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	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Lutheran Nursing & Rehabilitation Center	1515 2nd Ave West Williston, ND 58801

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 39211 Based on observation, review of facility policy and resident and staff interview, the facility failed to ensure a safe, clean, comfortable, and homelike environment for 3 of 21 sampled residents (Resident #21, #37 and #70) and 5 supplemental residents (#12, #18, #45, #46 and #60) observed during the survey. Failure to maintain a clean, comfortable, and sanitary environment does not provide a homelike living area for residents and fails to promote dignity Findings include: Review of the facility policy titled Wheelchair Cleaning occurred on 11/17/22. This policy, dated August 2022, stated, Resident wheelchairs will be cleaned by staff weekly on bath days per CNA [certified nurse assistant] electronic tasking and prn [as needed]. Review of the facility policy titled Supplies and Equipment, Nursing Services occurred on 11/17/22. This policy, dated August 2022, stated, . Equipment must be ready for use at all times of the day and night to serve the residents' needs. Care should be exercised in the handling and in the use of our equipment to prevent damage or breakage. For repair of equipment, pull all faulty equipment and place work order on the intranet marking it as high priority. Observation on all days of survey showed the following: - Resident #12's inside room door handle fell off when used to open and closed, the handle needed to be placed back onto the door with each use. A hole in the wall where the door handle meets the wall. - Resident #18's right hip wheelchair bolster cushion worn with peeled/missing material on the outer covering. - Resident #21's wheelchair with white debris on the upper right top of chair, dry liquid streaks on the right armrest/cushion, and dry debris on the footrest cushion. - Resident #37's left arm bolster and right back positioning wedge on the resident's wheelchair worn with peeled/missing material on the outer covering, the repair patch on the wheelchair seat cushion peeling off, cracks present to the upper wheelchair back, both wheelchair wheels soiled, and purple dried liquid drips on the wall adjacent to the resident's head of bed. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident #45's wheelchair with dust and debris on the lower metal frame and both wheelchair wheels with white splatters that appeared as dried spilled milk. The vinyl of the wheelchair back and right arm rest with cracks. - Resident #46's room showed paint scuffed and scratched off the wall next to the bed. During an interview the morning of 11/16/22, Resident #46 stated, I don't know what those marks are on the wall. - Resident #60's white chuck/draw sheet on top of his blankets with a dried gray colored stain and a fresh brown smear stain. - Resident #70's wheelchair with layer of dust on the spokes of the wheels, one spoke on the right wheel had dry liquid debris, and the metal frame under the wheelchair seat contained dust and debris. During an interview the morning of 11/17/22, an administrative staff (#1) reported staff are expected to clean resident wheelchairs and assistive devices weekly. 40488

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 40488 Based on information provided by the complainant, observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary services for 2 of 21 sampled residents (Resident #37 and #42) and 10 supplemental residents (#2, #4, #14, #18, #39, #49, #52, #53, #82 and #83) who required assistance with activities of daily living (ADLs). Failure of facility staff to provide needed assistance for toileting/hygiene of residents may result in low self-esteem, skin breakdown, and/or urinary tract infections. Findings include: Information provided by the complainant indicated staff failed to provide toileting assistance for residents. Review of the facility policy titled Incontinence Care occurred on 11/17/22. This policy, reviewed January 2022, stated, Residents who are incontinent are checked for toileting and changed according to their individualized toileting schedule and/or plan of care. Perineal care is provided to residents after each incontinent episode. Review of Resident's #2, #4, #14, #18, #37, #39, #42, #49, #52, #53, #82, and #83's medical records identified extensive to total assistance of one to two staff required for transfer, toileting, and personal hygiene. Observation on 11/15/22 of Resident's #2, #4, #14, #18, #37, #39, #42, #49, #52, #53, #82, and #83 showed the following: * The residents served breakfast, which began at 7:30 a.m. and ended at 9:00 a.m. * After breakfast, the resident's seated in their wheelchairs and pushed out to the Harmony unit lounge facing the television. * At 10:31 a.m., all 12 residents remained in their wheelchairs in the same location in the Harmony lounge. Nine of the 12 residents slept with their heads hanging down. * At 11:13 a.m., all 12 residents remained in their wheelchairs in the same location in the Harmony lounge facing the television. Without toileting, the staff began to take the residents to the dining room for lunch. During an interview on 11/16/22 at 5:15 p.m., an administrative nurse (#1) stated she expected facility staff to complete rounds every two hours including check/change and toileting of residents. During an interview the morning of 11/17/22, the administrative nurse (#1) stated she reviewed video footage on 11/15/22, after breakfast until lunch, and failed to confirm staff checked/changed or toileted Residents #2, #4, #14, #18, #37, #39, #42, #49, #52, #53, #82, and #83.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 40488 Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide perineal/catheter care in a manner consistent with standards of practice to prevent urinary tract infections (UTIs) for 2 of 2 sampled residents (Resident #37 and #42) observed receiving inappropriate perineal care. Failure to provide perineal care according to acceptable standards of practice placed residents at risk of developing urinary tract infections. Findings include: Review of the facility policy titled Catheter Care occurred on 11/17/22. This policy, reviewed January 2022, stated, . clean the tube first at the urethral opening [opening where urine leaves the body], and away from the opening. Use only one downward stroke at a time, use a clean area of the cloth each time. Remainder of perineal care is done as usual . Review of the facility policy titled Perineal Care occurred on 11/17/22. This policy, reviewed January 2022, stated, . Females . cleanse perineum . Clean urethral meatus [opening] and vaginal orifice [opening] using clean portion of washcloth . with each stroke. Males . Begin cleansing tip of penis and working outward. Cleanse the shaft of the penis, using downward strokes toward the scrotum. Use separate section of washcloth . with each stroke. - Review of Resident #37's medical record occurred on all days of survey. Diagnoses included a history of UTIs. The resident's care plan identified the resident as always incontinent of bowel and bladder and required extensive assistance of two staff members for toileting needs. Observation on 11/16/22 at 4:13 p.m. showed a certified nurse assistant (CNA) (#2) provided perineal cares to Resident #37 while in bed. The resident incontinent of urine. The CNA removed the resident's brief, used a washcloth to cleanse the resident's groin, and without folding the washcloth or obtaining a new washcloth, cleansed the frontal pubic area. The CNA (#2) failed to cleanse the urethral/vaginal areas. - Review of Resident #42's medical record occurred on all days of survey. Diagnoses included obstructive uropathy (obstruction of urine flow) and a history of UTIs. The resident's care plan identified the resident with an indwelling catheter, always incontinent of bowel, and required extensive assistance of two staff members for toileting needs. Review of Resident #42's medical record, from December 2021 through November 2022, showed the resident hospitalized with a UTI with urosepsis (infection of the bloodstream caused by a UTI) on 12/10/21, 01/23/22, 05/04/22 and 11/02/22. Observation on 11/16/22 at 9:15 a.m. showed a CNA (#2) provided catheter/perineal cares to Resident #42 while in bed. The CNA used a washcloth to wipe the resident's catheter tubing, and without folding the washcloth or obtaining a new washcloth, wiped the penis tip, the scrotum/groin area, and then the penis shaft. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/17/22 at 9:03 a.m., an administrative nurse (#1) agreed staff failed to perform cares for Residents #37 and #42 according to the facility's policy or acceptable standards of practice.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40488 Based on observation, record review, review of professional reference, review of facility policy, resident interview, and staff interview, the facility failed to provide proper respiratory treatment and care consistent with standards of practice and physician's orders for 2 of 4 sampled residents (Resident #40 and #56) receiving tracheostomy cares, suction, oxygen therapy, and nebulizer treatments. Failure to follow respiratory standards of practice may result in complications and compromise of the residents' respiratory status. Findings included: Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 1308 & 1310, stated, . Suctioning a Tracheostomy . Purposes: To maintain a patent airway and prevent airway obstructions. To promote respiratory function (optimal exchange of oxygen and carbon dioxide into and out of the lungs). To prevent pneumonia that may result from accumulated secretions. Document relevant data. Record the suctioning . Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 62, stated, . Carrying Out a Physician's Order. Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescriber . Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, pages 1311-1313, stated, . Providing Tracheostomy Care . Equipment . Cotton twill ties or Velcro collar . Velcro Collar Method . Take the second piece of the collar around the back of the client's neck, keeping it flat. Have the client flex the neck and secure the two pieces of the collar together with the Velcro, allowing space for one to two fingers between the collar and the client's neck. Review of the facility policy titled [NAME] Tube Care occurred on 11/17/22. This policy, dated August 2020, stated, . ensure that residents who need respiratory care are provided such care consistent with professional standards of practice . Cleaning the [NAME] Tube [a tube to maintain an airway after a laryngectomy (surgical removal of the larynx)] . scrub the tube with a . soft bristle brush with warm water and mild soap. Rinse clean. With insertion, only use a water-soluble lubricant to aid with placement. Review of the facility policy titled Oxygen Concentrator occurred on 11/17/22. This policy, reviewed January 2022, stated, . Obtain physician's orders for the rate of flow and route of administration of oxygen . Turn the unit on to the desired flow rate . Cannulas and masks should be changed weekly or as necessary . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Nebulizer Therapy occurred on 11/17/22. This policy, dated May 2022, stated, . Care of the Equipment. Clean after each use. Disassemble parts after every treatment. Rinse the nebulizer cup and mouth piece [mask for Resident #40] with tap water. Shake excess water. Air dry on an absorbent towel. Once completely dry, store the nebulizer cup and mouth piece in a zip lock bag. - Review of Resident #40's medical record occurred on all days of survey. Diagnoses included tracheostomy status (a surgically created hole (stoma) in your windpipe), chronic respiratory failure (failure of lungs to oxygenate the blood), chronic obstructive pulmonary disease (COPD) (obstructive airflow in the lungs), and dependence on supplemental oxygen. Physician's orders included the following: * 02/04/22, Larytube care: Remove tube from stoma and rinse with water then insert it back. every 4 hours and as needed. * 06/11/22, stated, Oxygen at (2) L/min [liters per minute] with humidity via trach at bedtime and PRN as needed . * 06/11/22, Albuterol Sulfate HFA Aerosol Solution . 1 inhalation via trach every 4 hours as needed for Shortness of breath . * 06/11/22, Budesonide Suspension . 1 vial via trach two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE . * 07/26/22, PRN [as needed] suctioning per residents request as needed for secretions . During an interview on 11/14/22 at 3:08 p.m., Resident #40 stated the following: * Some nurses don't use enough lubrication when they change it [[NAME] Tube] and it hurts when this happens. * Some nurses don't clean off all the soap when they clean it. * Reported staff suctioned her last night with her evening medications, around midnight, and again around 4:00 a.m. Observations of Resident #40 showed the following: * 11/14/22 at 3:08 p.m., two large bottles of clear liquid soap in the resident's bathroom with a sign on the mirror indicating only use to clean the [NAME] Tube. A Velcro collar used to secure the [NAME] Tube in the stoma folded up behind the resident's neck and secured with a safety pin. When asked how long the facility staff have been using safety pins on her collar, the resident stated, For quite a while. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 11/15/22 at 9:11 a.m., A nurse (#10) removed, cleaned, and replaced the [NAME] Tube. The nurse failed to clean the tube with liquid soap and failed to use lubrication prior to inserting the tube into the resident's stoma. The nurse attached a new Velcro collar to the [NAME] Tube, folded the collar behind the resident's neck and secured it with a safety pin. The nurse provided suction per the resident's request. Observation prior to a nebulizer treatment showed a disassembled nebulizer cup and mask located directly on the bedside table. The staff failed to place the nebulizer equipment on an absorbent towel barrier and place the equipment in a zip-lock bag once dry. * 11/16/22 at 8:19 a.m., The resident rested in bed attached to an oxygen concentrator with the liter flow set at 4L. When asked if she applies oxygen and/or adjusts the liter flow on the concentrator by herself, the resident stated, No. * 11/16/22 at 8:58 a.m., A nurse (#11) removed, cleaned, and replaced the [NAME] Tube. The nurse failed to clean the tube with liquid soap. The nurse attached the same Velcro collar to the [NAME] Tube, folded the collar behind the resident's neck and secured it with a safety pin. The nurse provided suction per the resident's request. Observation prior to a nebulizer treatment showed an assembled nebulizer cup and mask located directly on the bedside table. The staff failed to disassemble and rinse the nebulizer cup, rinse the mask, place the equipment on an absorbent towel barrier, and place the equipment in a zip-lock bag once dry. Review of Resident #40's November Medication Administration (MAR) lacked documentation for the suction the nursing staff provided on 11/14/22, 11/15/22 and 11/16/22. The MAR also lacked documentation for the PRN oxygen used on 11/16/22. The facility failed to complete the following for Resident #40: * Contact the prescriber regarding the order, dated 02/04/22, Larytube care: Remove tube from stoma and rinse with water . to ensure the order followed the facility's policy to cleanse the [NAME] Tube with mild soap. * Follow the physician's order for the correct oxygen flow rate and failed to document the residents PRN oxygen use and suctioning. * Provide a properly fitted tracheostomy collar. * Disassemble, rinse, place on an absorbent towel, air-dry the nebulizer medication cup and mask, and place the nebulizer equipment into a zip lock bag once dry. - Review of Resident #56's medical record occurred on all days of survey. Diagnoses included COPD. Physician orders included the following: * 02/15/21, O2 [oxygen] via NC [nasal cannula] 3L/min, titrate to maintain sats [oxygen saturations] > [greater than] 90% every shift. * 02/28/22, Change oxygen tubing, masks and label with date every Sunday night shift. (continued on next page)

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	355070	A. Building B. Wing	11/17/2022

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on all days of survey showed Resident #56's oxygen tubing/nasal cannula labeled 10/31 (indicating the date the staff changed the tubing). The facility failed to change the oxygen tubing/nasal cannula per policy. During an interview on 11/17/22 at 10:23 a.m., an administrative nurse (#1) stated she expected staff to change oxygen tubing per facility policy. 40489

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	355070	A. Building B. Wing	11/17/2022

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39211 Based on review of employee files and staff interview, the facility failed to ensure 1of 5 employees (Employee #1) reviewed completed nurse aide certification renewal every two years. Failure to verify certified nurse assistant (CNA) certification renewal has the potential to affect resident care. Findings include: Review of CNA employee files occurred on the morning of [DATE] and identified an expiration date of [DATE] on the Nurse Aide Registry form for Employee #1. During an interview on [DATE] at 10:30 a.m., an administrative staff member (#5) confirmed Employee #1's certification expired in 2020. The facility staff failed to ensure Employee #1 completed the certification renewal process prior to the expiration date and allowed a CNA to provide resident cares for over two years beyond the expiration date.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40488 Based on record review, the facility failed to obtain routine, regularly scheduled medications for 1 of 21 sampled residents (Resident #40). Failure to ensure each resident receives routine, regularly scheduled medications has the potential for residents to suffer adverse health events and failure to establish and implement an effective policy/procedure regarding unavailable medications resulted in Resident #40 missing 61 doses of a scheduled inhaler and 3 doses of a scheduled oral medication. Findings include: The facility failed to provide a policy/procedure related to provider notification when a scheduled medication is not available from the pharmacy. Review of Resident #40's medical record occurred on all days of survey. Diagnoses included chronic respiratory failure (failure of the lungs to oxygenate the blood), chronic obstructive pulmonary disease (COPD) (obstructed airflow in the lungs), shortness of breath, and hypothyroidism (underactive thyroid). Review of Resident #40's physician's orders identified the following: * 11/30/21, Albuterol Sulfate . Aerosol Solution [inhaler] . 1 puff . every 4 hours for COVID 19/pneumonia . D/C [discontinue] Date - 06/11/2022 * 12/02/21, Levothyroxine Sodium Tablet Give 150 mcg [micrograms] by mouth one time a day for hypothyroidism . D/C Date - 01/17/2022 * 01/18/22, Levothyroxine Sodium Tablet Give 175 mcg by mouth one time a day . D/C Date - 05/02/2022 Review of Resident #40's January 2022 - April 2022 medication administration record (MAR) and nursing progress notes showed the following: * 61 missed doses of Albuterol (16 doses from January 16-18, 35 doses from February 10-15, and 10 doses from April 26-28). The progress notes identified the medication as unavailable and too soon to refill per pharmacy. * Three missed doses of Levothyroxine on January 18-20. The progress notes stated, medication no longer in the [medication] cart, new dose increased by MD [medical doctor], awaiting delivery from pharmacy. The facility failed to notify Resident #40's provider or the prescribing provider when the albuterol inhaler and levothyroxine were unavailable from the pharmacy.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39211 Based on record review, review of facility policy, and staff interview, the facility failed to ensure adequate monitoring of a medication for 1 of 2 sampled residents (Resident #44) who received coumadin (blood thinner). Failure to monitor a PT/INR level (prothrombin time and international normalized ratio-A blood test to measure a person's blood clotting time) may result in a blood level out of therapeutic range and does not allow the resident to maintain the highest practicable level of well-being. Findings include: Review of the facility policy titled Physician Order-Ancillary Services occurred on 11/16/22. This policy, revised February 2013, stated, . When the physician Order is obtained . the order will be entered into . [electronic medical record (EMR)]. After the Telephone/Verbal order from [sic] has been signed by the physician this will be scanned into the [EMR] and placed under the misc [miscellaneous] tab of the Resident's electronic medical record. Review of Resident #44's medical record occurred on all days of survey. Diagnoses included atrial fibrillation (irregular heart rhythm). A faxed physician's order, dated 11/04/22, stated, Take 3 mg [milligrams] of warfarin [coumadin] Nov [November] 5 & [and] [DATE] and then resume regular warfarin dosing of 1.5 mg daily on Monday [DATE]. Recheck INR/PT in 1 week. The physician's orders in the EMR, dated 10/20/22, identified PT/INR every 14 days and the medication administration record (MAR) indicated the PT/INR to be completed on 11/17/22. The physician orders and MAR in the EMR lacked the 11/04/22 order to recheck PT/INR in one week. The medical record lacked evidence of a completed PT/INR in one week as ordered. During an interview on 11/15/22 at 4:37 p.m., a staff nurse (#9) stated the next PT/INR is scheduled for 11/17/22. When asked about the faxed physician's order dated 11/04/22, the nurse stated the PT/INR recheck should have been completed in one week, on 11/11/22. Facility staff failed to adequately monitor a medication and obtain a PT/INR on the date ordered by the physician.

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	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Lutheran Nursing & Rehabilitation Center	1515 2nd Ave West Williston, ND 58801

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40488 Based on observation, manufacturer's instructions, and staff interview, the facility failed to ensure the safe and secure storage of drugs and biologicals in 1 of 2 medication carts (Harmony unit) reviewed. Failure to lock the medication cart when unattended may result in unauthorized access to medications. Findings include: Review of the programming guide for the M-Series Tech-Ready Medication Cart occurred on occurred on 11/17/22. The guide stated, . To open: press user/supervisor code then the ENTER key. To close: Press the LOCK key . The locking system . is set to automatically re-lock after 5 minutes . Changing the Auto Re-lock open time . The new OPEN TIME will be active the next time you open the cart . Observation on 11/16/22 at 9:25 a.m. of the medication cart on the Harmony unit showed a nurse (#11) opened the cart via a keypad on top of the cart, prepared a resident's medications, and without pressing the cart's lock key, walked into the resident's room. After exiting the room, when asked if she locked the medication cart, the nurse stated, It [the medication cart] automatically locks within a few seconds. When asked to check if the cart locked, the nurse (#11) pulled on a drawer, and confirmed the cart was unlocked. During an interview on 11/17/22 at 10:23 a.m., an administrative nurse (#1) stated it took three minutes for the medication cart on the Harmony unit to automatically lock when she checked it.

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46477 Based on observation, review of facility policy, review of manufacturer's guidelines, review of professional reference, and staff interview, the facility failed failure to ensure sanitization of dishware (utensils, dishes, pots/pan) used to serve residents, staff, and visitors in 1 of 1 kitchen. Failure to ensure the mechanical dishwashing machine maintains the correct hot water temperature required by manufacturer's directions to destroy pathogens may result in the spread of illness and/or foodborne illness to residents, visitors, or staff During the on-site recertification survey, the team determined a potential Immediate Jeopardy (IJ) situation existed on 11/16/22 at 9:50 a.m. The IJ potential resulted from observation of the dishwashing machine temperatures not being maintained at the manufacturer's recommendations. This finding placed residents in immediate danger due to the potential of spread of illness and/or foodborne illnesses from improper sanitization. * 11/16/22 at 10:02 a.m. - The survey team notified the director of nursing and dietary management of the IJ situation and requested they develop a plan for removal of the immediate jeopardy. * 11/16/22 at 10:10 a.m. During an interview with a dietary director (#6) she stated, Unfortunately our machine temperatures may have been wrong for some time. * 11/16/22 at 10:15 a.m. The survey team contacted the State Survey Agency (SSA) to report the findings and to discuss IJ. * 11/16/22 at 10:26 a.m. An administrative nurse (#8) verified the facility did not have any gastrointestinal illnesses in the facility. * 11/16/22 at 10:45 a.m. The facility submitted a written immediate action plan. * 11/16/22 at 5:05 p.m. - The facility provided a revised written plan of correction for the IJ. * 11/16/22 at 5:30 p.m. - The survey team reviewed and accepted the facility's version of the written plan of correction for the IJ. * 11/16/22 at 5:35 p.m. - The survey team removed and reduced the IJ situation from a scope/severity of L to a scope and severity of F. * 11/16/22 at 5:40 p.m. - The SSA notified the Centers for Medicare and Medicaid Services location of the immediate jeopardy was removed. Findings include: (continued on next page)

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F 0812 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The FDA Food Code 2017 Annex 3 - Public Health Reasons, page 506, stated, 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures. The temperature of hot water delivered from a warewasher sanitizing rinse manifold must be maintained according to the equipment manufacturer's specifications and temperature limits . to ensure surfaces of multi-use utensils such as kitchenware and tableware accumulate enough heat to destroy pathogens that may remain on such surfaces after cleaning. The surface temperature must reach at least . 160 degrees F [Fahrenheit] as measured by an irreversible registering temperature measuring device to affect sanitization. Manufacturer's guidelines (page 24) for dishwashing machine model CLCS66eN states . Minimum Temperatures Using High-Temperature Sanitizing for wash tank is 160 degrees Fahrenheit and for final rinse is 180 degrees Fahrenheit. Review of the facility policy titled, Cleaning Dishes/Dish Machine occurred on 11/16/22, and stated .Check the dish machine gauges throughout the cycle to assure proper temperatures. Observations of the mechanical dishwasher currently in use in the main kitchen showed the following: * 11/16/22 at 9:25 a.m., Upon the completion of the rinse cycle, the plate simulator (a type of irreversible temperature registering device) indicated a food-contact surface temperature of 152.4 degrees F (Fahrenheit). The temperature display on the outside of the dishwasher showed 157 degrees F during the wash cycle and 128 F during the rinse cycle. * 11/16/22 at 9:35 a.m., wash temperature 155 degrees F and rinse temperature 135 degrees F; and plate simulator 152.4 degrees F. * 11/16/22 at 9:51 p.m., wash temperature 155 F and rinse temperature 135 degrees F; plate simulator 152.5 degrees F. The facility's plate simulator registered 153.3 degrees F. During an interview on 11/16/22 at 10:00 a.m., an administrative staff (#4) and two dietary administrative staff (#6 and #7) agreed the dishwasher temperatures were a concern and the facility immediately implemented to paper and plasticware and the three-compartment sink method for dishwashing, rinsing, and sanitizing until the facility could resolve the issue. An administrative staff member (#7) demonstrated the correct use of the three-compartment sink method.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46964 Based on review of facility policy and staff interview, the facility failed to complete a water risk assessment for 1 of 1 year reviewed (2022). Failure to conduct the water risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system placed staff, residents, and visitors at risk of developing Legionella and other opportunistic infections. Findings include: Review of the facility policy titled Bethel Lutheran Home Water Management Policy occurred on 11/17/22. This policy, dated October 2022, stated, . A risk assessment will be conducted . annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. Data to be used for completing the risk assessment may include, but are not limited to . Legionella environmental assessment . Based on the risk assessment, control points will be identified. The effectiveness of the water management program shall be evaluated no less than annually. Upon request on 11/17/22, the facility failed to provide a completed risk assessment for Legionella and other opportunistic waterborne pathogens as per the water management policy. During an interview on 11/17/22 at 10:36 a.m., administrative staff member (#4) confirmed the facility failed to complete the Legionella environmental assessment. 13101 40488