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 _____	09/15/2011

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 For the standard Medicare/Medicaid recertification survey started on 09/12/11 and completed on 09/15/11, the sample included five residents for complete review, 16 residents for focused review, and three closed records for review. The sample included four additional residents to verify specific concerns during the survey.	F 000		
F 157 SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	**F157** Correction: Please correct page 4 paragraph 3 date. The correct date is 01/17/11 not 09/17/11. 1. Licensed Nursing staff responsible for notification of the physician(s) for resident #7, #8, #9, and #12 have been informed of the deficient practice and re-educate on need to notify the physician and documentation. 2. Any resident has the potential to be affected. 3. Mandatory Nursing Staff in-services have been/will be conducted to re-educated staff on when to notify resident's physician, legal representative, or an interested family member when there is an accident, significant change, or a need to alter treatment. The Policy and Procedure for "Physician Notification" and "Guidelines for Physician Notification" have been reviewed and staff educated on the policy. Dates of in-services were/are September 20, 22, 2011 and October 11, 12, and 13, 2011. Laminated copies of the "Guidelines for Notification" have been placed on each of the neighborhoods for Licensed Staff to have for reference. These guidelines were reviewed with the Medical Director on October 13, 2011 for approval. 4. The Neighborhood Nurse Manager (or designee) will be responsible to monitor physician notification of resident changes/accidents/incidents. Monitoring	10/20/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10-14-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	09/15/2011

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 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the resident's physician for 4 of 15 sampled residents (Resident #7, #8, #9, and #12) who had a history of falls in the facility. Failure to notify the physician of the resident's falls did not allow the physician the opportunity to provide immediate treatment. Findings include: Review of the facility policy titled "Physician Notification" occurred on 09/15/11. This policy, dated 2006, stated, "Procedure: 1. The physician must be informed by the licensed nursing staff person in the following circumstances. 1.1 Accident involving the resident which results in injury and has the potential for requiring physician intervention . . . 2. Document date and time physician notified in resident medical record . . ." The facility's "Guidelines for Physician Notification" defined when the resident's physician should be notified as follows: * Immediate: Notify the attending or on-call physician as soon as possible. * Non-immediate: Notify the attending or on-call physician no later than the next office day. * Routine: Notify the attending or on-call physician at the next regular visit or phone conversation. The guidelines regarding a resident fall identified	F 157	will include review of twenty four hour report sheets, interview of staff and review of accident/incident report forms to view compliance of policy and procedure. Monitoring will be conducted weekly for three months. Results of monitoring will be conducted weekly for three months. Results of monitoring will be reported to DON. The DON will report to the QA Committee monthly for three months. 5. October 20, 2011	

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 _____	09/15/2011

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 157	Continued From page 2 the following: * Immediate: With any suspected serious injury such as fractures, any hip pain, or more than minor pain elsewhere. * Non-immediate: Fall with only insignificant injury. * Routine: Number of falls the resident experienced since last visit. - Review of Resident #12's medical record occurred on September 13-15, 2011. Diagnoses included dementia, hemiplegia (weakness to one side of the body), and seizure disorder. Review of Resident #12's progress notes identified the following: * 08/06/11 at 4:20 p.m. - "Res. [resident] was being toileted. Staff outside Res bathroom. Staff heard a thump. Staff checked and found res on floor . . . lying on her back. Hematoma noted to Lt [left] upper eye and skin tear. Bruising noted to Lt side of face . . ." * 08/07/11 at 6:00 a.m. "Lt eye swollen shut purple in color . . ." * 08/23/11 at 11:10 a.m. "Concern brought forward from another dept. [department] staff whether or not [physician name] was notified of res fall on 08/06/11 . . ." During an interview on 09/14/11 at 9:15 a.m., an administrative nurse (#1) stated facility staff failed to notify Resident #12's physician in a timely manner regarding her fall on 08/06/11. - Review of Resident #9's medical record occurred on September 13-15, 2011. Diagnoses included senile dementia, Alzheimer's disease, osteoarthrosis, and osteoporosis.	F 157		

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 _____	09/15/2011

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 157	Continued From page 3	F 157		

Review of Resident #9's progress notes identified the following:
* 01/14/11 at 5:20 p.m. - "CNA [certified nurse aide] was pushing resident to supper and resident tumbled forward out of w/chair [wheelchair]. Fell forward onto face, breaking glasses, gashing forehead pupils small reactive. Hand and legs weak. . . ."
* 01/14/11 at 6:00 p.m. "Pupils dilated. Son notified . . ."
* 01/17/11 at 6:00 p.m. "Received T.O. [telephone order] from [health care professional] to use soap [and] [water] to wound on forehead and to watch it."

An "Accident/Incident Report," dated 01/14/11, identified treatment as "First aid in facility." This same report identified a wound above the right eye "2.5 x 1" and below the right eye of "5 x 2.7." The nurse completing the form failed to identify centimeters or inches.

The progress notes following the fall, and the incident report, failed to identify facility staff notified Resident #9's physician prior to the telephone order of 09/17/11, three days later. The facility failed to notify the physician in a timely manner to obtain treatment for the "gashing" wound.

During an interview on the afternoon of 09/14/11, an administrative nurse (#17) identified facility staff failed to notify Resident #9's physician in a timely manner regarding his fall of 01/14/11.

- Resident #7's medical record, reviewed September 12-15, 2011, identified diagnoses

Per telephone conversation w Kurt Stoner on 10/31/11 @ 2:50 pm
09/17/11 Changed to 01/17/11
K Berchin

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 _____	09/15/2011

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 157	Continued From page 4 including dementia, anxiety, panic disorder, insomnia, and history of falls. The Interdisciplinary Progress Notes identified the following: * 12/18/10 at 1:30 p.m., ". . . heard her calling was noted sitting on floor leaning against bed. Legs wrapped in blankets. . . . Bruise 3 cm [centimeter] x 3 cm on rt [right] knee - daughter [Name] visited and informed of fall. . . ." * 02/03/11 at 3:10 a.m., ". . . resident laying on Rt side, walker next to her . . . 7 cm x 6 cm x 5 deep bump on back of head . . . c/o [complains of] pain in head when moving . . . ice applied to hematoma . . . remains confused and disoriented . . ." * 03/18/11 at 6:15 a.m., ". . . Noted to be lying on floor with walker on top of her. Stated I fell [and] hit my head. . . . 2 cm x 2 cm bruise back of head tender to touch. . . ." * 04/15/11 at 12:00 p.m., ". . . Resident found on floor by staff [at] 5:45. . . . Resident laying [with] head on floor [and] legs extended out . . . 2.5 cm skin tear noted on Lt [left] wrist, 0.8 cm skin tear noted on Rt elbow . . ." * 06/28/11 at 5:15 p.m., ". . . Resident on the floor by bedside stand in room. . . . Small skin tear noted to left hand. Cleansed and steri strips applied. . . ." * 07/30/11 at 2:45 p.m., ". . . Staff was putting the foot rest down when the resident slid out of the lounge chair. . . . At 7:00 staff found 3 bruises on Rt arm that are purple. Size of 1 x 1.5 inches on top of hand. Forearm 1.5 x 1.8 inches [and] 2 x 1 inches. Dark purple. . . ." * 08/28/11 at 4:00 p.m., "In room on floor. . . . Found on left side with face on gray mat at 11:00. Bruise above left eye 1 x 1 cm and 0.5 x 0.6 cm.	F 157		

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 _____	09/15/2011

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 157	Continued From page 5 Bruise on left hand 7.3 x 4 cm. . . ." The "Accident/Incident Reports," dated 12/18/11, 02/03/11, 03/18/11, 04/15/11, 06/28/11, 07/30/11, and 08/28/11, identified the facility failed to notify the physician of the resident's falls and subsequent head injuries, bruises, and skin tears. - Resident #8's medical record, reviewed September 12-15, 2011, identified diagnoses including severe Parkinson's Disease and history of falls. The Interdisciplinary Progress Note, dated 06/24/11, stated, "Called to rm [room], small toe lt [left] foot bleeding. Cleansed [with] soap [and] water, noted toe nail missing. Staff report res [resident] leaning way out of bed so lifted by [two] [and] gait belt to chair. [Question] hit foot on chair so toe nail got pulled off. Family notified of same. . . ." An "Accident/Incident Report," dated 06/24/11, identified the facility failed to notify the physician of the resident's injury. During an interview on 09/15/11 at 09:50 a.m., an administrative nurse (#1) stated, "If [the resident is] injured, staff are expected to call the primary or on-call physician. If it's a non-emergency, staff would call the next day during working hours. If [the resident has] a bruise or skin tear, they would call the next day also."	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of	F 221	F221	10/20/11

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 _____	09/15/2011

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 221	Continued From page 6 discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, professional reference, facility policy, and staff interview, the facility failed to recognize the use of a one piece garment with a zipper in the back as a restraint for 1 of 1 sampled resident (Resident #4). This device limited the resident's normal access to her own body and was used to control a behavior. Failure to identify the one piece outfit as a restraint resulted in the lack of a physician order before using the device, and resulted in the lack of adequate monitoring, ongoing assessment, care planning, and evaluation required for restraint use. Findings include: The Center for Medicare and Medicaid Services (CMS) state, "Physical Restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Review of a facility policy titled "Use of Physical Restraints" occurred on 09/15/11. This policy, dated 05/07, stated, ". . . Evaluation for Restraint Use: 1.1 Licensed Staff will identify a need for restraint use or possible alternative . . . 2.1 Social Services shall receive written consent for restraint use from resident or representative when a restraint is	F 221	1. An assessment for assistance devices/restraint reduction was completed for Resident #4 and the care plan updated on September 19, 2011. During the assessment period the resident utilized the one piece garment only two days out of the seven day period. No attempts were made by the resident to remove the one piece garment during the two days that she wore the one piece garment. A physician order has been obtained for the use of the one piece garment. Resident #4 's care plan and group sheets have been updated to include this one piece garment as an intervention for disrobing. The resident treatment record has been updated to have the one piece garment documented when utilized as an approach for when exhibiting signs of disrobing. 2. Any resident who requires the use of a restraint has the potential to be affected. 3. Mandatory nursing in-service has been/will be conducted to re-educated staff on what constitutes a physical restraint, when to completed the assessment and required documentation. Date of in-services were/are September 20, 22, 2011 and October 11, 12, and 13, 2011. The policy and procedure for use of Physical Restraints, Consent for Physical restraint Use, and Assistance Device/Restraint Reduction Assessment for were reviewed and revised as needed. 4. Neighborhood Nurse Manager (or designee) will monitor on a weekly basis restraint devices utilized on their perspective Neighborhood to assure compliance with BLNRC policy and procedure. These devices will be discussed at the Restraint Review meetings. Restraint Review meetings are held at least twice a month. Monitoring results will be reported to the DON.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	09/15/2011

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 221	Continued From page 7 deemed medically necessary . . . 2.2 Nursing will obtain physician order specifying type, duration. and reason for restraint use . . . 2.5 Resident's medical record will reflect: 2.5.1 Medical symptoms requiring restraint use. 2.5.2 Use of alternative restraints 2.5.3 Use of least restraint device . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia with aggressive behavioral disturbance, anxiety, and depression. A review of Resident #4's Minimum Data Sets (MDSs), dated 08/05/10, 05/04/11, and 08/04/11, identified the resident experienced long and short term memory deficits. The MDSs reviewed failed to indicate the use of a restraint. A review of Resident #4's current care plan failed to provide any information regarding the use of a one piece garment with a zipper on the back. The Interdisciplinary Progress Notes for Resident #4 lacked any documentation related to the use of the one piece garment such as an assessment, a physician order, date started, or any monitoring. Observation on all days of survey showed Resident #4 dressed in a one piece garment with a zipper on the back. Observation on 09/13/11 at 10:15 a.m., showed a certified nursing assistant (CNA) (#13) unzipped Resident #4's garment and assisted her to sit on the toilet. During an observation of personal care on 09/14/11 at 8:50 a.m., a CNA (#14) zipped	F 221	DON will report monthly to the QA Committee for three months. 5. October 20, 2011	

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 _____	09/15/2011

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 221	Continued From page 8 Resident #4's one piece garment closed. When asked about the use of the garment, a CNA (#14) reported the resident can not remove the garment by herself. The CNA reported the resident has a history of "disrobing." During an interview on 09/14/11 at 11:40 p.m., when asked about the use of the one piece garment for Resident #4, a social services staff member (#15) lacked information as to when the resident started wearing the garment. The social services staff member (#15) stated "she came from [the name of a nursing home] with the one piece outfits." When asked if the resident can remove the garment the staff member stated "no." During an interview on 09/14/11 at 1:45 p.m., a staff nurse (#16) stated the resident was admitted with the one piece garment and used it for a time, "but I don't know when it was started again."	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	F 225	F225 1. Resident # 13's October 3, 2010 injury of unknown origin was investigated. Staff questioned were unable to remember specific events. Resident #13 had been transferred as per care plan (assist lift with 2 staff members). No reported history of falls were noted prior to recognition of injury. The resident is not interviewable due to cognition. 2. Any resident has potential to be affected.	10/20/11

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 _____	09/15/2011

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 225	Continued From page 9 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 record review, policy and procedure review, and staff interview, the facility failed to investigate an injury of unknown origin for 1 of 1 sampled resident (Resident #13) with joint pain, swelling, and redness of unknown origin. Failure to investigate injuries of unknown origin and report these immediately to the administrator and to other officials in accordance with State law, does not allow the facility to determine causative factors of the injury and has the potential to place residents at risk for potential mistreatment, neglect, or abuse.	F 225	3. Mandatory Nursing Staff in-services have been/will be conducted to re-educate staff on requirements of F-tag 225 with emphasis on injuries of unknown source and policy and procedures of Abuse Prohibition, Abuse Reporting, and Abuse and Neglect. Nursing staff (licensed nursing and certified nursing assistants) were educated to document concerns, injuries, and/or changes in resident condition. Dates of in-services September 20 and 22, 2011 and October 11, 12, 13, 2011. Upon hire and annually each staff member completes a Healthcare Academy course on abuse. Policy and Procedures for Abuse and Neglect, Abuse Reporting, and Abuse Prohibition were reviewed and updated on October 1, 2011. The Accident/Incident report and twenty four hour report sheet were updated to provide cues to staff on what needs to be reported to Administrator/DON. The twenty four hour sheet is then brought to morning report Monday through Friday to review resident issues/concerns with all disciplines including Administrator and DON. 4. The DON will review all Accident/Incident reports and 24 hour report sheets for injuries of unknown source and possible abuse/neglect. Any injuries of unknown source (as defined in the State Manual) and abuse/neglect will be reported to the NDSHD. The Administrator will review investigation results and note the course of action as needed. The DON will report any investigative actions to the QA Committee. 5. October 20, 2011	

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 _____	09/15/2011

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 225	Continued From page 10 Findings include: Review of the facility policy titled "Abuse Investigation" occurred on 09/15/11. This policy, revised February 2007, stated, "Policy Statement: All reports of resident abuse, neglect, misappropriation of resident property, and injuries of an unknown source shall be promptly and thoroughly investigated. Policy Interpretation and Implementation: 1. When an incident or suspected incident of resident abuse, neglect, misappropriation of resident property, or injury of an unknown source is reported, the administrator will appoint a staff member to investigate the incident. 2. The administrator will provide to the person in charge of the investigation a copy of the Resident Incident Report Form and any supporting documents relative to the incident. . . ." Review of the facility policy titled "Abuse Reporting" occurred on 09/15/11. This policy, revised February 2007, stated, "Policy Statement: All personnel must promptly report any incident or suspected incident of resident abuse, including injuries of an unknown source and misappropriation of resident property . . . Policy Interpretation and Implementation . . . 2. The person(s) observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the charge nurse, the Director of Nursing and the Administrator or designee . . . 3. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident:	F 225		

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 _____	09/15/2011

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 225	Continued From page 11 a. State Licensing and Certification Agency (immediately) . . . 5. The charge nurse must complete an Incident Report Form. 6. A completed copy of the Incident Report Form and written statements from witnesses, if any, must be provided to the administrator within twenty-four hours of the occurrence of such incident . . . 7. The Administrator will notify the State Licensing and Certification Agency of the results of the investigation within five working days of the incident. . . ." - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included history of a cerebrovascular accident with right-sided hemiparesis (muscle weakness on one side of the body), blindness, chronic pain, depression, and dementia. An annual Minimum Data Set (MDS), dated 08/25/11, identified Resident #13 with a Brief Interview for Mental Status (BIMS) score of 2, indicating severely impaired cognition and showed the resident required total assistance of two or more staff members for bed mobility, transfers, dressing, toileting, and personal hygiene. Review of Interdisciplinary Progress Notes for Resident #13 identified the following: *10/03/10 at 10:15 a.m. - "Call placed to ER [emergency room] DR [doctor]. Received T/O [telephone order] to send resident to ER. Resident screaming and crying when Rt [right] arm or Rt leg moved. Rt foot swollen, right hand [and] wrist swollen. Two reddened areas to upper wrist noted 2.5 cm [centimeters] X [by] 1 cm X 2.5 cm X 1 cm. [Name of Power of Attorney (POA)]	F 225		

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 _____	09/15/2011

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 225	Continued From page 12 informed of sending resident to ER. Resident to ER @ [at] 1030 [a.m.] via Bethel bus [with] [name of family members]." *10/03/10 at 1:15 p.m. - "Return from ER [with] [name of family members] via Bethel bus. [Right] wrist [and] ankle swelling, probably the result of a sprain . . . Nurse gave resident Tylenol 650 mg [milligrams] . . . spoke [with] [Name of resident's POA]. Resident put to bed when return." A physician's note from Resident #13's 10/03/10 ER visit, stated, "Assessment: [Right] wrist [and] ankle swelling, probably the result of a sprain. Plan: Tylenol . . . as needed for pain, Elevate [Right] hand [and] foot as able, Recheck in clinic if not improving or worsening." During an interview on 09/14/11 at 11:30 a.m., an administrative nurse (#1) stated she lacked awareness of Resident #13's injury, identified on 10/03/10, and confirmed the facility failed to complete an incident report and investigation of the unknown injury.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to provide assistance for 2 of 2 sampled residents (Resident #17 and #18) and 1 supplemental resident (Resident #28) in the	F 241	F241 1. Resident # 28 was moved to an assist table, resident wheelchair footrests are to be moved to the side to allow resident to be positioned appropriate to table to	10/20/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	09/15/2011

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 241	Continued From page 13 Wheatland dining room observed eating their meal with their fingers. This facility practice failed to enhance each resident's dignity, self esteem, or self worth. Findings include: - Observation on 09/13/11 at 11:55 a.m. showed Resident #17 positioned at arm's length from the dining room table and eating her mashed potatoes with her fingers. As mashed potatoes dropped onto her clothing protector, the resident picked them off and placed them in her mouth. Observation showed facility staff in the dining room but no one assisted or cued Resident #17. - Observation on 09/13/11 at 5:30 p.m. showed Resident #28 positioned at arm's length from the dining room table and her silverware next to her plate. The resident ate her entire meal, which included chicken salad on tomato pieces and diced cooked carrots, with her fingers. Observation showed facility staff in the dining room but no one assisted or cued Resident #28. - Observation on 09/14/11 at 7:50 a.m. showed Resident #18 positioned at arm's length from the dining room table. The resident held a bowl of Rice Krispies cereal next to her body as she spooned them into her mouth. Observation showed her clothing protector saturated with liquid and covered with cereal. Observation showed facility staff in the dining room but no one assisted or provided a clean clothing protector for Resident #18. - Observation on 09/14/11 at 11:55 a.m. showed Resident #18 held a cup of fruit cocktail next to	F 241	be positioned appropriate to table to allow easy access to meal tray. Care plan and group sheets were updated on 09/16/11. Occupational Therapy screening was completed on 09/20/11. Resident #17 was moved to an assist table. Resident wheelchair footrests are to be moved to the side to allow resident to be positioned appropriately to table to allow easy access to meal tray. Care plan and group sheets were updated on 9/16/11. Resident #18 hemitray is adjusted at meal time to go over the top of the table to allow the resident to be positioned correctly at the table. Care plan and group sheets were updated on 09/16/11. Occupational therapy screening was completed on 09/20/11. Dietitian is presently evaluating a trial of finger foods for the resident. It is and has been this resident's preference to use her hands/fingers rather than utensils at mealtime and she has refused finger foods in the past. 2. Any resident has the potential to be affected. 3. Mandatory nursing staff in-service has been /will be conducted to re-educate staff on F tag 241 Dignity of the Resident. Dates of in-services were/are September 20 and 22, 2011 and October 11, 12 and 13, 2011. 4. The Neighborhood Nurse Manager (or designee) will be responsible to monitor provision of assistance for residents in the dining room. Monitoring will include proper positioning of the resident, appropriate use or need of assistive devices, proper assistance given as required (cueing, set up help, and/or actual assistance with meal) and interactions between resident/staff. Monitoring will be conducted weekly for	

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 _____	09/15/2011

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 241	Continued From page 14 her body and attempted to eat it but dropped it onto her clothing protector and then onto the floor. Observation showed facility staff in the dining room but no one assisted Resident #18, provided a clean clothing protector, or provided her with another cup of fruit cocktail. During an interview on 09/14/11 at 9:15 a.m., an administrative nurse (#1) stated she expected facility staff to assist residents as needed.	F 241	three months. Results of monitoring will be reported to the DON. The DON will report to QA Committee monthly for three months. 5. October 20, 2011	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's Infection Control Log, review of facility policy and procedure, and staff interview, the facility failed to provide a clean and homelike environment regarding cleanliness of fans and bathroom exhaust vents on 5 of 5 resident care units (Harmony, Legacy, Wheatland, Pine View, and Horizon Towers), fans and vents in 4 of 4 laundry areas (Harmony, Legacy, Wheatland, and Main Laundry), missing wallpaper in 1 of 1 special care unit (Pine View), and cracked/missing wall plaster on 1 of 5 resident care units (Wheatland). Failure to clean the fans and vents creates a source of airborne material which places residents, staff, and visitors at risk of inhaling. Failure to report missing wallpaper and cracked/missing wall plaster to the appropriate facility staff limited the facility's ability to repair these areas and maintain	F 253	**F253** 1. There were no specific residents identified in this deficiency. 2. All resident neighborhoods have the potential to be affected. 3. A work order was completed to repair the wall paper on the Pine View Neighborhood. All fans and vents with accumulation of dust and debris have been cleaned. The areas of cracked/missing wall plaster have been reported for repair and are in the process of being repaired. 4. The TELS system (Direct Supply) is currently utilized to identify preventative maintenance work to be completed. The program can be updated to meet the needs of our facility. The maintenance supervisor will monitor the progress/corrective action taken for work orders. Results of the preventative maintenance conducted will be reported to the QA Committee monthly for 3 months by the maintenance supervisor. Quarterly reports will then be submitted. 5. October 20, 2011	**10/20/11**

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 _____	09/15/2011

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 253	Continued From page 15 a homelike environment. Findings include: Review of the facility's policy and procedure, Dusting, occurred on 09/15/11. This document, dated March 2010, stated "POLICY . . . accumulated dust can soil clothing as well as irritate eyes and lungs. . . ." During the initial facility tour, on 09/12/11 at approximately 2:00 p.m., a supervisory nursing staff member (#31) reported several residents in the Horizon Towers unit had recently demonstrated upper respiratory illness symptoms, including coughing, sneezing, and sinus drainage. During the initial facility tour, on 09/12/11 at approximately 2:00 p.m., observation identified the following resident room fans and resident bathroom exhaust vents with heavy accumulations of dust and debris: *Legacy - fans - Room 26 and 30. - vents - Room 6, 7, 12, and 13. *Harmony - vents - Room 12, 14, 22, and 23. *Wheatland - fan - Room 9 *Horizon Towers - fans - Room 310, 312, and 406. During the facility environment tour, on 09/14/11 at 10:00 a.m., a supervisory environmental services staff member (#34) and a supervisory maintenance department staff member (#35) confirmed the observations from the initial tour. During the tour, staff member (#34) reported the fans and vents are not on a cleaning schedule, are cleaned "as needed," and the staff member	F 253		

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 _____	09/15/2011

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 253	Continued From page 16	F 253		

was uncertain when the vents and fans were last cleaned. In addition, observation during the facility environment tour identified the following:
*Fans with accumulated dust and debris
- Horizon Towers - Fourth Floor Resident Lounge and Second Floor Dining Room.
- Pine View - Resident Lounge
- Resident laundry areas - Harmony, Legacy, and Wheatland.
*Vents with accumulated dust and debris
- Pine View - tub room
- Main laundry
*Missing wallpaper
- Pine View Dining Room - generally rectangular area measuring 40 inches long and 27 inches high beginning at the top of the baseboard. The staff members (#34) and (#35) reported they were unaware of the missing wallpaper and it was not reported to them for repair.
*Cracked/missing wall plaster
- Wheatland, Room 1 bathroom - the wall behind the toilet showed a diagonal crack from approximately 24 inches above the floor to the baseboard. The wall between the crack and baseboard showed bulging and approximately three inches by six inches of missing plaster. The staff members (#34) and (#35) reported they were unaware of this wall and the missing wallpaper in the Pine View Dining Room, and these items were not reported to them for repair.

Review of the facility's Infection Control Log occurred in the morning on 09/15/11. This log identified numbers of residents per unit with upper respiratory illness symptoms including wheezing, nasal congestion, and coughing as follows:
*Horizon Towers - August 23 to September 10,

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 _____	09/15/2011

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 253	Continued From page 17 2011 - 24 residents, current census - 45 residents; and for the period August 01 - September 10, 2011: *Legacy - 7 residents, current census - 32 residents *Harmony - 3 residents, current census - 33 residents *Wheatland - 4 residents, current census - 30 residents *Pine View - 4 residents, current census - 19 residents Accumulated dust and debris on the laundry vent and fans may result in this material being deposited on resident laundry and linen. Accumulated dust and debris on fans in resident rooms and resident care areas may result in airborne material being inhaled by residents, staff, and visitors. This accumulated dust and debris may have contributed to the number of facility residents' upper respiratory illness symptoms and placed residents, staff, and visitors at risk of illness. Missing wallpaper and cracked/missing wall plaster did not provide cleanable surfaces and did not provide the residents a homelike atmosphere. Failure of facility staff to report these areas for repair limited the facility's ability to provide a homelike atmosphere.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	F309	10/20/11

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 _____	09/15/2011

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 309	Continued From page 18 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, policy and procedure review, and staff interview, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being regarding pain management for 1 of 1 sampled resident (Resident #14) identified with pain. Failure to report a resident's symptoms of pain, assess the pain, and implement pain management interventions for Resident #14 resulted in the resident experiencing unnecessary pain. Findings include: Review of the facility policy "PAIN ASSESSMENT" occurred on 09/15/11. This policy, dated May 2007, stated, ". . . The nurse will medicate the resident for pain based on nursing assessment, resident complaint of pain, or per physician order. . . " - Observations of Resident #14 showed the following: * 09/12/11 at 1:30 p.m. - Resident #14 laid in bed calling out for help stating, "hurting rectum." A LPN (Licensed Practical Nurse)(#33) entered the resident's room and stated, "get some rest, the girls just left." The LPN failed to assess the resident's pain and implement pain management interventions. * 09/13/11 at 9:50 a.m. - Resident #14 laid in	F 309	1. a. Resident # 14 staff caring for this resident have been educated on signs and symptoms of pain, process of how to report the pain, and treatment of pain. This resident is presently receiving Tylenol 650 mg po qid. Aspercreme prn as per physician order. b. Resident #8 staff caring for this resident were educated on how to safely assist in feeding as well as how to intervene during situations such as coughing and/or not swallowing effectively. Staff were also re-educated on appropriate thickness level. 2. Any resident has the potential to be affected. 3. Mandatory nursing staff in-service has been/will be conducted to re-educate staff on pain management and assisting residents with dysphasia, which included techniques to promote resident to swallow, how to intervene, and how to identify consistency of thickened liquids. Dates of in-service were/are September 20 and 22, 2011 and October 11, 12, 13, 2011. Education for nursing staff will be provided by Occupation Therapy on assisting dysphasic residents the week of October 17, 2011. A pain management in-service for licensed nursing staff was held on 10-12-11. This was presented by Mercy Medical Center Hospice program. All nursing staff were to read an	

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 _____	09/15/2011

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 309	Continued From page 19 bed. Two CNAs (Certified Nursing Assistants) (#9 and #10) entered the resident's room. The resident stated, "I don't feel good. I feel terrible; hurt all through my stomach." The resident stated "ouch" when staff cleansed her perineal area. The resident stated, "ow" when rolling from side to side. The resident stated, "ow my leg" when positioned in her wheelchair. The CNAs (#9 and #10) failed to report the resident's pain to the charge nurse. * 09/13/11 at 2:05 p.m. - Resident #14 laid in bed, and stated "I'm in pain, feels like I have a blockage in my anus. I'm really in pain." The CNAs (#12 and #13) entered the resident's room, and the resident stated "ow" when staff slid the bedpan under her. When rolled from side to side, the resident stated, "ow, do something, pull it out." After staff completed perineal cares, the resident hollered "ow, ow" when transferred to the wheelchair. Resident #14 stated "you're killing my bottom," when seated in her wheelchair. A CNA (#12) replied "you're okay." During an interview on 09/15/11 at 7:40 a.m., an administrative nurse (#1) stated, "I would expect the CNAs to report to the nurse if residents are in pain." Review of Resident's #14 medical record occurred on September 13-15, 2011. Diagnoses included a history of a CVA (cerebrovascular accident) with hemiplegia (one sided body weakness), multi-infarct dementia, and depression. The current Minimum Data Set, dated 08/23/11, identified the resident understands others and is able to make herself understood, required total assistance for transfers, dressing, toilet use, personal hygiene,	F 309	educational article "How you can help your elders who are in pain" with a post test on 09/30/11. 4. The Neighborhood Nurse Manager (or designee) will be responsible for monitoring pain management which may include signs/symptoms of pain, documentation and reporting to appropriate personnel The Neighborhood Nurse Manager (or designee) will be responsible for monitoring CNA's for correct feeding technique including appropriate consistency of liquids. Monitoring will be conducted weekly for three months. Results will be reported to the DON. The DON will report to the QA Committee monthly for 3 months. 5. October 20, 2011	

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 _____	09/15/2011

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 309	Continued From page 20 bathing, and extensive assist for bed mobility. The resident's scheduled pain medications included Tylenol 650 milligrams three times a day, initiated on 08/18/2009. Review of the resident's as needed (prn) medications used from May 2011 - September 2011 showed Tylenol 650 mg administered on 09/07/11 at 9:00 p.m., and 09/13/11 at 2:30 p.m. The Resident #14 most recent pain assessment, dated 08/27/11, showed a "4" written in the total score. A score of "5" or greater indicates the need for a comprehensive assessment. The previous pain screening form dated 05/24/11, showed a "5" crossed out with a "4" written in the total score, and a comprehensive pain assessment was not completed. Resident #14's care plan failed to address the resident's pain. An interdisciplinary progress note, dated 08/06/11 at 3:30 p.m., stated, "Staff reports this a.m. when doing am [morning] cares on resident that when lt [left] arm is moved resident hollers out in pain. Resident does receive scheduled Tylenol [with] no relief. Resident continues rest of day hollering out in pain when lt shoulder moved. Call placed to ER [emergency room] Dr [doctor] on 08/06/11, an order received to send the resident to ER." Review of the resident prn medication administration record (MAR) showed staff failed to provide Resident #14 with any pain medication on 08/06/11. An interdisciplinary progress note, dated 08/07/11 at 2:45 a.m. stated, "Resident returned from ER at 6:45 p.m. Sling in place to Lt arm . . . " An interdisciplinary progress note, dated 08/07/11 at	F 309		

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 _____	09/15/2011

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 309	Continued From page 21 9:30 a.m., stated, "Resident lt arm in sling, continues to holler out in pain when lt arm is moved." Review of the MAR showed the resident did not receive prn medication on 08/07/11. 2. Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #8), identified as having a history of aspiration pneumonia, received the care and services necessary to attain the highest degree of safety possible while being fed in his room and/or in the dining room. Failure to adequately assess and provide services based on the assessment has the potential to affect the resident's overall swallow safety, putting him at greater risk of aspiration and limiting his nutritional intake. Findings include: Nancy B. Swigert, The Source for Dysphagia: Third Edition, LinguiSystems, Inc, 2007, pages 9, 15-16 and the educational handouts identified the following: * "Signs and Symptoms of Dysphagia: . . . Weight loss . . . Coughing/Choking . . . Pocketing . . . Pneumonia . . . Changes in diet . . ." * "Neurological Causes [of dysphagia]: . . . Parkinson's Disease . . ." * "What are some signs of dysphagia?: Signs of oral phase dysphagia include pocketing of food . . . Signs of pharyngeal dysphagia are coughing or choking during a meal or a wet, gurgly vocal quality . . ." Resident #8's medical record, reviewed	F 309		

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 _____	09/15/2011

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 309	Continued From page 22 September 12-15, 2011, identified diagnoses including significant weight loss, left lower lobe pneumonia: possible aspiration, and severe Parkinson's Disease. The resident's quarterly Minimum Data Set (MDS), dated 08/16/11, identified a BIMS (Brief Interview of Mental Status) score of 3: severely impaired, extensive assist for eating, weight loss, and mechanically altered diet. Resident #8's current plan of care, dated 06/24/10, identified, ". . . Problem: Nutrition and Hydration . . . Approaches: . . . Assist resident with meals as needed. . . . mechanical soft diet, honey thick liquids by straw or cup. . . . Frequent suctioning per Doctor . . . as needed (08/31/11) [handwritten entry] . . ." The "Physician's Orders Sheet", dated 08/22/11, stated, ". . . Diet: . . . mech. [mechanical] soft food, honey thick liquids by straw or cup . . ." The [Name of Medical Center] Discharge Note, dated 08/09/11, stated, ". . . Discharge Diagnosis: 1. Left lower lobe pneumonia, possible aspiration etiology . . . He will have frequent suctioning as far as prevention for aspiration with head of the bed elevated greater than 30 degrees at all times. . . ." The Interdisciplinary Progress Note, dated 08/16/11, stated, ". . . Bedside swallow evaluation completed . . . will continue with . . . mechanical soft diet. Continue with honey thick liquids via straw or cup. . . ." Observations on 09/14/11 revealed the following: * At 7:55 a.m., two CNAs [Certified Nursing	F 309		

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 _____	09/15/2011

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 309	Continued From page 23 Assistants] (#18 and #19) transferred Resident #8 from his bed into his wheelchair. The resident barely responded to the CNAs as they made attempts to converse with him during the transfer; simply stating "yes" or "no" in response to questions. He sat in his wheelchair with his eyes closed, his mouth open, and his head tilted back. The CNA (#18) offered Resident #8 thickened water by cup after the transfer. The resident did not initiate a swallow and immediately presented with a wet, gurgly voice (a sign of aspiration). When asked if the resident swallowed, the CNA (#18) looked into his open mouth, stating, "I don't see it [water]. He must have [swallowed]. Oh, it's under his tongue." After the surveyor cued the CNA (#18) to hold the resident's jaw in a closed position, he triggered a swallow and his vocal quality cleared. * At 8:30 a.m., the CNA (#19) fed Resident #8 breakfast in the dining room. The response from the resident was minimal as the CNA made attempts to converse with him during the meal; responding to questions in one or two word phrases. The CNA (#19) spoon fed the resident, and offered nectar thickened liquids by cup between bites. Observation showed nectar thickened juice and water on the resident's tray. The CNA (#19) confirmed the liquids as being nectar thick. Resident #8 coughed three-to-four times and presented with a wet, gurgly vocal quality throughout the observation. An unidentified CNA from the next table, stated, "He has too much phlegm in his throat." During an interview the morning of 09/15/11, an administrative nurse (#1) agreed residents should be alert when fed and should receive the diet ordered.	F 309		

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 _____	09/15/2011

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 309	Continued From page 24 The facility failed to ensure Resident #8 received the care and services necessary to attain the highest degree of safety possible while being fed in his room and in the dining room. They failed to 1) identify the resident's signs/symptoms of aspiration (pocketing of food, coughing during a meal, and wet, gurgly vocal quality) and 2) offer honey thickened-liquids as ordered; not nectar thickened liquids.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON JULY 01, 2010. Based on observation, record review, and staff interview, the facility failed to provide the necessary services to maintain adequate nutrition for 6 of 21 sampled residents (Resident #9, #10, #11, #14, #17, #18) and two supplemental residents (Resident #27 and #28). Failure to provide the appropriate level of assistance required by each resident during meals places them at risk for weight loss, malnutrition, and a loss of dignity. Findings include:	F 312	F312 1. Resident #9 had Occupational Therapy screening completed on 09/21/11 and foot rests to be swung out to side with foot buddy to be removed to obtain optimal distance to table. Care plan and group sheets have been updated to reflect this information. Resident is to consume meal with thickened liquids in a nosey cup. Resident is variable in ability to feed self. Resident #10 is to be placed in a different wheel chair when taken to dining room to allow optimal positioning of resident at table. Care plan has been reviewed by staff caring for this resident. Resident #17 has been moved to an assist table. Resident #18 care plan has been revised. The hemitray on the wheelchair is to be removed at meal time. Staff caring for this resident have been re-educated on positioning and assist at meal time. Resident # 14 table has been elevated. Resident #27, #28, #11 staff have been re-educated on assisting resident at meal time. Resident #27 OT screening was	10/20/11

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 _____	09/15/2011

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 312	Continued From page 25 - Review of Resident #17's medical record occurred on September 14-15, 2011. Diagnoses included dementia, arthritis, and depression. The resident's quarterly Minimum Data Set (MDS), dated 07/10/11, identified the resident required extensive assistance with eating. Observation on 09/13/11 at 11:55 a.m. showed Resident #17 positioned at the dining room table. The resident sat approximately 18 inches from the dining table because the foot rests on her wheelchair were elevated and prevented closer positioning to the table. Resident #17 ate mashed potatoes with her fingers. As mashed potatoes dropped onto her clothing protector, the resident picked them off and placed them in her mouth. Observation showed facility staff in the dining room, but no one assisted or cued Resident #17. Observation on 09/13/11 from 5:30 p.m. to 6:00 p.m. showed Resident #17 seated at the dining table with her eyes closed. Her untouched meal remained in front of her with a warming cover over it. Observation showed facility staff in the dining room, but no one assisted Resident #17. Observation on 09/14/11 from 12:05 p.m. to 12:30 p.m. showed Resident #17 seated in her wheelchair at the dining room table with her eyes closed. Her noon meal remained uncovered and untouched in front of the resident. Staff members present in the dining room failed to assist or encourage the resident to eat her meal until a Certified Nursing Assistant (CNA) (#10) approached the resident to take a drink at 12:30 p.m. Observation on 09/14/11 from 5:30 p.m. to 5:55	F 312	done on 09/27/11, #14 OT screening was done on 09/19/11, and #28 OT screening was done on 09/20/11. 2. All residents have the potential to be affected. 3. Mandatory nursing staff in-service have been/will be conducted to re-educate staff on deficient practices in the dining room. Dates of in-service were/are September 20 and 22, 2011 and October 11, 12 and 13, 2011. 4. The Neighborhood Nurse Manager (or designee) will be responsible for monitoring for appropriate assistance in the dining room. Monitoring will be conducted weekly for three months. Results will be reported to the DON. The DON will report to the QA Committee monthly for 3 months. 5. October 20,2011.	

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 _____	09/15/2011

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 312	Continued From page 26 p.m. showed Resident #17 seated in her wheelchair at the dining table with her head down and eyes closed. The resident's meal remained uncovered and untouched in front of the resident. Staff members present in the dining room did not encourage or assist the resident to eat until 5:55 p.m. (25 minutes later) when a CNA (#12) fed her a few spoonfuls of soup. The CNA (#12) then left Resident #17's table and went to assist another resident. Resident #17 closed her eyes again and did not attempt to continue eating her meal. - Review of Resident #14's medical record occurred on September 13-15, 2011. Diagnoses included hemiplegia - late effects CVA. Resident #14's MDS, dated 08/23/11, identified the resident required extensive assistance with transfers and setup help for eating. The resident's care plan, dated 06/08/11, stated, "Problem: Impaired physical mobility actual related to history of CVA with left sided weakness . . . Problem: Nutrition: . . . Assist resident with meals as needed . . ." Observation on 09/13/11 at 12:00 p.m. showed Resident #14 seated in her wheelchair in the dining room approximately arm's length from the table. The resident rested her affected left arm on the tray attached to the left side of her wheelchair. Observation showed Resident #14 unable to reach her glass of juice however; she accessed her water glass by stretching her right arm and placing her index finger in the glass, sliding it towards her. Observation showed facility staff in the dining room assisting other residents. Observation on 09/13/11 at 5:30 p.m. showed Resident #14 seated in the dining room	F 312		

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 _____	09/15/2011

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 312	Continued From page 27 approximately arm's length from the table and her meal. Observation showed the resident unable to reach her water or juice. Observation on 09/14/11 at 7:46 a.m. showed Resident #14 attempted to open her jelly package with her right hand and teeth. She opened the package but spilled it on the table. The resident ate her toast with no jelly. Observation showed Resident #14 unable to access her cereal bowl, juice glass, and milk glass; remained untouched for the entire meal. Observation on 09/14/11 at 12:00 p.m. showed Resident #14 seated in her wheelchair approximately arm's length from the table and her water and juice glasses out of reach. The resident placed a bowl of diced fruit on her right leg to eat with a spoon held in her right hand. - Review of Resident #18's medical record occurred 09/15/11. Diagnoses included dementia. Resident #18's MDS, dated 05/31/11, identified the resident required extensive assistance with eating. A functional assessment, dated 03/01/2011, stated, "ROM [range of motion]: limited bilateral shoulders and left arm and hand." The current care plan, dated 09/12/11, stated, "Problem: Nutrition and Hydration, at risk due to DX [diagnosis] . . . Dementia . . . Intake [less than] 25% [percent] most meals . . . Assist resident with meals as needed . . ." Observation on 09/14/11 at 7:50 a.m. showed Resident #18's positioned approximately arm's length from the dining table with foot rests and a side tray on her wheelchair. The resident held a bowl of Rice Krispies cereal next to her body as	F 312		

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 _____	09/15/2011

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 312	Continued From page 28 she spooned them into her mouth. Observation showed her clothing protector saturated with liquid and covered with cereal. Observation showed facility staff in the dining room but no one assisted or provided a clean clothing protector for Resident #18. Observation on 09/14/11 at 11:55 a.m. showed Resident #18 positioned approximately arm's length from the dining table with foot rests and a side tray on her wheelchair. She held a cup of fruit cocktail next to her body and attempted to eat but dropped it onto her clothing protector and then onto the floor. Observation showed facility staff in the dining room but no one assisted Resident #18, provided a clean clothing protector, or provided her with another cup of fruit cocktail. Observation on 09/14/11 at 5:35 p.m. showed Resident #18 in the dining room seated in her wheelchair positioned approximately arm's length from the table. The resident rested her left arm on a tray attached to the left side of her wheelchair. Resident #18 picked up a package of crackers attempted to open the cracker package with her right hand and teeth. Observation showed three facility staff members in dining room and did not assist Resident #18. - Review of Resident #9's medical record occurred on September 13-15, 2011. A quarterly MDS, dated 07/14/11, identified Resident #9 as dependent on one staff member for eating. A therapy note, dated 07/21/11, stated, "Note left [with] CN [charge nurse] on the following. Take off the w/ch [wheelchair] foot rest buddy and swing away w/ch [foot] pedals (or take them off)	F 312		

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 _____	09/15/2011

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 312	Continued From page 29 when sitting him up to DR [dining room] table." The current care plan for Resident #9 identified, "Problem . . . 2. Impaired physical mobility . . . Approaches . . . Take off foot rest buddy [and] swing away wheelchair foot pedals (or take them off) when sitting up to dining room table." During cares on 09/14/11 at 11:00 a.m. two certified nursing assistants (CNAs) (#20 and #2) assisted Resident #9 from his bed to his wheelchair. The CNA (#20) offered Resident #9 a glass of thickened water. The CNA (#20) held the glass up to the resident's lips. Resident #9 reached up, took hold of the glass drinking the water independently and consumed all the water offered. As Resident #9 drank, the CNA (#20) stated Resident #9 would eat and drink independently during meals when really hungry or thirsty. During meals observed on 09/13/11 at 11:50 a.m. and 5:40 p.m., on 09/14/11 at 8:40 a.m., 12:15 p.m., and 5:55 p.m., and on 09/15/11 at 7:35 a.m., staff positioned Resident #9 at the table leaving the wheelchair foot buddy and foot pedals down in use. This positioned Resident #9 away from the table preventing independent access or consumption of the food and beverages provided. Observations showed staff fed Resident #9 his food and beverages. - Review of Resident #10's medical record occurred on September 13-15, 2011. An annual MDS, dated 08/17/11, identified Resident #10 as independent with eating after set up. The current care plan for Resident #10 identified,	F 312		

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 _____	09/15/2011

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 312	Continued From page 30 "Problem . . . 2. Impaired physical mobility . . . Approaches . . . Swing away foot pedals or take off foot pedals when up to D.R. [dining room] table in D.R." Observations of Resident #10 seated in the dining room on 09/13/11 at 5:40 p.m., and 09/14/11 at 5:55 p.m. showed staff positioned the resident at the dining room table without swinging the foot pedal away, as care planned. During the meal on 09/13/11, observation showed Resident #10 positioned the bowl a little over the edge of the table and spooned her food with her arm straightened in order to reach the bowl. During an interview, on 09/15/11 at 8:10 a.m., with an administrative nurse (#17) she identified staff are to follow the care plans for Resident #9 and #10. Both Resident #9 and #10 should have had the wheelchair pedals moved out of the way for proper positioning at the dining room table. - Review of Resident #11's medical record occurred on all days of survey. The MDS, dated 07/08/11, identified the resident required extensive assistance for eating. Observation on 09/15/11 at 8:10 a.m. showed Resident #11 seated in the dining room with his morning meal tray positioned in front of him. At 8:45 a.m., observation showed Resident #11's eyes closed, his meal untouched, and his sausage links not cut. Observation showed facility staff in the dining room, but no one assisted Resident #11. - Review of Resident #27's medical record occurred on 09/14/11. The current MDS, dated	F 312		

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 _____	09/15/2011

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 312	Continued From page 31 08/07/11, identified the resident required extensive assistance for eating. Observation on 09/14/11 at 8:15 a.m. showed Resident #27 positioned in the dining room with his eyes closed. At 8:45 a.m., a CNA (#22) attempted to assist the resident with his meal but he could not be aroused. On 09/15/11 at 8:45 a.m., an unidentified CNA transported Resident #27 out of the dining room. Observation of the resident's dining area showed an untouched glass of water, juice, and chocolate Ensure and three nosey cups (a drinking cup designed to aide in the consumption of fluids). All three nosey cups were clean and showed no evidence of use. - Review of Resident #28's medical record occurred on 09/15/11. The MDS, dated 08/09/11, identified severely impaired cognition and required set up assistance only for eating. Observation on 09/13/11 at 5:30 p.m. showed Resident #28 positioned approximately 12 inches from the dining room table and her silverware next to her plate. The resident ate her entire meal, which included chicken salad on tomato pieces and diced cooked carrots, with her fingers. Observation showed facility staff in the dining room but no one assisted or cued Resident #28. During an interview on 09/15/11 at 7:50 a.m., an administrative nurse (#1) stated she expected all staff to encourage and assist residents with meals.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314	F314 1. Nursing staff responsible for the care of Resident #10 and #13 were educated on	10/20/11

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 _____	09/15/2011

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 314	Continued From page 32 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON JULY 01, 2010. Based on observation, record review, review of facility policy/procedure, and staff interview, the facility failed to assess and provide pressure relief interventions for 2 of 3 sampled residents (Resident #10 and #13) with a history of healed pressure sores. Failure to provide pressure/shear reducing interventions for Resident #10 and #13 placed these residents at risk for continued pain and the risk of developing new pressure ulcers. Findings include: Review of the facility policy titled "Pressure Ulcer: Prevention, Assessment and Care of" occurred on 09/15/11. This policy, dated August 2010, stated, "Policy: 1. Promote the prevention of pressure ulcer development. 2. Promote the healing of pressure ulcers that are present. 3. Prevent the development of additional pressure ulcers . . . B. Pressure Ulcer Prevention: 1. Institute a preventive plan for any resident who	F 314	the intervention for prevention of pressure ulcer development and appropriate documentation. 2. All residents at risk for pressure ulcers have the potential to be affected. 3. Prevention of pressure ulcer development and documentation of pressure ulcers in-service was presented by Cathy Weiber, RN, CWOCN, from AMT on September 19, 2011. This was mandatory for all staff. Mandatory in-servicing for all nursing staff was held on September 20th and 22nd and October 11, 12, and 13. Staff was re-educated on prevention of pressure ulcers, early identification and reporting pressures and the regulation F 314. The Pressure Ulcer Prevention team will continue to meet at least monthly. All residents with current pressure ulcers are reviewed. The team also reviews pressure relieving mattress replacements and special needs, such as air mattresses, derma savers, etc. Any new admissions with a Braden Scale score of less than 12 (high risk for pressure ulcer development) are reviewed. 4. The Unit Manager (or designee) will be responsible to monitor skin assessment reporting forms and care planning (interventions) for new admissions at risk for pressure ulcer development. Monitoring will also include observation of residents with current pressure ulcers to assure care plan interventions are in place. Results of the monitoring will be reported to the QA Committee by the DON monthly for 3 months. 5. 10-20-11	

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 _____	09/15/2011

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 314	Continued From page 33 has the potential for developing a pressure ulcer or whose condition is rapidly deteriorating. This plan may include the following: a. Implement written turning schedule, changing position at least every 2 hours while in bed . . . d. Use devices such as pillows and foam wedges to prevent direct contact between bony prominence . . . f. Raise heels off the bed with pillow lengthwise to support legs. There are also heel pillows that can be obtained from physical therapy department to keep heels floating off the bed. g. Limit sitting time to one hour at a time, whether in bed, chair or wheelchair . . . C. Interventions: 1. Utilize preventative measures as listed above . . . 9. Documentation is made by licensed staff members . . ." - Review of Resident #10's medical record occurred on September 16-17, 2011. Diagnoses included multiple sclerosis, paraplegia. An annual MDS, dated 08/17/11, identified Resident #10 required extensive assistance of two staff members for bed mobility and toilet use; dependent on two staff members for transfers; incontinent of bowel and bladder; at risk of developing pressure ulcers; a healed Stage 2 pressure sore since the completion of the last MDS; utilization of pressure reducing devices for the chair and bed; had nutrition and/or hydration interventions for skin. The care plan, dated 09/07/11, for Resident #10 identified, "Problem . . . 4. Skin integrity, impaired: . . . history of pressure ulcer to right heel. Pressure ulcer right buttock . . . Approaches . . . Foam or dermasaver heel guards on heels in bed and PRN [as needed] . . ."	F 314		

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 _____	09/15/2011

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 314	Continued From page 34 Observation of Resident #10 occurred on 09/13/11 at 9:12 a.m. and showed Resident #10 lying in bed without heel protectors and her heels resting on the mattress. Three CNAs (#21, #23 and #27) transferred her to the shower chair and the CNA (#28) assisted her into the bath and Resident #10 stated, "[The] bottom of my heel sure hurts." Failure of facility staff to follow the care plan and use the heel protectors may have contributed to the discomfort Resident #10 voiced about her heel. During an interview, on 09/15/11 at 8:10 a.m., with an administrative nurse (#17) she identified staff are to follow the care plans for Resident #10 in use of the heel protectors. - Review of Resident #13's medical record occurred on all days of survey. Diagnoses included history of a cerebrovascular accident (CVA) with right-sided hemiparesis (muscle weakness on one side of the body), chronic pain, and dementia. An annual MDS, dated 08/25/11, identified Resident #13 required total assistance of two or more staff members for bed mobility, transfers, dressing, toileting, and personal hygiene, and identified the resident at risk for the development of pressure ulcers. Resident #13's care plan, dated 08/26/10, identified the problem "Skin integrity, impaired: potential related to CVA with right side hemiparesis. History of pressure area right buttocks." Approaches for this problem included "Reposition/shift resident weight every 2-3 hours . . . Assist with turning, rising, position change . . .	F 314		

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 _____	09/15/2011

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 314	Continued From page 35 Observe for signs of breakdown (intactness, color, sensation, temperature) . . . Pillow under calves of legs to elevate heels off bed . . . Reposition Q [every] 2 HRS [hours] (more frequent time frame than 2-3 hour approach listed above). Dermasaver heel guards on at all times. . . ." During the initial tour on the afternoon of 09/12/11, a staff member (#33) stated Resident #13 remains in bed the majority of the day. Review of the Interdisciplinary Progress Notes showed a Stage 2 pressure ulcer to Resident #13's right buttock identified on 02/01/11 and healed on 03/10/11. Observations of Resident #13 on 09/13/11 showed the resident remained on her back in bed without the Dermasaver heel guards to her heels and without a pillow under her calves to elevate her heels, from 9:40 a.m. to 5:10 p.m. (over seven hours). The facility failed to reposition the resident every two to three hours, place a pillow under her calves to elevate her heels off the bed, and failed to apply the Dermasaver heel guards at all times, as identified in the resident's care plan. Observation during cares on 09/13/11 at 5:10 p.m. showed pink areas to the resident's coccyx and bilateral heels. During an interview on 09/15/11 at 7:50 a.m., an administrative nurse (#1) stated she expected staff to attempt to reposition the resident, place a pillow under her calves, and apply the Dermasavers to her heels, as identified in the resident's care plan to prevent skin breakdown.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	F323 1. Staff caring for Resident #7, #9, #11 and #1 has been informed of the deficient	10/20/11

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 _____	09/15/2011

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 323	Continued From page 36 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, review of facility policy and procedure, and staff interview, the facility failed to ensure 3 of 19 sampled residents (Resident #7, #9, and #11) who required limited to extensive assistance with transfers and 1 of 18 sampled residents (Resident #1) with a history of falls, received adequate supervision and assistance devices to prevent accidents. Failure to ensure the use of wheelchair foot rests resulted in Resident #9's fall from the wheelchair and head injury. Failure to ensure the use of Resident #1's chair alarm limited the facility staff's ability to prevent the resident's fall and head injury. Failure to use wheelchair foot rests and equipment devices during transport, placed Resident #7 and #9 at risk for falls and injury. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 8th Edition, Pearson/Prentice Hall, Upper Saddle River, New Jersey, 2008, pages 1141-1145, states, ". . . Practice Guidelines Wheelchair Safety: . . . Lower the footplate's after the transfer and place the	F 323	practice(s) identified. The care plans for Resident #7, #9, #11 and #1 have been reviewed. The CNA Assignment sheets (group sheets) have been reviewed to identify fall prevention interventions for Residents #7, #9, #11, and #1. 2. Any residents confined to a wheelchair and at risk for falls has the potential to be affected. 3. Mandatory Nursing in-services were conducted on September 20 and 22, 2011 and October 11, 12, and 13, 2011 to inform staff of the deficiencies identified and corrective action. All nursing staff were to read an educational article "Preventing Falls: The Latest Information that Works" with post test 09/17/11. 4. The Neighborhood Nurse Manager (or designee) will conduct random monitoring of gait belt use, transporting the resident with foot pedals in place and chair alerts in place according to care plan. The results of the monitoring will be reported to the QA Committee by the DON monthly for 3 months. 5. October 20, 2011	

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 _____	09/15/2011

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 323	Continued From page 37 client's feet on them . . ." Review of the facility policy and procedure, Fall Prevention, occurred on 09/15/11. This document, revised August 2010, stated "POLICY . . . each resident receives adequate supervision and assistance devices to prevent accidents. PROCEDURE . . . 2. If it is determined the resident is 'at risk' . . . Interventions will be selected, documented on the care plan and implemented. Any changes to the resident's care plan will be communicated to appropriate staff (e.g. [example given] communication log, CNA [certified nursing assistant] assignment sheet, shift report). . . .". - Review of Resident #9's medical record occurred September 13-15, 2011. Diagnoses included senile dementia, Alzheimer's disease, osteoarthrosis, osteoporosis, history of right and left hip fracture and degenerative joint disease. An annual Minimum Data Set (MDS), dated 10/12/10, identified Resident #9 required extensive assistance of one staff member for bed mobility; extensive assistance of two staff members for transfers and locomotion on/off the unit; and severely cognitively impaired. Review of Resident #9's progress notes identified the following: * 01/14/11 at 5:20 p.m. "CNA was pushing resident to supper and resident tumbled forward out of w/chair [wheelchair]. Fell forward onto face, breaking glasses, gashing forehead, pupils small reactive. Hand and legs weak. . . ." An "Accident/Incident Report," dated 01/14/11, identified the same incident as the 5:20 p.m.	F 323		

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 _____	09/15/2011

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 323	Continued From page 38 progress note and a wound above the right eye 2.5 x 1 and below the right eye of 5 x 2.7. The nurse completing the form failed to identify centimeters or inches. The report section titled "Follow up/Interventions to Prevent Recurrence: Other" stated, "Staff educated to tilt chair back (reclining back on chair) if resident leaning forward [and] to be sure foot pedals are on w/c [wheelchair]". The care plan in place at the time of the fall, dated 11/17/10, stated, "Problem . . . 2. Impaired physical mobility: . . . At risk for falls . . . Propels self in wheel chair with his feet. Staff does [sic] push him in wheelchair at times. Tries to get up on his own not waiting for staff assist. . . . At risk for falls. Goals: Resident will maintain highest level of physical mobility by review date. . . . Will continue to propel w/c short distances, per self. Approaches: . . . Chair alert . . . Reclining-back Wheelchair with standard leg rests . . .". Approaches added on 01/20/11 following the fall on 01/14/11 include: "Elevated leg rests. Dicem [non-slip rubberized product] mat on top of pommel cushion. Elevate leg rests if sliding or leaning forward. Ft [foot] rest buddy prn on ft pedals (may need to be [sic] remove pedals [and] ft rest buddy [at] meals.) Take ft pedals [and] ft rest buddy off w/ch [wheelchair] if he wants to pedal himself [with] his ft." During an interview on the afternoon of 09/14/11, an administrative nurse (#17) reported staff may have failed to place the leg rests for Resident #9 to use prior to pushing him in the wheelchair.	F 323		

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 _____	09/15/2011

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 323	Continued From page 39	F 323		

Failure to ensure use of the leg rests may have resulted in Resident #9 falling from the wheelchair, and experiencing a head injury with changes in pupil size.

- Review of Resident #1's medical record occurred on September 13-15, 2011. The facility admitted the resident in January 2011. Current diagnoses included dementia and Parkinson's disease. The resident's MDSs since admission, dated 01/25/11, 04/18/11, and 07/18/11, identified the resident's cognition as severely or moderately impaired and required extensive assistance of two or more persons for transfers and walking.

Resident #1's Fall Prevention Assessments, dated 01/27/11, 04/25/11, and 07/19/11, identified the resident was "at risk" for falling. The resident's current care plan, dated 08/02/11, stated "Problem, Impaired physical mobility . . . At risk for falls. . . . Approaches . . . Chair alert. . . ."

Resident #1's Interdisciplinary Progress Notes identified the resident experienced falls on 06/01/11, 06/15/11, and 08/19/11. The facility's Accident/Incident Reports for these falls identified the following:
*06/01/11, 7:00 p.m. - ". . . Saw resident walking by herself in front of dinning [sic] room. . . . She lost her balance and fell . . .
Followup/Interventions to Prevent Recurrence: . . . Chair Alert was added. . . ."
*06/15/11, 4:30 p.m. - "Location . . . Found on floor - unwitnessed. . . . Account of Occurrence . . . Found by nurse lying on Rt [right] side on floor beside TV stand. 1.0 cm [centimeter] abrasion [identified on right side of head of body image] . .

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 _____	09/15/2011

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 323	Continued From page 40 . Investigation . . . Resident was in recliner et [and] alert was not placed on her. . . . Followup/Interventions to Prevent Recurrence: . . . Be sure chair alert is on in recliner when resident is sitting in it. . . ." *08/19/11, 7:00 p.m. - ". . . Account of Occurrence . . . Saw resident falling out of w/c in room . . . Hit her head on the floor, laceration to forehead and skin tear to Lt. [left] elbow. . . ." The Accident/Incident Report failed to identify if a chair alert was or was not in place. The Interdisciplinary Progress Note for this fall stated ". . . 3 cm bruise/skin tear midline on forehead, 3 x [by] 2 cm skin tear to Lt. elbow. . . ." Observation on September 12-14, 2011 identified Resident #1 with a scab area on her forehead at the hairline. During interview on the initial facility tour, on 09/12/14/11 at approximately 1:30 p.m., a supervisory nursing staff member (#36) reported the scab was the result of a fall from the resident's chair. Observation on these days also identified Resident #1 seated in her recliner without a chair alert or alarm in place. During interview, on 09/15/11 at 10:30 a.m., an administrative nursing staff member (#1) and a supervisory nursing staff member (#31) agreed Resident #1 should have a chair alert or alarm in her recliner when sitting in it. The facility identified Resident #1 was at risk for falls beginning with her initial Fall Prevention Assessment, dated 01/27/11. The facility staff initiated a chair alert after the fall on 06/01/11. The facility staff failed to ensure the chair alert was in place at the time of the fall on 06/15/11 and it is unknown if the chair alert was in place at	F 323		

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 _____	09/15/2011

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 323	Continued From page 41 the time of the fall on 08/19/11. The falls of 06/15/11 and 08/19/11 resulted in a bruise, skin tear, and abrasion to the resident's head. Failure to ensure the chair alert was in place on 06/15/11 limited the staff's ability to respond to the resident independently rising from the chair. The records lack information if the chair alert was in place at the time of the fall on 08/19/11 that may have enabled the staff to respond to the resident independently rising from the chair. Failure to ensure the chair alert or alarm was in place on September 12-14, 2011 limited the staff's ability to respond to any attempts by the resident to independently rise from the chair. These failures resulted in Resident #1 experiencing an unwitnessed fall and abrasion to her head on 06/15/11, may have contributed to the resident's fall and laceration to her forehead on 08/19/11, and placed her at continued risk of falls and injuries. - Resident #7's medical record, reviewed on September 12-15, 2011, identified diagnoses including dementia, anxiety, panic disorder, and history of falls. The resident's quarterly MDS, dated 07/18/11, identified severely impaired cognitive skills and limited-to-extensive assist required for all ADLs (activities of daily living). Resident #7's current plan of care, dated 10/19/10, identified, ". . . Problem: Impaired physical mobility . . . Approaches: . . . FWW [front wheeled walker], gaitbelt, & [and] 1 assist for ambulation in hallways/at times refuses gait belt to be put on. . . ." Observation on 09/13/11 at 10:55 a.m. showed, a	F 323		

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 _____	09/15/2011

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 323	Continued From page 42 CNA (#27) assisted Resident #7 to stand, transferred her into the bathroom using her walker, and failed to place a gait belt around Resident #7's waist prior to assisting her into the bathroom. Following toileting cares, CNAs (#26 and #27) transferred Resident #7 into her wheelchair. Again, facility staff failed to place the gait belt. The CNA (#27) stated, "[Resident #7] refuses to use her gait belt." Observation on 09/13/11 at 2:25 p.m. showed, a CNA (#25) transferred Resident #7 from the bathroom to her bed using her walker. She failed to place the gait belt prior to assisting the resident. Instead, the CNA (#25) walked directly behind the resident with her hands under the resident's arms. Observation on 09/13/11 at 3:35 p.m. with CNA (#25) and on 09/14/11 at 8:05 a.m. with CNA (#18) showed these staff members transported Resident #7 in her wheelchair from her room to the bathroom, and back again. Resident #7's shoes slid along the surface of the floor, making an audible noise whenever they made full contact with the floor. The resident did not lift her feet. During the 09/14/11 at 8:05 a.m. observation, Resident #7's shoes caught and bounced on the rubber transition strip as staff transported her into the bathroom. The staff members failed to place foot pedals, to ensure the resident's feet/shoes cleared the floor during transport, and failed to remind the resident to lift her feet. During an interview on 09/14/11 at 04:45 p.m., an administrative nurse (#17) stated, "Yes, the gait belt should be used. She may refuse. They [staff] should at least try . . . offer . . . not assume she'll	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	09/15/2011

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 323	Continued From page 43 refuse." During an interview the morning of 09/15/11, an administrative nurse (#1) agreed residents should be transferred using gait belts and foot pedals, or should be cued to raise their feet. The facility staff failed to transfer Resident #7 using a gait belt and foot pedals, and failed to cue her to lift her feet. - Review of Resident #11's medical record occurred on September 13-15, 2011. Diagnoses included dementia. The quarterly MDS, dated 07/08/11, identified the resident required extensive assistance for transfers and locomotion. Observation on 09/13/11 at 11:55 a.m. showed Resident #11 seated in a merry-walker and an unidentified CNA pushed him on the carpeted floor towards the dining room. The toe of the resident's shoe bent backward and bounced along the carpet. Just before they entered the dining room, the CNA placed Resident #11's feet on the white bars across the lower part of the merry-walker to prevent them from dragging. Failure to place Resident #11's feet on the merry walker frame placed him at risk of injury.	F 323		
F 371 SS=B	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371	F371 1. There were no residents identified in this deficiency. 2. All residents have the potential to be affected. 3. A mandatory dietary in-service was conducted on 09/23/11, by the Dietary Manager. Mandatory Nursing in-services for nursing staff were held on September 20, 22 and	10/20/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	09/15/2011

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 371	Continued From page 44 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's recommendations, review of facility policy/procedure and staff interview, the facility failed to store foods in a safe and sanitary manner in 3 of 4 service kitchens (Legacy, Wheatland, and Horizon) and 2 of 4 nursing stations (Legacy and Wheatland). This practice placed foods at risk of contamination, and placed residents at risk of consuming expired beverages. Findings include: Review of the facility policy titled "Food Storage" occurred on 09/15/11. This policy, not dated, stated, ". . . 15.e. All foods should be covered, labeled and dated. . . ." The dietary tour, conducted 09/15/11 at 9:45 a.m., showed the following improper food storage in the service kitchens: * Legacy: 29 ice cream or ice cream type supplements stored in a freezer at 30 degrees Fahrenheit. When checked these products were no longer frozen and thrown away by a facility staff member (#4). * Wheatland: Thickened water beverage, not dated when opened. * Horizon: Thickened water beverage, not dated when opened, and thrown away by a facility staff member (#4).	F 371	October 11, 12 and 13 to review the survey results and corrective action for F tag 371. Signs will be placed on the freezers of neighborhood refrigerators to indicate storage area is for ice packs only. 4. Food storage areas will be monitored weekly by the Dietary Manager (or designee). Results will be reported to the QA Committee monthly for 3 months. 5. October 20, 2011	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	09/15/2011

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 371	Continued From page 45 Improper food storage at the nurse's station: * Legacy: Five commercial ice packs in the freezer and two commercial ice packs in plastic bags, stored with frozen ice cream cups. Thickened water beverage, not dated when opened. * Wheatland: Five commercial ice packs in the freezer and one baggie holding frozen water/ice chunks, stored next to individually wrapped ice cream treats. A dietary staff member (#4) identified the commercial ice packs were used by facility therapy staff members. Use of the baggie of frozen water was not identified. Review of the manufacturer's recommendations for the thickened water beverage, identified the product is to be refrigerated after opening, and discarded if not used within 10 days. By not identifying the day opened, facility staff cannot identify the discard date. Facility staff (#4 and #3) on the tour identified the ice packs do not belong in the refrigerators located at the nurse's stations. The staff members (#4 and #3) identified staff are to label the thickened water beverages when opened.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	F441 Comments: Please remove sample Resident #17 and Resident #27 and statement"...during 3 of 3 tray line observations." These references were not included in the findings. Also the facility policy titled "Hand Hygiene"	10/20/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	09/15/2011

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 441	Continued From page 46 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow proper infection control procedures for 4 of 9 sampled residents (Resident #7, #13, #14, and ~~#16~~ 19) who required assistance with perineal cares;	F 441	was revised and dated July 2011 and this was the copy given to the surveyors by the DON. In Paragraph 3 (page 48 of 52) the Surveyor failed to identify correct resident #. The correct resident # is 16 not 19. 1. Staff caring for resident #7, #13, #14 and #16 have been re-educated in proper perineal care. There was no resident identified for eye drop administration. All eye drop bottles cited in the deficiency have been removed from the resident care area. The charge nurse has been re-educated in proper eye drop administration techniques. 2. Any resident has the potential to be affected. 3. Mandatory nursing in-services were held on September20, 22 and October 11, 12 and 13, 2011. The policy and procedure for eye drop administration will be developed. Nursing competency checklists have been developed. The competency checklist for perineal care will be completed for the certified nurse assistants and eye drops administration competency checklist for the licensed staff. 4. The Infection Control Nurse (or designee) will be responsible for monitoring perineal care; hand hygiene, and proper glove use. The neighborhood nurse manager will monitor medication administration, specifically eye drop administration, on a random sample of residents weekly for 2 weeks then monthly for 3 months. Monitoring will also be done on a random sample of residents weekly for 3 months. Results will be reported to the QA Committee monthly by the DON. 5. October 20, 2011	

Res #16 changed to resident #19 during a telephone conversation with Kurt Stoner on 10/31/11 @ 2:50pm

KBucher

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 _____	09/15/2011

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 441	Continued From page 47 ~~for 1 of 21 sampled residents (Resident #17) and 1 of 2 supplemental residents (Resident #27) who required assistance with meals~~; for 1 of 6 observations of eye drop administration; ~~and during 3 of 3 tray line observations.~~ Failure to follow infection control procedures related to hand hygiene and glove usage has the potential for cross contamination and the spread of infection to other residents. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 09/15/11. This policy, dated July 2007, stated, ". . . 1. All personnel shall follow our established hand hygiene procedure to prevent the spread of infection and disease to other personnel, patients, and visitors. . . . [They are expected to perform hand hygiene] g. After contact with blood, body fluids, excretions, . . . h. After handling items potentially contaminated with blood, body fluids, excretions, . . . j. Residents who perform their own perineal care receive the necessary services (assistance/cueing) to wash hands after toileting . . . k. After removing gloves . . ." - Review of Resident #19's medical record occurred on September 14-15, 2011. The record identified Resident #19 had a history of self manual extraction of stool. The admission Minimum Data Set (MDS), dated 07/14/11, identified Resident #19 required extensive assistance with toilet use and personal hygiene. Observation on 09/15/11 at 8:20 a.m. showed Resident #19 stood in the bathroom with the assistance of a walker. The certified nursing	F 441	This information was deleted from the last statement on 10/31/11 @ 2:50pm during a conversation w Kurt Stoker K Beuchler	

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 _____	09/15/2011

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 441	Continued From page 48	F 441		

assistant (CNA) (#2) applied gloves, removed the resident's soiled incontinence pad, and cleansed the resident's perineal area. The CNA (#2) removed her gloves, combed the resident's hair and applied her glasses, opened the door, and assisted the resident to the dining room. Observation showed the CNA (#2) failed to perform hand hygiene after assisting Resident #19 with personal cares and before leaving the room. Observation showed the CNA (#2) failed to offer or assist Resident #19 with hand hygiene.

- Review of Resident #14's medical record occurred on September 13-15, 2011. The resident's current MDS, dated 08/23/11, identified the resident required total assistance with toileting and personal hygiene.

Observation on 09/13/11 at 9:50 a.m. showed two CNAs (#9 and #10) assisted Resident #14 with incontinence cares while she remained in bed. After the CNA (#10) completed pericares with disposable peri-wipes. Without changing gloves or performing hand hygiene, the CNA (#10) applied Calmoseptine ointment to an excoriated area on the resident's buttock. The CNA (#10) changed her gloves, removed the soiled brief, applied a clean brief, and finished dressing the resident, and then removed her gloves. The CNA (#10) failed to perform hand hygiene prior to assisting the resident with dressing.

Observation on 09/13/11 at 2:05 p.m. showed two CNAs (#12 and #13) assisted Resident #14 onto a bedpan. After the resident finished using the bedpan, observation showed stool and urine in the bedpan. The CNA (#12) performed perineal cares, applied Calmoseptine ointment to an

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 _____	09/15/2011

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 441	Continued From page 49	F 441		

excoriated area on resident's buttock, and placed a clean brief. The CNA (#12) removed his gloves, assisted Resident #14 to her wheelchair, offered water, and combed her hair. The CNA (#12) donned gloves and dumped the contents of the bedpan into the toilet. The CNA then obtained the disposable wipes from the resident's bedside table drawer and cleaned the bedpan. The CNA (#12) failed to perform hand hygiene after assisting the resident with perineal cares and removing his gloves.

- Review of Resident #13's medical record occurred on all days of survey. An annual MDS, dated 08/25/11, identified Resident #13 required total assistance of two or more staff members for bed mobility, transfers, dressing, toileting, and personal hygiene.

Observation on 09/13/11 at 5:10 p.m. showed two CNAs (#12 and #30) assisted Resident #13 with incontinence cares while she remained in bed. Observation showed the resident incontinent of urine and stool. After completing pericares, the CNA (#12) changed his gloves without performing hand hygiene, continued to apply a clean brief, assisted the resident with dressing, and transferred the resident with the mechanical lift to her wheelchair. The CNA (#12) then removed his gloves, failed to perform hand hygiene and proceeded to comb the resident's hair, offer fluids, place a pillow under the resident's legs, and cover the resident with a blanket. The CNA (#12) exited the resident's room without completing hand hygiene at any time during the cares provided.

On 09/14/11 at 7:50 a.m., two CNAs (#9 and #32)

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 _____	09/15/2011

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 441	Continued From page 50	F 441		

assisted Resident #13 with incontinence cares while the resident remained in bed. Observation showed the resident incontinent of urine and stool. After completing pericares, the CNA (#9) changed her gloves, failed to perform hand hygiene and placed a clean brief. The CNA (#9) then removed her gloves and continued to reposition the resident and offer her fluids.

- Observation on 09/13/11 at 10:55 a.m. showed, Resident #7 in the bathroom. After the resident voided, a CNA (#26) donned gloves, assisted the resident to stand, and provided pericares using a pre-soaked wipe. The CNA cleansed the resident's perineum from the pubis to the rectum three times without turning the wipe to a clean area. The CNA (#26) failed to use a different area of the cleansing wipe or to obtain a fresh wipe when cleansing the resident's perineum.

- Berman, Snyder, Kozier, and Erb, Kozier & Erb's Fundamentals of Nursing Concepts, Process, and Practice, 8th edition, Pearson Education, Inc., Upper Saddle River, New Jersey, 2008, page 888, stated ". . . Approach the eye from the side and instill the correct number of drops onto the outer third of the lower conjunctival sac. . . Rationale: . . . The dropper must not touch the sac or the cornea."

Observation of medication pass occurred on 09/14/11 beginning at 10:45 a.m. During this observation, three random residents received eye drops. A facility nurse (#11) administered eye drops for two residents using designated multidose bottles. While administering the eye drops, the resident's eyelids (the border of the conjunctival sac) came in contact with their

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 _____	09/15/2011

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 441	Continued From page 51 bottles, causing contamination of the bottle by the proteins in the mucus of the eye.	F 441		