STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1058	A. BUILDING: _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITAT	1515 2ND AVE WEST WILLISTON, ND 58801

(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) COMPLETE DATE
L1810	33-07-03.2-18,1 PHARMACEUTICAL SERVICES The facility shall obtain the services of a licensed pharmacist who shall develop policies and procedures for the provision of pharmaceutical services within the facility consistent with chapter 61-03-02, state laws, and federal laws. These policies and procedures must be approved by medical staff or medical director and governing body and must include provisions for: This State Licensing Rule is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow regulations outlined in Chapter 61-03-02 Consulting Pharmacist Regulations for Long-Term Care Facilities for 1 of 1 Emergency Medication Kit (E-Kit). Failure to remove expired medications may result in residents receiving ineffective medication in an emergency. Findings include: Review of the facility policy titled "Emergency and After Hour Drug Supply" occurred on 12/05/23. This policy, dated June 2022, stated, ". . . 5. The pharmacist shall inspect the emergency medication kit monthly. . ." Review of policy titled "Emergency Pharmacy Service and Emergency Kits" occurred on 12/05/23. This policy, revised October 2022,	L1810	1. Thrifty White Pharmacy and nursing staff educated on the importance of making sure all drugs in the emergency kit are up to date. E kit was updated on 12/05/23. 2. All residents have the potential to be affected. 3. Mandatory All Staff education will be held on January 3rd & January 5th @ 1:30p 2024 to provide education on the importance of making sure all mediations in the emergency kit are up to date. Reviewed policy/procedure titled "Emergency and After Hour Drug Supply" and "Emergency Pharmacy Service and Emergency Kits". 4. DON or designee will monitor emergency kit to make sure emergency kit does not contain any expired medications. Monitoring will be weekly	1/8/24

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

Electronically Signed | 01/02/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1058	A. BUILDING: _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITAT	1515 2ND AVE WEST WILLISTON, ND 58801

(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) COMPLETE DATE
L1810	Continued From page 1 stated, ". . . F. An emergency medication kit may be maintained at a designated area, along with a list of contents. The kit must be properly locked and sealed and must comply with all state and federal requirements. . . ." Observation of the E-Kit occurred on 12/05/23 at 4:45 p.m. with a staff nurse (#3). The medication list on the E-Kit identified medications with an expiration date of 10/31/23. During an interview on 12/05/23 at 5:00 p.m., an administrative nurse (#1) confirmed the E-Kit contained expired medications.	L1810	x4, monthly x3 then quarterly thereafter. If concerns are identified, immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 5. 01/08/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 12/04/23 and concluded 12/07/23.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a bed hold notice to 2 of 5	F 625	1. Social Services staff were educated on the importance of doing bed hold notice	1/8/24

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

Electronically Signed | 01/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 625	Continued From page 1 sampled residents (Residents #15 and #79) reviewed with a hospital transfer. Failure to provide a bed hold notice does not allow the residents and/or their representatives to make an informed decision regarding their rights. Findings include: - Review of Resident #15's medical record occurred on all days of survey and identified a transfer to the hospital on 03/07/23. The record lacked a bed hold notice for the hospital transfer. - Review of Resident #79's medical record occurred on all days of survey and identified a transfer to the hospital on 10/12/23. The record lacked a bed hold notice for the hospital transfer. During an interview on 12/07/23 at 9:05 a.m., an administrative staff member (#2) confirmed Resident #15 and #79's medical records lacked a copy of the bed hold notices.	F 625	for all residents that are transferred to the hospital. This education was for residents #15 and #79 and other residents that may be transferred. 2. All residents have the potential to be affected if they are transferred to a hospital. 3. Mandatory All Staff education will be held on January 3rd & January 5th @ 1:30p 2024 to provide education on the importance of doing bed holds when any resident is transferred to the hospital. Reviewed policy/procedure titled "Bed Hold". 4. Social Service or designee will monitor to ensure that a bed hold notice is given to resident or POA is notified prior to hospital transfers. Monitoring will be weekly x4, monthly x3 then quarterly thereafter. If concerns are identified, immediate corrective action will be implemented. Social Service or designee will report monitoring results to the quarterly QA committee meeting. 5. 01/08/2024	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the	F 644		1/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 644	Continued From page 2 PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASRR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 2 of 4 sampled residents (Resident #2 and Resident #63) reviewed for PASRR. Failure to complete a change in status assessment for a newly diagnosed mental illness may result in the delivery of care and services that are inconsistent with residents' needs. Findings include: The North Dakota PASRR Provider Manual, revised December 2020, page 13, states, ". . . Change in Status Process: Whenever the following events occur, nursing facility staff must contact [the contracted agency] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC [mental illness, intellectual disability, and conditions related to intellectual disability (referred to in	F 644	1. Social Services staff & Medical Records staff were educated on the importance of doing a new PASARR on any resident that has any change in a mental health diagnosis. This education was for residents #2 and #63 and any other resident that has a change in mental health diagnosis. A new PASARR was completed on 12/06/23 for resident #2 and #63. No level 2 was triggered for either resident. 2. All residents have the potential to be affected. 3. Mandatory All Staff education will be held on January 3rd & January 5th @ 1:30p 2024 to provide education on the importance of doing a PASARR for any resident who has a change in a mental health diagnosis. Reviewed policy/procedure titled "PASARR Coordination". 4. Social Service or designee will monitor to ensure that a new PASARR is completed for any resident who has a change in a mental health diagnosis. Monitoring will be weekly x4, monthly x3 then quarterly thereafter. If concerns are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 644	Continued From page 3 regulatory language as related conditions or RC)] was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." - Review of Resident #2's medical record occurred on all days of survey. The record showed an initial PASRR completed on 03/30/01. The resident's diagnosis list identified a new diagnosis of psychotic disorder with delusions due to known physiological condition, dated 08/14/20. The record lacked evidence the facility completed a Level I screening/change in status assessment with the new diagnosis. During an interview on 12/06/23 at 4:00 p.m., an administrative staff member (#2) confirmed the facility failed to submit another PASRR for Resident #2 following the new diagnosis. - Review of Resident #63's medical record occurred on all days of survey and identified a Level I PASARR completed on 05/27/22. The record showed Resident #63 received a new diagnosis of psychotic disorder with hallucinations on 08/15/23. The record lacked evidence the facility completed an updated Level I screening/change in status assessment with the new diagnosis. During an interview on 12/06/23 at 5:16 p.m., an administrative staff member (#2) confirmed the facility failed to submit another PASRR for Resident #63 following the new diagnosis.	F 644	identified, immediate corrective action will be implemented. Social Service or designee will report monitoring results to the quarterly QA committee meeting. 5. 01/08/2024	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		1/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 657	Continued From page 4 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise comprehensive care plans to reflect the current status for 3 of 21 sampled residents (Resident #1, #43, and #89). Failure to review and revise the care plan limited staffs' ability to communicate needs and ensure continuity of care and safety. Findings include:	F 657	1. Nursing staff were educated on the importance of reviewing and revising all care plans to reflect the current status of the resident. This education was for residents #1, #43, and #89 and any other resident who needs care plans updated. Resident #1's care plan was updated on 12/28/23 to include a problem, goal and intervention related to the pressure ulcer. Resident #43's care plan was updated to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 657	Continued From page 5 Review of the facility policy titled "Comprehensive Care Plans" occurred on 12/07/23. This policy, dated August 2022, stated, ". . . develop and implement a comprehensive person-centered care plan for each resident consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. . . . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive assessment and quarterly MDS [Minimum Data Set] assessment. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included a Stage 2 pressure ulcer of the sacral region. A physician's order, dated 11/26/23, stated, "Clean open areas to coccyx and right buttocks with wound cleanser pat dry apply oil emulsion and cover with Mepilex dressing [an adhesive absorbent foam dressing] and monitor every shift and notify MD [medical doctor] if worsen. . . ." Resident #2's care plan lacked a problem, goals, and interventions related to a Stage 2 pressure ulcer of the sacral region. - Review of Resident #43's care plan identified, "I am on Contact precautions [additional precautions for patients known or suspected to be infected with microorganisms] related to [names of several types of bacteria]. . . . I am currently taking antibiotics . . . via PICC line [a type of intravenous catheter]. Date Initiated: 08/04/2023 . . ."	F 657	remove the contact precautions as resident completed antibiotic treatment. Resident #89's care plan was updated to include a problem, goal, and intervention related to oxygen therapy. 2. All residents have the potential to be affected if their care plan is not updated to reflect their current status. 3. Mandatory All Staff education will be held on January 3rd & January 5th @ 1:30p 2024 to provide education on the importance of updating care plans. Reviewed policy/procedure titled "Comprehensive Care Plans." 4. DON or designee will monitor care plans after each comprehensive assessment and quarterly MDS to ensure they are updated to reflect the current status of the resident. Monitoring will be weekly x4, monthly x3 then quarterly thereafter. If concerns are identified, immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 5. 01/08/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 657	Continued From page 6 During an interview on the afternoon of 12/07/23, an administrative staff member (#6) stated the PICC line and contact precautions were discontinued on 08/17/23 after Resident #43's antibiotic course completed. - Review of Resident #89's medical record occurred on all days of survey. Diagnoses included acute respiratory failure [impaired oxygen exchange between the lungs and the blood] with hypoxia [low level of oxygen in the body tissues]. A quarterly MDS, dated 11/24/23, identified oxygen therapy. A physician's order, dated 11/18/23, stated, "Oxygen at 2L/NC [liters per nasal cannula] as needed for sho1tness [sic] of breath, chest pain, hypoxia. May titrate oxygen to keep saturations greater than 90%. Contact MD on initiation of oxygen therapy/current flow rate to obtain continued use and other pertinent orders two times a day." Resident #89's care plan lacked a problem, goals, and interventions related to oxygen therapy use. During an interview on the afternoon of 12/07/23, an administrative staff member (#1) stated they expected staff to update care plans with new diagnoses and orders.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §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	F 686		1/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 686	Continued From page 7 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 record review, review of facility policy, and staff interview, the facility failed to provide the necessary treatment/services to promote the healing of pressure ulcers for 1 of 3 sampled residents (Resident #64) identified with a pressure ulcer. Failure to routinely assess, monitor, and measure pressure ulcers may result in delayed healing of the pressure ulcer. Findings include: Review of the facility policy titled "Pressure Ulcer Management & [and] Surveillance" occurred on 12/07/23. This undated policy stated, ". . . 2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment . . . monitoring the impact of the interventions . . . 4. Interventions for Prevention and to Promote Healing . . . ii. Treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate (if present), presence of pain, signs of infections, wound bed, wound edge and surrounding tissue characteristics. . . ." Review of the facility policy titled "Skin Injury Prevention Guidelines" occurred on 12/07/23. This policy, dated August 2022, stated, ". . . The facility is committed to the prevention of	F 686	1. Nursing staff educated on the importance of making sure to document weekly on any wound specific to the size and appearance. This education was for resident #64 and any other resident that has a wound. Resident #64 has order in medical record to do weekly skin assessments. Also resident #64 has had weekly skin assessments completed x2 since survey. 2. All residents who have a wound have the potential to be affected. 3. Mandatory All Staff education will be held on January 3rd & January 5th @ 1:30p 2024 to provide education on the importance of doing weekly wound skin assessments. Reviewed policy/procedure titled "Pressure Ulcer Management & Surveillance", "Skin Injury Prevention Guidelines", "In-House Wound Care Nurse & Out-Sourced Wound Care Specialist Flow Explanation", "New Skin Issue Check Off List", "Pressure Injury Risk Assessment", "Wound Treatment Management", "Pressure Injury Staging Guide". 4. Wound Nurse or designee will monitor to ensure that all residents with a wound have a weekly skin assessment that includes any wound size and appearance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 686	Continued From page 8 avoidable skin injuries . . . 8. . . . b. For residents who have an injury present: . . . weekly wound summary charting . . ." Review of Resident #64's medical record occurred on all days of survey. The quarterly Minimum Data Set (MDS), dated 10/08/23, identified one unstageable pressure ulcer. A skin assessment, dated 10/04/23, stated, ". . . L [left] 3rd toe Pressure 0.5 x 0.5 [centimeters (cm)] unstageable, r [right] 4th top top [sic] Pressure 0.5 x 0.4 [cm] . . ." Current physician's orders stated, "Daily Dressing Left Foot: Clean left third (3rd) toe with Saline. Apply dry gauze after thin film of BACITRACIN [antibiotic ointment] to TIP third (3rd) toe. Wrap with 3 pieces of gauze around toes 2,3,4 secure with conforming gauze roll, one time a day . . . Apply dry band aid to right fourth (4th) toe, one time a day." Review of the nursing progress notes identified the following: * 10/20/23 at 2:28 p.m., ". . . Pressure ulcer/ injury. Location: Left toe(s). Length (cm): 0.5 Width (cm): 0.5 Peri wound: Normal. Dressing saturation: None 0% [percent]. Wound odor: No. Tunneling: No. Undermining: No. Treatment schedule: Daily. Pressure ulcer staging: Deep tissue pressure ulcer / injury - persistent nonblanchable deep red, maroon or purple discoloration. Painful: No. . . . " * 10/20/23 at 4:39 p.m., "MDS Nursing Noted . . . Clarified with nurse manager that resident has one SDTI [suspected deep tissue injury] to left 3rd toe." * 11/17/23 at 4:31 p.m., ". . . Skin Only Evaluation	F 686	Monitoring will be weekly x4, monthly x3 then quarterly thereafter. If concerns are identified, immediate corrective action will be implemented. Wound Nurse or designee will report monitoring results to the quarterly QA committee meeting. 5. 01/08/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 686	Continued From page 9 . . . Issue type: Pressure ulcer/ injury. Location: Left toe(s). Length (cm): 1 Width (cm): 0.8 Wound bed: Epithelial. Wound exudate: None. Wound odor: No. Tunneling: No. Treatment schedule: Daily. Pressure ulcer staging: Unstageable pressure ulcer / injury - obscured full thickness skin and tissue loss. Painful: No. Skin note: area to front of 3rd left toe unblanching and appears as a callous. podiatry following . . . ." The facility failed to document the wound size and appearance during the week between October 4-20 and the three weeks between October 20-November 17, 2023. During an interview on 12/06/23 at 10:37 a.m., an administrative nurse (#1) confirmed the medical record lacked weekly documentation of measurement and monitoring of Resident #64's toe ulcer.	F 686		
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---	F 758		1/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 758	Continued From page 10 §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; §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, review of facility policy, and staff interview, the facility failed to ensure residents remained free from unnecessary psychotropic medications for 1 of 3 sampled	F 758	1. Nursing staff educated on the importance of making sure residents remained free from unnecessary PRN psychotropic medications. This education	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 758	Continued From page 11 resident (Resident #9) who received an as needed (PRN) psychotropic. Failure to limit PRN psychotropic use to 14 days unless reevaluated by a practitioner placed the resident as risk of receiving unnecessary medications and experiencing adverse drug effects. Findings include: Review of the facility policy titled "PRN Orders for Phsychotropic [sic] Medications" occurred on 12/07/23. This policy, dated August 2022, stated, ". . . PRN orders for psychotropic drugs will be limited to 14 days. The attending physician or prescribing practitioner may extend the duration of the order . . . beyond 14 days provided their rationale is documented in the resident's medical record and duration for the PRN order is specified. . . . ." Review of Resident #9's medical record occurred on all days of survey. A physician's order, dated 07/25/23, included Ativan (antianxiety) 0.5 milligrams every twelve hours PRN. The facility failed to obtain an order to extend the psychotropic medication beyond the original 14 days and failed to include the rationale/specific circumstances for its extended use and a stop date established by the prescriber. During an interview on 12/06/23 at 10:37 a.m., an administrative nurse (#1) confirmed the facility failed to obtain a new order for the extended use of Resident #9's Ativan.	F 758	was for resident #9 and any other resident on an unnecessary PRN psychotropic medication. Resident #9's psychotropic medication Lorazepam was discontinued on 12/13/2023. 2. All residents who are on a PRN psychotropic medication have the potential to be affected. 3. Mandatory All Staff education will be held on January 3rd & January 5th @ 1:30p 2024 to provide education on the importance of making sure any resident who is on a PRN psychotropic medication does not go beyond 14 days unless it is re-evaluated by a provider and the provider believes that it is appropriate for the PRN order to be extended beyond those 14 days. Reviewed policy/procedure titled "PRN orders for Psychotropic Medications". 4. DON or designee will monitor those residents on a PRN psychotropic medication to ensure that they do not go beyond 14 days unless stated by provider that it is appropriate. Monitoring will be weekly x4, monthly x3 then quarterly thereafter. If concerns are identified, immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 5. 01/08/2024	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		1/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 12 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 review of facility policy, the facility failed to ensure safe and secure storage of narcotic medications for 2 of 4 medication carts (Harmony and Wheatland Units). Failure to store medications securely may result in unauthorized access to medications and/or medication errors. Findings include: Review of the facility policy titled "Controlled Medication Storage" occurred on 12/06/23. This	F 761	1. Nursing staff were educated on the importance of making sure all controlled drugs listed in schedule II-V are separately locked in a permanently affixed compartment. This education was specific to Harmony & Wheatland nurses. On this date 12/07/23 all schedule II-V narcotic medications were moved to the permanently secured separate lock box in the medication cart. 2. All residents have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 13 policy, dated August 2022, stated, ". . . B. Scheduled II medications are stored in a separate area under double lock. . ." Observation on 12/05/23 at 8:22 a.m. showed a staff nurse (#4) assigned to the medication cart for the Harmony Unit showed narcotics/controlled medications (Schedule II-V), located in the bottom left-hand drawer not double locked. Observation on 12/05/23 at 4:10 p.m. showed a staff nurse (#5) assigned to the medication cart for the Wheatland Unit showed narcotics/controlled medications (Schedule II-V), located in the bottom left-hand drawer not double locked.	F 761	3. Mandatory All Staff education will be held on January 3rd & January 5th @ 1:30p 2024 to provide education on the importance of making sure all scheduled II-V controlled narcotic medications are locked in a separate permanent affixed box. Also reviewed policy/procedure titled "Controlled Medication Storage". 4. DON or designee will monitor all mediation carts to ensure all scheduled II-V controlled narcotic medications are locked in a separate permanent affixed lock box. Monitoring will be weekly x4, monthly x3 then quarterly thereafter. If concerns are identified, immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 5. 01/08/2024	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in	F 849		1/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 849	Continued From page 14 paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 849	Continued From page 15 (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 849	Continued From page 16 §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient.	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 849	Continued From page 17 (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure residents records contained the hospice election form and the certification of a terminal illness for 1of 1 supplemental resident (Resident #74) receiving hospice services. Failure to obtain these documents limits staff's ability to ensure coordination of care between the facility and the hospice. Findings include: Review of Resident #74's medical record	F 849	1. Nursing staff and medical records were educated on the importance of making sure that a resident who is on hospice has the hospice election form and the certification of terminal illness in the resident's chart. This education is for resident #74 and any other resident who is on hospice. For resident #74 the hospice election form and the certification of terminal illness was scanned into the resident chart on 12/07/23. 2. Any resident on hospice has the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 849	Continued From page 18 occurred on 12/06/23 and identified Resident #74 elected Hospices services on 11/07/23. The medical record lacked the hospice election form and the physician's certification of the terminal illness. During an interview on 12/07/23 at 7:50 a.m., an administrative nurse (#1) confirmed the medical record for Resident #74 lacked the certification of terminal illness and the hospice election form.	F 849	3. Mandatory All Staff education will be held on January 3rd & January 5th @ 1:30p 2024 to provide education on the importance of the hospice election form and certification of terminal illness being in resident's chart. Reviewed policies/procedures titled "Coordination of Hospice Services", "Hospice Services Facility Agreement", "Providing End of Life Care", "Hospice Admission & Community of Care Flow Sheet/Checklist". New policies have been established to support the already in place Hospice Contract in order to be compliant with F899. 4. DON or designee will monitor all residents on hospice to make sure residents chart contains hospice election form and certification of terminal illness. Monitoring will be weekly x4, monthly x3 then quarterly thereafter. If concerns are identified, immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 5. 01/08/2024	
F 880 SS=D	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	F 880		1/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 19 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 §483.70(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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 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 standards of infection control for 3 of 6 sampled residents (Resident #32, #43 and #54) on precautions. Failure to practice infection control standards related to use of personal protective equipment (PPE) and perineal cares has the potential to spread infection throughout the facility. Findings Include: PERSONAL PROTECTIVE EQUIPMENT - Observation on 12/05/23 at 9:16 a.m. showed a sign outside Resident #43's room door that stated, "Entering the room: Hand hygiene with sanitizer; Isolation gown; Use N-95 [type of	F 880	1. Nursing staff were educated on the importance of following infection control standards related to the use of personal protective equipment and the difference between enhanced barrier and contact precautions and also educated on proper perineal care. This education was for residents #32, #43 and #54 and any other resident who has the potential to be affected. 2. Any resident who is on any isolation precaution or requires perineal care has the potential to be affected. 3. Mandatory All Staff education will be held on January 3rd & January 5th @ 1:30p 2024 to provide education on the importance of doing perineal care correctly and the difference between	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 mask]; Place tear away goggles on; gloves; enter room. . . ." Observation showed two certified nurse aides (CNAs) (#12 and #13) entered Resident #43's room without an isolation gown, N-95 mask, or goggles. Staff failed to wear PPE upon entering Resident #43's room. - An Enhanced Barrier Precaution sign outside Resident #54's room door stated, "EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing; Bathing/Showering; Transferring; Changing Linens; Providing Hygiene; Changing briefs or assisting with toileting; Device care or use: central line, urinary catheter, feeding tube, tracheostomy; Wound Care: any skin opening requiring dressing." Observation on 12/05/23 at 11:20 a.m. showed a CNA (#7) performed hand hygiene, donned a gown and gloves, entered Resident #54's room, and provided morning cares. A second CNA (#8) entered the room and wore a gown, gloves, and a surgical mask. After the CNAs dressed Resident #54, the CNA (#7) removed all PPE and assisted the other CNA (#8) to transfer the resident from the bed to the wheelchair with a mechanical lift. The CNA (#7) performed hand hygiene, donned gloves, and then shaved and performed oral cares for Resident #54. Staff failed to use the appropriate PPE while providing care to Resident #54.	F 880	enhanced barrier precautions and contact precautions. Visual aides and facility signage were provided to all nursing staff. Reviewed policy/procedure titled "Perineal care", "Personal Protective Equipment Policy", "Enhanced Barrier Precautions", "Transmission Based Precautions Infection Control". 4. Infection Preventionist or designee will monitor to ensure enhanced barrier precautions and transmission-based precaution are being followed correctly when doing resident care. Also Infection Preventionist or designee will monitor those residents requiring perineal care to ensure it is done correctly. Monitoring will be weekly x4, monthly x3 then quarterly thereafter. If concerns are identified, immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 5. 01/08/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING _____ B. WING _____	12/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	**1515 2ND AVE WEST WILLISTON, ND 58801**

(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 During an interview on 12/07/23 at 9:15 a.m., two administrative nurses (#1 and #6) stated they expected staff to use appropriate PPE in rooms requiring enhanced barrier precautions. PERINEAL CARE Review of the facility policy titled "Perineal Care" occurred on 12/07/23. This policy, revised January 2022, stated, ". . . Males . . . Begin cleansing tip of penis at urethral meatus using a circular motion and working outward . . . Cleanse the shaft of the penis, using downward strokes toward the scrotum. . . ." Observation on 12/05/23 at 10:18 a.m. showed a CNA (#11) performed Resident #32's perineal cares while in bed. The CNA (#11) used a washcloth to cleanse the shaft of the penis, used upward strokes, and then cleansed the penis tip. During an interview on 12/07/23 at 10:16 a.m., an administrative nurse (#1) stated she expects staff to provide male perineal cares clean to dirty (tip of penis first).	F 880		