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 12/04/2024

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 survey started on 12/02/24 and concluded 12/04/24.	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		1/2/25

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

Electronically Signed | 12/26/2024

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 12/04/2024

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 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: Based on record review, review of facility policy, resident representative interview, and staff interview, the facility failed to notify the resident representative for 1 of 2 sampled residents (Resident #34) reviewed for falls and resident to resident altercations. Failure to notify the resident representative of a fall and resident to resident altercations does not allow the representative to be fully informed of the resident's current status. Findings include: Review of the facility policy titled "Fall Protocol Policy" occurred 12/04/24. This policy, dated December 2020, stated, ". . . If the resident doesn't obtain an injury during the fall, the emergency contact will be notified as soon as possible, or next morning if the fall occurs during overnight hours."	F 580	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: - Resident #34's family representative was notified of the fall and resident-to-resident altercation on 12/2/2024. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: - All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: a. While reviewing all incident reports	

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 12/04/2024

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 580	Continued From page 2 Review of the facility policy titled "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Employee Policy . . ." occurred 12/04/24. This policy, revised May 2023, stated, ". . . All alleged violations involving abuse . . . are reported immediately to the facility Administrator or other designated staff . . . in accordance with State Law through established procedures. These include: . . . Resident Representative . . ." Review of Resident #34's medical record occurred on all days of survey. Diagnoses included dementia and falls. A quarterly Minimum Data Set, dated 11/28/24, identified four falls, and moderately impaired cognition. Review of Resident #34's nurse's notes identified the following: * 10/19/24 at 3:52 p.m., ". . . Staff had heard hollering from residents [sic] room and another resident [sic] in his room and both were swinging there [sic] arms. Resident in w/c [wheelchair] in room stated the other resident hit him in face. No injuries noted at this time. Will monitor. . . ." * 11/17/24 at 6:38 p.m., ". . . Resident yelling, 'help, help', CNA [certified nurse aide] walked into resident's room and noticed that resident was sitting upright on the floor with legs extended out towards toilet. Denying hit head. Resident stated, 'I was trying to sit in w/c [wheelchair] after coming back from the bathroom.' Vital signs WDL [within defined limits] per resident's baseline. No c/o [complaints of] pain or discomfort. MD [medical doctor] notified. . . ." During an interview on 12/02/24 at 4:46 p.m., Resident #34's representative stated the resident	F 580	(falls, injuries, resident-to-resident altercations, etc.) the risk manager will start checking to ensure there is documentation to support that the POA/family representative were notified of the event. If there is no documentation stating the representative was notified, the risk manager will notify them and supply documentation. b. A memo was placed at the nurse's station on 12/4/2024 stating that family/POA needs to be notified of all incidents. Nursing staff will also be educated in person at our mandatory Nursing/CNA meeting on January 2, 2025. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit. - The DON will perform random audits of 50% of all incident reports to see if there is documentation stating the POA/family representative was notified of the incident. Audits will be performed on a weekly basis x 12 weeks, monthly basis x 3 months and then quarterly basis x 2 quarters. The findings will be reported to	

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 12/04/2024

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 580	Continued From page 3 had multiple falls and was not sure the facility had contacted him for all falls. He further stated the facility did not contact him regarding the incident between Resident #34 and the other resident, he was told by Resident #34's brother who also resides in the facility. During an interview on 12/03/24 at 3:10 p.m., an administrative nurse (#2) confirmed the facility failed to notify Resident #34's representative of the resident to resident altercation until he called the facility to ask about it. During an interview on 12/03/24 at 3:33 p.m., an administrative nurse (#1) confirmed the facility failed to notify Resident #34's representative about the resident's fall on 11/17/24, and she expected staff to notify the resident representative with all falls, and resident to resident altercations.	F 580	the Quality Assurance Committee quarterly at the quarterly QA meetings. 5. Include dates when corrective action will be completed: - January 2, 2025	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		

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 12/04/2024

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 600	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of the facility reported incident and investigation documents, record review, review of facility policy, and staff interview the facility failed to protect the residents' right to be free from physical abuse and psychosocial harm for 1 of 2 sampled residents (Resident #34) and 1 supplemental resident (Resident #3) who experienced abuse by another resident. Failure to ensure an environment free from abuse placed Residents #3, #34, and other residents at risk for abuse, fear, anxiety, and/or psychosocial harm. This citation is considered past non-compliance based on review of the corrective action the facility implemented following the incident. Findings include: The surveyor determined a deficient practice existed on 10/19/24 and 11/04/24. The facility implemented and completed corrective action on 11/04/24. Review of the facility policy titled "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Employee Policy . . ." occurred on 12/04/24. This policy, revised May 2023, stated, ". . . Abuse, Neglect, exploitation, mistreatment . . . is prohibited. . . . Physical Abuse is defined as the willfully hitting, slapping, pinching, kicking, etc. . . ." Review of the facility policy titled "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation Prevention Facility Policy . . ." occurred on 12/04/24. This policy, revised May 2023, stated, ". . . Each resident has the right to	F 600	Past noncompliance: no plan of correction required.	

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 12/04/2024

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 600	Continued From page 5 freedom from all forms of abuse . . . Residents must not be subjected to abuse by anyone including, but not limited to . . . other residents . . . Resident to Resident Altercations: . . . Altercations that must be reported in accordance with regulations include ay [sic] willful action that results in physical injury, mental anguish, or pain . . ." - Review of Resident #3's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 10/09/24, identified moderately impaired cognition. Review of Resident #3's nurses notes identified the following: * 11/02/24 at 5:00 p.m., ". . . [Resident #3] was in her room while staff was down the hall from her, [Resident #17] had entered [Resident #3's] room, the resident had yelled out for help so staff ran to her room and when staff entered the resident room [Resident #17] had [Resident #3's] arm grasped with his one hand and was hitting the resident with his other hand, staff quickly grabbed [Resident #17] to keep him from making contact with the resident, staff tried asking him to leave the room but he would not listen or leave and continued attempting to assault the resident, staff had to physically remove [Resident #17] from the residents room . . . staff tried asking ifthe[sic] resident was harmed or hurt in anyway but [Resident #3] was overwhelmed with anxiety and was very upset so staff left the resident so she could calm down. . . ." * 11/04/24 at 1:32 p.m., stated, ". . . Incident was reported to ND HHS [North Dakota Department of Health and Human Services] due to resident being hit by another resident."	F 600		

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 12/04/2024

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 600	Continued From page 6 - Review of Resident #34's medical record occurred on all days of survey. A quarterly MDS, dated 11/28/24, identified moderately impaired cognition. Review of Resident #34's nurses notes identified the following: * 10/19/24 at 3:52 p.m., stated, ". . . Staff had heard hollering from [Resident #34's] room and [Resident #17] in his room and both were swinging there [sic] arms. Resident in w/c [wheelchair] in room stated [Resident #17] hit him in face. No injuries noted at this time. Will monitor." * 10/22/24 at 4:27 p.m., stated, ". . . Incident was reported to ND HHS. Maintenance has been notified to place a yellow strip in front of resident's door to try divert other resident from wanting to enter his room." Review of the facility investigation report occurred 12/04/24. This report, dated 10/19/24, stated, ". . . Staff watched other resident enter resident's room, and got up to remove the other resident from [Resident #34's] room. While on their way to his room they heard [Resident #34] say 'get the hell out of my room.' by [sic] the time the CNA got to his room CNA observed both resident's swinging their arms and observed the other resident hit [Resident #34] on the lip one time. . . ." The report included a statement from a CNA (#1), which stated, ". . . saw [Resident #17] enter [Resident #34's] room . . . observed [Resident #17] hit [Resident #34] in the lip one time. . . ." Based on the following information,	F 600		

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 12/04/2024

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 600	Continued From page 7 non-compliance at F600 is considered past non-compliance. The facility implemented corrective actions as follows: * The interdisciplinary team met to problem solve and implement changes and interventions for resident care and safety. * Implemented a safety plan addressing the behaviors of Resident #17. * Notified medical director and psychiatric provider for Resident #17 of the incidents. * Notified resident representatives of the incident and actions implemented. * Education provided to all staff on safety plan and behavioral interventions for Resident #17.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		1/2/25

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 12/04/2024

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 609	Continued From page 8 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of the facility reported incidents (FRI), record review, review of facility policy, and staff interview, the facility failed to report incidents of abuse to the State Survey Agency (SSA) for 1 of 1 sampled resident (Resident #34) and 1 supplemental resident (Resident #3) who experienced physical abuse. Failure to report physical abuse in the prescribed time frame does not comply with regulations established to protect residents. Findings include: Review of the facility policy titled "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Employee Policy" occurred on 12/04/24. This policy, revised May 2023, stated, ". . . Abuse, Neglect, exploitation, mistreatment . . . is prohibited. . . . To assist our facility's staff members in recognizing incidents of abuse, the following definitions of abuse are provided: . . . Immediately: Means as soon as possible, in absence of a shorter State time frame requirement, but not later than . . . 24 hours if the events that cause the allegation . . . do not cause serious bodily injury. . . . Physical Abuse is defined as the willfully hitting, slapping, pinching, kicking, etc. . . . alleged violations and results of	F 609	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: - The incident with Resident #3 was reported to the state on 11/4/2024. The incident with Resident #34 was reported to the state on 10/22/2024. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: - All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: - Nurses were educated via a memo on 12/4/2024 that they must notify the DON of any resident-to-resident altercations at the time of the incident. The DON will then report the incident immediately via the online portal. Nurses will be educated in-person of the requirement to notify the DON immediately of any resident-to-resident altercations at our mandatory Nursing/CNA meeting on	

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 12/04/2024

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 609	Continued From page 9 all investigations must be reported to the administrator of the facility and/or other designees in accordance with state law AND the state survey and certification agency. . . . " Review of the facility policy titled "Abuse, Neglect, Exploitation, Mistreatment and Misappropriation Prevention Facility Policy" occurred on 12/04/24. This policy, revised May 2023, stated, ". . . Each resident has the right to freedom from all forms of abuse . . . Residents must not be subjected to abuse by anyone including, but not limited to . . . other residents . . . All alleged violations involving . . . abuse . . . will be reported immediately . . . to the administrator of the facility and to other officials in accordance with State law through established procedures (including the State survey and certification agency). . . . Resident to Resident Altercations: . . . Altercations that must be reported in accordance with regulations include ay [sic] willful action that results in physical injury, mental anguish, or pain . . ." - Review of Resident #3's medical record occurred on all days of survey. A quarterly Minimum Data Set (MDS), dated 10/09/24, identified moderately impaired cognition. Review of Resident #3's nursing notes identified the following: * 11/02/24 at 4:25 p.m., ". . . CNA [certified nurse aide] reported that [Resident #17] was near resident's door and the two [Resident #3 and #17] got into an altercation. CNA also reported that [Resident #17] tried hitting her. When asking [Resident #3] what happened she was not able to answer due to the amount of anxiety she was	F 609	January 2, 2025. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit. - The DON will complete a review of all resident-to-resident altercations to ensure they were reported to the state within 24 hours. Auditing will be completed weekly x 12 weeks, monthly x 3 months and quarterly x 2 quarters. Findings will be reported to the Quality Assurance Committee quarterly at the quarterly QA meeting. 5. Include dates when corrective action will be completed: January 2, 2025	

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 12/04/2024

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 609	Continued From page 10	F 609		

having. No signs of injuries that nurse writing can observe. Will reapproach when she is more calmed down.
* 11/02/24 at 5:00 p.m., ". . . [Resident #3] was in her room while staff was down the hall from her, [Resident #17] had entered the resident's room, the resident had yelled out for help so staff ran to her room and when staff entered the resident room [Resident #17] had [Resident #3's] arm grasped with his one hand and was hitting the resident with his other hand, staff quickly grabbed [Resident #17] to keep him from making contact with the resident, staff tried asking him to leave the room but he would not listen or leave and continued attempting to assault the resident, staff had to physically remove [Resident #17] from the residents room . . . staff tried asking ifthe[sic] resident was harmed or hurt in anyway but [Resident #3] was overwhelmed with anxiety and was very upset so staff left the resident so she could calm down. . . ."
* 11/04/24 at 1:32 p.m., ". . . Incident was reported to ND HHS [North Dakota Department of Health and Human Services] due to resident being hit by another resident." Two days after the altercation.

- Review of Resident #34's medical record occurred on all days of survey. A quarterly MDS, dated 11/28/24, identified moderately impaired cognition.

Review of Resident #34's nurses notes identified the following:
* 10/19/24 at 3:52 p.m., ". . . Staff had heard hollering from [Resident #34] room and another resident in his room and both were swinging there [sic] arms. [Resident #34] in w/c

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 12/04/2024

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 609	Continued From page 11 [wheelchair] in room stated the other resident hit him in face. No injuries noted at this time. Will monitor." * 10/22/24 at 4:27 p.m., ". . . Incident was reported to ND HHS. Maintenance has been notified to place a yellow strip in front of resident's door to try divert other resident from wanting to enter his room." Three days after the altercation. During an interview on 12/04/24 at 12:30 p.m., administrative nurses (#1 and #2) confirmed the facility failed to report the incidents between Residents #3, #17, and #34 to the SSA within 24 hours.	F 609		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §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: 1. Based on observation, record review, review of manufacturer's instructions for use, and staff interview the facility failed to ensure staff followed standards of practice for 1 of 2 residents (Resident #34) observed for insulin preparation and administrations. Failure to administer rapid-acting insulin within the time specified by the manufacturer may result in a hypoglycemic (low blood sugar) reaction. Findings include: Review of "Important safety information for	F 658	Tag 0658 #1 Novolog was administered greater than 5-10 minutes before a mealtime: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: - The order for resident's Novolog will be updated to state the medication should be given 5-10 minutes before a meal, and the administration window will be updated to reflect being given 10 minutes before	1/2/25

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 12/04/2024

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 658	Continued From page 12 NovoLog (rapid acting insulin)", found at https://www.novolog.com occurred on 12/04/24 and stated, and "About NovoLog® Rapid-Acting Insulin . . .", occurred on 12/04/24 and stated, "Novolog starts acting fast. Eat a meal within 5 to 10 minutes after taking it. . . ." - Review of Resident #34's medical record occurred on 12/04/24. Current physician's orders included Novolog Insulin; Inject 3 unit subcutaneously three times a day. Observations on 12/04/24 showed the following: * 11:04 a.m., a nurse (#3) prepared and administered 3 units of NovoLog insulin to resident #34. * 11:45 a.m., Resident #34 was seated in the dining room without access to juice and dessert until 41 minutes after receiving rapid-acting insulin. The facility failed to follow manufacturer's instructions for rapid-acting insulin related to administration and timing of the meal for Resident #34. During an interview on 12/04/24 at 2:37 p.m., two administrative staff members (#1 and #2) stated, "our expectation is the nurse should administer insulin between 11:00 a.m. and 12:00 p.m. as stated on the medication administration record." 2. Based on observation and staff interview, the facility failed to ensure 1 of 1 treatment cart contained medications prescribed and labeled for residents of the facility. Failure to store and/or dispense medications not intended for residents of the facility has the potential to result in a	F 658	scheduled meal times. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: - All residents who receive insulin are at risk for being affected by this deficiency. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: - Our insulin policy will be updated to state that all insulin orders will reflect exact administration times for how soon before a meal an insulin can be administered per the insulin manufacturer guidelines. All nurses/CMAs will be educated at the mandatory meeting on 1/2/2025 that insulins may not be administered earlier than the times indicated in the medication orders. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit. - Audits will be completed by the Director of Nursing to ensure that all	

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 12/04/2024

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 658	Continued From page 13 medication error. Finding include: Observations on 12/04/24 at 10:00 a.m. showed a medication cup with several loose tablets and capsules in the corner of the first drawer of the treatment cart. During an interview on 12/04/24 at 10:00 a.m., a staff nurse (#3) stated, "oh, those are mine, I need to remember to take them." The nurse (#3) removed the medication cup from the cart and put it in her pocket. During an interview on 12/04/24 at 2:37 p.m., two administrative staff members (#1 and #2) stated, "personal medications should not be stored in the medication or treatment carts."	F 658	insulin orders have a specification for how soon before meals the insulin can be given, and visual audits of staff will be done to ensure they are given the insulin per the orders. Audits will be completed weekly x 12 weeks, monthly x 3 months and quarterly x 2 quarters. Audit findings will be presented to the Quality Assurance Committee quarterly during quarterly Quality Assurance meetings. 5. Include dates when corrective action will be completed: - January 2, 2025 Tag 0658 #2 Staff Medication was stored in the medication cart: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: - No residents were affected by this tag. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: - No residents were affected by this tag. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: - Nursing staff were educated via a memo on 12/4/2024 that they cannot store personal medications in the medication cart. The staff who stored their	

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 12/04/2024

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 658	Continued From page 14	F 658	medication in the medication cart was given a verbal warning on 12/11/2024. Nurses and CMAs will all be educated in person at the mandatory Nursing/CNA meeting on 1/2/2025. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is not evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit. - Random audits will be done by the Director of Nursing of the medication/treatment carts and they will be checked to see if any personal medications are being stored in them. Audits will be completed weekly x 12 weeks, monthly x 3 months and quarterly x 2 quarters. Audit findings will be presented to the Quality Assurance Committee at quarterly Quality Assurance meetings. 5. Include dates when corrective action will be completed: - Corrective action will be completed on 1/2/2025.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		1/2/25

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 12/04/2024

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 689	Continued From page 15 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of a professional reference, and staff interview, the facility failed to utilize the assistive devices necessary to prevent accidents for 1 of 4 sampled resident (Resident #19) observed during a transfer. Failure to use a gait belt during transfers has the potential to place residents at risk of falls with/without injury. Findings include: Review of the facility policy titled "Use of Gait Belt", occurred on 12/04/24. This policy, dated December 2020, stated, ". . . use gait belts with residents that need assistance to ambulate or transfer for the purpose of safety . . . Physical Therapy will assess residents upon admission and determine their need for a gait belt . . . [the facility] will have designated gait belts for each resident who requires one . . . All employees will receive education on the proper use of a gait belt . . ." Review of Resident #19's medical record occurred on December 4, 2024. The care plan, stated, ". . . I am at risk for falls related to physical decline . . . I pivot transfer with assist of 1 staff for transfers . . . use gait belt for safety . .	F 689	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: - Resident #19's care plan and pocket care plan were reviewed to ensure they stated staff need to use the gait belt for all transfers. Her room was checked by the Director of Nursing to ensure a gait belt is in her room, and it was. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: - All residents who need to have a gait belt utilized, have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: - Staff education stating all residents who have a gait belt in their care plan need to be transferred with a gait belt. Pocket care plans will be updated weekly and on an as needed basis to ensure they are accurate for the type of transfer/transfer	

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 12/04/2024

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 689	Continued From page 16 ." Observations on 12/03/24 showed the following: * At 3:56 p.m., a staff nurse (#3) and a certified nurse aide (CNA) (#5) transferred Resident #19 from the wheelchair to the bedside commode. Both staff members (#3 and #5) placed their hands under the Resident's arms and lifted her to a standing position. The staff members (#3 and #5) failed to use a gait belt during the transfer. * At 4:10 p.m., while transfering Residnt #19 from the commode both staff members (#3 and #5) again placed their hands under Resident #19's arms and lifted her to a standing position. Resident #19 lost her balance, supported herself by leaning on the arms of the wheelchair, and required staff assistance to sit back down. The staff members (#3 and #5) failed to use a gait belt during the transfer. During an interview on 12/03/24 at 8:15 a.m., an administrative nurse (#1) stated she expected staff to use a gait belt during transfers.	F 689	equipment needed for each resident. CNAs and Nurses were educated via a memo on 12/4/2024 stating they need to use gait belts for all transfers on all residents who are supposed to use a gait belt, and CNAs and Nurses will be educated of this in-person at the mandatory CNA/Nursing meeting on 1/2/2025. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit. - Visual auditing will be completed by the CNA Coordinator and Physical Therapy Director to ensure staff are using a gait belt as appropriate for residents. Audits will be done weekly x 12 weeks, monthly x 3 months and quarterly x 2 quarters. Audit findings will be reported to the Quality Assurance Committee at quarterly QA meetings. 5. Include dates when corrective action will be completed. - At the CNA/Nursing meeting on 1/2/2025.	
F 761	Label/Store Drugs and Biologicals	F 761		1/2/25

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 12/04/2024

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 761 SS=D	Continued From page 17 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. §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 and staff interview, the facility failed to ensure safe and secure storage of medications in 1 of 2 medication/treatment carts observed. Failure to store all medications securely may result in unauthorized access to medications. Findings include:	F 761	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: - No residents were affected by this tag. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	

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 12/04/2024

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 761	Continued From page 18 On 12/02/24 at 11:51 a.m., Observation showed staff nurse (#4) unlock the treatment and walk away to administer insulin. The staff nurse (#4) left the treatment cart unlocked and unattended for five minutes by the nurse's station out of the nurses' view with visitors, staff members, and residents present. During an interview on 12/04/24 at 2:37 p.m., two administrative staff members (#1 and #2) stated, "it is our expectation that the carts be locked when out of sight."	F 761	- All residents have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: - Education was provided to staff via a memo on 12/4/2024 that the medication cart needs to be always locked when it is not in the field-of-vision of the nurse. In-person education will be provided on 1/2/2025 at the mandatory Nursing/CNA meeting. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is not evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit. - Visual audits will be completed by the DON to ensure the medication cart is locked when the nurse is not at the medication cart. Audits will be completed weekly x 12 weeks, monthly x 3 months and quarterly x 2 quarters. Audit findings will be reported to the Quality Assurance Committee quarterly at the quarterly QA meetings.	

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 12/04/2024

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 761	Continued From page 19	F 761	5. Include dates when corrective action will be completed: - On 1/2/2025 at the Nursing/CNA 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: §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 §483.71 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;	F 880		1/2/25

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 12/04/2024

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 880	Continued From page 20 (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. §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: Based on observation, review of facility policy, and staff interview, the facility failed to follow	F 880	1. Address how corrective action will be accomplished for those residents found to	

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 12/04/2024

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 880	Continued From page 21 standards of infection control and prevention for 5 of 12 sampled residents (Resident #8, #10, #17, #19, and #25) observed during cares. Failure to practice infection control standards related to hand hygiene, catheter care, equipment disinfection, and enhanced barrier precautions (EBP) has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene Policy" occurred on 12/04/24. This policy, dated December 2020, stated, ". . . All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors . . . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. . . ." Review of the facility policy titled "Foley Catheter Care Policy" occurred on 12/04/24. This policy, revised October 2022, stated, ". . . to provide catheter care to all residents that have an indwelling catheter to reduce UTIs [urinary tract infections] . . . With a new moistened cloth, wipe the catheter making sure to hold the catheter in place . . ." Review of the facility policy titled "Enhanced Barrier Precautions Policy" occurred on 12/04/24. This policy, revised May 2024, stated, ". . . use of gown and gloves for use during high-risk resident care activities for residents known to be colonized or infected with a MDRO [multidrug-resistant organisms] as well as those	F 880	have been affected by the deficient practice: - Staff educated regarding proper infection control techniques including: hand hygiene, hand hygiene between glove use, catheter cares, peri-cares, equipment disinfection and enhanced barrier precautions for Residents #8, #10, #17, #19 and #25. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: - All residents could be affected by this deficiency. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: - All staff will receive annual infection control training, and training upon hire. Nurses and CNAs will all be educated about proper infection control techniques including: hand hygiene, hand hygiene between glove use, catheter cares, peri-cares, equipment disinfection and enhanced barrier precautions during our mandatory CNA/nursing meeting on 1/2/2025. Education will include policy and procedure review of all areas mentioned above, and review of power-points on hand hygiene and enhanced barrier precautions made by our Infection Preventionist. 4. Indicate how the facility plans to monitor its performance to make sure that	

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 12/04/2024

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 880	Continued From page 22 at increased risk of MDRO acquisition (e.g., [examples] residents with wounds or indwelling medical devices . . . High-contact resident care activities include: . . . Urinary Catheter Care . . . Wound care . . . Dressing, AM [morning] or PM [evening] cares, peri [perineal] cares, transferring. . . ." Review of the facility policy titled, "Mechanical Lift Policy", occurred on 12/04/24. This policy, revised December 2020, stated, ". . . Total body lift . . . disinfect lift after each resident use . . . standing lift . . . disinfect lift after each resident use . . ." - Observation on 12/02/24 at 3:57 p.m. showed two certified nurse aides (CNAs) (#6 and #7) assisted Resident #8 to the bathroom. The CNAs performed perineal cares after a bowel movement, removed their gloves and failed to perform hand hygiene. - Observation on 12/02/24 at 2:59 p.m. showed two CNAs (#6 and #7) transfer Resident #10 to the bathroom. After completing perineal cares, the CNAs removed their gloves and failed to perform hand hygiene. then without cleaning the lift removed it from the room, and placed it in the hallway storage area. - Review of Resident #17's medical record occurred on all days of survey. Diagnosis included history of urinary tract infection. The current care plan stated, ". . . enhanced barrier precautions r/t [related to] placement of indwelling catheter . . ." Observation on 12/02/24 at 11:32 a.m. showed	F 880	solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit. - The CNA Coordinator and DON will include audits of hand hygiene, peri-cares, catheter cares, equipment disinfection, dressing changes and enhanced barrier precautions to ensure staff complete cares properly. Education will be provided as needed at the time of audit. Audits will be completed weekly x 12 weeks, monthly x 3 months and quarterly x 2 quarters. Audit findings will be reported to the Quality Assurance Committee quarterly at the quarterly Quality Assurance Meeting. 5. Include dates when corrective action will be completed: - Corrective action will be completed on 1/2/2025 at the mandatory CNA/Nursing meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. BUILDING _____ B. WING _____	C 12/04/2024

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 880	Continued From page 23	F 880		

an enhanced barrier precaution sign outside of Resident #17's room.

Observation on 12/02/24 at 4:59 p.m. showed two CNAs (#6 and #7) performed hand hygiene, donned gowns and gloves, and entered Resident #17's room to provide catheter and incontinence cares. The CNA (#7) performed perineal cares after a bowel movement and wiped back to front. The CNA (#7) removed her gloves and without performing hand hygiene donned clean gloves, wet a washcloth, cleaned Resident #17's groin area, and with the same cloth wiped the catheter tubing, applied a clean brief, and pulled up the resident's pants. The CNA (#7) removed gloves and performed hand hygiene before exiting the room.

The CNA (#7) failed to perform hand hygiene after removing soiled gloves and donning clean gloves, and failed to use a clean washcloth for cleansing the catheter tubing.

- Review of Resident #19's medical record occurred on all days of survey. Diagnosis included pressure ulcer to coccyx and heel. The current care plan stated, ". . . staff to utilize enhanced barrier precautions per policy . . . stage 3 PU [pressure ulcer] to my coccyx . . ."

Observation on 12/02/24 at 12:02 p.m. showed an enhanced barrier precaution sign outside of Resident #19's room.

Observation on 12/02/24 showed the following:
* At 3:11p.m., two CNAs (#6 and #7) entered Resident #19's room to provide incontinence cares. The CNAs performed hand hygiene,

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 12/04/2024

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 880	Continued From page 24	F 880		

donned gloves, and without donning gowns, performed perineal cares and removed a wound dressing after a bowel movement. The CNAs removed their gloves and without performing hand hygiene, exited the room. The CNAs failed to don gowns when performing high-contact resident cares.
* At 3:50 p.m., two CNAs (#6 and #7) entered Resident #19's room to provide incontinence cares. The CNAs performed hand hygiene, donned gloves, and without donning gowns, performed perineal cares. The CNAs removed their gloves and without performing hand hygiene, exited the room. The CNAs failed to don gowns when performing high-contact resident cares.

- Review of Resident #25's medical record occurred on all days of survey. The current care plan stated, ". . Enhanced Barrier precautions r/t [related to] stasis ulcers to BLE [bilateral lower extremities] . . ."

Observation on 12/02/24 at 11:31 a.m. showed an enhanced barrier precaution sign outside of Resident #25's room.

Observation on 12/03/24 at 9:55 a.m. showed Resident #25 seated in a wheelchair. Two CNAs (#6 and #7) entered Resident 25's room. The CNAs performed hand hygiene and donned gloves, and without donning gowns, assisted the resident with incontinence cares. The CNA (#7) performed bowel movement cares, removed her gloves and without performing hand hygiene, donned new gloves, applied a new brief, pulled up the resident's pants, and assisted the resident to the wheelchair. The CNAs removed their

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 12/04/2024

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 880	Continued From page 25	F 880		

gloves, performed hand hygiene, and exited the room.

Both CNAs failed to wear gowns when performing high-contact resident cares, and the CNA (#7) failed to perform hand hygiene after removing soiled gloves and before donning clean gloves.

Observation on 12/03/24 at 1:13 p.m. showed Resident #25 seated in a wheelchair. A nurse (#3) entered Resident #25's room, performed hand hygiene, donned a gown and gloves, and sat on the floor and performed a dressing change to the resident's bilateral lower extremities. The nurse (#3) removed the soiled dressings from both lower extremities, removed her gloves, and without performing hand hygiene, donned new gloves. The nurse (#3) cleaned the wounds, completed the dressing change, removed her gown and gloves, performed hand hygiene and exited the room.

The nurse (#3) failed to perform hand hygiene after removing soiled gloves and donning clean gloves.

During an interview on 12/04/24 at 08:15 a.m., an administrative nurse (#1) confirmed she expected staff to sanitize lift equipment after each resident use.

During an interview on 12/04/24 at 2:45 p.m., an administrative nurse (#1) confirmed she expected staff to perform hand hygiene after removing soiled gloves and before donning clean gloves, wipe front to back when performing cares involving bowel movements, use clean cloths for