STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355086	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany on University	201 S University Dr Fargo, ND 58103

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46477 Based on observation, record review, review of professional reference, and resident and staff interview, the facility failed to follow standards of infection control and prevention for 3 of 8 sampled residents (Resident #34, #88, and #139) receiving treatment for a wound or pressure ulcer. Failure to practice infection control standards related to enhanced barrier precautions (EBP) has the potential to spread infection throughout the facility. Findings include: Review of the Centers for Disease Control document titled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 06/28/24, stated, . Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). In the guidance, wound care is included as a high-contact resident care activity and is generally defined as the care of any skin opening requiring a dressing. However, the intent of Enhanced Barrier Precautions is to focus on residents with a higher risk of acquiring an MDRO over a prolonged period of time. This generally includes residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, and chronic venous stasis ulcers. - Review of Resident #34's medical record occurred on all days of survey. A physician's order, dated 09/19/24, identified the onset of an open unstageable pressure ulcer (PU) to the coccyx. The care plan stated, . [resident] is at risk for developing a pressure ulcer due to: malnutrition, moisture, decreased activity, decreased mobility, nutrition, friction/sheer and/or history of pressure injury. [resident] has a unstageable PU to coccyx. Observation on 10/23/24 at 9:27 a.m., failed to show a sign for EBP on Resident #34's door or in her room. A staff nurse (#4) entered Resident #34's room and failed to don a gown before performing a dressing change on an open/draining wound. Observation on 10/23/24 at 9:47 a.m., failed to show a sign for EBP on Resident #34's door or in her room. Two certified nurse aides (CNAs) (#5 and #6) entered Resident #34's room and failed to don a gown before performing cares and transfering the resident to and from the toilet. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355086	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany on University	201 S University Dr Fargo, ND 58103

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 3:29 p.m., a managerial staff member (#7) stated, We have not used EBP for newer wounds. 45873 - Review of resident #88's medical record occurred on all days of survey and showed diagnoses of non-pressure chronic ulcer of the left lower leg, right heel, right midfoot and other part of right foot with fat layer exposed present on admission. Physician's orders stated, . L) [left] anterior lower leg, L) lateral foot, R) [right] heel, R) medial foot, R) third toe, and any other open wound to BLE [bilateral (both) lower extremities (legs)]: Cleanse with soap and water each dressing change. Apply skin prep [a moisture barrier]. Allow to dry. Then cover with dry gauze. Then apply tubigrip [a type of covering] from toes to knees bil [bilateral] for light compression. Change dressing BID [two times a day] and PRN [as needed]. Should gauze stick upon removal simply get gauze wet for easy removal. The current care plan stated, [Resident] has several arterial ulcers to bilateral lower extremities. Observation on 10/22/24 at 8:57 a.m., failed to show a sign for EBP on Resident #88's door or in her room. A staff nurse (#8) entered room, performed hand hygiene, applied gloves, and applied wet towels to the resident's lower legs to moisten the old dressing. After removing the outer dressing, gauze pads stuck to the wound on the left leg requiring further moistening. After removing the dressing, the staff nurse (#8) proceeded with the dressing change. Staff nurse (#8) failed to don a gown before performing a dressing change on an open/weeping wound. 28398 - During an interview on 10/22/24 at 9:14 a.m., Resident #139 stated she came to the nursing facility from the hospital about a month ago with a wound on her right lower abdomen, which the doctor debrided as the wound had an infection. The resident stated the nurses here wear gloves to pack the open wound, but not a gown, during the twice daily dressing change. Observation throughout the survey failed to show a sign for EBP on Resident #139's door or in her room. Review of Resident #139's medical record occurred on all days of survey. Diagnoses included necrotic anterior abdominal wall wound, status post debridement and partial panniculectomy [surgery to remove excess skin/fat from the lower abdomen]. The care plan and activities of daily living (ADL) information sheet lacked inclusion of EBP. Nurses' notes stated the following: * 09/18/2024 at 11:54 a.m., . Reason for admission (diagnosis): Necretic [sic] anterior abdominal wound . Has JP [Jackson Pratt surgical suction device] drain for abodminal [sic] wound on right lower abdomen . * 09/27/2024 at 5:22 p.m., . Removed j/p drain today. Sutures and every other staple removed at right side abdominal. Continue to cover incision with dsg [dressing]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355086	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany on University	201 S University Dr Fargo, ND 58103

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 10/07/2024 at 8:14 a.m., . JP drain removed. Sutures removed at right side abdominal. 11 staples at right side abdominal wound. Abdomen- Pack with Vashe [type of wound cleanser] moistened Kerlix [type of gauze dressing] (single piece) pack twice per day, followed by Abd [Abdominal pad - thick absorbent pad] dressing. A weekly skin assessment, dated 10/23/24 at 6:55 a.m., identified a moderate amount of serosanguineous (pink to pale red fluid) wound drainage in the surgical right flank wound. During an interview on 10/24/24 at 10:28 a.m., a nurse manager (#9) stated Resident #139 only had a surgical wound with no infection and was not on precautions, so we do not wear gowns while changing the dressing.