

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  355044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/05/2026
NAME OF PROVIDER OR SUPPLIER  Mountrail Bethel Home		STREET ADDRESS, CITY, STATE, ZIP CODE  615 6th St SE Stanley, ND 58784	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on review of the facility assessment, review of the new employee checklist, review of the certified nurse aide (CNA) orientation packet, and staff interview, the facility failed to provide the required CNA training for dementia management. Failure to provide dementia management training limits the CNA's ability to effectively care for residents with dementia and promote the residents' highest level of functioning. Findings include: Review of the most recent facility assessment occurred on all days of the survey and stated, . the facility is licensed for 36 LTC [long term care] beds with 15 of those residents diagnosed with cognition issues . Dementia . Review of the facility checklist for new employees and the CNA orientation packet lacked evidence of dementia management training. During an interview on 03/04/26 at 11:12 a.m., an administrative staff nurse (#1) confirmed the facility's new hire/CNA orientation failed to include dementia management training and the facility failed to provide this required training to all current staff for over a year.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>Based on review of the facility assessment, review of the facility training/education documents, and staff interview the facility failed to provide the required behavioral health training to include care specific to the individual needs of residents diagnosed with dementia. Failure to provide behavioral health training limits the staffs' ability to effectively care for residents with behaviors and promote the residents' highest practicable level of functioning. Findings include: Review of the most recent facility assessment occurred on all days of the survey and stated, . the facility is licensed for 36 LTC [long term care] beds with 15 of those residents diagnosed with cognition issues . Dementia . Review of the facility training documents occurred on 03/04/26 and included: * Nursing orientation checklist* New employee checklist* CNA orientation packet* Employee Handbook revised 06/27/24 The above documents lacked evidence of dementia management or behavioral health care training. During an interview on 03/04/26 at 11:12 a.m., an administrative staff nurse (#1) confirmed the facility failed to provide dementia management training or behavioral health care training for new and current facility staff members.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.20.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 17 sampled residents (Resident #1). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Finding include: The Long-Term Care Facility RAI User's Manual, revised October 2025, pages A-30-32, stated, . Section A1500: Preadmission Screening and Resident Review (PASRR) . Coding Instructions . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . and continue to A1510 . Section A1510 . Coding instructions Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness . Review of Resident #1's medical record occurred on all days of survey. A PASRR Level II, dated 05/16/23, identified diagnoses of bipolar disorder and anxiety disorder. A comprehensive MDS, dated [DATE], showed the facility failed to code Sections A1500 and A1510 for serious mental illness. During an interview on 03/05/26 at 9:35 a.m., an administrative staff member (#5) confirmed the facility failed to code sections A1500 and A1510 accurately.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, record review, review of facility policy, and staff interview, the facility failed to properly utilize necessary assistive devices to prevent accidents for 1 of 3 sampled residents (Resident #24) observed during a transfer. Failure to utilize a gait belt and place the walker within reach during a transfer placed the resident at risk for injury and pain. Findings include: Review of the policy titled Use of Gait Belt Policy at Mountrail Bethel Home occurred on 03/05/26. This policy, dated December 2020, stated, . It is the policy of Mountrail Bethel Home to use gait belts with residents that need assistance to ambulate or transfer for the purpose of safety. Review of Resident #24's medical record occurred on all days of survey. Diagnoses included weakness. The current care plan stated, . I have an ADL [activities of daily living] self-care deficit r/t [related to] weakness and decreased mobility . I transfer with staff Ax2 [assist of 2] and my 4WW [four wheeled walker] . I am at risk for falls . Observation on 03/02/2026 at 4:15 p.m. showed two certified nurse aides (CNAs) (#2 and #3) transferred Resident #24 from the bed to a wheelchair. Both CNAs placed their forearms under the resident's armpits and pulled the resident from a lying position to sit on the edge of the bed. Without applying a gait belt or placing the walker within reach, the CNA's placed their arms under the resident's armpits, stood the resident, held onto her pants, and pivoted the resident into the wheelchair. During an interview on 03/05/26 at 9:45 a.m., an administrative staff member (#1) stated she expected staff to utilize a gait belt and place walkers within reach during transfers.</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on observation, record review, review of facility policy, review of a professional reference, and resident and staff interview, the facility failed to provide appropriate treatment and services for 1 of 1 sampled resident (Resident #4) with an indwelling urinary catheter. Failure to provide catheter cares may have contributed to or placed the resident at risk for urinary tract infections (UTIs). Findings include: Review of the facility policy titled Foley Catheter Care Policy at Mountrail Bethel Home occurred on 03/05/26. This policy, dated October 2022, stated, . It is the policy of Mountrail Bethel Home to provide catheter care to all residents that have an indwelling catheter to reduce UTIs. Catheter cares will be performed by a nursing assistant with AM [morning] and HS [hour of sleep/bedtime] cares, and as needed. Kozier &amp; Erb's Fundamentals of Nursing: Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 892, stated, . any accumulation of secretions or excretions is irritating to the skin, harbors microorganisms, and makes an individual prone to skin breakdown and infection. Review of Resident #4's medical record occurred on all days of survey and identified an antibiotic prescribed for a urinary tract infection on four separate occasions between August 2 and November 4, 2025. The care plan stated, . CATHETER: I am at risk for complications r/t [related to] foley catheter placement. BLADDER: I am at risk for UTI . I want staff to assist with performing catheter cares BID [twice daily] and as needed . The certified nurse aide (CNA) care Kardex stated, I want staff to assist with performing catheter cares BID and as needed. Observation on 03/02/26 at 3:42 p.m. showed Resident #4 is in his room with a urinary catheter bag in his chair next to him. He stated, I put it there, so it doesn't get in my way. He was unable to confirm how often staff perform his catheter cares. During an interview on 03/04/26 at 1:20 p.m., a CNA (#4) when asked about catheter cares for Resident #4, stated, He will let us provide cares, maybe once a day and sometimes none. Review of Resident #4's medical record lacked documentation staff provided catheter cares or that the resident refused cares. During an interview on 03/05/26 at 9:45 a.m., an administrative staff member (#1) confirmed the CNA task list failed to include an area for staff to document completion of cares or resident refusal catheter cares.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 5 sampled residents (Resident #24 and #32) observed during cares. Failure to practice infection control standards related to hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled Hand Hygiene Policy at Mountrail Bethel Home occurred on 03/05/26. This policy, dated December 2020, stated, . All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. - Observation on 03/02/26 at 4:15 p.m. showed two certified nurse aides (CNAs) (#2 and #3) entered Resident #24's room to complete perineal cares. Without performing hand hygiene, both CNAs applied gloves, removed the resident's pants, and one CNA (#3) removed the wet brief and provided perineal care. With the same gloves, the CNA (#3) picked up the resident's shoes, and the other CNA (#2) cued the CNA (#3) to change gloves. The CNA (#3) dropped the shoes, removed her gloves, and without performing hand hygiene, applied clean gloves, and placed the shoes on the resident's feet and both CNAs transferred the resident into the wheelchair. The CNA (#3) failed to perform hand hygiene before applying clean gloves.- Observation on 03/02/26 at 4:56 p.m. showed two CNAs (#6 and #7) entered Resident #32's room to complete perineal cares. Both CNAs performed hand hygiene, applied gloves, removed the resident's wet brief and provided perineal cares. Without removing their gloves, both CNAs applied a clean brief. One CNA (#7) removed her soiled gloves, completed hand hygiene, and applied clean gloves. The other CNA (#6) failed to remove her soiled gloves and assisted CNA (#7) to apply the resident's pants and transfer the resident from the bed to a wheelchair. During an interview on 03/05/25 at 9:45 a.m., an administrative staff member (#1) confirmed she expected staff to perform hand hygiene before applying clean gloves, between glove changes, and change soiled gloves before moving on to other tasks.</p>		