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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. 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 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. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Bethel Lutheran Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1515 2nd Ave West Williston, ND 58801	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	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 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 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 (continued on next page)

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	355070	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Actual harm Residents Affected - Few	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 #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.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 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: * 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 on 04/15/26. The current care plan stated, . I (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 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 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 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. 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 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 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 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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.

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	355070	A. Building B. Wing	04/16/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 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: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 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 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, review of facility policy, and 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. 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.

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	355070	A. Building B. Wing	04/16/2026

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 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 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.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 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 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 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. (continued on next page)

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	355070	A. Building B. Wing	04/16/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 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 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. 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 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 . 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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 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. 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 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 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. 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.

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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 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 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.