STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	**615 6TH ST SE PO BOX 700, STANLEY, North Dakota, 58784**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The standard Medicare/Medicaid survey and facility reported incident survey started on 03/02/25 and ended on 03/05/26. During the facility reported incident survey, the facility was found compliant with regulatory requirements.	F0000		03/23/2026
F0947 SS = E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is NOT MET as evidenced by: Based on review of the facility assessment, review of the new employee checklist, review of the certified nurse aide (CNA) orientation packet, and staff interview, the facility failed to provide the required CNA training for dementia management. Failure to provide dementia management training limits the CNA's ability to effectively care for residents with dementia and promote the residents'	F0947	F0947: Required in-service training for CNAs. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this tag. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: No residents were affected by this tag. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: New CNA orientation checklist/packet was updated to include dementia management training. Training titled “Demetia Management and Caring for the resident with challenging Behaviors” will be added to all CNA orientation via Care learning as well as a yearly training of the same nature. All CNAs are required to view the training “Demetia Management and Caring for the resident with challenging Behaviors” prior to 4/9/2026. CNAs will all be educated in person at the mandatory Nursing/CNA meeting on 4/7/2026. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for	04/09/2026

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 reverse for further 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	**615 6TH ST SE PO BOX 700, STANLEY, North Dakota, 58784**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0947 SS = E	Continued from page 1 highest level of functioning. Findings include: Review of the most recent facility assessment occurred on all days of the survey and stated, ". . . the facility is licensed for 36 LTC [long term care] beds with 15 of those residents diagnosed with cognition issues . . . Dementia . . . " Review of the facility checklist for new employees and the CNA orientation packet lacked evidence of dementia management training. During an interview on 03/04/26 at 11:12 a.m., an administrative staff nurse (#1) confirmed the facility's new hire/CNA orientation failed to include dementia management training and the facility failed to provide this required training to all current staff for over a year.	F0947	Continued from page 1 ensuring that correction is achieved and sustained. This plan must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit: Random audits will be done by the DON or DON designee to make sure new orientation checklist includes Dementia/Behavior training and of Care learning that it is being offered and completed on orientation. Audits will be completed weekly on any new hires x 4 weeks, then randomly on 3 new hires monthly x 2 months and quarterly x 3 quarters. Audit findings will be presented to the Quality Assurance Committee at quarterly Quality Assurance meetings. Include dates when corrective action will be completed: Corrective action will be completed by 4/9/26.	04/09/2026
F0949 SS = E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is NOT MET as evidenced by: Based on review of the facility assessment, review of the facility training/education documents, and staff interview the facility failed to provide the required behavioral health training to include care specific to the individual needs of residents diagnosed with dementia. Failure to provide behavioral health training limits the staffs' ability to effectively care for residents with behaviors and promote the residents' highest practicable level of functioning. Findings include: Review of the most recent facility assessment occurred on all days of the survey and stated, ". . . the facility is licensed for 36 LTC [long term care]	F0949	F0949: Behavioral Health Training Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by this tag. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: No residents were affected by this tag. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: New staff orientation checklist/packet was updated to include Behavioral Health Training. Training titled “Dementia Management and Caring for the resident with challenging Behaviors” will be added to all new staff orientation via Care learning as well as a yearly	04/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	**615 6TH ST SE PO BOX 700, STANLEY, North Dakota, 58784**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0949 SS = E	Continued from page 2 beds with 15 of those residents diagnosed with cognition issues . . . Dementia . . . " Review of the facility training documents occurred on 03/04/26 and included: * Nursing orientation checklist * New employee checklist * CNA orientation packet * Employee Handbook revised 06/27/24 The above documents lacked evidence of dementia management or behavioral health care training. During an interview on 03/04/26 at 11:12 a.m., an administrative staff nurse (#1) confirmed the facility failed to provide dementia management training or behavioral health care training for new and current facility staff members.	F0949	Continued from page 2 training of the same nature. All LTC staff (Nurses, CNAs, Dietary, Activities and Social Services) are required to view the training “Dementia Management and Caring for the resident with challenging Behaviors” prior to 4/9/2026. Nurses and CNAs will all be educated in person at the mandatory Nursing/CNA meeting on 4/7/2026. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit: Random audits will be done by the DON or DON designee to make sure new orientation checklist includes Dementia/Behavior training and of Care learning that it is being offered and completed on orientation. Audits will be completed weekly on any new hires x 4 weeks, then randomly on 3 new hires monthly x 2 months and quarterly x 3 quarters. Audit findings will be presented to the Quality Assurance Committee at quarterly Quality Assurance meetings. Include dates when corrective action will be completed: Corrective action will be completed by 4/9/26.	04/09/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification.	F0641	F0641: Accuracy of Assessments Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1’s MDS was corrected and resubmitted to CMS/state on 3-5-2026. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	04/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	**615 6TH ST SE PO BOX 700, STANLEY, North Dakota, 58784**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0641 SS = D	Continued from page 3 §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.20.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 17 sampled residents (Resident #1). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Finding include: The Long-Term Care Facility RAI User's Manual, revised October 2025, pages A-30-32, stated, ". . . Section A1500: Preadmission Screening and Resident Review (PASRR) . . . Coding Instructions . . . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . . . and continue to A1510 . . . Section A1510 . . . Coding instructions Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness . . ." Review of Resident #1's medical record occurred on	F0641	Continued from page 3 All residents have the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: MDS Coordinator educated LBSW on section A1500 and A1510 of MDS. A diagnosis report was run from Point Click Care on 3-31-26 identifying only resident #1 as resident with this code classification. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit: The MDS Coordinator and LBSW will perform random audits on MDS section A1500 and A1510 to ensure coded correctly. Audits will be performed on 2 MDS's on a weekly basis x 4 weeks, monthly basis x 2 months and then quarterly basis x 3 quarters. The findings will be reported to the Quality Assurance Committee quarterly at the quarterly QA meetings. Include dates when corrective action will be completed: Corrective action will be completed by 4/9/26.	04/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	**615 6TH ST SE PO BOX 700, STANLEY, North Dakota, 58784**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0641 SS = D	Continued from page 4 all days of survey. A PASRR Level II, dated 05/16/23, identified diagnoses of bipolar disorder and anxiety disorder. A comprehensive MDS, dated 12/26/25, showed the facility failed to code Sections A1500 and A1510 for serious mental illness. During an interview on 03/05/26 at 9:35 a.m., an administrative staff member (#5) confirmed the facility failed to code sections A1500 and A1510 accurately.	F0641		04/09/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to properly utilize necessary assistive devices to prevent accidents for 1 of 3 sampled residents (Resident #24) observed during a transfer. Failure to utilize a gait belt and place the walker within reach during a transfer placed the resident at risk for injury and pain. Findings include: Review of the policy titled "Use of Gait Belt Policy at Mountrail Bethel Home" occurred on 03/05/26. 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 #24's medical record occurred on all days of survey. Diagnoses included weakness. The current care plan stated, ". . . I have an ADL [activities of daily living] self-care deficit r/t [related to] weakness and decreased mobility . . . I transfer with staff Ax2 [assist of 2] and my 4WW [four wheeled walker] . . . I am at risk for falls . . ."	F0689	F689: Free of Accident Hazards/Supervision/Devices. Staff were observed transferring a resident without a gait belt Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #24’s care plan and pocket care plan were reviewed and updated reflecting the need to use the gait belt for all transfers. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents who need to have a gait belt utilized have the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: PT reviewed care plans and updated those residents that use a gait belt for transfer/ambulation. ADON updated pocket care plans for gait belt use. Staff educated that all residents who have a gait belt on their care plan need to be transferred with a gait belt. Care plans will be updated by PT as changes in residents’ abilities change. Pocket care plans will be updated on an as needed basis as PT changes to ensure they are accurate and match care plan. CNAs and Nurses were educated via a memo on 3/6/2026 stating they need to use gait belts for all transfers on all residents who are care planed for gait belt use. CNAs and Nurses will be educated of this in-person at the mandatory CNA/Nursing meeting on 4/7/2026.	04/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	**615 6TH ST SE PO BOX 700, STANLEY, North Dakota, 58784**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = D	Continued from page 5 Observation on 03/02/2026 at 4:15 p.m. showed two certified nurse aides (CNAs) (#2 and #3) transferred Resident #24 from the bed to a wheelchair. Both CNAs placed their forearms under the resident's armpits and pulled the resident from a lying position to sit on the edge of the bed. Without applying a gait belt or placing the walker within reach, the CNA's placed their arms under the resident's armpits, stood the resident, held onto her pants, and pivoted the resident into the wheelchair. During an interview on 03/05/26 at 9:45 a.m., an administrative staff member (#1) stated she expected staff to utilize a gait belt and place walkers within reach during transfers.	F0689	Continued from page 5 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit: Visual auditing will be completed by the DON, ADON or Physical Therapy Director to ensure staff are using a gait belt as appropriate for residents. Audits will be done on resident #24 and 4 more transfers weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters. Audit findings will be reported to the Quality Assurance Committee at quarterly QA meetings. Include dates when corrective action will be completed: Corrective action will be completed by 4/9/26.	04/09/2026
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as	F0690	F0690: Bowel/Bladder Incontinence, Catheter, UTI. Medical record lacked documentation staff provided catheter cares or refused cares. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #4's tasks were updated to add catheter care to the CNA task assignments. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents with catheters could be affected by this deficiency. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	04/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	**615 6TH ST SE PO BOX 700, STANLEY, North Dakota, 58784**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0690 SS = D	Continued from page 6 possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, review of a professional reference, and resident and staff interview, the facility failed to provide appropriate treatment and services for 1 of 1 sampled resident (Resident #4) with an indwelling urinary catheter. Failure to provide catheter cares may have contributed to or placed the resident at risk for urinary tract infections (UTIs). Findings include: Review of the facility policy titled "Foley Catheter Care Policy at Mountrail Bethel Home" occurred on 03/05/26. This policy, dated October 2022, stated, ". . . It is the policy of Mountrail Bethel Home to provide catheter care to all residents that have an indwelling catheter to reduce UTIs. Catheter cares will be performed by a nursing assistant with AM [morning] and HS [hour of sleep/bedtime] cares, and as needed. . . ." Kozier & Erb's "Fundamentals of Nursing: Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 892, stated, ". . . any accumulation of secretions or excretions is irritating to the skin, harbors microorganisms, and makes an individual prone to skin breakdown and infection. . . ." Review of Resident #4's medical record occurred on all days of survey and identified an antibiotic prescribed for a urinary tract infection on four separate occasions between August 2 and November 4, 2025. The care plan stated, ". . . CATHETER: I am at risk for complications r/t [related to] foley catheter placement. . . . BLADDER: I am at risk for UTI . . . I want staff to assist with performing catheter cares BID [twice daily] and as needed . . ."	F0690	Continued from page 6 For all residents with catheters, tasks were checked to ensure catheter care was a task assigned for that resident. CNAs and Nurses were educated via a memo on 3/6/2026 stating all residents with catheters need catheter care done BID and to document it was done or refused. CNAs and Nurses will be educated of this in-person at the mandatory CNA/Nursing meeting on 4/7/2026. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit: The DON or DON designee will audit any new catheter placements and new admissions with catheters that the resident task is correct and that the catheter care task has been assigned for the CNAs to document the care. Audits will be completed weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters. Audit findings will be reported to the Quality Assurance Committee quarterly at the quarterly Quality Assurance Meeting. Include dates when corrective action will be completed: Corrective action will be completed by 4/9/26.	04/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	**615 6TH ST SE PO BOX 700, STANLEY, North Dakota, 58784**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0690 SS = D	Continued from page 7 The certified nurse aide (CNA) care Kardex stated, "I want staff to assist with performing catheter cares BID and as needed." Observation on 03/02/26 at 3:42 p.m. showed Resident #4 is in his room with a urinary catheter bag in his chair next to him. He stated, “I put it there, so it doesn’t get in my way.” He was unable to confirm how often staff perform his catheter cares. During an interview on 03/04/26 at 1:20 p.m., a CNA (#4) when asked about catheter cares for Resident #4, stated, "He will let us provide cares, maybe once a day and sometimes none." Review of Resident #4's medical record lacked documentation staff provided catheter cares or that the resident refused cares. During an interview on 03/05/26 at 9:45 a.m., an administrative staff member (#1) confirmed the CNA task list failed to include an area for staff to document completion of cares or resident refusa catheter cares.	F0690		04/09/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but	F0880	F880: Infection Prevention and Control. Hand Hygiene (no HH between glove use). Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Staff educated regarding proper infection control techniques including hand hygiene, hand hygiene between glove use for residents #24 and #32 and all residents. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents could be affected by this deficiency. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All staff will receive annual infection control training, and training upon hire. Nurses and CNAs will all be educated about proper infection control techniques	04/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	**615 6TH ST SE PO BOX 700, STANLEY, North Dakota, 58784**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 8 are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 5	F0880	Continued from page 8 including: hand hygiene, hand hygiene between glove use during the mandatory nurse/CNA meeting on 4/7/2026. Education will include policy and procedure review of hand hygiene and glove use. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be integrated into the quality assurance system. At the revisit, the quality assurance plan will be reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit: The DON or DON designee will do visual audits of hand hygiene and glove use to ensure staff complete hand hygiene properly. Education will be provided as needed at the time of audit. Audits will be completed on resident #24 and #32 and 3 random residents weekly x 4 weeks, monthly x 2 months and quarterly x 3 quarters. Audit findings will be reported to the Quality Assurance Committee quarterly at the quarterly Quality Assurance Meeting. 5. Include dates when corrective action will be completed: Corrective action will be completed by 4/9/26.	04/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355044	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTRAIL BETHEL HOME	**615 6TH ST SE PO BOX 700, STANLEY, North Dakota, 58784**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 9 sampled residents (Resident #24 and #32) observed during cares. Failure to practice infection control standards related to hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene Policy at Mountrail Bethel Home" occurred on 03/05/26. 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. . . . Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. . . . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. . . ." - Observation on 03/02/26 at 4:15 p.m. showed two certified nurse aides (CNAs) (#2 and #3) entered Resident #24's room to complete perineal cares. Without performing hand hygiene, both CNAs applied gloves, removed the resident's pants, and one CNA (#3) removed the wet brief and provided perineal care. With the same gloves, the CNA (#3) picked up the resident's shoes, and the other CNA (#2) cued the CNA (#3) to change gloves. The CNA (#3) dropped the shoes, removed her gloves, and without performing hand hygiene, applied clean gloves, and placed the shoes on the resident's feet and both CNAs transferred the resident into the wheelchair. The CNA (#3) failed to perform hand hygiene before applying clean gloves. - Observation on 03/02/26 at 4:56 p.m. showed two CNAs (#6 and #7) entered Resident #32's room to complete perineal cares. Both CNAs performed hand hygiene, applied gloves, removed the resident's wet brief and provided perineal cares. Without removing their gloves, both CNAs applied a clean brief. One CNA (#7) removed her soiled gloves, completed hand hygiene, and applied clean gloves. The other CNA (#6) failed to remove her soiled gloves and assisted CNA (#7) to apply the resident's pants and transfer the resident from the bed to a wheelchair. During an interview on 03/05/25 at 9:45 a.m., an administrative staff member (#1) confirmed she expected staff to perform hand hygiene before applying clean gloves, between glove changes, and change soiled gloves before moving on to other tasks.	F0880		04/09/2026