STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification, complaint, and facility reported incidence survey started on 04/13/26 and concluded on 04/16/26.	F0000		05/12/2026
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: 1. Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services to maintain the highest practicable physical well-being for 1 of 1 closed record (Resident #85) with an identified breast lump. Failure to ensure follow up on the identified breast abnormality prevented timely treatment interventions. Findings include: Review of the facility policy titled "Bethel Lutheran Nursing & [and] Rehabilitation Center-Wound Treatment Management" occurred on 04/16/26. This policy, dated February 2026, stated, "Procedure . . . 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the wound care consultant, treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. . . . 5. Treatment decisions will be based on: . . . a. Etiology of the wound: . . . iv. Atypical (i.e. dermatological or cancerous lesion, pyoderma, calciphylaxis) . . . c. Location of the wound . . . 8. The effectiveness of treatments will be monitored through ongoing	F0684	Nursing staff were educated on the importance of following thorough on identified skin abnormalities and dietary instructed to update promptly the care plan with changes to residents liquid intake per speech recommendations and physicians orders. This is education is for residents #85 and #48 and any other resident who needs skin abnormalities followed up on or needs care plan updated with correct liquid intake per speech and physicians orders. Resident #48 care plan updated on 05/12/26 to remove the sipper cups. Resident #85 is deceased. All residents have the potential to be affected if their care plan is not updated to follow the speech recommendations and physicians orders and/or if they have a skin abnormality that is not followed up on. Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of following up on skin abnormalities and updating care plans with speech and/or physician orders. Reviewed policy/procedure “Wound Treatment Management”, “Thickened Liquids”, “Therapeutic Diet Orders”. DON or designee will monitor any identified skin abnormalities; Dietary or designee with monitor care plan to make sure speech recommendations and physician orders are updated. Monitoring will be weekly x4, monthly x3, then quarterly thereafter. If concerns are identified immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 05/18/26	05/18/2026

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: 355070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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F0684 SS = G	Continued from page 1 assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards healing. b. Changes in the characteristics of the wound (see above.) 3. Changes in the resident's goals and preferences, such as at the end- of-life or in accordance with his/her rights. . . .” - Review of Resident #85's medical record occurred on April 15-16, 2026 and identified a breast lump on 10/19/24. The nurse's notes showed the facility notified the provider of the lump on 10/21/24. The resident agreed to have a mammogram. From October 2024 to June 2025, the nurse's notes identified continued presence of a hard lump on the right breast. The record lacked evidence the provider assessed the lump and ordered a mammogram. Further review of Resident's #85 progress notes identified the following: * 07/03/25 at 10:45 p.m., ". . . Scab below the right areola was noted tonight during bath. Area around the right areola still hardened. Resident denies pain or discomfort. No discharges noted to the right nipple. Kept monitored." * 07/07/25 at 9:36 p.m., ". . . Right breast. . . . Hardened around her areola . . . . Scab below the right areola was noted during bath, ..." * 07/21/25 at 10:55 p.m., ". . . Right breast. . . . Hardened around her areola. . . . Right breast. . . . dry scab with minimal discharge. . . . Length (cm) [centimeter]: 4 Width (cm): 3 Surrounding tissues: Erythema. Skin Issues Note: Bacitracin ointment applied to right breast scab. . . ." * 08/04/25 at 10:23 p.m., ". . . Right breast. . . . Hardened around her areola. . . .dry scab with minimal discharge. . . . Deteriorating: wound characteristics deteriorated. Wound acquired in-house. Signs and symptoms of infection: Size has increased. Length (cm): 5 Width (cm): 3.5 Depth (cm): 0 Exudate amount: Light. Exudate type: Purulent: indication of pus, typically thick, yellow, green, tan or brown. slough Surrounding tissue: Erythema. Cleansing solution: Soap & Water. Other additional care: Bacitracin ointment applied. . . ."	F0684		05/18/2026

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F0684 SS = G	Continued from page 2 * 08/06/25 at 7:18 a.m., ". . . No improvement in right breast region area measuring 14 cm by 14 cm redness and hardness to the breast with 5 cm by 4 cm scabbed/crusty area to the right of the nipple area no drainage tender to the touch. . . . Resident will be sent to ER [emergency room] to get evaluated. . . ." * 08/06/25 at 2:00 p.m., ". . . CNA that went with resident this Am---States that resident was admitted to the hospital for infection and possible breast cancer. . . .Did inform one of the guardians about the admission." * 08/06/25 at 3:36 p.m., ". . . Hospital personal returned my Call--States resident was admitted---she is on IV [intravenous therapy] antibiotic for breast infection. had a CT [computed tomography]-scan while in ER-the results showing the unlaying breast tissue is cancerous. . . ." During an interview on 04/16/26 at 9:38 a.m., three administrative staff members (#1, #2, and #3) confirmed the facility failed to notify the provider of changes in wound characteristics and obtain skin/wound treatment orders. The facility failed to ensure adequate follow-up including timely assessments and treatment options which could have allowed Resident #85 or the resident's guardian to make informed decisions regarding her health care. 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure the necessary care and services to attain the highest degree of safety with oral intake for 1 of 1 sampled resident (Resident #48) who required diet modifications and specific eating utensils. Failure to ensure staff offered residents food/liquids utilizing the recommended eating utensils resulted in Resident #48 experiencing coughing episodes and may have resulted in aspiratation. Findings include: Review of the facility's policy titled, "Thickened	F0684		05/18/2026

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F0684 SS = G	Continued from page 3 Liquids," occurred on 04/16/26. This policy, updated February 2026, stated, ". . . 'Thickened liquids' refer to liquids in which the consistency has been altered to facilitate safe, oral intake. They are ordered as part of treatment for a . . . clinical condition, such as dysphagia [swallowing disorder] due to a stroke . . ." Review of the facility's policy titled, "Therapeutic Diet Orders," occurred on 04/16/26. This policy, dated February 2026, stated, ". . . 'Mechanically Altered Diet' is one in which the texture or consistency of food is altered to facilitate oral intake. Examples include . . . thickened liquids . . . Therapeutic diets, including mechanically altered diets . . . will be based on the resident's individual needs as determined by the resident's assessment. . . . Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form . . ." Review of Resident #48's medical record occurred on all days of survey. Diagnoses included cerebrovascular disease, dementia, oropharyngeal (the middle part of the throat) dysphagia (swallowing difficulty), and reflux disease. Resident #48's Speech Therapy Evaluation, dated 04/03/26, identified dysphagia, coughing with thin liquids, and required a mechanically altered diet that included nectar thickened liquids via straw sip. The current physician's orders identified, " . . . nectar thick liquids using straws per SLP [Speech Language Pathologist] . . ." The current care plan stated, ". . . I have . . . potential nutritional problem . . . Assist me with meals as needed. Straws with nectar thick liquids per SLP 4/3/26. . . . Adaptive Devices: . . . straws, and sipper cups with spouts as necessary. . . ." The facility failed to remove the sipper cups with spouts from the care plan following the 04/03/26 dysphagia assessment. Observation showed the following: * 04/14/26 at 10:34 a.m., Two certified nurse aides (CNAs) (#13 and #14) completed Resident #48's morning cares. The CNA (#13) offered Resident #48 a drink of nectar thickened water via a glass. Resident	F0684		05/18/2026

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F0684 SS = G	Continued from page 4 #48 took a drink of water and immediately coughed. The CNA (#14) then asked if the water had been offered from a straw. * 04/15/26 at 3:48 p.m., Two CNAs (#8 and #13) completed Resident #48's afternoon cares. Observation showed a mug of non-thickened water in the resident's room. The CNAs (#13) poured water from a mug into a smaller glass, realized the water had not been thickened, and handed the glass to the other CNA (#8) to discard. The CNA (#13) transported Resident #48 to the nurses' station. An unidentified CNA approached Resident #48 and offered her a drink of nectar thickened liquids via a sipper cup. Resident #48 took a drink from the sipper cup (not a straw) and immediately coughed. A nurse (#6) asked Resident #48 if the liquids "went down the wrong tube," before checking her lung sounds. During an interview on 04/16/26 at 8:20 a.m., two administrative staff members (#2 and #3) confirmed staff should follow the physician's orders for use of appropriate utensils (straws). The facility failed to ensure staff provided Resident #48 nectar thickened liquids via a straw and update the care plan per the speech therapist's recommendation and physician's order.	F0684		05/18/2026
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F0550	Nursing staff were educated on the importance of providing care in a manner that maintains, enhances, and respects resident dignity. This education was for resident #18, #47, #74, #76, and #56 and any other resident that has the potential to be affected. Resident #18 care plan updated on 05/12/26 to reflect 'I prefer my mouth to be wiped with napkin or tissue if food is noted in corners of my mouth'. Resident #47 care plan updated 05/12/26 to reflect 'I prefer my mouth to be wiped with napkin or tissue if food or medication is noted in corners of my mouth'. Resident #56 care plan updated on 05/12/26 to reflect 'If I am hollering out, check on my needs as at times I forget how to use my call light'. Resident #74 care plan states 'I am able to feed myself. I use a lip plate and built up silverware with supervision with meals. I may occasionally need assistance to eat but often get agitated with help. I like to do things for myself when I can.' Resident #76 care plan states 'I am able to feed myself with set up assistance and encouragement. I use a tray table in the dining room. at times I require more assistance.' Care plan updated 05/12/26 to reflect 'Encourage me to actively participate at meals if I become disengaged'.	05/18/2026

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F0550 SS = E	Continued from page 5 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policies, and staff interviews, the facility failed to provide care in a manner that maintained, enhanced, and respected the resident's dignity for 2 of 2 sampled residents (Resident #18 and #47) and 2 supplemental residents (Resident #74 and #76) observed during meals and 1 of 1 sampled resident (Resident #56) who requested assistance in their room. Failure to treat residents with dignity and respect has the potential to affect the residents' psychosocial wellbeing and does not enhance their quality of life. Findings include: Review of the facility's policy titled, "Promoting/Maintaining Resident Dignity," occurred on 04/16/26. This policy, revised 2025, stated, ". . . It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. . . . Respond to requests for assistance in a timely manner. . . ." - Observations during dining showed the following:	F0550	Continued from page 5 All residents have the potential to be affected if they require assistance with feeding, if they wear a clothing protector, and/or require their face to be cleaned, if they use adaptive utensils to eat, and/or require staff to respond to verbal calls as resident is unable to use call light in a timely manner. Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of making sure to assist those residents who need help with eating, making sure adaptive utensils are within reach, wiping resident faces with a napkin and not using a spoon to scrape the sides of their mouth or using the clothing protector to wipe mouth and responding to the residents who holler out in a timely manner. Reviewed policy/procedure "Promoting/Maintaining Resident Dignity" DON or designee will monitor all residents who require assistance with feeding to ensure resident dignity is maintained by having adaptive utensils within reach, using napkins to wipe face, by not using spoon or clothing protector to wipe/scrape food from mouth and to ensure staff respond in a timely manner when residents holler out for assistance. Monitoring will be weekly x4, monthly x3, then quarterly thereafter. If concerns are identified immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 05/18/26	05/18/2026

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F0550 SS = E	Continued from page 6 * 04/14/26 at 8:10 am, A certified nurse aid (CNA) (#12) sat between Resident #18 and Resident #47. The CNA (#12) fed Resident #47 and used the resident's clothing protector to wipe excess food from the corners of her mouth. The CNA (#12) sanitized her hands and then fed Resident #18 and used the resident's clothing protector to wipe excess food from the corners of her mouth. A nurse (#6) administered medications to Resident #47, and used a small, coated spoon to remove excess food from the corners of the resident's mouth. * 04/14/26 at 12:10 a.m., A CNA (#13) fed Resident #18 and used a spoon to remove excess food from the corners of her mouth. * 04/15/26 at 8:14 am, A CNA (#12) sat between Resident #18 and Resident #47. The CNA (#12) fed Resident #47 and used the resident's clothing protector to wipe excess food from the corners of her mouth. A nurse (#6) administered medications to Resident #47, and used a small, coated spoon to removed excess food from the corners of the resident's mouth. During an interview on 04/16/26 at 8:20 a.m., two administrative staff members (#2 and #3) confirmed staff should utilize a napkin to remove excess food from a resident’s face. - Review of Resident #56's medical record occurred on all days of survey. The current care plan stated, ". . . I am . . . unaware of safety needs and history of falls . . . I need prompt response to all requests for assistance. . . . I exhibit confusion, forgetfulness, agitation and anxiety. . . . I am able to make myself understood . . . Encourage me to use bell to call for assistance. I need reminders. . . ." Observations on 04/13/26 from 4:48 p.m. to 5:25 p.m. (37 minutes), showed Resident #56's room door closed and the resident repeatedly hollered for staff assistance until the surveyor summoned staff assistance. During an interview on 04/15/26 at 2:15 p.m., administrative staff members (#1 and #2) confirmed staff should respond to Resident #56's verbal calls in a timely manner. - Review of Resident #74's medical record occurred	F0550		05/18/2026

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F0550 SS = E	Continued from page 7 on 04/15/26. The current care plan stated, ". . . I have a problem or potential nutritional problem related to Hemiplegia [paralysis of one side of the body] and hemiparesis [weakness or partial paralysis affecting one side of the body] following cerebral infarction [stroke] affecting right dominant side . . . mild cognitive impairment . . . dysphagia [difficulty swallowing] . . . I frequently use my fingers to eat instead of my utensils. . . . Assist me with meals as necessary. Per therapy, I feed myself but require supervision. Adaptive equipment . . . built up silverware . . ." Observation on 04/15/26 at 11:48 a.m. showed Resident #74 seated in a wheelchair at the dining room table with eyes closed, adaptive silverware on the table out of the resident's reach, and the meal and drinks in front of the resident. At approximately 12:10 p.m., the resident unsuccessfully reached for the glass of apple juice and made repeated attempts to self-feed. The resident again reached for the apple juice, the cup tipped over, and the juice spilled onto the floor. At 12:15 p.m., an unidentified staff member cleaned up the spill, placed a new glass of juice on the table, gave the resident the adaptive silverware, and walked away. The resident attempted to eat the larger pieces of the croissant, but most of the food fell to her lap. The facility staff failed to supervise and offer Resident #74 assistance during the noon meal. - Review of Resident #76's medical record occurred on 04/15/26. The care plan stated, ". . . I have potential nutritional problem r/t [related to] . . . dysphagia . . . Assist me with meals as needed. . . . I am able to feed myself with set up assistance and encouragement. . . . At times I may require more assistance. . . ." Observation on 04/15/26 at 11:48 p.m. showed Resident #76 seated in a wheelchair at the dining room table drinking liquid from a coffee cup. The resident lifted the cup up in the air and repeatedly stated, "Take this. Take this." and almost spilled the liquid. At 12:15 p.m., the resident closed her eyes and lowered her head. The resident's meal appeared barely eaten. The facility staff failed to encourage, cue, and/or assist Resident #76 during the noon meal.	F0550		05/18/2026

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F0550 SS = E	Continued from page 8 During an interview on 04/15/26 at 2:15 p.m., administrative staff members (#1 and #2) confirmed Residents #74 and #76 require supervision and/or encouragement and cueing during meals.	F0550		05/18/2026
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility policy, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent for 3 of 6 residents (Resident #3, #12 and #77) observed during medication administration. Four medication errors occurred during staff administration of 27 medications, resulting in a 14 percent error rate. Failure to follow physician's orders and/or pharmacy recommendations may inhibit the effectiveness of the medication, cause subtherapeutic levels, and may have a negative impact on the resident's overall health. Findings include: Review of the facility policy titled "Crushed Medications" occurred on 04/16/26. This policy, dated June 2022, stated, ". . . Medications shall be crushed in accordance with standard of practice for safety and accuracy in medication administration. . . . Medications shall be crushed in accordance with physician orders. . . ." Review of the facility policy titled "Insulin Pen" occurred on 04/16/26. This policy, revised March 2026, stated, ". . . Prime the insulin pen. i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger . . ." Information for finasteride, updated 02/01/26, found at https://www.mayoclinic.org/drugs-supplements/finasteride-oral-route/description/drg-20063819 stated, ". . . Finasteride is used to treat men who	F0759	Nursing staff were educated on the importance of priming insulin pens at a 90 degree angle, administering levothyroxine on an empty stomach, and not to crush finasteride. This education was for resident #3, #12 (resident is deceased as of 05/04/26), and #77 and any other resident who requires insulin pen administration, levothyroxine (orally) and finasteride (orally). Resident #3 orders state to 'prime needle with lid off with 2 units at 90 degrees'. Resident #12, resident deceased. Resident #77 orders updated 05/12/26 to state 'prime needle with lid off with 2 units at 90 degrees' All residents have the potential to be affected if they receive insulin, levothyroxine orally, or finasteride orally. Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of giving levothyroxine orally on an empty stomach, not crushing finasteride and making sure to prime insulin pen with lid off with 2 units at 90 degrees. Reviewed policy/procedures "Crushed Medication" and "Insulin Pen" DON or designee will monitor giving levothyroxine on an empty stomach, making sure staff is not crushing finasteride and making sure insulin pens are primed with lid off with 2 units at 90 degrees'. Monitoring will be weekly x4, monthly x3, then quarterly thereafter. If concerns are identified immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 05/18/26	05/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0759 SS = E	Continued from page 9 have symptoms of benign prostatic hyperplasia (BPH) . . . Swallow the tablet whole. Do not crush, break, or chew it. . . . " Prescribing information for levothyroxine (treats thyroid disorders), revised April 2019, found at https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/021116s017lbl.pdf, stated, ". . . 2.1 General Administration Information. Administer Levothyroxine Sodium Tablets as a single daily dose, on an empty stomach, one half to one hour before breakfast. . . ." Review of Resident #12's medical record occurred on 04/15/26. Physician's orders identified "Finasteride Oral Tablet 5 MG [milligrams] . . . . DO NOT crush or split. . . ." and "Levothyroxine Oral Tablet 50 MCG [micrograms] . . . " -Observation on 04/15/26 at 8:14 a.m. showed a nurse (#7) prepared Resident #12's medications. The nurse crushed the finasteride and placed it and other medications, including the levothyroxine, in strawberry ice cream, and administered them to the resident. -Observations on 04/15/26 at 11:35 a.m. and 11:47 a.m. showed a nurse (#7) primed Resident #3 and #77's insulin pens at a 45-degree angle. The nurse (#7) failed to follow physician's orders and crushed the finasteride, failed to prime insulin pens with the needle pointing upward, and failed to administer the levothyroxine on an empty stomach. During interviews on 04/15/26 at 10:50 a.m. and 2:15 p.m., administrative staff members (#1 and #2) confirmed staff should not crush finasteride, levothyroxine should be administered on an empty stomach, and insulin pens should be primmed pointing up at a 90-degree angle.	F0759		05/18/2026
F0880 SS = E	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.	F0880	Nursing staff were educated on the importance of infection control standards related to medication administration and preparation, toileting cares, glove use, hand hygiene and enhanced barrier precautions. This education was for resident #1, #3, #12, #34, #56 and #77 and any other resident who is on enhanced barrier precautions (EBP), requires insulin, required assistance during toileting cares, medication preparation and administration, and/or requires wound care. Resident #1 care plan reflects resident is on EBP. Resident #3 was placed on EBP 04/16/26 and care plan updated. Resident #12 is deceased as of 05/04/26. Resident #34 care plan updated 04/19/26 to reflect left gluteal unstageable pressure wound. Resident #77 is on insulin; education will	05/18/2026

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F0880 SS = E	Continued from page 10 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 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.	F0880	Continued from page 10 occur regarding disinfecting the rubber stoppers before attaching the needles. All residents have the potential to be affected if they are on enhanced barrier precautions, not following IC standards during toileting cares, and medication preparation and administration, and wound care. Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of enhanced barrier precautions, changing of gloves during medication preparation and administration, changing of gloves for wound care, gloves during toileting cares and disinfecting the rubber stoppers before attaching the needles with insulin. Reviewed policy/procedures titled “Enhanced Barrier Precautions”, “Personal Protective Equipment”, “Hand Hygiene” and “Insulin Pen”. DON or designee will monitor enhanced barrier precautions, glove changing during wound care, glove changing during toileting, glove changing during medication preparation and administration and disinfecting the rubber stoppers before attaching the needles with insulin administration. Monitoring will be weekly x4, monthly x3, then quarterly thereafter. If concerns are identified immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 05/18/26	05/18/2026

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F0880 SS = E	Continued from page 11 §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, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 4 of 18 sampled residents (Resident #1, #3, #12, #34, and #56) and 1 supplemental resident (Resident #77) observed during toileting cares and medication preparation and administration. Failure to practice infection control standards related to hand hygiene, glove use, and enhanced barrier precautions (EBP) has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Enhanced Barrier Precautions" occurred on 04/16/26. This policy, revised September 2025, stated, ". . . implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. . . . employs targeted gown and gloves use during high contact resident care activities. . . . An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g. chronic wounds such as . . . diabetic foot ulcers . . .) and/or indwelling medical devices (e.g. . . . urinary catheters . . .) . . . High-contact resident care activities include: . . . Transferring . . . Changing briefs or assisting with toileting . . . Device care or use: . . . urinary catheters . . . Wound care: any skin opening requiring a dressing. . . ." Review of the facility policy titled "Personal Protective Equipment" occurred on 04/16/26. This undated policy stated, ". . . appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff. . . . Gloves . . . Wear gloves when direct contact with blood, body fluids, mucous membranes, non-intact skin, or potentially contaminated surfaces or equipment is anticipated. . . . Perform hand hygiene before donning gloves and after removal. . .	F0880		05/18/2026

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F0880 SS = E	Continued from page 12 ." Review of the facility policy titled "Hand Hygiene" occurred on 04/16/26. This policy, revised July 2025, 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 under the conditions listed in, but not limited to, the attached hand hygiene table. . . . 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. . . . Hand Hygiene Table . . . Condition . . . Between resident contacts . . . After handling contaminated objects . . . Before applying and after removing personal protective equipment (PPE), including gloves . . . Before preparing or handling medications . . . Before and after handling clean or soiled dressings, linens . . . When, during resident care, moving from a contaminated body site to a clean body site . . ." Review of the facility policy titled "Insulin Pen" occurred on 04/16/25. This policy, revised March 2026, stated, ". . . i. Remove the pen cap from the insulin pen. ii. Wipe the rubber seal with an alcohol pad. iii. Screw the pen needle onto the insulin pen. . . ." - Review of Resident #1's medical record occurred on all days of survey. The care plan stated, ". . . Enhanced Barrier Precautions Due to indwelling catheter . . . Staff will wear gown and gloves for dressing . . . assisting with toileting . . ." Observation on 04/13/26 at 4:02 p.m. showed an EBP sign on Resident #1's door and PPE supplies outside of the room. Two certified nurse aides (CNAs) (#9 and #10) applied PPE, entered the resident's room, and transferred the resident from a wheelchair onto the toilet. The CNA (#9) emptied urine from the resident's foley catheter bag into a urinal. The CNA's completed toileting cares and transferred the resident back into the wheelchair. The CNAs removed their PPE, performed hand hygiene, and the CNA (#10) exited the room. The CNA (#9) failed to apply a gown and gloves, emptied the urine from the urinal into the toilet, performed hand hygiene, applied clean gloves, removed the resident's soiled shirt, applied a clean shirt, and offered the resident water.	F0880		05/18/2026

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F0880 SS = E	Continued from page 13 The CNA (#9) failed to apply a gown and gloves prior to emptying the urine from the urinal into the toilet, failed to wear a gown when changing the resident's shirt, and failed to remove gloves and perform hand hygiene prior to touching the resident's water mug. During an interview on 04/15/26 at 10:50 a.m., administrative staff members (#1 and #2) stated they expect staff to wear a gown and gloves when emptying a urinal. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included a history of methicillin resistant staphylococcus aureus (MRSA) (a multi-drug resistant infection). Nurses' notes identified a left heel pressure ulcer and two right foot/leg diabetic ulcers. Physician's orders identified daily dressing changes to the areas. Observation of Resident #3 on all days of survey showed no enhanced barrier precautions in place. Observation on 04/13/26 at 4:29 p.m. showed Resident #3 resting in bed. Two CNAs (#5 and #16) performed hand hygiene, applied gloves, and entered the room. The CNAs performed a check and change of the resident's brief and transferred the resident to the wheelchair with a full body mechanical lift. The CNAs failed to wear gowns during Resident #3's cares. During an interview on 04/15/26 at 3:30 p.m., an administrative nurse (#3) confirmed the facility failed to implement EBP for Resident #3. - Review of Resident #12's medical record occurred on all days of survey. The current care plan stated, ". . . Enhanced Barrier Precautions Due to indwelling catheter . . ." Observation on 04/13/26 at 4:03 p.m. showed an EBP sign on the resident's door and PPE supplies outside of the room. A CNA (#5) and a nurse (#4) applied PPE and entered the room. The CNA (#5) completed bowel movement cares, removed the soiled gloves, and without performing hand hygiene or applying clean gloves, moved the sit to stand lift	F0880		05/18/2026

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F0880 SS = E	Continued from page 14 and the garbage can closer to the bed. The CNA (#5) washed her hands and applied clean gloves. The CNA (#5) completed the remaining perineal cares, removed the soiled gloves, and without performing hand hygiene or applying new gloves, assisted the resident to turn, pulled up the resident's pants, placed the package of wipes in the bedside drawer, and performed hand hygiene. Without applying gloves, the CNA moved the sit to stand lift, handed the resident's shoes to the nurse, lowered the bed, and transferred the resident to the wheelchair. The CNA placed the urinary drainage bag under Resident #12's wheelchair in a privacy bag, adjusted the resident's clothing, and straightened the bedding. The nurse (#4) removed the soiled gown and gloves, performed hand hygiene, and exited the room with the sit to stand lift. The CNA emptied the trash, removed the soiled gown, washed her hands and exited the room. The CNA (#5) failed to perform hand hygiene after removing the soiled gloves and before touching other items in the room and failed to wear gloves while performing cares for a resident in EBP. During an interview on 04/16/26 8:40 a.m., a nurse (#3) confirmed she expected staff to wear gloves for the duration of cares provided in EBP, perform hand hygiene after glove removal, and before touching other objects. -Review of Resident #34's medical record occurred on all days of survey. Diagnoses included a pressure ulcer of the sacral region. Physician's orders identified dressing changes every three days and as needed. Observation on 04/14/26 at 10:08 a.m. showed an EBP sign on the resident's door and PPE supplies outside of the room. A nurse (#6) performed hand hygiene, applied a gown, mask, and gloves, and entered the resident's room to complete pressure ulcer cares. A CNA (#8) assisted Resident #34 to roll onto her right side. The nurse removed two soiled dressings and discarded them. Without removing the soiled gloves and performing hand hygiene, the nurse cleansed the left lower buttocks wound with normal saline and a dried with a gauze pad. The nurse applied Anacept (antimicrobial solution) to her gloved finger and rubbed it into the wound and applied Anacept to the wound area to the upper coccyx. The nurse applied Mepilex (foam dressing) to both wound areas, gathered opened packages and	F0880		05/18/2026

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F0880 SS = E	Continued from page 15 discarded them. The nurse removed her gown, gloves, mask, and completed hand hygiene prior to exiting the room. The nurse failed to remove the soiled gloves, perform hand hygiene, and apply new gloves when moving from a dirty to clean task during wound care. - Observation during medication pass showed the following: * 04/15/26 at 8:14 a.m., A nurse (#7) applied gloves and administered Resident #12's oral medications. Without removing the soiled gloves, performing hand hygiene, and applying clean gloves, the nurse administered eye drops. * 04/15/26 at 11:35 a.m. and 11:47 a.m., A nurse (#7) prepared two insulin pens (Resident #3 and #77) and failed to disinfect the rubber stoppers before attaching the needles. During an interview on 04/15/26 at 10:50 a.m., administrative staff members (#1 and #2) stated they expected staff to change gloves between administering oral medications and eye drops and disinfect insulin pen tips before attaching sterile needles. .	F0880		05/18/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a	F0580	Nursing staff were educated on the importance of notifying guardians and providers on any change in skin conditions specifically breast tissue. This education was for resident #77 (deceased) and other resident(s) who develop a skin condition that requires notification of family and provider. All residents have the potential to be affected if they develop a skin condition that required treatment related to an infection. Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of notifying the guardian and provider with any changes in skin condition. Reviewed policy/procedure "Change in Resident's Condition or Status". DON or designee will monitor all residents to ensure	05/18/2026

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F0580 SS = D	Continued from page 16 need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to notify the physician or resident's representative for 1 of 1 closed records (Resident # 85) reviewed for change in breast tissue. Failure to notify the resident's representative and physician of an identified breast abnormality does not allow the representative or physician to be fully informed of the resident's care, current status, and to make informed decisions regarding medical care. Findings Include:	F0580	Continued from page 16 guardians/POA and providers are notified when there is either an accident resulting in injury or a significant change in the residents condition, a change in treatment, resident is transferred or discharged, or a change in the resident room. Monitoring will be weekly x4, monthly x3, then quarterly thereafter. If concerns are identified immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 05/18/26	05/18/2026

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F0580 SS = D	Continued from page 17 Review of the facility policy titled "Change in a Resident's Condition or Status" occurred on 04/16/26. This policy, reviewed March 2026, stated, "2. Unless otherwise instructed by the resident. the Neighborhood Nurse Manager (or designee) or Social Worker will notify the resident's next of kin or representative (sponsor) when: . . . b. There is a significant change in the resident's physical, mental, or psychosocial status. c. There is a need to alter the resident's treatment significantly. . . " -Review of Resident's #85 medical record occurred on April 15-16, 2026 and identified a right breast lump on 10/19/24. Review of Resident's #85 progress notes identified the following: * 07/03/25 at 10:45 p.m., ". . . Scab below the right areola was noted tonight during bath. Area around the right areola still hardened. Resident denies pain or discomfort. No discharges noted to the right nipple. Kept monitored." * 07/07/25 at 9:36 p.m., ". . . Right breast. . . . Hardened around her areola . . . . Scab below the right areola was noted during bath, ..." * 07/21/25 at 10:55 p.m., ". . . Right breast. . . . Hardened around her areola. . . . Right breast. . . .dry scab with minimal discharge. . . . Length (cm) [centimeter]: 4 Width (cm): 3 Surrounding tissues: Erythema. Skin Issues Note: Bacitracin ointment applied to right breast scab. . . ." * 08/04/25 at 10:23 p.m., ". . . Right breast. . . . Hardened around her areola. . . .dry scab with minimal discharge. . . . Deteriorating: wound characteristics deteriorated. Wound acquired in-house. Signs and symptoms of infection: Size has increased. Length (cm): 5 Width (cm): 3.5 Depth (cm): 0 Exudate amount: Light. Exudate type: Purulent: indication of pus, typically thick, yellow, green, tan or brown. slough Surrounding tissue: Erythema. Cleansing solution: Soap & Water. Other additional care: Bacitracin ointment applied. . . ." * 08/06/25 at 7:18 a.m., ". . . No improvement in right breast region area measuring 14 cm by 14 cm redness and hardness to the breast with 5 cm by 4	F0580		05/18/2026

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F0580 SS = D	Continued from page 18 cm scabbed/crusty area to the right of the nipple area no drainage tender to the touch. . . . Resident will be sent to ER [emergency room] to get evaluated. . . ." * 08/06/25 at 2:00 p.m., ". . . CNA that went with resident this Am---States that resident was admitted to the hospital for infection and possible breast cancer. . . .Did inform one of the guardians about the admission." * 08/06/25 at 3:36 p.m., ". . . Hospital personal returned my Call--States resident was admitted---she is on IV [intravenous therapy] antibiotic for breast infection. had a CT [computed tomography]-scan while in ER-the results showing the unlaying breast tissue is cancerous. . . ." During an interview on 04/15/26 at 4:53p.m., Administrative staff member (#1) confirmed the resident's the facility did not notify Resident #85's guardian about the breast lump and the provider's recommendation for no further treatment. The facility failed notify Resident #85's guardian about the breast lump and failed to notify the provider when the breast tissue surrounding the lump showed signs of infection and the application of bacitracin on 07/21/25.	F0580		05/18/2026
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and	F0600	Nursing staff were educated on the importance of reporting resident to resident abuse and to investigate it thoroughly. This education was for residents #48 and #9 and any other residents who have an altercation. Resident #9 care plan updated on 04/16/26 to reflect the physical aggressive behavior that occurred on 12/04/25. All residents have the potential to be affected if they have a resident to resident altercation. Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of reporting and investigating thoroughly all resident to resident altercations. Reviewed policy/procedures titled “Abuse, Neglect and Exploitation”. DON or designee will monitor to ensure reporting and thorough investigation of any/all resident to resident altercations. Monitoring will be weekly x4, monthly x3, then quarterly thereafter. If concerns are identified immediate corrective action will be	05/18/2026

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F0600 SS = D	Continued from page 19 staff interview, the facility failed to ensure residents remained free from abuse for 1 of 1 sampled resident (Resident #48) reviewed for abuse. Failure to provide the necessary services to protect residents from physical abuse resulted in a bruise to Resident #48's arm. Failure to protect all residents from physical abuse placed all residents at risk for psychosocial harm and/or injury. Findings include: Review of the facility's policy titled, "Abuse, Neglect and Exploitation," occurred on 04/16/26. This policy, dated February 2026, stated, ". . . 'Physical Abuse' includes, but is not limited to hitting, slapping, punching, biting, and kicking. . . . 'Sexual Abuse' is non-consensual sexual contact of any type with a resident . . . The facility will implement policies and procedures to prevent and prohibit all types of abuse. . . that achieves . . . the identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. . . ." Review of Resident #48's medical record occurred on all days of survey. Diagnoses included anxiety, dementia with psychotic disturbance, depression, restlessness and agitation. Review of Resident #48's nurse's notes identified the following: * 12/04/25 at 7:12 p.m., "Writer was doing evening med pass when writer heard a scream coming from the unit's lounge. Writer ran and saw [CNA's name] in between residents [Resident #48] and [Resident #9]. CNA informed writer that resident was yanked on left wrist and was slapped on left side of face x [times] 2 by [Resident #9]. Noted resident's left cheek was reddish in color on assessment. No noted bruising/redness on resident's left hand. De-escalation done. Cold compress applied on left cheek and left dorsal hand. . . ." * 12/05/25 at 10:09 p.m., ". . . CNA notified this nurse that resident [Resident #48] has a 1.5 cm [centimeter] by 1.5 cm bruise to the L [left] inner forearm. Resident is oriented to self only and is unable to verbalize what happened. Resident does not appear to have pain in this area. . . ."	F0600	Continued from page 19 implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 05/18/26	05/18/2026

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F0600 SS = D	Continued from page 20 Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia with agitation, depression, irritability/anger, and psychotic disorder with hallucinations. The current physician's orders included Valproic Acid capsule during the day and two capsules at bedtime for a psychotic disorder with hallucinations. The current care plan stated, ". . . I have potential to demonstrate physical and verbal behaviors. . . . I can be started [sic] easily. . . . I at times get frustrated if there are too many people around me . . . Remove from stressful situation . . ." Resident #9's care plan failed to address his physically aggressive behaviors towards other residents in the facility. During an interview on the morning of 04/16/26, an administrative staff member (#2) confirmed the facility failed to report/thoroughly investigate the incident between Resident #48 and #9.	F0600		05/18/2026
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required	F0604	Nursing staff educated on the importance of refraining from using a manual method of restraints when caring for residents. This education was for resident #9 and any other resident who staff may use manual method(s) of restraints. Resident #9 care plan updated on 05/11/26 to reflect to reapproach resident if they are aggressive during cares. All residents have the potential to be affected if they are aggressive during cares and restraints are used for the purpose of discipline or convenience and are not required to treat a residents medical symptom(s). Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of not using any manual method of restraints when caring for residents. Reviewed policy/procedure titled "Use of Physical Restraints" DON or designee will monitor staff during all shifts to ensure no manual method of restraints are being used/done. Monitoring will be weekly x4, monthly x3, then quarterly thereafter. If concerns are identified immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 05/18/26	05/18/2026

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F0604 SS = D	Continued from page 21 to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from restraints for 1 of 1 sampled resident (Resident #9) reviewed for restraints. Failure to ensure staff refrained from using a manual method of restraining a resident placed Resident #9 at risk for increased behaviors, fear, anxiety, and injury. Findings Include: Review of the facility policy titled “Use of Physical Restraints” occurred on 04/16/26. This policy, dated February 2026, stated, “. . . all residents have the right to be free from any physical restraints . . . Within 72 hours the interdisciplinary team must be notified of the application of the restraint so that they may complete a follow-up evaluation and determine the need to initiate the non-emergency physical restraint procedure. . . .” Review of Resident #9's medical record occurred on all days of survey. Diagnoses include irritability, anger, and dementia with agitation and psychotic disturbances. The current care plan stated, ". . . I have potential to demonstrate physical and verbal behaviors. And at times will refuse cares . . . Give me as many choices as possible about my care and activities . . . I at times get frustrated if there are too many people around me . . . Reapproach . . ." Review of Resident #9's nurse's notes identified the following: * 08/09/25 at 11:00 p.m., ". . . needs brief change . . . started throwing punches and kicking. Called for assistance. Another RN [registered nurse] and 2 CNAs [certified nurse aides] came and help [sic]. One staff [sic] held his hands and another on hold [sic] his legs. 2 other staff cleaned . . ." * 08/18/25 at 11:55 p.m., ". . . needed to be changed. . . . started to be violent and throwing punches . . . called CNA to help but resident was even [sic] kicking the staffs [sic]. . . . called another CNA to assist. Writer held resident's arms, 1 CNA	F0604		05/18/2026

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F0604 SS = D	Continued from page 22 held his legs while the other CNA washed . . ." The medical record lacked documentation the staff attempted to reapproach Resident #9 or minimize the number of staff in the room during the above incidents. During an interview on 04/16/26 at 10:12 a.m., an administrative nurse (#1) stated facility staff should not physically restrain residents. The facility failed to ensure Resident #9 remained free from manual restraint use by multiple staff members.	F0604		05/18/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to report incidents of potential abuse to officials including the State	F0609	Nursing staff were educated on the importance of reporting all allegations of physical or sexual abuse to the state agency. This education was for resident #9, #42, and #48 and any other resident who has had any allegation of physical or sexual abuse. State was notified of incidents during state survey. All residents have the potential to be affected if they experience staff to resident or resident to resident abuse. Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of reporting resident to resident or staff to resident abuse. Reviewed policy/procedure titled “Abuse, Neglect and Exploitation”. DON or designee will monitor to make sure all resident to resident and staff to resident abuse is reported to the state agency. Monitoring will be weekly x4, monthly x3, then quarterly thereafter. If concerns are identified immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 05/18/26	05/18/2026

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F0609 SS = D	Continued from page 23 Survey Agency (SSA) for 3 of 3 sampled residents (Resident #9, #42, and #48) with allegations of physical or sexual abuse. Failure to report incidents of potential physical or sexual abuse to the State agency placed all residents at risk of abuse, mental and emotional distress, and or physical injury. Findings include: Review of the facility's policy titled, "Abuse, Neglect and Exploitation," occurred on 04/16/26. This policy, dated February 2026, stated, ". . . The facility will have written procedures that include . . . Reporting of all alleged violations to the . . . state agency, adult protective services and to all other required agencies . . . within specified timeframes . . . Immediately, but not later than 2 hours after the allegation is made, if the events that caused the allegation involved abuse . . ." - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia with agitation, depression, irritability/anger, and psychotic disorder with hallucinations. The current care plan identified, ". . . I have potential to demonstrate physical and verbal behaviors. . . . I can be started [sic] easily. . . . I at times get frustrated if there are too many people around me . . . Remove from stressful situation . . ." Review of Resident #9's nurse's notes identified the following: * 8/9/25 at 11:00 p.m., ". . . needs brief change . . . started throwing punches and kicking. Called for assistance. Another RN [registered nurse] and 2 CNAs [certified nurse aides] came and help [sic]. One staff [sic] held his hands and another on hold [sic] his legs. 2 other staff cleaned . . ." * 8/18/25 at 11:55 p.m., ". . . needed to be changed. . . . started to be violent and throwing punches . . . called CNA to help but resident was even [sic] kicking the staffs [sic]. . . . called another CNA to assist. Writer held resident's arms, 1 CNA held his legs while the other CNA washed . . ." The facility failed to report potential staff-to-resident abuse to the SSA. - Review of Resident #48's medical record occurred	F0609		05/18/2026

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F0609 SS = D	Continued from page 24 on all days of survey. Diagnoses included anxiety, dementia with psychotic disturbance, depression, restlessness and agitation. A nurse's note, dated 12/04/25 at 7:12 p.m., stated, "Writer was doing evening med pass when writer heard a scream coming from the unit's lounge. Writer ran and saw [CNA's name] in between residents [Resident #48] and [Resident #9]. CNA informed writer that resident was yanked on left wrist and was slapped on left side of face x [times] 2 by [Resident #9]. Noted resident's left cheek was reddish in color on assessment. No noted bruising/redness on resident's left hand. De-escalation done. Cold compress applied on left cheek and left dorsal hand. . . . Family informed, physician fax form prepared, DON [director of nursing] and nurse managers notified." The facility failed to report resident-to-resident abuse to the SSA. - Review of Resident #42's medical record occurred on all days of survey. Diagnoses included dementia, anxiety, restlessness, agitation, and hallucinations. A nurse's note, dated 11/19/2025 at 7:00 p.m., stated, "Resident [Resident #42] was on her wheelchair and on her way back to her room when she passed by a male resident and touched his shoulder. Male resident grabbed her breast and she just laughed. Took resident back to her room. . . ." The facility failed to report potential resident-to-resident abuse to the SSA. During an interview on the morning of 04/16/26, two administrative staff members (#1 and #2) confirmed the facility failed to report the incidents identified above to the SSA.	F0609		05/18/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F0610	Nursing staff were educated on the importance of investigating thoroughly all resident to resident and staff to resident abuse. This education was for resident #9, #42, #48 and any other resident who has resident to resident or staff to resident abuse. Will investigate all resident to resident or staff to resident abuse allegations.	05/18/2026

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F0610 SS = D	Continued from page 25 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to thoroughly investigate alleged violations of possible abuse for 3 of 3 sampled residents (Resident #9, #42, and #48) subjected to physical abuse, sexual abuse, and restraint use. Failure to thoroughly investigate allegations of abuse, implement corrective actions, and evaluate the effectiveness of those actions, placed all residents at risk of abuse, mental/emotional distress, and physical injury. Findings include: Review of the facility's policy titled, "Abuse, Neglect and Exploitation," occurred on 04/16/26. This policy, dated February 2026, stated, ". . . An immediate investigation is warranted when suspicion of abuse . . . or reports of abuse . . . occur. . . . Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following . . . analyzing the occurrence(s) to determine why abuse . . . occurred, and what changes are needed to prevent further occurrences. . . . Defining how care provision will be changed and/or improved to protect residents receiving services . . ." - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia with agitation, depression, irritability/anger, and psychotic disorder with hallucinations. The current care plan identified, ". . . I have potential to demonstrate physical and verbal behaviors. . . . I can be started [sic] easily. . . . I at times get frustrated if there are too many people around me . . . Remove	F0610	Continued from page 25 All residents have the potential to be affected if they experience staff to resident or resident to resident abuse that are not investigated thoroughly. Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of investigating resident to resident or staff to resident abuse. Reviewed policy/procedure titled "Abuse, Neglect and Exploitation". DON or designee will monitor to make sure all resident to resident and staff to resident abuse is thoroughly investigated. Monitoring will be weekly x4, monthly x3, then quarterly thereafter. If concerns are identified immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 05/18/26	05/18/2026

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F0610 SS = D	Continued from page 26 from stressful situation . . .” Review of Resident #9's nurse's notes identified the following: * 8/9/25 at 11:00 p.m., ". . . needs brief change . . . started throwing punches and kicking. Called for assistance. Another RN [registered nurse] and 2 CNAs [certified nurse aides] came and help [sic]. One staff [sic] held his hands and another on hold [sic] his legs. 2 other staff cleaned . . ." * 8/18/25 at 11:55 p.m., ". . . needed to be changed. . . . started to be violent and throwing punches . . . called CNA to help but resident was even [sic] kicking the staffs [sic]. . . . called another CNA to assist. Writer held resident's arms, 1 CNA held his legs while the other CNA washed . . ." The facility failed to investigate the potential abuse to Resident #9 by staff, - Review of Resident #48’s medical record occurred on all days of survey. Diagnoses included anxiety, dementia with psychotic disturbance, depression, restlessness and agitation. A nurse’s note, dated 12/04/25 at 7:12 p.m., stated, “Writer was doing evening med pass when writer heard a scream coming from the unit's lounge. Writer ran and saw [CNA’s name] in between residents [Resident #48] and [Resident #9]. CNA informed writer that resident was yanked on left wrist and was slapped on left side of face x [times] 2 by [Resident #9]. Noted resident's left cheek was reddish in color on assessment. No noted bruising/redness on resident's left hand. De-escalation done. Cold compress applied on left cheek and left dorsal hand. . . . Family informed, physician fax form prepared, DON [director of nursing] and nurse managers notified.” The facility failed to investigate the incident of resident-to-resident abuse. - Review of Resident #42’s medical record occurred on all days of survey. Diagnoses included dementia, anxiety, restlessness, agitation, and hallucinations.	F0610		05/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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

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F0610 SS = D	Continued from page 27 A nurse's note, dated 11/19/2025 at 7:00 p.m., stated, "Resident [Resident #42] was on her wheelchair and on her way back to her room when she passed by a male resident and touched his shoulder. Male resident grabbed her breast and she just laughed. Took resident back to her room. . . ." The facility failed to investigate the potential incident of resident-to-resident abuse. During an interview on the morning of 04/16/26, two administrative staff members (#1 and #2) confirmed the facility failed to investigate the incidents identified above.	F0610		05/18/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer.	F0628	Nursing staff and Social Services staff were educated on the importance of making sure to notify the state Long Term Care Ombudsman when a resident is discharged or transferred from a facility. This education was for resident #81 and any other resident who is discharged or transferred. Resident #81 was discharged on 02/18/26. All residents have the potential to be affected if the LTC State Ombudsman is not notified of discharge or transfers. Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of notifying the LTC Ombudsman of any transfers or discharges. Social Services or designee will monitor to ensure Long Term Care Ombudsman is notified of all transfers and discharges of residents. Monitoring will be weekly x4, monthly x3, then quarterly thereafter. If concerns are identified immediate corrective action will be implemented. Social Services or designee will report monitoring results to the quarterly QA committee meeting. 05/18/26	05/18/2026

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F0628 SS = D	Continued from page 28 Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;	F0628		05/18/2026

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F0628 SS = D	Continued from page 29 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	F0628		05/18/2026

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F0628 SS = D	Continued from page 30 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by:	F0628		05/18/2026

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F0628 SS = D	Continued from page 31 Based on record review and staff interview, the facility failed to provide the State Long Term Care Ombudsman with a written notice of discharge for 1 of 1 closed record (Resident #81) reviewed for facility discharge. Failure to notify the State Ombudsman does not provide residents with access to an advocate who can inform them of their options and rights, and to provide them with protection from being discharged inappropriately. Findings include: Review of Resident #81's medical record occurred on 04/14/26. A progress note dated 02/12/26 at 2:17 p.m., stated, "Resident seen for rounds today . . . will be discharging home on 2/18/26 as therapy complete. . . ." The record failed to include evidence the facility notified the State Ombudsman of the discharge. During an interview on 04/14/2026 at 3:35 p.m. an administrative staff member (#2) confirmed Resident #81's medical record lacked the required notification to the State Ombudsman.	F0628		05/18/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F0657	Nursing staff were educated on the importance of reviewing and revising all care plans of the resident. This education was for resident #9 and any other resident who needs care plan updated. Resident #9 care plan was updated 05/12/26 to reflect residents agitation with cares and updated to include nurse and CNA held his legs and hands on 08/09/25 and 08/18/25. All residents have the potential to be affected if their care plan is not updated to reflect their current status. Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of updating care plans. Reviewed policy/procedure titled “Comprehensive Care Plans”. DON or designee will monitor care plans after each comprehensive assessment and quarterly MDS to ensure they are updated to reflect the current status of the resident. Monitoring will be weekly x4, monthly x3, then quarterly thereafter. If concerns are identified immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting.	05/18/2026

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F0657 SS = D	Continued from page 32 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 1 of 18 sampled residents (Resident #9). Failure to update care plans limited the staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility's policy titled "Comprehensive Care Plans" occurred on 04/16/26. This policy, dated March 2026, stated, ". . . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS [Minimum Data Set] assessment. . . ." Review of Resident #48's medical record occurred on all days of survey. A nurse's note, dated 12/04/25 at 7:12 p.m., stated, "Writer was doing evening med pass when writer heard a scream coming from the unit's lounge. Writer ran and saw [CNA's name] in between residents [Resident #48] and [Resident #9]. CNA informed writer that resident was yanked on left wrist and was slapped on left side of face x [times] 2 by [Resident #9]. Noted resident's left cheek was reddish in color on assessment. No noted bruising/redness on resident's left hand. De-escalation done. Cold compress applied on left cheek and left dorsal hand. . . . Family informed, physician fax form prepared, DON [director of nursing] and nurse managers notified." - Review of Resident #9's medical record occurred on all days of survey. Diagnoses included dementia with agitation, depression, irritability/anger, and psychotic disorder with hallucinations. The current care plan identified, ". . . I have potential to demonstrate physical and verbal behaviors. . . . I can be started [sic] easily. . . . I at times get frustrated if there are too many people around me . . . Remove from stressful situation . . ."	F0657	Continued from page 32 05/18/26	05/18/2026

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F0657 SS = D	Continued from page 33 Review of Resident #9's nurse's notes identified the following: * 8/9/25 at 11:00 p.m., ". . . needs brief change . . . started throwing punches and kicking. Called for assistance. Another RN [registered nurse] and 2 CNAs [certified nurse aides] came and help [sic]. One staff [sic] held his hands and another on hold [sic] his legs. 2 other staff cleaned . . ." * 8/18/25 at 11:55 p.m., ". . . needed to be changed. . . . started to be violent and throwing punches . . . called CNA to help but resident was even [sic] kicking the staffs [sic]. . . . called another CNA to assist. Writer held resident's arms, 1 CNA held his legs while the other CNA washed . . ." The facility failed to update Resident #9's care plan following the incidents identified above. During an interview on the morning of 04/16/26, two administrative staff members (#1 and #2) confirmed the facility failed to update Resident #9's care plan following the incidents.	F0657		05/18/2026
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, review of manufacturer's instruction manual, and staff interview, the facility failed to ensure staff used a mechanical lift appropriately for 1 of 4 sampled residents (Resident #48) observed during sit-to-stand lift transfers. Failure to ensure staff used the mechanical lift according to manufacturer's instructions placed Resident #48 at risk for pain/discomfort and/or injury.	F0689	Nursing staff were educated on the importance of using the mechanical lift, specifically the sit to stand, and making sure to use it appropriately following manufactures instructions. This education was for residents #48 and any other resident who uses a mechanical lift specifically the sit to stand. Resident #48 had a physical therapy evaluation ordered on 05/11/26 to make sure resident is safe in sit to stand lift. All residents have the potential to be affected if they are using a mechanical lift, specifically the sit to stand. Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of using all mechanical lifts correctly, specifically sit to stand. Reviewed policy/procedure titled "Safe Resident Handling/Transfers". DON or designee will monitor the residents who use a sit to stand lift to make sure they are using them correctly according to manufactures guidelines. Monitoring will be weekly x4, monthly x3, then	05/18/2026

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F0689 SS = D	Continued from page 34 Findings include: Review of the facility's policy titled, "Safe Resident Handling/Transfers," occurred on 04/16/26. This policy, reviewed February 2026, stated, ". . . All residents require safe handling when transferred to prevent or minimize the risk for injury . . . Staff will perform mechanical lifts/transfers according to the manufacturer's instructions . . ." The facility provided a copy of the manufacturer's instructions for the Easy Way sit-to-stand lift. Review of the instructions occurred on 04/16/26. The instructions stated, ". . . Raise the patient's arms on the outside of the harness and have them place their hands on the padded handles. . . . As the patient is being raised, simultaneously tighten the safety strap buckled around their torso. . . . Stop lifting when the patient is in a standing position. . . . With the patient in a standing position, transfer the patient to the desired location. . . ." Review of Resident #48's medical record occurred on all days of survey. Medical diagnoses included dementia, disc degeneration; cervical, lumbar, and thoracic regions, and extremity pain. The current care plan stated, ". . . I have an ADL [Activities of Daily Living] Self Care Performance Deficit r/t [related to] Dementia . . . TRANSFER: PAL [sit-to-stand] lift and assist of 2 . . . I have history of chronic pain and history of fractures . . . Monitor . . . complications related to arthritis: Joint pain; Joint stiffness . . . Swelling . . ." Observations showed the following: * 04/14/26 at 10:34 a.m., two certified nurse aides (CNAs) (#13 and #14) transferred Resident #48 from the bed to the toilet with a sit-to-stand lift. When the CNAs raised the lift, the resident failed to bear weight, remained in a seated position, and hung from the harness. The harness straps pulled upward into Resident #48's axillae (armpits), rolled/pinched the skin above the sling strap, and raised her shoulders. The resident remained in this position until the CNAs (#13 and #14) lowered her onto the toilet. * 04/15/26 at 3:48 pm, two CNAs (#8 and #13) transferred Resident #48 from the bed to the toilet with a sit-to-stand lift. When the CNAs raised the	F0689	Continued from page 34 quarterly thereafter. If concerns are identified immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 05/18/26	05/18/2026

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F0689 SS = D	Continued from page 35 lift, the resident failed to bear weight, remained in a seated position, and hung from the harness. The harness straps pulled upward into Resident #48's axillae, bunched her shirt sleeves above the sling strap, and raised her shoulders. The resident remained in this position until the CNAs (#8 and #13) lowered her onto the toilet. During an interview on 04/16/26 at 8:20 a.m., two administrative staff members (#2 and #3) confirmed staff should ensure residents can bear weight when utilizing a sit-to-stand lift.	F0689		05/18/2026
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, review of the dialysis communications forms, and resident and staff interview, the facility failed to provide care and services consistent with professional standards of practice for 1 of 1 sampled resident (Resident #63) receiving hemodialysis. Failure to receive dialysis treatment communication on a consistent basis and complete post-dialysis assessments may result in an unidentified change in the resident's condition. Findings include: Review of the facility policy titled "Hemodialysis" occurred on 04/16/26. This policy, dated 2025, stated, ". . . The facility will assure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include . . . Ongoing assessment and oversight of the resident before, during and after dialysis treatment . . . Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. . . . The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications. . . ."	F0698	Nursing staff were educated on the importance of receiving dialysis treatment communication on a consistent basis and completing post dialysis comments. This education was for resident #63 and any other resident on dialysis. Updated resident #63 treatment to include post fistula, vital signs and resident conditions to make sure to enter progress notes upon resident return from dialysis. Fistula checked before dialysis and at bedtime and ensure communication is received from CHI dialysis on days of dialysis. All residents have the potential to be affected if they are on dialysis. Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of receiving dialysis communication and completing post dialysis comments within progress notes. Reviewed policy/procedure "Hemodialysis". DON or designee will monitor the residents who receive dialysis to make sure communication is received and documented and that fistula is checked. Monitoring will be weekly x4, monthly x3, then quarterly thereafter. If concerns are identified immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 05/18/26	05/18/2026

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BETHEL LUTHERAN NURSING & REHABILITATION CENTER	**1515 2ND AVE WEST , WILLISTON, North Dakota, 58801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0698 SS = D	Continued from page 36 Review of Resident #63's medical record occurred on all days of survey. A hospital discharge order, dated 04/02/26, stated, ". . . Continue dialysis 3 times per week . . ." A physician's order, dated 03/10/26, stated, "Assess AV [arteriovenous] fistula [dialysis access site] to right forearm, appearance, bruit, and thrill. two times a day . . ." Observation on 04/14/26 at 8:01 a.m. showed a fistula to Resident #63's right forearm. The resident confirmed dialysis treatments three times a week on Mondays, Wednesdays, and Fridays. Review of Resident #63's dialysis communication forms, dated 03/13/26 through 04/13/26 (12 visits), showed 5 of the 12 forms failed to include the dialysis centers pre and/or post dialysis information. Review of the resident's treatment administration records (TARs) and nurses' notes from 03/13/26 through 04/13/26 lacked documentation of the facility's post-dialysis/fistula site assessments for 12 of the 12 visits. During an interview on 04/14/26 at 5:14 p.m., two administrative staff members (#1 and #2) confirmed nursing staff failed to ensure the dialysis center completed the communication forms or the facility nursing staff called the center to obtain a report on the resident's status. The administrative staff members also stated nursing staff failed to complete and document post dialysis/fistula assessments after the resident returned to the facility on all 12 visits.	F0698		05/18/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal	F0761	Nursing staff were educated on the importance of making sure labels match the providers' orders. This education was for Resident #3 and any other residents whose label does not match provider orders. Resident #3 label for insulin pen was updated on 04/15/26 to match providers' orders. All residents have the potential to be affected if the labels on their medication do not match provider orders. Mandatory All Staff Education will be held on May 13 @ 1:30p and May 14 @ 4p to provide education on the importance of making sure all labels match the provider orders.	05/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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F0761 SS = D	Continued from page 37 laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to ensure medication labels matched provider's orders for 1 of 2 residents (Resident #3) observed for insulin administration. Failure to ensure medication labels matched the provider's orders placed the resident at risk for medication errors. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 838, stated, ". . . Obtain the appropriate medication. . . . Compare the label of the medication container or unit-dose package against the order on the MAR [medication administration record] or computer printout. Rationale: This is a safety check to ensure that the right medication is given. If these are not identical, recheck the prescriber's written order in the client's chart. If there is still a discrepancy, check with the pharmacist. . . . Prepare the medication. . . . While preparing the medication, recheck each prepared drug and container with the MAR again. Rationale: This second safety check reduces the chance of error. . . ." Review of Resident #3's medical record occurred on 04/15/26. A physician's order, dated 11/27/24, identified to administer Novolog insulin sliding scale in addition to the scheduled insulin before meals and at bedtime as follows: with a blood sugar reading of 150 - 199 administer 1 additional unit of insulin; 200 - 299 = 3 units; 300 - 399 = 5 units; 400 - 500 = 7 units; greater than 500, call the provider. Observation on 04/15/26 at 11:47 a.m. showed a	F0761	Continued from page 37 DON or designee will monitor insulin pens to make sure label matches provider orders. Monitoring will be weekly x4, monthly x3, then quarterly thereafter. If concerns are identified immediate corrective action will be implemented. DON or designee will report monitoring results to the quarterly QA committee meeting. 05/18/26	05/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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F0761 SS = D	Continued from page 38 nurse (#7) prepared Resident #3's Novolog sliding scale. The label on the pen showed 0 - 199 = 0 units; 200 - 299 = 2 units; 300 - 399 = 4 units; 400 - 500 = 6 units; greater than 500, call the provider. The facility failed to ensure the label on the insulin pen and the provider's order matched. During an interview on 04/15/26 at 2:15 p.m., administrative staff members (#1 and #2) confirmed the label on the insulin pen and the provider's orders did not match.	F0761		05/18/2026