STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. Building B. Wing	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountrail Bethel Home	615 6th St SE Stanley, ND 58784

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Potential for minimal harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 28398 Based on record review, policy review, and resident and staff interviews, the facility failed to provide a quarterly financial statement for 1 of 1 sampled resident (Resident #2) and 1 supplemental resident (Resident #22) reviewed for personal fund accounts. Failure to provide residents or their representatives with quarterly financial statements prevented the resident or representative from verifying transactions and fund balances. Findings include: Review of the facility policy titled Trust Fund Account, dated April 2012, stated, . Statements showing the transactions and interests are sent out on a quarterly basis to the resident or the person they have designated for this. During interviews on the afternoon of 12/06/22, Resident #22, identified as cognitively intact, stated her son left money for her, but if there was a statement it would go to him. Resident #2, identified with moderately impaired cognition, was unaware she had money in a personal fund account. During an interview on 12/06/22 at 2:22 p.m., a business office staff member (#4) stated she has never sent out a quarterly financial statement to the residents/representatives related to their trust funds, but the resident/representative can call and check the balance at any time.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46259 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/23/21. Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 1 supplemental resident with a MDS review (Resident #1). Failure to accurately code the MDS does not allow each resident's assessment to reflect their current status/needs and may negatively affect the development of a comprehensive care plan and the care provided to the resident. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2019, page K-5 to K-6 stated, . Weight loss . From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago. If the current weight is less than the weight in the observation period 30 days ago, calculate the percentage of weight loss . Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician. Review of Resident #1's medical record occurred on 12/05/22 and 12/06/22. A quarterly MDS, dated [DATE], identified a weight loss. Review of Resident #1's weight documentation showed a weight of 150 pounds on 10/13/22, 152 pounds on 09/07/22, and 158 pounds on 04/07/22 (1.32% weight change in 30 days and 5. 06% weight change in 180 days). This is not indicative of a significant weight loss in 30 or 180 days. During an interview on 12/08/22 at 12:56 p.m., an administrative dietary staff member (#3) confirmed the facility staff inaccurately coded the MDS for weight loss.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28398 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/23/21. Based on observation, record review, policy review, and resident and staff interview, the facility failed to review and revise the comprehensive care plans to reflect the residents' current status for 2 of 12 sampled residents (Resident #2 and #10). Failure to update the care plans as needed may result in delayed treatment interventions and inadequate/inconsistent care delivery. Findings include: Review of the facility policy titled Care Plan and Care Conference occurred on 12/08/22. This policy, dated 02/09/17, stated, . The Care Plan will [sic] completed in accordance with the State and Federal guidelines. Each resident is assessed on a quarterly basis by the members of the Care Planning Team. The team members then meet to go over each assessment at least quarterly and at a minimum of two times per year. - Review of Resident #10's medical record occurred on all days of survey. Diagnoses included non-pressure chronic ulcer of other part of right foot with unspecified severity and type 2 diabetes mellitus with other skin ulcer. Resident #10's physician's orders included: * 10/20/22, For ulcer between right 4th and 5th toe apply iodine and 2x2 [two inch by two inch gauze pad] between toes every morning for 2 weeks if not improving schedule with Dr. [doctor] [name of podiatrist]. [discontinued 11/17/22] * 11/18/22, use silicone spacer between 4th and 5th toe of right foot one time a day for ulcer The podiatry consult, dated 11/16/22, stated, dx [diagnosis] diabetic ulcer r. [right] 5th toe, hx [history] prior surgery r. 5th toe. no s/s [sign/symptom] infection, faint pulse bil [bilaterally], debrided ulcer today, shoes too narrow, causing condition to begin with likely. need wider shoes, use silicone spacer b/t [between] 4-5 toes r. may need surgery in office, f/u [follow-up] 1 month. During an interview on 12/05/22 at 3:57 p.m., Resident #10 stated she had a sore between her 4th and 5th right toes, now healed. The podiatrist told her to wear wider shoes, but she does not like them, but liked her current shoes which she thought fit well. Observation showed the resident's laced shoes appeared snug on her feet. During an interview on 12/08/22 at 12:53 p.m., an administrative nurse (#1) stated Resident #10's ulcer healed, the facility notified the resident and family of the podiatrist's recommendation for wider shoes, but the resident refused and family is okay with that. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at 12/08/22 at 1:33 p.m., an administrative nurse (#2) stated Resident #10's ulcer healed; the ulcer tends to come and go. The nurse stated, We are implementing care plan reviews to include CNAs [certified nurse aides] for their input to catch things that are being missed. The current care plan stated, . SKIN: I have potential for skin breakdown related to immobility, Diabetes, and dependence on staff for ADL [activities of daily living] cares. I want my skin to remain intact. Report to my doctor as indicated. Assist with bathing and monitor skin frequently. Report any concerns to nurse/MD [medical doctor] as appropriate. Failure to include Resident #10's history of recurrent toe ulcers in the care plan, the podiatrist's recommendation for wider shoes, use of silicone toe spacers, or other pertinent interventions may result in future ulcer development. 45873 - Review of Resident #2's medical record occurred on all days of survey. Diagnoses included type II diabetes mellitus. A podiatry consult, dated 11/16/22 stated, Chemical ablation [medical procedure that removes a layer of tissue] of all 10 toes [sic]. Resident #2's physician's orders included: *11/16/22, Cover toenails with 4x4 gauze daily and clean sock. No hard toe shoes. one time a day for Ablation of all 10 toenails until 11/30/2022. [completed 11/30/22] The primary care provider note, dated 12/01/22 at 10:30 a.m., stated, . Chief complaint: Re-check bilateral feet. History of present illness: The patient is seen today resting comfortably in her wheelchair. The patient had chemical removal of all 10 of her toenails by podiatry two weeks ago. We are doing regular dressing changes and is seen today just to recheck these feet. She does state some mild discomfort with dressing changes, otherwise no pain noted. Assessment: chronic dystrophic toenails, status post chemical matrixectomy [removing the growth area of the nail that is leading to the curved ingrown toenail]. Plan: no sign of any active inflammation or infection currently. We will continue the dressing changes as recommended per podiatry, otherwise will continue to follow for regular scheduled rounds and sooner if any problems arise. The progress notes stated the following: * 12/1/2022 at 12:27 p.m., . Dr. [name of primary care provider] here and assessed resident's toes due to Nursing staff voicing concerns. Toes continue to drain and large [sic] to right foot is quite red. Resident has increased pain in her toes also. Dr. [name] will consult Dr. [name of podiatrist] for any further instructions. * 12/8/2022 at 9:26 a.m., . Dressing change complete, drainage noted. Ace wraps applied. During an interview on 12/05/22 at 12:46 p.m., Resident #2 stated her toenails were removed. The resident stated her toes were sore and that her stockings rubbed. She liked when they wrapped them, but she must ask for that. Observation showed the stockings had dried blood. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current care plan stated, . SKIN/PRESSURE: I am at risk for skin breakdown due to intermittent incontinence and decreased mobility. , The care plan lacked inclusion of the toenail removal and related interventions. Failure to include Resident #2's recent toenail removal as a new problem and develop/implement pertinent interventions may result in wound complications and pain for the resident. During an interview on 12/08/22 at 1:05 p.m., two administrative nurses (#1 and #2) agreed care plans should be updated when new problems are identified.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45873 UTI TREATMENT 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide care in accordance with professional standards for 1 of 2 sampled residents (Resident #23) with a urinary tract infection (UTI). Failure to promptly treat a resident's urinary tract infection caused pain, discomfort, need for further treatments, and the potential for a serious bloodstream infection. Findings include: A review of the facility's Suspected UTI Protocol Form occurred on 12/08/22. This protocol, revised 09/30/2020, stated, . With Catheter: MUST have TWO of the following symptoms, Fever 100.4 degrees Fahrenheit (F) or above, new or increased incontinence, urgency, dysuria [painful urination] foul smelling urine, chills, frequency, suprapubic or flank pain/tenderness, change or worsening of mental or functional status. If resident meets the criteria for UTI protocol, push fluids and administer UtyMax [a cranberry based supplement which provides the nutrients for the dietary management and prevention of recurrent urinary tract infections] BID [twice a day] for 72 hours. Symptoms shall be reassessed each shift for presence of the above symptoms. At the end of 72 hours IF symptoms persist, obtain a urinalysis and review results with physician. Review of the facility's policy titled Lab and Radiology Services occurred on 12/08/22. This policy, implemented December 2020 stated, . 4. Results of lab and /or radiology are printed to the nurse's station printer, and results need to be relayed onto the provider to be reviewed. Review of Resident #23's medical record occurred on all days of survey. Diagnoses included: type 2 diabetes mellitus with diabetic chronic kidney disease, urinary incontinence, presence of urogenital implants, and disorders of bladder. The current care plan stated, . Urinary: I am at risk for UTI's r/t [related to] placement of foley catheter. I want to remain free of UTI and other complications through review date. I want staff to assist in performing catheter cares BID and as needed. I want staff to encourage me to drink adequate amounts of fluid throughout the day. I want staff to monitor for s/sx [signs and symptoms] of UTI and report to nurse/MD [medical doctor] as indicated. Initiate UTI protocol when indicated per policy. During an interview on 12/05/22 at 1:20 p.m., Resident #23 stated she had a UTI and was on an antibiotic that took them a while to start because they said they were waiting for the culture to come back. The resident reported a history of UTIs. Record review showed UTI treatment on 09/23/22 and 10/28/22 and frequent pain. Resident #23's progress notes showed the following: * 11/22/22 at 09:04 a.m., . UTI Protocol completed and urine sample has been sent to the lab. Urine continues to be cloudy and foul smelling. Resident had complaint of suprapubic and flank pain on HS [hour of sleep]. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	* 11/22/22 at 2:35 p.m., . Concern slip back from Dr. [name] . UA collected and sent to lab and results sent to Dr. [name]. * 11/22/22 at 3:40 p.m., . Labs have been reviewed by Dr. [name]. He is waiting until the culture come [sic] back before new orders. * 11/29/22 at 12:10 p.m., . Culture back and Dr. [name] reviewed and placed resident on Macrobid 100mg 2x daily times 5 days. * 11/30/22 at 8:10 p.m., . Resident very lethargic and moaning. Vital signs taken and BP [blood pressure] very low at 74/45, pulse 88, Temp 97.7, resp 24, O2 [oxygen saturation] 96%. Resident was just started on Macrobid for UTI. TC [telephone call] to on call provider [name] PA [physician's assistant] regarding situation. Orders received to give Bolus of 1 liter NS [normal saline] IV [intravenously] now. * 11/30/22 at 9:45 p.m., . IV infusion complete. Vital signs are as follows, BP 87/42, Resp 20, Pulse 89, Temp 98.4, 93% O2 RA. Disconnected IV tubing from arm. TC to [name] PA with results . * 12/01/22 at 6:23 a.m., . Foley catheter changed as balloon had deflated. New 16FR indwelling foley catheter inserted with immediate return of urine. Urine dark yellow in color. BP checked et [and] was 113/59-P [pulse] 88 . O2 sat 99% on RA [room air]. * 12/01/22 8:57 a.m., . C/o [complained of] lower backpain and tylenol given at breakfast. Tearful at times. vitals-98.3-62-20 109/54 95% on room air. Remains in bed per request. Appetite fair. On antibiotic therapy and no adverse reaction noted. Fluids encouraged. Foley catheter draining dark yellow urine. * 12/01/22 at 11:34 a.m., . Resident was seen by Dr. [name] for C/O back pain. Last evening had a very low BP and received fluids. Resident has not felt well the last couple of days and has been in bed. Order for CBC [complete blood count] and a CMP [comprehensive metabolic panel]. * 12/02/22 at 2:28 a.m., . Resident in better spirits during HS cares. No crying noted and states she had said she wanted to die but if she thinks she is doing better she will feel better. She states that she is feeling better and would like to play on tablet and sit in wheelchair. Urine continues to be dark amber in color. No sediment noted. No s/s of ADR [adverse drug reaction] noted to starting macrobid. vitals WNL[within normal limits]. Record review identified the urine culture report as final on 11/24/22; however, facility staff failed to implement interventions until 11/29/22 (five days later). The facility failed to follow up on labs and treatment for a resident with a history of UTIs. This delay in treatment caused Resident #23 to experience pain, other symptoms of an infection, and the need for IV fluids. WOUND ASSESSMENT AND TREATMENT (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. Based on observation, record review, review of facility policy, and staff and resident interview, the facility failed to provide treatment and care in accordance with professional standards for 1 of 1 sampled residents (Resident #2) with edema (excess fluid accumulation in the body tissues) and a new surgical wound. Failure to utilize compression stockings or wraps as ordered for edema and assess wounds may result in worsening edema, skin breakdown, or infection. Findings include: Review of facility policies occurred on 12/08/22. The Elastic Stocking/Anti-Embolism/Ted Hose Policy, dated December 2020, stated, . A provider's order must be obtained. [NAME] hose should be applied in the morning and taken off at bedtime unless otherwise ordered. The Wound Treatment Management Policy, dated December 2020, stated, . Policy: to promote wound healing of various types of wounds. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. Wounds will be assessed weekly, every Tuesday, and documented on the wound Assessment Sheet within the Wound Binder at the nurse's station. Any concerns will be forwarded to the provider. Review of Resident #2's medical record occurred on all days of survey. Diagnoses included chronic diastolic (congestive) heart failure and type 2 diabetes mellitus. The facility completed a significant change Minimum Data Set (MDS) on 11/07/22 for weight gain and the addition of a diuretic. The current care plan stated, . Excess Fluid Volume: I am at risk for edema. I want to have minimal edema and any presence of edema to be well managed. I need assisted [sic] with putting on my ted stocking/ace wraps in the morning and off at bedtime. Interviews and observations showed the following: * 12/05/22 at 12:46 p.m., Resident #2 stated her toenails were removed. The resident stated her toes were sore and that her stockings rubbed on them. She liked when they wrapped them, but she must ask for that. Observation showed dried blood on her stockings, and no compression stockings or wraps on lower extremities. * 12/05/22 at 03:50 p.m., two nurses (#10 and #11) applied dressings to Resident #2's toes per her request. The nurse (#11) stated, you must've been up a lot today your feet are more swollen. Observation showed no compression stockings or wraps on the resident's lower extremeties and the presence of edema. * 12/06/22 at 11:40 a.m., no compression stockings or wraps present on Resident #2's lower extremities. * 12/07/22 at 3:20 p.m., no compression stockings or wraps present on Resident # 2's lower extremities. Orders included: 08/15/22, TED stocking/ace wraps to bilateral lower extremities [BLE], on in am, off in pm every day and evening shift for edema. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	11/16/22, Cover toenails with 4x4 [size of gauze dressings] gauze daily and clean sock. No hard toe shoes. One time a day for Ablation (medical procedure that removes a layer of tissue) of all 10 toenails until 11/30/2022. [Completed 11/30/22] The primary care provider note, dated 12/01/22 at 10:30 a.m., stated, . Chief complaint: Re-check bilateral feet. The patient had chemical removal of all 10 of her toenails by podiatry two weeks ago. We are doing regular dressing changes and is seen today just to recheck these feet. She does state some mild discomfort with dressing changes, otherwise no pain noted. We will continue the dressing changes as recommended per podiatry, otherwise will continue to follow for regular scheduled rounds and sooner if any problems arise. Resident #2's treatment administration record (TAR) showed staff applied the TED hose on December 5, however, observation showed no TED hose in place. On December 6 and 7, facility staff documented a 9 on the TAR indicating other and to refer to the progress notes. The record lacked documentation in the progress notes. Review of Resident #2's medical record lacked weekly wound assessments as per policy. The record also lacked documentation for not applying the compression stockings or wraps. During an interview on 12/08/22 at 01:05 p.m., two administrative staff (#1 and #2) stated they expected staff to document wound assessments in the progress notes. They also stated that if staff document a 9 in the TAR, they expected staff to document the reason in a progress note.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46259 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices necessary to prevent accidents for 1 of 6 sampled residents (Resident #4) and 1 supplemental resident (Resident #1) observed during a pivot transfer. Failure to utilize a gait belt during transfers places residents at risk of an accident and/or injury. Findings include: Review of the facility policy titled Use of Gait Belt Policy at Mountrail Bethel Home occurred on 12/07/22. This policy, dated December 2020, stated, . It is the policy of Mountrail Bethel Home to use gait belts with residents that need assistance to ambulate or transfer for the purpose of safety. - Review of Resident #4's medical record occurred on all days of survey. The care plan stated, . TRANSFERS: I transfer with assistance of 2 staff or Hoyer lift or standing lift . Observations of Resident #4 showed the following: * 12/06/22 at 8:53 a.m., two certified nursing assistants (CNAs) (#5 and #6) transferred the resident from the Broda [specialized mobility] wheelchair to the bed. The CNAs lifted the resident under each arm to pivot transfer. * 12/06/22 at 11:13 a.m., two CNAs (#5 and #7) transferred the resident from the bed to the Broda wheelchair. The CNAs lifted the resident under each arm to pivot transfer. * 12/06/22 at 4:11 p.m., two CNAs (#5 and #8) transferred the resident from the bed to the Broda wheelchair. The CNAs lifted the resident under each arm to pivot transfer. A gait belt hung on a hook outside the bathroom door. Staff failed to use the gait belt during each observed transfer. -Review of Resident #1's medical record occurred on all days of survey. The care plan stated, . FALLS . I require Ax2 [assistance of two staff] for pivot transfer or the use of stand-lift. Observation on 12/06/22 at 10:06 a.m., showed two CNAs (#5 and #7) transferred Resident #1 from the Broda wheelchair to the recliner chair. The CNAs lifted the resident under each arm to pivot transfer. Staff failed to use a gait belt during the transfer. During an interview on 12/08/22 at 1:57 p.m., two administrative nurses (#1 and #2) stated they expected staff to use the gait belt during all assisted transfers and staff should not lift residents under the arms to perform a transfer.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28398 Based on review of the Payroll Based Journal (PBJ) Staffing Data Report, information from the complainant, review of nurse staffing schedules, and staff interview, the facility failed to provide the services of a licensed nurse for 24 hours a day, seven days a week, on 48 of 168 days of nursing schedules ([DATE]-[DATE]) reviewed. Failure to schedule a nurse 24 hours a day may result in inefficient or lack of coordination of care/services, limited ability to promptly respond to residents' needs or administrative concerns, and could lead to confusion and/or an adverse outcome in an emergency; therefore, endangering residents' health, safety and well-being. During the on-site recertification and complaint survey, the team determined a potential Immediate Jeopardy (IJ) situation existed on [DATE] at 4:19 p.m. The IJ potential resulted from review of the nurse staffing schedules indicating lack of licensed nurse coverage 24 hours a day. This finding placed residents in immediate danger due to the lack of a licensed nurse present to assess and manage resident health and safety. * [DATE] at 1:45 p.m., During an interview, an administrative nurse (#9) and an administrative staff member (#13) stated the practice to staff a medication aide in place of a nurse from 6:00 p.m. to 10:00 p.m. started sometime in the past year per a prior administrative staff member's suggestion, so management or other nurses would not have to cover those hours. They stated the hospital emergency room (ER) nurses were available to call if needed. The administrative staff member (#13) stated, We have changed that practice now, and will never staff that way again. We have fixed the schedule right away. * [DATE] at 4:19 p.m., The survey team contacted the State Survey Agency (SSA) to report the findings and discuss potential IJ. * [DATE] at 5:15 p.m., The SSA contacted the survey team after discussion with the CMS (Centers for Medicare & Medicaid Services) location and verified the presence of IJ. * [DATE] at 5:28 p.m., The survey team notified the assistant director of nursing (ADON), who notified the administrator and director of nursing by phone/email, of the IJ situation, provided them with the IJ template, and requested they develop a plan for removal of the immediate jeopardy. * [DATE] at 6:44 p.m., The ADON presented the IJ removal plan which the survey team reviewed and accepted. The ADON stated the current schedule ended on [DATE] and there were no medication aides scheduled to work alone for that time period. Review of the schedule confirmed this statement. * [DATE] at 10:13 a.m., The survey team verified the facility carried out the IJ removal plan and the survey team removed and reduced the IJ situation from a scope/severity of L or a scope/severity of F. * [DATE] at 2:58 p.m., The SSA notified the CMS location of the removal of IJ. Findings include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355044	A. Building B. Wing	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountrail Bethel Home	615 6th St SE Stanley, ND 58784

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the PBJ Staffing Data Report, for the quarter of [DATE] - [DATE], showed the facility triggered for Failed to have Licensed Nursing Coverage 24 Hours/Day on four days. Information provided by the complainant stated concern for cares and assessments of residents as the complainant noted only a medication aide and certified nurse aides scheduled at night, but no nurse. The facility provided a copy of the nurse staffing schedules for the time period of [DATE] - [DATE]. A review of the schedules identified 48 days the facility scheduled a medication aide instead of a licensed nurse during a portion of the 24-hour day. The facility lacked nurse coverage from 6:00 p.m. to 10:00 p.m. on 45 days and from 7:00 p.m. to 10:00 p.m. on three days. The last day scheduled without a nurse for 24 hours was [DATE]. Medical record review of the past four months identified six of 12 sampled residents (Resident #18, #24, #25, #27, #28, and #29) with falls with or without injuries, a resident (#29) on intravenous (IV) antibiotics per a PICC line (peripherally inserted central catheter, a form of IV access) who pulled out the PICC line twice, two residents (#21 and #28) with wander guards of which one resident eloped, and one resident on comfort cares who expired. The nurse staffing schedule showed at the time of the resident's death, only one medication aide and five certified nurse aides scheduled, with one administrative nurse on-call. During an interview on [DATE] at 5:28 p.m., the ADON stated when a medication aide was scheduled without a nurse present, the medication aide was supposed to call one of the nurse managers before contacting a hospital nurse. The ADON stated, I don't think the ER nurse ever had to come over to the facility. We would help per phone or come in. During an interview on [DATE] at 6:09 p.m., a certified nurse aide/medication aide (#14) who worked evenings and nights, stated the last time she worked without a nurse present was last week from ,d+[DATE] p.m. We were told that a nurse from the hospital was available if needed, but were told to call the nurse on-call first. The medication aide clarified the on-call nurse as the facility director of nursing (DON), ADON, or other nurse manager. She stated she never called a hospital nurse for assistance as she always called the DON or ADON first, for example, when a resident needed an as-needed (PRN) medication or questions from family members.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 28398 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 09/23/21. Based on review of the Payroll Based Journal (PBJ) Staffing Data Report, policy review, review of nurse staffing schedules, and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day, seven days a week, for six days of the 100-day period from 08/27/22 to 12/04/22. Failure to ensure sufficient, qualified nursing staff are available on a daily basis has the potential to affect the health and safety of all the residents residing in the facility. Findings Include: Review of the facility policy titled RN Coverage occurred on 12/07/22. This policy, dated 03/16/06, stated, . a Registered Nurse will be on duty for 8 consecutive hours every 24 hours. Mountrail Bethel Home will define the 24 hour period of time from 0600-0600. Review of the PBJ Staffing Data Report, for the quarter of July 1 - September 30, 2022, showed the facility triggered for No RN Hours on four different days. The facility provided a copy of the nurse staffing schedules for the time period of June 26 - December 10, 2022. A review of the schedules showed the facility designated RN coverage with an RN scheduled the same shift in the hospital on six weekend days: August 27 and 28, September 25, October 9 and 23, and December 4, 2022. During an interview on 12/07/22 at 10:15 a.m., three administrative nurses (#1, #2, and #9) stated they staffed 8-hour RN coverage with a hospital emergency room RN only as a last resort. The hospital RN was available to call for questions/assistance, but was not physically present in the skilled nursing facility as required. They agreed assigning a hospital RN does not meet the requirement for 8-hour RN coverage.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 28398 Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 2 of 5 residents observed during medication administration (Resident #10 and #32). Two medication errors occurred during staff administration of 32 medications, resulting in a 6% error rate. Failure to properly administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of the facility policy titled Insulin Pen occurred on 12/07/22. This policy, dated December 2020, stated, . Attach safety pen needle . Prime the insulin pen: a. Dial 2 units by turning the dose selector clockwise. b. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. Review of the facility policy titled Medication Administration occurred on 12/07/22. This policy, dated December 2020, stated, . Review MAR [Medication Administration Record] to identify medications to be administered. 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. Observation of medication pass showed the following: * 12/06/22 at 11:40 a.m., a nurse (#10) attached a needle to Resident #10's Novolog insulin flex pen, dialed the dose to two units, held the pen horizontally and pushed the button to expel the air. The nurse then dialed the dose selector to three units prior to administering the insulin to Resident #10. The nurse failed to hold the insulin pen upright to prime it or watch for a drop of insulin at the tip of the pen. * 12/07/22 at 8:20 a.m., a nurse (#12) administered magnesium oxide 400 milligrams (mg) from a stock bottle to Resident #32. The medical record showed the order for the resident's magnesium oxide stated 500 mg. The nurse gave an incorrect dose of magnesium oxide to Resident #32. During an interview on 12/07/22 at 3:32 p.m., a nurse (#12) verified 500 mg as the correct magnesium oxide dose. During an interview on 12/07/22 at 3:43 p.m., an administrative nurse (#1) stated staff should prime insulin pens with 2 units, pointing the pen upward.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46259 Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 1 of 6 sampled residents (Resident #4) observed during perineal care. Failure to follow infection control practices related to hand hygiene has the potential to transmit infections to other residents, staff, and visitors. Findings include: Review of the facility policy titled Hand Hygiene Policy at Mountrail Bethel Home occurred on 12/07/22. This policy, dated December 2020, stated, . All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. Hand hygiene is indicated and will be performed . Before applying and after removing personal protective equipment (PPE), including gloves. When, during resident care, moving from a contaminated body site to a clean body site. After assistance with personal body functions (e.g., elimination, hair grooming, smoking) . Observation of Resident #4 showed the following: * 12/06/22 at 8:53 a.m., two certified nursing assistants (CNAs) (#5 and #6) transferred the resident from the wheelchair to bed and completed perineal cares. One CNA (#5) cleansed the rectal area with disposable wipes. The CNA (#5) removed her gloves, applied new gloves, assisted the CNA (#6) to place brief, and adjusted the resident's pants. The CNA (#5) removed her gloves, applied new gloves, and covered the resident with a blanket. The CNA (#5) failed to perform hand hygiene after cleansing the resident's rectal area and between glove use. *12/06/22 at 11:13 a.m., two CNAs (#5 and #7) completed perineal cares. One CNA (#5) lowered the resident's pants, removed the brief, cleansed the perineal area with a disposable wipe, and removed her gloves. The CNA (#5) applied new gloves, assisted the CNA (#7) to place brief, and removed her gloves. The CNA (#5) failed to perform hand hygiene after cleansing the resident's perineal area and between glove use. *12/06/22 at 4:11 p.m., two CNAs (#5 and #8) completed perineal cares. One CNA (#8) cleansed the resident's rectal area with a disposable wipe, placed a new brief on the resident, removed her gloves, donned new gloves, and continued to assist CNA (#5) with dressing of the resident. The CNA (#8) failed to perform hand hygiene after cleansing the resident's rectal area and between glove use. During an interview on 12/08/22 at 1:57 p.m., two administrative nurses (#1 and #2) confirmed staff failed to follow the facility's policy regarding hand hygiene.