, an administrative nurse (#10) stated, "Staff are expected to bathe/weigh residents weekly."	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		12/6/23

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F 758	Continued From page 24 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a rationale and duration for the use of an as needed (PRN) psychotropic medication for 1 of 1 sampled resident(Resident #9) with a PRN psychotropic. Failure to ensure a rationale and duration of a PRN medication places the resident at risk for receiving unnecessary medications and experiencing adverse consequences related to their use. Findings include: Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia and anxiety. Physician's orders included lorazepam (an antianxiety) one	F 758	What corrective action will be accomplished for those residents/patients affected by the deficient practice? The order for prn Ativan for Resident #9 was updated/renewed and will be discontinued/reviewed after 14 days. How will you identify other residents having the potential to be affected by the same deficient practice? Charts were audited for residents receiving prn psychotropic medications to see if they were more than 14 days old. Any prn psychotropic medication orders that were over 14 days old were either discontinued or renewed for a 14 day	

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F 758	Continued From page 25 milligram intramuscularly every 24 hours as needed for anxiety, initiated on 08/04/23. Communication with the physician regarding renewals of the lorazepam failed to identify a rationale for its continued use or indicate a duration (i.e., end date) for the PRN order. During an interview on 11/15/23 at 2:40 p.m., an administrative nurse (#1) confirmed the lorazepam order failed to identify a rationale for its continued use or indicate a duration.	F 758	period per provider recommendations. How will the deficiency be corrected? All prn psychotropic medications will be set to discontinue after 14 days. At that time, if the resident has not received the medication, the order will be discontinued. If the resident has been requiring the medication, the provider will be notified and asked for a new order/renewal. How will we monitor our performance to ensure solutions are permanent? The Assistant Director of Nursing will complete chart audits to ensure there are no prn psychotropic orders older than 14 days old. Auditing will begin on 12/19/2023 and will be completed weekly X 2 months, monthly X 3 months and then quarterly X 3 quarters. Audit findings will be reported to the QA committee quarterly. When will the deficiency be corrected? The deficiency was corrected on 12/06/2023.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		12/5/23

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F 761	Continued From page 26 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to ensure safe and secure storage of medications for 1 of 2 medication carts (south cart) observed unlocked or with unattended medications. Failure to store all medications securely may result in unauthorized access to medications. Findings include: Review of the facility policy titled "Medication Storage Policy at Mountrail Bethel Home" occurred on 11/15/23. This policy, dated December 2020, stated, ". . . All drugs and biologicals will be stored in locked compartments (i.e., medication carts . . .) . . . During a medication pass, medications must be under direct observation of the person administering medication or locked in the medication storage	F 761	What corrective action will be accomplished for those residents/patients affected by the deficient practice? Education was provided to nursing staff that medication carts need to be locked at all times when they are out of sight, and that medication cannot be left on top of the medication cart. How will you identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by this deficiency. How will the deficiency be corrected? Education was provided to nursing staff as stated above.	

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F 761	Continued From page 27 cart. . . ." Observation on 11/13/23 at 12:36 p.m. showed an unattended medication cart in the south hallway with three medications on the top of the cart. Observation on 11/13/23 at 12:46 p.m. showed an unlocked/unattended medication cart in the south hallway. After a few minutes a nurse (#7) exited a resident's room. Observation on 11/13/23 at 4:26 p.m. showed an unlocked/unattended medication cart in the south hallway with the keys in the lock of the cart. During an interview on 11/16/23 at 1:05 p.m., an administrative nurse (#1) stated she expected staff to lock the medication cart and keep all medications in the cart when the cart is not in sight of the nurse.	F 761	How will we monitor our performance to ensure solutions are permanent? Visual auditing will be completed by the Director of Nursing or Assistant Director of Nursing to ensure all medication carts are locked when they are not in the nurses' line of sight, and that there is no medication left on top of the cart. Auditing will begin on 12/19/2023 and will be completed weekly X 2 months, monthly X 3 months and then quarterly X 3 quarters. Auditing results will be reported to the QA committee on a quarterly basis. When will the deficiency be corrected? The deficiency was corrected and completion date for this tag was on 12/5/2023 when education was provided to the nurses at the nurses' meeting.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		12/5/23

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F 880	Continued From page 28 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 29 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/08/22. Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control for 2 of 4 sampled residents (Resident #24 and #237) observed during dressing changes and 1 supplemental resident (#18) with Covid 19. Failure to practice infection control standards related to hand hygiene during dressing changes and use of personal protective equipment (PPE) has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Clean Dressing Change Policy and Procedure at Mountrail Bethel Home" occurred on 11/16/23. This policy, dated December 2020, stated, ". . . remove the existing dressing . . . Remove gloves . . . Wash hands and put on clean gloves . . . cleanse the wound .	F 880	What corrective action will be accomplished for those residents/patients affected by the deficient practice? Education will be provided to nursing staff regarding appropriate infection control practices during wound dressing changes. Education will be provided to all staff regarding PPE use for care of a COVID positive resident. How will you identify other residents having the potential to be affected by the same deficient practice? All residents have the ability to be affected by this deficiency. How will the deficiency be corrected? Education will be provided to staff. How will we monitor our performance to ensure solutions are permanent? Visual auditing will be completed by the Director of Nursing, Assistant Director	

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F 880	Continued From page 30 . . Wash hands and put on clean gloves . . ." Review of the facility policy titled "COVID-19 Policy at Mountrail Bethel Home" occurred on 11/15/23. This policy, dated May 2023, stated, ". . . If a resident tests positive for COVID-19, immediately bring them to their room, close their door, place a PPE cart outside their door and hang a "Droplet Precautions" sign on the outside of the door. 2. All staff who enter the residents' room shall wear an: n95 respirator, gown, gloves and face shield . . ." HAND HYGIENE DURING DRESSING CHANGE - Observation on 11/15/23 at 9:50 a.m. showed a licensed nurse (#11) donned gloves and removed Resident #237's wound dressing from the right ankle. Without changing gloves or performing hand hygiene, the nurse cleansed the wound with normal saline and applied a new dressing. The nurse changed her gloves without performing hand hygiene, provided frontal perineal care for the resident, again changed her gloves without performing hand hygiene, and applied a dressing to Resident #237's coccyx. The nurse failed to remove her gloves and perform hand hygiene after removing a dressing, cleansing the wound, and performing perineal care. - Observation on 11/15/23 at 2:30 p.m. showed a licensed nurse (#11) donned gloves and performed bowel incontinence care for Resident #24. The resident did not have a dressing on the sacrum. Without changing gloves or performing hand hygiene after perineal care, the nurse picked up the dressing and attempted to open it	F 880	of Nursing, or Infection Preventionist during dressing changes, and during care of COVID positive residents, to ensure proper infection control techniques are used. Auditing will start on 12/19/2023 and will be completed weekly X 2 months, monthly X 3 months and then quarterly X 3 quarters. Findings will be reported to the QA committee on a quarterly basis. When will the deficiency be corrected? The deficiency was corrected on 12/5/2023 when education was provided to nurses and CNAs at the nurse/CNA meeting.	

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F 880	Continued From page 31 when the surveyor stopped the nurse (#11) and requested she remove her gloves and perform hand hygiene before continuing with the dressing change. PPE for Covid 19 - Observation on 11/15/23 at 12:40 p.m. showed Resident #18's room with a PPE cart outside of the room, a sign on top of the cart stated, "Stop Droplet Precautions Everyone must . . . Make sure their eyes, nose and mouth are fully covered before room entry . . ." A licensed nurse (#2) applied a gown, a N95 respirator mask over her surgical mask, and gloves, before entering Resident #18's room. The nurse (#2) failed to apply a face shield before entering the room. During an interview on 11/15/23 at 12:45 p.m., two certified nurse aides (#12 and #13) stated they did not wear a face shield in Resident #19's room while providing care as the PPE cart did not contain face shields. During an interview on 11/16/23 at 12:30 p.m., an Infection Preventionist nurse (#14) stated she expected staff to remove gloves and perform hand hygiene after removing a dressing and after perineal cares. She also stated it is not acceptable to wear a N95 mask over a surgical mask, and she expected staff to wear a face shield in a Covid positive room.	F 880		