DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0FMJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00167

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245578**

2. STATE VENDOR OR MEDICAID NO. (L2) **422670600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY RESIDENCE AND REHABILITATION CENTER**
(L4) **2309 HAYES STREET NORTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55418**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **03/01/2015**

6. DATE OF SURVEY **1/18/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **03** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **66** (L18)

13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On: **X**
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56	**10**		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Carrie Euerle, HFE NE II 03/07/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/07/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **09/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered

February 27, 2017

Mr. Scott Kallstrom, Administrator
Bethany Residence And Rehabilitation Center
2309 Hayes Street Northeast
Minneapolis, MN 55418

RE: Project Number S5578027

Dear Mr. Kallstrom:

On November 17, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 22, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for an extended survey completed on October 27, 2016. The most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby significant corrections are required.

On December 29, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on October 27, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 15, 2016. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our extended survey, completed on October 27, 2016. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

In addition, on January 5, 2017, as authorized by Centers for Medicare and Medicaid Services (CMS), we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid Admissions, effective January 27, 2017. (42 CFR 488.417 (b))

On February 28, 2017, the Centers for Medicare and Medicaid Services (CMS) informed you that the

following enforcement remedies were being imposed:

- Per instance civil money penalty of $3,763 for the deficiency cited at F226 (S/S: F), effective October 27, 2016. (42 CFR 488.430 through 488.444).

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 27, 2017. (42 CFR 488.417 (b)).

- Mandatory termination effective April 27, 2017.

Also, the CMS Region V Office notified you in their letter of February 28, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 27, 2016.

This was based on the deficiencies cited by this Department for an extended survey completed on October 27, 2016. The most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby significant corrections are required.

On January 18, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 29, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 18, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on December 29, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 27, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of February 28, 2017:

- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 27, 2017 be rescinded effective January 27, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

As we notified you in our letter of November 17, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 27, 2016.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245578		1/18/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(b)(1) LSC	Correction Completed 01/18/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** GD/kfd	**DATE** 2/27/2017	**SIGNATURE OF SURVEYOR** 30951	**DATE** 01/18/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 10/27/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245578 Y1	A. Building 01 - BETHANY COVENANT HOME B. Wing Y2	2/7/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0011	01/27/2017	LSC K0029	10/26/2016	LSC K0033	01/27/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0052	01/27/2017	LSC K0062	01/27/2017	LSC K0069	10/28/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0107	01/27/2017	LSC K0144	11/17/2016	LSC K0147	10/26/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	2/27/2017	37009	2/7/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/25/2016	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0FMJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00167

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245578**

2. STATE VENDOR OR MEDICAID NO. (L2) **422670600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY RESIDENCE AND REHABILITATION CENTER**
(L4) **2309 HAYES STREET NORTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55418**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **03/01/2015**

6. DATE OF SURVEY **12/29/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **66** (L18)

13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56	10		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date : 3/6/2017
Rebecca Wong, HFE NE II (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 3/6/2017
Kamala Fiske-Downing, Enforcement Specialist (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **09/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

January 5, 2017

Mr. Scott Kallstrom, Administrator
Bethany Residence And Rehabilitation Center
2309 Hayes Street Northeast
Minneapolis, MN 55418

RE: Project Number S5578027

Dear Mr. Kallstrom:

On November 17, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on October 27, 2016 that included an investigation of complaint number H5578021. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 29, 2016, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on October 27, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 6, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our extended survey, completed on October 27, 2016. The deficiency not corrected is as follows:

F0156 -- S/S: C -- 483.10(b)(5) - (10), 483.10(b)(1) -- Notice Of Rights, Rules, Services, Charges

Also, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the October 27, 2016 extended survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the extended survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective January 10, 2017. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 27, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 27, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 27, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Bethany Residence And Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 27, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an

explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE

SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 27, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 12/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418**

(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
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted by surveyors of this department on 12/27/16 through 12/29/16, to determine compliance with Federal deficiencies issued during a recertification survey exited on 10/28/16. During this visit the following regulation was determined to be not corrected. Tag/s that were not found corrected at the time of onsite PCR are located on the CMS2567. The certification tags that were corrected can be found on the CMS2567B. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 156} SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.	{F 156}		1/18/17

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

Electronically Signed | 01/13/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 12/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 156}	Continued From page 1 The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.	{F 156}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 12/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418**

(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
{F 156}	Continued From page 2 A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit a requested appeal of Medicare Non-Coverage and failed to suspend billing as required while a demand bill determination by Medicare was pending for 1 of 1 resident (R51) who requested their bill submitted to the intermediary for a Medicare decision. Findings include:	{F 156}	Please accept the following as the facility's credible allegation of compliance. Please note that this POC is submitted per State and Federal requirements only and should not be considered as the facility's admission of non-compliance with any State or Federal standard, requirement or regulation:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 12/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418**

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{F 156}	Continued From page 3 Review of a progress note dated 11/10/16, at 3:16 p.m. indicated "spoke with resident's family and informed them of the fact that resident's Medicare coverage would end on 11/13/16. Family stated an understanding and said they would be here this Saturday 11/13/16 to sign required forms." Review of the Bethany Care Center Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) dated 11/13/16, indicated Family Member (F)-A who was Power of Attorney (POA) for R51 signed the document on 11/12/16, and requested the demand bill be submitted for a Medicare review decision. Review of the Bethany Residence and Rehabilitation Center billing statement dated 12/9/16, indicated R51 had been charged for room and board services since 11/14/16. During an interview on 12/28/16, at 1:27 p.m. the Administrator stated "I talked with FM-A and he was aware of private pay and did not intend to check that box for submitting to Medicare. Administrator verified he had no documentation regarding the conversation and could not recall what date it occurred. During an interview on 12/28/16, at 1:32 p.m. FM-A stated he was POA for R51 and it was his job to make health care and financial decisions in R51's best interest. FM-A stated he did not have a copy of the form in front of him but that if it meant finding out if Medicare would continue to pay for any services or even if they would not to pay, "then that would have been my decision." During an interview on 12/29/16, at 11:46 a.m. the	{F 156}	1. The following corrective action(s) have been taken for the resident noted to be directly affected by this alleged deficient practice: The Medicare Denial Skilled Nursing Facility Advance Beneficiary Notice was submitted on 12/29/16. POA instructed not to pay privately until a determination has been made. 2. One of 49 residents has been identified as having the potential to be affected by this alleged deficient practice. 3. The following measures have been taken to assure that this alleged deficient practice does not occur: Training will be provided on the demand bill process by the VP of Clinical Reimbursement. Attendees to include: Administrator, Director of Nursing, Nurse Manager, Admissions Coordinator and Social Services Director. Instruction will include a template to be created for step-by-step process including documentation for continuation of stay. This process will ensure compliance with Medicare/Medicaid Regulations. 4. Indicate how the facility plans to monitor its performance to make sure the solutions are maintained. Corrective actions are evaluated for effectiveness through the QA program. Facility audit began 12/30/17 on all new admissions/readmissions to the facility. This audit will continue every week, then monthly for three months for compliance. Noted problems will be immediately	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 12/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418**

(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
{F 156}	Continued From page 4 administrator verified the demand bill was not submitted, "I went according to our conversation, not the paperwork." Administrator stated it was his recollection from a conversation with the former Minimum Data Set Coordinator that there was no issue to resubmit to Medicare and that the "paperwork got filed without anyone looking at it." Administrator verified R51 had been getting billed since 11/14/16. Review of the undated Bethany Residence & Rehabilitation Center Medicare Denial Policy and Procedure, indicated the policy was "to ensure that all Medicare A denials are given in a timely manner and recorded appropriately" and for resident's with a continuing stay, the "MDS staff, in addition of the notice of Non-Medicare Coverage will issue a SNFABN form to the resident or responsible party, information to be used on the form will be verified by the Administrator or his designee and that the Administrator will meet with residents and their representatives with questions regarding ongoing coverage, insurance issues, Medicaid eligibility or other issues related to ongoing stay."	{F 156}	corrected and identified patterns/trends of non-compliance will be brought to the Quality Improvement Committee for further corrective action(s). The Administrator and/or designee will be responsible for continued compliance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245578 Y1	A. Building B. Wing Y2	12/29/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0159	Correction	ID Prefix F0160	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.10(c)(2)-(5)	Completed	Reg. # 483.10(c)(6)	Completed
LSC	12/15/2016	LSC	12/15/2016	LSC	12/15/2016
ID Prefix F0161	Correction	ID Prefix F0176	Correction	ID Prefix F0225	Correction
Reg. # 483.10(c)(7)	Completed	Reg. # 483.10(n)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed
LSC	12/15/2016	LSC	12/15/2016	LSC	12/15/2016
ID Prefix F0226	Correction	ID Prefix F0241	Correction	ID Prefix F0246	Correction
Reg. # 483.13(c)	Completed	Reg. # 483.15(a)	Completed	Reg. # 483.15(e)(1)	Completed
LSC	12/15/2016	LSC	12/15/2016	LSC	12/15/2016
ID Prefix F0279	Correction	ID Prefix F0282	Correction	ID Prefix F0314	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(c)	Completed
LSC	12/15/2016	LSC	12/15/2016	LSC	12/15/2016
ID Prefix F0371	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.35(i)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed
LSC	12/15/2016	LSC	12/15/2016	LSC	12/15/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	3/3/2017	31591	12/29/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245578 Y1	A. Building B. Wing Y2	12/29/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0490	Correction	ID Prefix	F0496	Correction	ID Prefix	F0503	Correction
Reg. #	483.75	Completed	Reg. #	483.75(e)(5)-(7)	Completed	Reg. #	483.75(j)(1)(i-iv)	Completed
LSC		12/15/2016	LSC		12/15/2016	LSC		12/15/2016
ID Prefix	F0518	Correction	ID Prefix	F0520	Correction			
Reg. #	483.75(m)(2)	Completed	Reg. #	483.75(o)(1)	Completed			
LSC		12/15/2016	LSC		12/15/2016			

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/27/2016	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0FMJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00167

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245578**

2. STATE VENDOR OR MEDICAID NO. (L2) **422670600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY RESIDENCE AND REHABILITATION CENTER**
(L4) **2309 HAYES STREET NORTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55418**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **03/01/2015**

6. DATE OF SURVEY **10/27/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **66** (L18)

13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56	10		
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Carrie Euerle, HFE NE II 12/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/07/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **09/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Revised Letter with revised date

Electronically delivered

November 17, 2016

Mr. Scott Kallstrom, Administrator
Bethany Residence And Rehabilitation Center
2309 Hayes Street Northeast
Minneapolis, MN 55418

RE: Project Number S5578027 and Complaint H5578021

Dear Mr. Kallstrom:

On October 27, 2016, an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby significant corrections are required. In addition, at the time of the October 27, 2016 extended survey the Minnesota Department of Health completed an investigation of complaint number H5578021 that was found to be unsubstantiated.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate

jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the electronic plan of correction should be directed to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of Substandard Quality of Care (SQC) that are not immediate jeopardy and are identified on the current survey. The current survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. Your facility meets the criterion and remedies will be imposed immediately pursuant to a survey completed on October 27, 2016. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 22, 2016. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F226. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid Admissions, effective January 27, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bethany Residence And Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 6, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include electronic acknowledgement signature of provider and date.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 27, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 27, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

(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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint, H5578021 was completed. The complaint was not substantiated. An extended survey was conducted by the Minnesota Department of Health on 10/26/16 to 10/27/16.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.	F 156		10/28/16

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

Electronically Signed | 11/27/2016

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.

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F 156	Continued From page 1 The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.	F 156		

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F 156	Continued From page 2 A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) upon termination of Medicare Part A skilled services for 2 of 3 residents (R49, R15), and failed to ensure the notice was provided in a timely manner for 1 of 3 residents (R15) reviewed for liability and beneficiary rights. Findings Include:	F 156	Residents have been reviewed to determine if any of them, other than those identified, are at risk for this deficient practice, including Advanced Beneficiary Notice SNFABN and violations of liability and beneficiary rights. Where concerns were identified, appropriate corrections were made. Facility administration, including the MDS	

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F 156	Continued From page 3 R49 was discharged from Medicare Part A on 6/30/16, and remained in the facility. The facility did not provide R49 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. R15 was discharged from Medicare Part A on 5/17/16, and remained in the facility. The facility did not provide R15 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare. In addition, the facility failed to issue the Denial Letter- Current Resident Medicare non-coverage letter for a current resident whose coverage was ceasing two days prior to Medicare A services being discontinued, the issue date was 5/16/16, for last covered date of 5/17/16. There was also no signed acknowledgement of the reciept of this information. On 10/27/16, at 9:10 a.m. the administrator stated that therapy will let the facility know when therapy will be ending and the Minimum Data Set (MDS) nurse, will give a two day notice of prior to discontinuation of Medicare Part A coverage. The administrator verified that R49 and R15 had stayed in the facility after their Medicare Part A coverage ended and should have received the SNFABN liability notice. The Administrator verified the Denial letter Current Resident Medicare Non-coverage Letter for a Current Resident whose coverage was ceasing was signed by R15, but there was no date by the signature on the	F 156	Coordinator, were trained on the proper use of the SNFABN termination form and liability and beneficiary rights for residents. Included in this were proper notification and use of the appropriate forms as well as timely delivery and notice. The facility has re-implemented form SNFABN on 10-28-16. The form will be used in conjunction with the Medicare Denial/Non-Coverage Letter. The procedure will be that when a notice letter is to be delivered, the facility administrator is notified in conjunction with preparation of the SNFABN. This allows the facility administrator to ensure that follow-through occurs and that the resident is given the opportunity to ask for explanations and to obtain information concurrent with delivery of notice about appeal rights and other methods of coverage, if they are available. This same process will be used when any cessation of benefits occurs, including those that come from the business office who will also notify the facility administrator concurrent with the delivery of notice to the resident. All relevant policies/procedures have been reviewed and updated. The facility ED has appointed a designee to review and audit compliance with this process and to report to the QA Committee monthly on this program. Completion date: 10-28-16	

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F 156	Continued From page 4 form. The administrator stated he was unsure of what date the denial was given based on documentation in the medical record. The facility's Medicare Denial Policy and Procedure, undated, instructed staff to ensure that all Medicare-A denials are given in a timely manner and recorded appropriately. Medicare-A denial needs to be given three days prior to last day on their Medicare-A stay. A progress note will be placed into the resident's medical record that the Medicare denial and appeals rights was given to the resident.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157		12/15/16

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F 157	Continued From page 5 specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident's representative was notified when medications changed for 1 of 1 residents (R17). In addition, the facility failed to ensure the resident's representative and nurse practitioner were notified of an incident involving 1 of 1 resident (R17) reviewed for notification of change. Findings include: On 10/24/16, at 5:14 p.m. when R17's representative was asked if she was the person who was notified of a change in resident condition or accident involving R17 representative stated "Yes." When asked if the facility staff notified her when R17's treatment was changed, representative stated, "No they don't." R17's diagnoses included cerebral palsy, major depressive disorder, gastro-esophageal reflux disease with esophagitis, polyneuropathy, osteoarthritis, hypertension and age-related osteoporosis obtained from the October 2016, Medication Administration Record dated 10/27/16.	F 157	R 17□s niece and nurse practitioner (NP) were notified of incident that took place on 10/26/16. New orders noted from NP. No injury noted from x-ray results. Family updated on current plan of care and medications. Family to join next care conference in 12-16. Referral made to PT/OT for screening and restorative program. Replaced dresser to prevent further injury. Care plan updated to reflect resident□s current level of functioning. Residents have been evaluated to determine if any change of condition issues were currently in existence and if notifications had been made. Where any existed proper notifications have been made to family, resident representatives, Nurse Practices, and/or physicians. This includes medication changes, and incidents/accidents. Additionally, nursing staff has ensured that all residents have choices and preferences added to group sheets. Staff nurses were in-serviced on 10/30/16 to notify family, NP, MD and IDT team of any significant changes related to	

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F 157	Continued From page 6 On 10/26/16, at 9:09 a.m. R17 moved her wheelchair backwards and asked surveyor to re-apply a towel on her left foot that was lying on the floor. Surveyor requested one of the nursing assistant (NA) in the dining room at the time to assist R17. As NA-E was coming towards R17, NA-F stated the towel had a ice pack inside for R17's left foot as a dresser drawer had fallen on R17 this morning before breakfast. NA-E re-applied the ice inside the towel. During review of the Physician Orders the following were revealed: -On 5/3/16, Prilosec (medication used to treat acid reflex) had been discontinued -On 9/30/16, the nurse practitioner (NP) had written new order to increase Gabapentin (medication used to treat neuropathy pain, seizures and restless syndrome) from 100 milligram (mg) three times daily (TID) to 200 mg TID. -On 7/28/16, Ibuprofen 400 mg by mouth one time for chronic pain had been give immediately (STAT) During review of the interdisciplinary team notes (IDT) and physician progress notes dated 5/1/16, through 10/27/16, the medical record lacked documentation the legal representative had been notified of any of the treatment changes. In addition, review of the IDT notes dated 10/26/16, through 10/27/16, the staff had not notified the nurse practitioner and legal representative of the incident of the dresser drawer falling on resident. R17's Care plan dated 9/10/16, indicated R17 had a communication problem and speech was difficult to understand at times. The communication Care Area Assessment (CAA)	F 157	medication, treatments or incidents that involve residents. Nursing staff were also trained on the new programs listed below including resident choices and function on the group sheets and significant changes and notification on the 24-hour report: Nurse assistant group sheets will be updated to reflect resident choices and level of function. Where significant changes occur for residents, nurses will be required to list on the 24-hour report sheet the significant change and who they notified so that this information will be available for IDT review. This will also act as a double check and alert system so that the 24-hour report will notify other nursing staff about resident change in condition and the notifications that were done. Facility audit began on 11/1/16 and will continue weekly x 4weeks then monthly x 3 months for audits on random resident charts for family and NP/MD notification. Noted problems will be immediately corrected and identified patterns/trends of non-compliance will be brought to the Quality Assurance Committee for further corrective action(s). Director of Nursing and/or designee will monitor for continued compliance. Additionally, Unit Managers or their designees (housing supervisors or charge nurses on weekends) will review 24 hour reports for nursing documentation about change of condition and notifications. This will be done to verify that notifications have been done. Completion Date: January 5, 2017	

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F 157	Continued From page 7	F 157		

dated 9/13/16, indicated resident had minimal difficulty with hearing, usually understood others although had some cognitive impairments related cerebral palsy. The CAA indicated R17 and family are aware of the communication deficits.

On 10/27/16, at 8:55 a.m. licensed practical nurse (LPN)-A nurse manager and registered nurse (RN)-A verified there was no family notified of the changes in medications/treatments noted on the physician orders for 5/3/16, 7/28/16, and 9/30/16. In addition, both verified the nurse practitioner and the legal representative had not been notified of the incident of the drawer falling on R17 on 10/26/16, and there was no even document of the incident in the medical record. Both stated the family and/or the legal representative was supposed to be notified of any treatment changes, which included medications, and any accident-involving resident. RN-A stated, "If it's not documented it was not done." LPN-A stated he heard about the incident and thought the floor nurse had taken care of it.

On 10/27/16, at 12:11 p.m. the director of nursing (DON) acknowledged the family and/or legal representative was supposed to be notified of any condition change, accidents and treatment/medications involving resident.

The undated facility Change in a Resident Condition or Status policy directed "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.)..." The policy also indicated a resident family or representative was supposed to be notified of any

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F 157	Continued From page 8 accident or incident involving resident.	F 157		
F 159 SS=F	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	F 159		12/15/16

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F 159	Continued From page 9 The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review the facility failed provide quarterly statements to residents and/or the legal representative for 33 of 33 residents whose personal funds were managed by the facility. Findings include: On 10/24/16, at 5:10 p.m. during a telephone interview when asked if the facility provided a statement of how much money was in the resident's account R17's representative stated she had not received a statement for over two months now to her recollection as the facility sent the statements on the mail quarterly. On 10/25/16, at 10:33 a.m. during a telephone interview the power of attorney (POA) for R36 stated "Not in the last 6 months." when asked if the facility give him a statement of how much money was in R36's account. On 10/27/16, at 8:34 a.m. the facility administrator stated he had inquired with the corporate business office and verified statements had not been sent to residents/ legal	F 159	Residents listed in the citation who have not received a quarterly statement of their trust fund have now received a quarterly statement and this will continue quarterly as per new policy. On 12-15-16 resident trust fund statements will be mailed and then as per the following schedule: January, April, July, and October of each year. All residents have been reviewed to determine if any other resident has been affected by this deficient practice and corrections have been made. The facility policy for management of resident trust funds has been updated to reflect the provision of quarterly statements given to residents who have a trust fund at the facility. Nursing facility staff (business office, receptionists, social workers, and other applicable staff) involved in managing resident funds and notification via statements have been re-trained on the newly updated policy. The policy will also	

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F 159	Continued From page 10 representatives since 4/26/16. The administrator stated it was an oversight on the corporate business office part. The facility Resident Trust Fund policy last modified 11/25/15, did not address the frequency of statements being provided to resident and/or legal representative.	F 159	include a statement about a calendared date with an auto reminder which will generate a reminder to the facility ED or his designee that resident trust fund statements are due to be distributed. Administrator will appoint a designee to audit on-going compliance with the mailing of quarterly resident trust statements. The designee will report findings about the success of the program to QA Committee monthly. Completion Date: December 15, 2016	
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to convey resident funds deposited into trust accounts upon death, for 4 of 4 residents (R67, R68, R69, R70), who expired and did not have their money returned to their family or personal estate within 30 days. Findings include: On 10/27/16, at 8:40 a.m. the facility administrator provided a list of resident who had	F 160	Funds related to Residents R67, R68, R69 and R70 have been conveyed to proper dispensation location, either estate/family or Medicaid. Administration reviewed for any other residents involved and made corrections accordingly Business Office staff, Receptionists, Social Workers and other applicable staff will be trained on policies and procedures	12/15/16

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F 160	Continued From page 11 died at the facility and had personal trust account managed by the facility. During review of the closed records personal funds accounts the following were identified: R67 expired on 6/6/16, at which time R67's personal fund account balance was $1680.00. During review of the PNA ledger from 3/1/16, through 10/27/16, it was revealed R67's balance of $1680.00 had been to the Cremation Society of Minnesota on 6/27/16, however another amount of $260.45 had not been sent to family or estate. On 10/27/16, at 12:32 p.m. the administrator stated R67 was on Medicaid and the $1680.00 had been sent out however, after he thought resident Social Security check may have been deposited but funds were still being held by the facility and had not been conveyed to the family, estate or county. R68 expired on 3/11/16, at which time R68's personal fund account balance was $4168.55 and the funds were not conveyed to the estate until 6/29/16, which 109 days after R68 had expired and been discharged from the facility. R69 expired on 5/4/16, at which time R69's personal fund account balance was $121.40. As of 10/27/16, the funds were still being held by the facility and had not been conveyed to the family of R69's estate. On 10/27/16, at 12:34 p.m. the facility administrator verified and stated because the resident was on Medicaid the county had not called the facility about the money and neither the facility still had called the county about conveying the money. The administrator stated he would be	F 160	and the new program contained within them. The policy/procedure for resident trust accounts has been updated to include a list of items to be managed for residents at their death and a check-off with it. When a resident passes or is discharged, the checklist will be processed by the business office. This checklist includes proper management of resident monies still in trust back to the resident estate or Medicaid. The facility Administrator or designee will audit this process, including the checklist, for on-going compliance with this program monthly and will then report monthly to the QA Committee on the success of the program. Completion Date: December 15, 2016	

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F 160	Continued From page 12 following up with the county about where and when to send the money to. R70 expired on 3/11/16. During review of the PNA ledger from 3/1/16, through 10/27/16, it was revealed, as of 8/1/16, the personal funds account had a balance of $545.96. During further review it was revealed, as of 10/27/16, the funds were still being held by the facility and had not been conveyed to the family or R70's estate. On 10/27/16, at 12:35 p.m. the administrator verified the money had not been sent out since the death. The administrator stated R70 was a Medicaid recipient and the county again had not contact the facility regarding conveying the money. -At 12:37 p.m. the administrator verified the findings and acknowledged he had been in touch with corporate and was going to address the concerns and ensure trust funds balances were being dispersed within 30 days from the date of discharge/death. The facility Resident Trust Fund policy last modified 11/25/15, indicated "4. The Corporate Business Office will reconcile and replenish the Resident Trust Petty Cash box." The policy did not address the procedure for conveying funds to family and/or estate after a resident was discharge/death.	F 160		
F 161 SS=D	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.	F 161		12/15/16

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F 161	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident fund accounts were insured with a surety bond not less than the total amount of funds held for 33 residents who had fund accounts managed by the facility. Findings include: The facility's Skilled Nursing Facility, Intermediate Care Facility, or Nursing Facility Bond effective 3/1/15 and continued until canceled by the Surety , indicated the bond was for the amount of $20,000, however, the resident fund account total was $24,344.92. On 10/27/16, at 12:32 p.m. the facility administrator verified the surety bond was for only 20,000 and indicated the balance as of 10/19/16, account balance was $24,344.92 and he was going to let corporate aware of the concern. On 10/27/16, at 4:38 p.m. the Resident Trust Fund modified last 11/25/15, did not address the Surety bond and was responsible for ensuring the Surety bond was of the correct amount held in the resident trust account.	F 161	The surety bond amount was raised to $30,000.00 and all residents with funds in the facility trust are listed as insured by the bond. A new bond in the amount of $30,000.00 has been purchased. Administrator will insure compliance by managing the surety bond and updating as needed based on resident funds in the trust account and report monthly to the QA Committee on this program. Completion Date: December 15,2016	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	F 176		12/15/16

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F 176	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review facility failed to assess and/or obtain physician order for self-administration of medication (SAM) for 1of 1 resident (R64) who self-administered medication. Findings include: During observation of R64's medication administration on 10/25/16, at 4:17 p.m. the trained medication aide (TMA)-A entered R64's room with R64's medications. R64 was lying in bed. R64 sat up and TMA-A gave R64 Tylenol (a mild analgesic) 650 milligrams (mg), then Combivent (a medication that improves breathing) inhaler one puff. R64 moved from her bed to the chair next to the nebulizer machine (a machine that aerosolized medication). The TMA-A set up the nebulizer with DuoNeb solution 0.5 to 2.5 (3) milligrams/3 milliliters (a medication that improves breathing), one vial and put the mask on R64 and said "I will come back in about 10 minutes." TMA-A then left the residents room. R64's admission Minimum Data Set (MDS) dated 9/21/16, indicated R64 was cognitively intact with problems with recall. The MDS indicated R64 diagnoses included schizophrenia (mental illness that can cause failure to recognize what is real), chronic obstructive pulmonary disease (a lung disease that has been caused by damage over the years making it hard to breath) (COPD), and Emphysema (a disease where the small air sacs in the lungs are damaged). R64's care plan printed 10/27/16, did not address	F 176	R64□s medication regime was immediately reviewed and resident was assessed for self-administration of medication using the self-administration screening tool. Resident deemed appropriate after assessment. NP contacted and order□s received. Facility residents were reviewed for any other eligible for or who are administering medications as per self. Proper protocol with assessments and physician orders were initiated where required. Nurses will be trained on the use of the Resident Medication Self-Administration Screening Tool and the specific elements for its use as explained below. Newly admitted residents will be evaluated for self-administration of medication using the self-administration screening tool which will be provided in the new resident□s chart. Assessment for self-administration will be added to the new admission checklist. Where an existing resident wishes to self-administer medications, the same screening tool will be used, delivered to the Unit Manager for review with a copy being delivered to the DON. If appropriate, the resident will be allowed to self-administer per policy and MD approval based on the screening tool mentioned above. Residents who are	

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F 176	Continued From page 15 self-administration of any medications. R64's Order Summary Report dated 10/27/16, included DuoNeb solution 0.5 to 2.5 (3) milligrams/3 milliliters (a medication that improves breathing), one vial inhale orally every four hours while awake for COPD. There was no order for self-administration of medications on the Order Summary Report. Review of the medical record did not include evidence of an assessment related to R64's ability to self-administer medication During interview on 10/27/16, at 7:08 a.m. RN-A said, "[R64] does not have an order to self-administer her medication, She does not have an assessment to self-administer her medications." RN-A said the TMA should have stayed with the resident while she was using the nebulizer. On 10/27/16, at 1:48 p.m. the director of nursing said she expected staff to stay with a resident if they do not have an order for self-administration of a medication including nebulizers. The undated self administration of medication policy instructed staff: "Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so." "1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill	F 176	deemed appropriate for self-administration of medications will be reviewed quarterly, or sooner, if change in status occurs. Care plans will be updated to reflect self-administration status. Physician orders will be obtained where self-administration of medications is warranted. Policy/Procedure has been updated to reflect these changes. The Director of Nursing or her designee will review each screening assessment for self-administration after it has been completed to ensure accuracy and proper functioning of the program. Any problems will be immediately addressed. This review will be perpetual as a remaining part of the self-administration of medications program and will include new admits, existing residents, and those who are undergoing a quarterly review to verify their continuing self-administration skills as per the self-administration screening tool. The Director of Nursing will report monthly to the QA Committee on this program. Completion Date: December 15, 2016	

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F 176	Continued From page 16 assessment, including (but not limited to) the resident's: a. Ability to read and understand medication labels; b. Comprehension of the purpose and proper dosage and administration time for his or her medications; c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) them: and d. Ability to recognize risks and major adverse consequences of his or her medications. 3. If the staff determine that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications."	F 176		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225		12/15/16

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F 225	Continued From page 17 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 interview and document review, the facility failed to adequately and throroughly screen 30 of 83 employees who had direct patient contact across various shifts/units. Findings include: Employee records reviewed on 10/26/16, at 11:00 a.m. revealed five employees (E-AA, E-BB, E-CC, E-DD, and E-EE) reviewed did not have background checks in their records, the sample of employees was expanded and an additional 25 employee records were reviewed at 1:00 p.m. (E-FF, E-GG, E-HH, E-II, E-JJ, E-KK, E-LL, E-MM, E-NN, E-OO, E-PP, E-QQ, E-RR, E-SS, E-TT, E-UU, E-VV, E-WW, E-XX, E-YY, E-ZZ, E-AAA, E-BBB, E-CCC, and E-DDD). A total of 30 employees were identified as not having had a background check completed at the time of hire.	F 225	On 10/26/16 the Administrator completed an audit of the employee files and identified that 30 employees did not have a background check. Once identified these employees were informed and instructed that they would: 1. Need to complete a background check, including fingerprints 2. Until receipt of cleared background check was received by the facility that they would need to work under direct supervision of a staff member who had a cleared background check. Staff immediately began to complete Net Study 2.0 background checks. By 11-11-16 all active staff members had a completed and cleared Net Study 2.0 background check. During this interval all	

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F 225	Continued From page 18 In addition, E-EEE had been rehired 7/31/15, and no verification that the NA was on the registry could be found. The facility then conducted an audit of all of their nursing assistants on 10/26/16 to determine whether they were appropriately registered on the State's nursing assistant registry. E-EEE was verified as not having current registration. As a result, E-EEE was taken off the working schedule as of 10/27/16. LPN (E-TT) personnel record was reviewed. E-TT had been hired on 9/17/16. Review of E-TT's nursing licensure information revealed her LPN license had expired 7/31/16, and had not been renewed. The administrator stated during interview on 10/27/16, at 10:00 a.m. that he had not verified E-TT's nursing licensure at the time of hire. The administrator was interviewed on 10/26/16, at 11:05 a.m. and stated that several employees had not completed background checks. He stated the facility implemented the new State agency (SA) process (Net Study 2.0) and that employees had not completed fingerprints and had a background study done. He verified the employees were working on the schedule and are not in direct supervision at that time. During further interview at 12:15 p.m. on 10/26/16, the administrator stated the facility had started to use the State's new screening system in April of 2016. He said he had intended to start using the new system but had not implemented the system by asking new employees to have fingerprints taken, and had not logged into verify background checks were completed. After completing a full audit of all employees on 10/26/16, at 3:00 p.m., the administrator identified a total of 30 employees	F 225	staff without a background check who continued to work in the facility worked under direct supervision. Facility Administrator and Director of Nursing checked schedules to make sure appropriate staff were available to provide direct supervision to staff without background checks. All appropriate staff members, including department heads who hire staff members, and Human Resources managers were trained on the policies/procedures of background checks, current licensure and certification registration, and preventing or tracking expired licensure by 11-11-16. New hire policies and procedures have been reviewed and updated to include background checks, current licensure and certification registration, and preventing and tracking expired licensure. Additionally, the ED or designee along with department manager will ensure that all new hires have background checks done as per policy. Ed or designee will keep a list of professional licenses and a tickler system that will alert the ED and department managers when a license is up for renewal/and expiration. This will prompt the ED and department managers to verify with the licensed or certified employee that they are aware of their licensure renewal and are actively pursuing it. Notification of being removed from the work schedule will be given if pending updates are not forthcoming. This	

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F 225	Continued From page 19 without background checks. He verified the date background checks had stopped being completed was January 2016. The administrator verified that it was the policy of the facility to conduct background checks at the time of hire and to verify that the employee passed the check before scheduled to have contact with residents. The administrator verified that four staff currently working at that time had not had background checks completed, and that the afternoon shift had five staff scheduled who had also not passed a background check. The DON was interviewed on 10/26/16, at 1:00 p.m., and stated the administrator had updated her today that no background checks had been conducted. The DON stated she had not been aware of that, and had assumed that during the hiring process background checks were being completed according to the facility's policy. The abuse policy titled "Vulnerable Adult Abuse Prevention Plan" dated 11/27/15, indicated the employees would be screened by background checks. The policy indicated "It is the policy not to employ anyone who poses an unacceptable risk to its residents, employees, and other members of its community." "Background checks are conducted for all new employees, current employees, and volunteers/contractors as specified in the background check policy." The employee handbook dated 6/13/13, included the background check policy and indicated in the employment policies "To comply with applicable federal and state laws, and to support our commitment to providing safe housing, medical care, and related services for residents	F 225	system will also prevent anyone from working in the facility without their required credentials. On an ongoing basis both the Administrator and the Department Managers must sign off on all new hires for each department verifying receipt of background study clearance letter. Administrator will appoint a designee to audit completion of background studies and to maintain ongoing compliance. Designee will also report finding and the success of the program to QA committee. Completion date: December 15, 2016	

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(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
F 225	Continued From page 20 and clients, criminal background checks are required for all employees before beginning employment with Bethany."	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse prevention policies and procedures for screening and training employees. The facility failed to conduct background checks for 30 of 83 employees prior to the employees providing direct patient contact, failed to provide vulnerable adult education to 15 of 20 employees at the time of hire, failed to ensure 1 of 34 nursing assistants (NA) was in good standing on the State nursing assistant registry, and failed to ensure 1 of 13 licensed practical nurses (LPN) held a current license to practice. This had the potential to effect all 49 residents in the facility. Findings include: The facility's abuse policy titled, "Vulnerable Adult Abuse Prevention Plan" dated 11/27/15, indicated employees would be screened by background checks. The policy included: "It is the policy not to employ anyone who poses an unacceptable risk to residents, employees, and other members of	F 226	On October 26, 2016 the Administrator completed an audit of the resident files and identified that 30 employees without a background check. Once identified these employees were informed and instructed that they would: 1. Need to complete a background check, including fingerprints as needed 2. Until receipt of cleared background check that they would need to work under direct supervision of a staff member who had a cleared background check. Facility Administrator and Director of Nursing checked schedules to make sure appropriate staff were available to provide direct supervision to staff without background checks. Staff immediately began to complete Net Study 2.0 background checks. By November 11, all active staff members had a completed and cleared Net Study 2.0 background check. During this	12/15/16

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F 226	Continued From page 21 it's community...Background checks are conducted for all new employees, current employees, and volunteers/contractors as specified in the background check policy." The facility policies indicated employment eligibility was verified by the State's nurse aide registry for all currently certified nursing assistants, and to document successful completion of the required training and competency evaluation. In addition, the policy indicated they would track nursing assistants against whom allegation of abuse, neglect, or theft have been substantiated, and professional certification and licensure was to be verified for all nurses according to the policy. The policy also indicated all new employees were required to complete new employee orientation training on Elder Abuse and Neglect. The employee handbook dated 6/13/13, also included the background check policy which included: "To comply with applicable federal and state laws, and to support our commitment to providing safe housing, medical care, and related services for residents and clients, criminal background checks are required for all employees before beginning employment with Bethany." Background checks: Employee records reviewed on 10/26/16 at 11:00 a.m. revealed 5 employees (E-AA, E-BB, E-CC, E-DD, and E-EE) had not had background checks conducted. As a result, the sample of employees was expanded and an additional 25 employee records were reviewed at 1:00 p.m.(E-FF, E-GG, E-HH, E-II, E-JJ, E-KK, E-LL, E-MM, E-NN, E-OO, E-PP, E-QQ, E-RR, E-SS, E-TT, E-UU, E-VV, E-WW, E-XX, E-YY, E-ZZ, E-AAA, E-BBB, E-CCC, and E-DDD) None of these	F 226	interval all staff without a background check who continued to work in the facility worked under direct supervision. Staff were reviewed to ensure or correct issues concerning background checks, licensure renewal and current registration, and training on abuse and abuse prevention. Facility staff were trained on the importance of maintaining their professional licensure or registration, training on abuse prevention and reporting (vulnerable adult), operationalizing the abuse policy, and background checks. New hire policies and procedures have been reviewed and updated to include background checks, current licensure and certification registration, and preventing and tracking expired licensure. Additionally, the ED or designee will ensure that all new hires have background checks done as per policy. ED or designee will keep a list of professional licenses and a tickler system that will alert the ED and department mangers when a license is up for renewal/and expiration. This will prompt the ED and department managers to verify with the licensed or certified employee that they are aware of their licensure renewal and are actively pursuing it. Notification of being removed from the work schedule will be given if pending updates are not forthcoming. This system will also prevent anyone from working in the facility without their required credentials.	

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F 226	Continued From page 22 employees had undergone background checks at the time of hire. State nurse aide registry or licensing authorities: E- EEE had been rehired 7/31/15 and no verification that the NA was on the registry could be found. The facility then conducted an audit of all of their nursing assistants on 10/26/16 to determine whether they were appropriately registered on the State's nursing assistant registry. E-EEE was verified as not having current registration. As a result, E-EEE was taken off the working schedule as of 10/27/16. LPN (E-TT) personnel record was reviewed. E-TT had been hired on 9/17/16. Review of E-TT's nursing licensure information revealed her LPN license had expired 7/31/16 and had not been renewed. The administrator stated during interview on 10/27/16 at 10:00 a.m. that he had not verified E-TT's nursing licensure at the time of hire. Training: Twenty employee records were also reviewed for compliance with the facility's abuse/neglect policies. On 10/26/16 at 1:00 p.m., it was determined fifteen employees (E-BB, E-CC, E-EE, E-FF, E-II, E-KK, E-LL, E-MM, E-NN, E-OO, E-PP, E-QQ, E-RR, E-SS, and E-TT) had not recieved training at the time of hire regarding vulnerable adult issues including prevention and reporting of abuse. The administrator was interviewed on 10/26/16, at 11:05 a.m. and stated that several employees had not completed background checks. He stated the facility implemented the new State agency (SA) process (Net Study 2.0) and that employees	F 226	On an ongoing basis both the Administrator and the Department Managers must sign off on all new hires for each department verifying receipt of background study clearance letter. Administrator will appoint a designee to audit completion of background studies and to maintain ongoing compliance. Designee will also report finding and the success of the program to QA committee. Also, with regard to training on vulnerable adult, new hires will be trained on abuse prevention and reporting and this will be recorded in the training/orientation file for each new employee. To ensure that this will be accomplished, vulnerable adult has been added to the training modules by the DON/Staff Development and calendared for the next year and at new employee orientations. Administrator will appoint a designee to audit completion of background studies and to maintain ongoing compliance. This auditor will also verify vulnerable adult training for new hires. Designee will also report monthly to the QA Committee about the success of the program. Completion by December 15, 2016	

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F 226	Continued From page 23 had not completed fingerprints and had a background study done. He verified the employees were working on the schedule and are not in direct supervision at that time. During further interview at 12:15 p.m. on 10/26/16, the administrator stated the facility had started to use the State's new screening system in April of 2016. He said he had intended to start using the new system but had not implemented the system by asking new employees to have fingerprints taken, and had not logged into verify background checks were completed. After completing a full audit of all employees on 10/26/16, at 3:00 p.m., the administrator identified a total of 30 employees without background checks. He verified the date background checks had stopped being completed was January 2016. The administrator verified that it was the policy of the facility to conduct background checks at the time of hire and to verify that the employee passed the check before scheduled to have contact with residents. The administrator verified that four staff currently working at that time had not had background checks completed, and that the afternoon shift had five staff scheduled who had also not passed a background check. The DON was interviewed on 10/26/16, at 1:00 p.m., and stated the administrator had updated her today that no background checks had been conducted. The DON stated she had not been aware of that, and had assumed that during the hiring process background checks were being completed according to the facility's policy.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		12/15/16

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F 241	Continued From page 24 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal cares were provide in a dignified manner for 1 of 3 residents (R13) reviewed for dignity. Findings include: On 10/24/16, at 4:45 p.m. R13 was interviewed in his room. When the interview was completed R13 left the room and wheeled himself down the hall towards the nursing station. R13's pants were unzipped exposing the undergarment. A dietary aide had stopped R13 and spoke with him and did not adjust R13's pants. R13 proceeded down the hall once again and passed two nurses. Neither nurse stopped R13 to adjust the unzipped pants. R13 continued around the corner and went into the bathroom. A nursing assistant (NA) followed R13 and assisted him in the bathroom. When R13 came out of the bathroom he was appropriately dressed. On 10/24/16, at 7:00 p.m. R13 was interviewed again regarding the lack of adjustment of the pants by the staff that had encountered him in the hallway. R13 indicated he would be concerned and it would have bothered him knowing that the zipper was unzipped and no one adjusted the pants. R13's Minimum Data Set dated 10/12/16, noted	F 241	R13 was providing with assistance to maintain his dignity with regard to his clothing after toileting. This type of assistance has been care planned and will continue to be provided. Residents throughout the facility have been assessed to determine if they require assistance after using the restroom that would help maintain their dignity or at any other observable time. Where assistance is required for residents to maintain their dignity, especially with regard to clothing and proper management of it to protect modesty, assistance is being rendered. Additionally, a new policy for resident dignity which includes elements regarding resident modesty, has been developed and implemented. Facility staff have been in-serviced on the need to properly assist residents who have modesty/dignity needs and with regard to the new policy/procedure on resident dignity and modesty. This re-training includes updated on ADL care status and care planning of it. Residents receiving ADL assistance will be re-assessed for appropriate level of	

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F 241	Continued From page 25 R13 was needed extensive assist with dressing and had moderately impaired cognition. On 10/26/16, at 10:00 a.m. licensed practical nurse (LPN)-B was interviewed regarding R13's appearance. LPN-B was unaware of R13's unzipped pants. A policy for providing dignity was requested prior to exit and none was received.	F 241	assistance. Nurse assistant group sheet will be updated to reflect changes in ADL assistance. Care plans will also be updated to reflect current resident status. Referrals to be initiated by nursing department as needed to screen for resident ADL decline. Additionally, nursing staff will be trained to develop a new work habit of checking residents as they observe them during the day or evening to ensure that they appear dignified, properly dressed, and modest. Where their observation results in detection of immodest clothing and a need for immediate correction, nursing staff will immediately intervene. Dignity/Modesty audits will be conducted on 20% of the resident population weekly x4 weeks then monthly to ensure compliance. Any noted problems will be immediately corrected and trends of non-compliance will be brought to the Quality Assurance Committee for further corrective action. Director of Nursing and/or designee will monitor for continued compliance. Completion Date: December 15, 2016	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246		12/15/16

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F 246	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation interview and document review facility failed to provide a call light for 1 of 1 resident (R4) who was capable of using it and was sitting in a wheel chair Findings include: R4's quarterly Minimum Data Set (MDS) dated 8/10/16, indicated R4 was cognitively intact and able to communicate his needs.. R4 was dependent on staff to transfer from bed to wheelchair and for toileting. R4 required assistance for dressing bed mobility, personal hygiene and to propel the wheelchair in the room or hallway. R4 was independent after being set up with eating. R4 had a foley catheter and was incontinent of bowel. R4's MDS indicated R4 had diagnosis of Cerebral Palsy (disease that results in loss of muscle tone movement and motor skills due to damage in the brain usually as an infant or young child) , Seizure disorder, emphysema (a disease where the small air air sacs in the lungs are damaged) and chronic pain. Admission Record dated 10/27/16, indicated R4 had a new diagnosis of diabetes with onset date of 10/22/16. R4's care plan printed 10/25/16, indicated R4 was able to call for assistance when in pain and R4 was at risk for falls related to weakness and left sided hemiplegia (paralysis of one side of the	F 246	R4□s call light was blocked by over-bed table and was made available immediately upon nurse assistant return to the resident□s room. Staff continues to ensure that his call light is within reach, even while in his wheelchair. Residents were reviewed to determine that all had a call light within reach. Additionally, residents were reviewed to determine that call lights would be available if they were in their wheelchairs or other devices and situations; corrections were made where necessary to ensure call light availability. Nurse staff have been in-serviced on placing call lights within resident reach while in room and on following through with the reminders and encouragement of nursing management to make sure call lights are within reach. Also, nursing staff are being trained on developing new work habits such as checking routinely for proper placement and availability of resident call lights. Call lights will be placed on the resident bed after bed-making or given to resident if in wheelchair and nearby. Nurse assistant group sheets will be updated as a reminder for compliance. Nursing staff have also been trained on developing the positive work habit of checking on residents routinely to ensure that they	

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F 246	Continued From page 27 body) and instructed staff to "be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. On 10/25/16, at 8:57 a.m. R4 was observed sitting inthe wheel chair aproximately six feet from R4's bed. The over the bed table was in front of R4. On the table was R4's breakfast tray with two slices of toast, scrambled eggs, and a bowl of dry cereal. Call light was on the bed. At 9:01 a.m. nursing assistant (NA)-A verified R4 was able to use call light and with the tray set up on the table, R4 was unable to get to the call light on his bed. Na-A stated, "normally he eats in the dining room so I forgot to put his call light over here before I went to get his tray. He asked for jelly so I went and got it and came back." On 10/27/16 at 11:52 a.m. licensed practical nurse (LPN)-A said, "[R4] is able to use the call light. He should have it within reach at all times when in room in his bed or wheel chair." On 10/27/16, at 1:38 p.m. the director of nursing (DON) said expect that the staff would give a call light to a resident who was in a wheelchair. Call light policy requested but not provided.	F 246	have their call lights within reach, including while in wheel chairs. This work habit is encouraged by nursing managers on a routine basis as part of a unified drive for nursing services improvement. A new policy for call light accommodation has been developed and implemented. Facility audits will be conducted by director of Nursing or designees for call light compliance (making sure they are properly placed and available for all residents including those in wheelchairs or who might be disadvantaged some way in reaching them) and functionality weekly x 4 weeks then monthly to ensure compliance. Noted problems will be immediately corrected. Identified patterns/trends of non-compliance will be brought to the Quality Assurance Committee for further corrective action. Director of Nursing and/or designee will monitor for ongoing continued compliance. Completion date: December 15, 2016	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		12/15/16

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F 279	Continued From page 28 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a care plan intervention related anticoagulation therapy for 1 of 2 residents (R3), who currently received Coumadin (blood thinner). Findings include: R3 was admitted on 8/21/15, with diagnosis of unspecified atrial fibrillation (AF) and long term (current) use of anticoagulation's as found on admission record face sheet dated 8/21/15. R3's Physician Orders dated 10/12/16, noted R3 was to receive Coumadin 13 milligrams (mg) by mouth one time a day on Monday, Tuesday, Wednesday, Thursday and Friday and give 14 mg by mouth on Saturday and Sunday, due to AF. Review of comprehensive care plan (last review	F 279	R3□s care plan for Coumadin was added to reflect interventions related to the use of this medication. A review was done for any other resident taking Coumadin or similar medications and care plan updated were initiated to include safety measures with this medication associated with bleeding and bruising. Nurses were in-serviced on the importance of updating and reviewing resident care plans and tracking monitoring who are receiving Coumadin or similar anti-coagulants Residents who are receiving Coumadin therapy care plans have been updated to include interventions to monitor for adverse effects (bruising/bleeding) of this medication. Upon admission residents who receive Coumadin will have a care	

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F 279	Continued From page 29 completed on 9/20/16), noted the care plan did not include intervention(s) in regards to anticoagulation therapy with the potential of bruising and bleeding secondary to use of Coumadin. R3 had been observed on 10/25/16, at 3:55 p.m. just finishing with shower by assisted NA. No bruising or skin issues noted. R3 on 10/27/16, at 12:06 p.m. was observed sitting at dining table in wheelchair, noted that only hands and face are visible with no sign of bruising or skin issues noted. During an interview on 10/26/16, at 7:20 a.m. R3 was asked if writer could talk with her, R3 looked at writer and then looked away shook her head and said "No." During an interview on 10/27/16, at 8:45 a.m. with the director of nursing (DON), in regards to Coumadin monitoring for side effects for R3, the DON stated they would have expected a care plan for Coumadin to monitor for increased bruising and bleeding. The DON looked through care plan for monitoring of Coumadin side effect and none found, also found no current treatment order for monitoring, Policy for Coumadin intervention and monitoring requested and none provided.	F 279	plan and tracking sheet initiated immediately with appropriate diagnosis confirmed. This tracking sheet and the care plan will be reviewed weekly to ensure compliance with anti-coagulant monitoring and care. A new policy on care planning and tracking for residents receiving anticoagulants has been instituted. Facility audit began 11/23/16 and will continue weekly x4 weeks then monthly to ensure continued compliance; audit includes evaluating tracking forms and care plan compliance for residents on anticoagulants. Audits will be conducted by Director of Nursing or designees. Noted problems will be immediately corrected and identified patterns/trends will be brought to the Quality Assurance Committee for further corrective action. Completion date: December 15, 2016	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		12/15/16

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F 282	Continued From page 30 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review facility failed to ensure 1 of 1 resident (R4) who had a pressure ulcer was offered assistance to reposition in his wheelchair as the care plan instructed. Findings include: R4's quarterly Minimum Data Set (MDS) dated 8/10/16, indicated R4 was cognitively intact and able to communicate his needs. The MDS also indicated R4 was dependent on staff to transfer from bed to wheelchair and for toileting, required assistance for dressing bed mobility, personal hygiene and to propel the wheelchair in the room or hallway. R4 was independent after being set up with eating, and R4 had a foley catheter and was incontinent of bowel. R4's MDS indicated R4 had diagnosis of Cerebral Palsy (disease that results in loss of muscle tone movement and motor skills due to damage in the brain usually as an infant or young child), seizure disorder, emphysema (a disease where the small air air sacs in the lungs are damaged) and chronic pain. R4's MDS indicated R4 was at risk for developing pressure ulcers and that R4's skin was intact. Admission Record dated 10/27/16, indicated R4 had a diagnosis of pressure ulcer with onset date of 10/22/16. R4's pressure ulcer care area assessment (CAA) dated 11/12/15, indicated R4 required extensive	F 282	R4 was offered repositioning but refused. R4□s care plan and nurse assistant group sheet was updated to reflect turn and reposition every 2 hours while in bed and to offer to place resident back in bed every 2 hours during waking hours to alleviate pressure when up in wheelchair. Continued resident refusal will be care planned and documented and new measures will be developed to help with resident compliance. Residents identified as at risk as per the Braden Scale were reviewed for turning and repositioning needs and interventions were instituted and care planned. Nursing staff was in-serviced on the need to properly identify residents who have skin break-down risk, the proper use of turning and repositioning methods, and care planning. Resident preferences was part of this teaching. Resident Braden scores will be updated quarterly or obtained upon admission to determine if turning and repositioning needs exist. Where Braden values indicate the need for intervention, the nursing team caring for that resident will develop a turning and repositioning program including tissue tolerance interventions and care plan the program. Facility audits will be performed on 20% of	

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	245578	A. BUILDING _____ B. WING _____	10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 31 assistance with bed mobility was at risk of developing a pressure ulcer and had a stage II pressure ulcer on his buttocks that had been present prior to initial admission to facility. CAA identified that R4 remained at risk for further pressure ulcer development. CAA indicated R4 needed special mattress and seat cushion to reduce or relieve pressure and that these were in place. R4's Care plan printed 10/25/16, indicated on 8/22/16, a problem was initiated that indicated "[R4] has actual impairment to skin integrity r/t [related/to] fragile skin and bowel incontinence." and instructed staff R4 had a pressure relieving /reducing mattress and chair pad to protect the skin while up in chair, follow facility protocols for treatment of injury, keep skin clean and dry and apply barrier cream as needed. Care plan problem statement was revised during survey on 10/27/16 to read "[R4] has actual impairment (pressure ulcer on right buttocks) to skin integrity r/t [related/to] fragile skin and bowel incontinence." Goals and instructions to staff were not changed. Care problem initiated 11/20/15 indicated [R4] had hemiplegia/hemiparesis r/t spastic hemiplegia affecting left non dominate side and instructed staff to, "reposition/ambulate as tolerated and at least every 2 hours." Care plan printed on 10/27/16 indicated in the Dietary problem revised 10/26/16 that R4 had a new diagnosis of diabetes and an open area on the right buttock. Undated and unlabeled nursing assistant assignment sheet instructed staff to turn and reposition R4 every two hours and tilt resident for one hour while up in chair as tolerated.	F 282	the resident daily x 2 weeks, weekly x 4 weeks then monthly for compliance with turn and repositioning programs; this is to ensure that Braden values are being obtained as required and turning and repositioning with tissue tolerance reviews are being completed as required. Finally, these audits will ensure that what is care planned with regard to this program is actually being performed for residents. Nurse managers will conduct these audits and will deliver their results to the DON. Noted problems/trends/patterns will be immediately corrected and the DON will report on this program to the QA Committee monthly. Completion date: December 15, 2016	

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F 282	Continued From page 32	F 282		

During continuous observation on 10/27/16, from 11:52 a.m. until 3:25 p.m.
11:25 a.m. R4 was sitting in the dining room waiting for lunch.
1:01 p.m. R4 working with occupation therapy assistant (OTA) in R4's room
1:15 p.m. OTA took R4 to dining room
1:25 p.m. unknown staff member took R4 to main lobby
1:54 p.m. R4 in main lobby playing trivia
2:13 p.m. R4 asked LPN-A to take him to the dining room.
2:46 p.m. R4 in 1st floor dining room having a snack LPN-A standing outside of dining room
3:01 p.m. R4 in dining room bingo starting
3:07 p.m. Nursing assistant (NA)-A walking through dining room talking with residents. Surveyor asked NA-A when R4 had last been repositioned. NA-A said [R4] refused at 11 a.m. and 11:30 am we did not offer after that.
3:25 p.m. NA-B and an unidentified staff member approached R4 during bingo and offered to reposition R4. R4 refused.
During observation period R4's chair was in an upright position.

Progress note by LPN-C dated 10/22/16, at 2:45 p.m. indicated R4 had returned to the facility from the hospital with a new diagnosis of diabetes and an open area on right buttock.

Braden Scale (a tool for predicting pressure sore risk) dated 10/22/16, indicated R4 was at low risk with problems in the area of mobility not being able to make significant changes in body position independently and in the area of friction and shear requiring moderate to maximum assistance

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F 282	Continued From page 33 in moving. Nursing admission/readmission Assessment dated 10/22/16, indicated R4 had a macerated area that was 4cm by 3.5 cm and was a stage one and within that area had an open area that was 1cm by 0.7 cm by 0.1 cm stage 2. During interview on 10/25/16 at 3:15 p.m. LPN-A said R4 had a stage II pressure ulcer. LPN-A stated he had not seen the wound as [R4] came in on Saturday and he does wound rounds on Thursday. During interview on 10/27/16 at 3:07 p.m. NA-A said R4 refused to be repositioned at 11 am and 1130 am saying leave me alone. NA-A said, "R4 ate and then he has been busy since then. I have not asked him to let me toilet or reposition him since about 1130 am. I was suppose to leave at 2 p.m. but I am working on first floor this evening." During interview on 10/27/16, at 3:25 p.m. NA-B said "[NA-A] came up and asked me to do so because he had not been repositioned in greater than two hours. " During interview on 10/27/16, at 4:30 p.m. the director of nurses stated staff are to offer to reposition residents in accordance with their care plans and notify the nurse if the resident refuses. Repositioning policy requested but not received.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		12/15/16

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F 314	Continued From page 34 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review facility failed to ensure 1 of 1 resident (R4) who was readmitted to the facility with a stage one pressure ulcer(Nonblanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators.) and a stage two pressure ulcer (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.) Received the care and services needed to prevent the ulcers from worsening to an unstageable ulcer (a pressure ulcer that is known to exist but not able to be staged because those wound bed can not be seen) and a stage two pressure ulcer. Findings include: R4's quarterly Minimum Data Set (MDS) dated 8/10/16, indicated R4 was cognitively intact and able to communicate his needs. The MDS also indicated R4 was dependent on staff to transfer from bed to wheelchair and for toileting, required assistance for dressing bed mobility, personal hygiene and to propel the wheelchair in the room or hallway. R4 was independent after being set	F 314	R4□s pressure wounds were reassessed on 10/27/16 and staged to reflect current status. NP made aware and new order□s received. Other residents with pressure ulcers had their staging verified and any changes that were necessary were processed properly. All residents have had a complete skin review and care plan evaluation based on this skin review. Nurses will receive training on properly staging wounds and follow-up documentation by 12-30-16. Additionally, this training will include the importance of immediate assessment of resident skin upon admission (within the first 8 hours) to determine the existence of pressure ulcers or areas of potential skin breakdown and the importance of interventions including staging, treatment, documentation, and care planning immediately. In this training, communication about resident skin condition will be emphasized as a standard of practice. Training will include introduction to the National Pressure	

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F 314	Continued From page 35 up with eating, and R4 had a foley catheter and was incontinent of bowel. R4's MDS indicated R4 had diagnosis of Cerebral Palsy (disease that results in loss of muscle tone movement and motor skills due to damage in the brain usually as an infant or young child), seizure disorder, emphysema (a disease where the small air air sacs in the lungs are damaged) and chronic pain. R4's MDS indicated R4 was at risk for developing pressure ulcers and that R4's skin was intact. Admission Record dated 10/27/16, indicated R4 had a new diagnosis of diabetes with onset date of 10/22/16. R4's pressure ulcer care area assessment (CAA) dated 11/12/15, indicated R4 required extensive assistance with bed mobility was at risk of developing a pressure ulcer and had a stage II pressure ulcer on his buttocks that had been present prior to initial admission to facility. CAA identified that R4 remained at risk for further pressure ulcer development. CAA indicated R4 needed special mattress and seat cushion to reduce or relieve pressure and that these were in place. R4's Care plan printed 10/25/16, indicated on 8/22/16, a problem was initiated that indicated "[R4] has actual impairment to skin integrity r/t [related/to] fragile skin and bowel incontinence." and instructed staff R4 had a pressure relieving /reducing mattress and chair pad to protect the skin while up in chair, follow facility protocols for treatment of injury, keep skin clean and dry and apply barrier cream as needed. Care plan problem statement was revised during survey on 10/27/16 to read "[R4] has actual impairment	F 314	Ulcer Advisory Panel (NPUAP) guidelines and practice. The facility has a new skin/pressure ulcer policy/procedure which emphasizes the following: 1. Skin inspection for potential breakdown and/or the existence of wounds/pressure ulcers upon admission (first 8 hours) 2. The development of interventions to prevent breakdown and/or to treat skin breakdown including pressure ulcers immediately following skin inspection in (1). This will include physician involvement and physician orders. 3. Staging will occur based on the standard of practice and the National Pressure Ulcer Advisory Panel (NPUAP) standards for staging geriatric pressure ulcers. 4. Follow-up measures for treatment, monitoring, and improvement will be instituted. These elements will follow the standard of practice in the industry and will be based on the NPUAP recommendations. 5. Resident who are newly admitted or readmitted and identified as having pressure wounds will have updated hospital records for review before admission for the purpose of identifying skin issues prior to admission. 6. Upon discharge residents will have skin checks completed and documented, representing a comprehensive skin condition program with treatment that starts upon admission (even before admission with record reviews) and ends	

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F 314	Continued From page 36 (pressure ulcer on right buttocks) to skin integrity r/t [related/to] fragile skin and bowel incontinence." Goals and instructions to staff were not changed. Care problem initiated 11/20/15 indicated [R4] had hemiplegia/hemiparesis r/t spastic hemiplegia affecting left non dominate side and instructed staff to, "reposition/ambulate as tolerated and at least every 2 hours." Care plan printed on 10/27/16 indicated in the Dietary problem revised 10/26/16 that R4 had a new diagnosis of diabetes and an open area on the right buttock. Undated and unlabeled nursing assistant assignment sheet instructed staff to turn and reposition R4 every two hours and tilt resident for one hour while up in chair as tolerated. During a random observation on 10/25/16 at 2:42 p.m. registered nurse (RN)-B removed the dressing from R4's right buttock. The upper wound on the right buttock was large and irregularly shaped. RN-B described the wound as 2 centimeter (cm) x 2cm and said was unable to see the wound bed. RN-B said, "What I see is dead tissue so I call it eschar (Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound). It is not hard like the green eschar of an unstageable wound. RN-B said stage III wounds involve muscle and this is not that deep, stage II pressure ulcers do not have eschar but I do not believe that this is a stage III wound. I he had one [a pressure ulcer] it healed and then he went to the hospital. He came back with it [the pressure ulcer] from the	F 314	upon discharge. Facility skin audits will be performed weekly on resident shower day. Each week, residents will have all their skin reviewed for any potential or actual breakdown and this will be documented. Where any skin potential breakdown or actual breakdown is noted, the responsible nurse manager and director of nursing will be notified and interventions will be instituted. Additionally, a checklist audit will be developed that will follow new admits to ensure that each step of the program listed above based on NPUAP guidelines is completed as designed. This audit will follow (2) new admits weekly and will continue throughout the length of their skin treatment for short stay residents. This audit will be done weekly x 4 weeks and then monthly thereafter with (2) residents selected each week for 4 weeks and then 2 residents for each month during which the audits are done monthly. Any noted problems will be immediately corrected. Patterns/trends will be brought to the Quality Assurance Committee by the DON for further corrective action. The audits will be performed by the Unit Managers or their designees. Completion date: December 15, 2016	

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hospital." The lower wound on the right buttock was described by RN-B as a 1cm in diameter circular stage II pressure ulcer with 100% [percent]granulation tissue in the wound bed. RN-B applied a thin hydrocolloid dressing to the wounds.

On 10/27/16 at 8:11 a.m. R4's wounds were observed during wound rounds with RN-A and Licensed practical nurse (LPN)-A. LPN-A applied gloves and removed the dressing from R4's right buttock dated 10/25/16. LPN-A cleaned the wounds with saline. R4 grimaced. LPN-A asked R4 about pain and R4 said "it hurts, just finish the job." Refused offer of pain medication. LPN-A measured the upper wound and described it as," 2cm times [x] 1.5cm. unstageable pressure ulcer The wound bed is 100% covered with eschar." LPN-A measured the lower wound and described it as, "0.4cm [x] 0.7cm., stage 2 pressure ulcer. The wound bed is 100% red moist healthy tissue." LPN-A applied skin prep to the surrounding tissue and then applied an extra thin hydrocolloid 4cm x4cm dressing that was able to cover both wounds.

During continuous observation on 10/27/16 from 11:52 a.m. until 3:25 p.m.
11:25 a.m. R4 was sitting in the dining room waiting for lunch.
1:01 p.m. R4 working with occupation therapy assistant (OTA) in R4's room
1:15 p.m. OTA took R4 to dining room
1:25 p.m. unknown staff member took R4 to main lobby
1:54 p.m. R4 in main lobby playing trivia
2:13 p.m. R4 asked LPN-A to take him to the dining room.
2:46 p.m. R4 in 1st floor dining room having a

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snack LPN-A standing outside of dining room
3:01 p.m. R4 in dining room bingo starting
3:07 p.m. Nursing assistant (NA)-A walking through dining room talking with residents. Surveyor asked NA-A when R4 had last been repositioned. NA-A said [R4] refused at 11 a.m. and 11:30 am we did not offer after that.
3:25 p.m. NA-B and an unidentified staff member approached R4 during bingo and offered to reposition R4. R4 refused.
During observation period R4's chair was in an upright position.

Progress note by LPN-C dated 10/22/16, at 2:45 p.m. indicated R4 had returned to the facility from the hospital with a new diagnosis of diabetes and an open area on right buttock.

Braden Scale (a tool for predicting pressure sore risk) dated 10/22/16, indicated R4 was at low risk with problems in the area of mobility not being able to make significant changes in body position independently and in the area of friction and shear requiring moderate to maximum assistance in moving.

Nursing admission/readmission Assessment dated 10/22/16, indicated R4 had a macerated area that was 4cm by 3.5 cm and was a stage one and within that area had an open area that was 1cm by 0.7 cm by 0.1 cm stage 2.

Progress note by RN-B dated 10/26/15, as a late entry for day shift 10/25/16, indicated "Open area has dried dead skin across the main wound bed. There is a secondary wound lateral to the first that has a moist pink wound bed. Peri wound skin is macerated, denude and reddened."

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Documentation for all skin issues,for R4 including LPN-A's documentation of wound rounds 10/27/16, were requested. No documentation of wound rounds 10/27/16, was provided.

During interview on 10/25/16 at 3:15 p.m. LPN-A said R4 had a stage II pressure ulcer. LPN-A stated he had not seen the wound as [R4] came in on Saturday and he does wound rounds on Thursday.

During interview on 10/27/16 at 9:14 a.m. LPN-A (wound nurse) said R4 went into the hospital on 10/18/16 for change of condition and elevated blood sugar. R4 did not have an open area when sent to the hospital. When R4 came back there was an open area. LPN-A said the nurse that did the admission assessment staged the wound as a stage II pressure ulcer. The process when there is a new wound is the nurse who finds the wound notifies dietician, myself and the doctor. We will get treatment orders for the wound that day. The dietician will look at the residents diet for wound healing and make recommendations as needed. If the resident does not have a cushion in the wheel chair we will get one. We will get a specialty mattress. R4 has a cushion in his chair. When there is a worsening of the wound the nurse is to notify the doctor, dietician and family. the nurse is to check with doctor to see if new orders obtained. I would see it on wound rounds on Thursdays.

During follow up interview on 10/27/16, at 11:52 a.m. LPN-A said the nurse practioner said R4 refused to allow the wound to be observed on 10/24/16. LPN-A stated he spoke with LPN-C who stated the 4 x 3.5 cm measurement was the upper wound and the 1cm x 0.7cm measurement

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F 314	Continued From page 40 was the lower wound. LPN-A verified there was no documentation of how the wound bed looked. LPN-A stated wounds were incorrectly staged at time of admission. LPN-A stated he had spoken with the nurse practioner today and was to continue same wound treatment. During interview on 10/27/16 at 3:07 p.m. NA-A said R4 refused to be repositioned at 11 am and 1130 am saying leave me alone. NA-A said, "R4 ate and then he has been busy since then. I have not asked him to let me toilet or reposition him since about 1130 am. I was suppose to leave at 2 p.m. but I am working on first floor this evening." During interview on 10/27/16, at 3:25 p.m. NA-B said "[NA-A] came up and asked me to do so because he had not been repositioned in greater than two hours. " During interview on 10/27/16, at 3:31 p.m. LPN-C said that when R4 returned from the hospital his bottom was covered with yellow ""goop". When it was cleaned off R4's bottom had a big area of grey skin. LPN-C said I counted the gray area as one area and measured it. It was 4 cm by 3.5 cm. it was not blanchable so I labeled it a stage one pressure area. It was macerated. the small area was inside the grey area on the upper part of the buttock and it measured 1cm by 0.7cm. I called that area a stage two. "LPN-C said there was only one open area and the wound bed was red." Pressure ulcer and repositioning policy requested but not received.	F 314		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		11/15/16

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BETHANY RESIDENCE AND REHABILITATION CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

(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
F 371	Continued From page 41 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: :371 Based on observation and interview the facility failed to store and distribute food in a safe and a sanitary conditions for 3 of 3 kitchenettes: 1st floor Activity Kitchen, 2 West, and 2 East. Findings include: On 8/24/16, at 12:00 p.m. the Activity kitchen was reviewed with Administrative Assistant (AA). Covers for the electric burners had blackened marks over one end of each cover. -In the stove a plastic dish was sitting on the self, it was unknown why unsafe dishware was in the oven. The bottom of the oven was heavily soiled with burned on food. In the cabinets: -1 can of cherries beyond the manufacturers expiration date of August 2011 -A bag of flour which was opened, but not dated, had exceeded the manufacturer expiration date of 10/11/14. In addition the flour was not sealed or stored in a closable container to keep it pest free. -AA indicated the brown granular substance in a	F 371	The 1st floor Activities Kitchen stove, cabinets and refrigerator were cleaned and all food containers removed and properly disposed. The 2nd floor dining room refrigerator was cleaned and all food containers were removed and properly disposed. The 2nd floor kitchenette cabinets and refrigerator were cleaned and all food containers were removed and properly disposed. All residents who used the refrigerators and kitchenettes are at potential risk. Evaluations were done and corrections made as necessary to those refrigerators and kitchenettes. Facility policies and procedures for food handling were reviewed and updated. All staff and residents were informed of the new policies which requires all foods that are stored in the facility be placed in proper containers as well as being labeled with the resident name as well as date food was opened or prepared. All staff are expected to assist with identifying any	

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F 371	Continued From page 42 zipper lock bag was the brown sugar. The zip lock bag had not been dated and did not have a label to identify the contents of the zipper lock bag, the food lacked manufacturer packaging. -AA indicated the white powder in a zip lock bag was powdered sugar, had not been dated when opened, and did not have a label to identify the contents of the zipper lock bag. The food lacked manufacturer packaging. -Glass container of Salsa had a manufacturer expiration date of 9-3-16 -Graham Cracker Crust: Manufacturer expiration 4-19-15 -Egg noddle's: opened but undated, had exceeded manufacturer expiration of 9-27-16, -Marshmallows 4 bags were opened, none were dated when opened, and one had exceeded the manufacturer expiration date. In addition two bags of marshmallows were not sealed or stored in a closable container to keep it pest free. -Two boxes of Ice Cones had exceeded the manufacturer ' s expiration date, one was opened on 6/29/16, but had expired 5/5/16. In addition two were not sealed or stored in a closable container to keep pest free. -Bag of walnuts opened but undated, exceeded manufacturer expiration date 3-23-16 -Health Toffee bar open with no date, not placed in a plastic bag or container to keep it fresh and free of pest -Unidentified Cereal out of the original box was in a clear bag which could not be resealed for freshness or to keep pest free. -Bag of Coconut for baking was open, but undated in addition was not sealed or stored in a closable container to keep it pest free. -Corn Syrup, opened but undated, had exceeded the manufacturer ' s expiration date of 8/4/16. -A Box of chocolate pudding exceeded the	F 371	improper use of the kitchenettes and refrigerators. The facility housekeeping staff were assigned to perform daily inspections of the various kitchenettes and refrigerators. Any food not in compliance with the facility policies and procedures will be removed and properly disposed. Log sheets will be kept to provide compliance information. In addition, the administrator has assigned a designee to perform additional inspections of the kitchenettes and refrigerators and to audit the completion of the daily log sheets. This designee will also report facility compliance at the QA meetings monthly. Completion Date: November 15, 2016	

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F 371	Continued From page 43 manufacturer ' s expiration date of 8-2016. -Bottle of Tomato Juice, Did not have a readable manufacturer expiration date. -Refrigerator temperature checked last checked 7/26/16, freezer burned meat, brats and pizza were undated and remained in the freezer. -At 2:00 p.m. The kitchenette in the 2 West dining/activity room, was reviewed with Licensed Practical Nurse (LPN)-B and registered nurse (RN)-A -Freezer section had one single use ice pack that was covered with a yellow substance (it was lying next to a container of vanilla ice cream). Three additional reusable blue Ice packs were in the freezer, LPN-B stated they just started using them, on their medication carts, to keep their applesauce/pudding cold while passing their medications. LPN - B stated that they are cleaned by wiping them with an unidentified disinfectant wipe, before returning them to the refrigerator/freezer section. The reusable ice packs were kept in a refrigerator/freezer for patient food, which also contained staff food, not all of the food was dated. -At 4:00 p.m. the Small 2 East kitchenette next to the nursing station: -had an Ice maker sitting on top of the stove. The oven area was a storage area for a plastic containers. -Next to the stove was another smaller size refrigerator with an Ice box in the right upper side was heavily iced over. Nursing staff members (LPN-A, RN-A, and	F 371		

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F 371	Continued From page 44 LPN-B, found in the refrigerator numerous bags of food for both the residents and staff. The items were not marked with resident or employee names, dates were unreadable on the bags and some were undated. RN-A opened bags, some were found to have green substance on the food. The Director of Nursing (DON) was also present and directed the staff to dispose of all food in the refrigerator. The food storage policy was requested but not provided. Nursing home residents were at risk of complications from foodborne illness as a result of their compromised health status. Unsafe food handling practices represented a potential source of pathogen exposure for residents.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		12/15/16

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F 441	Continued From page 45 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility to ensure proper linen handling was performed for 1 of 5 residents (R60) and the facility failed to ensure proper handwashing was performed to prevent the potential spread if infection for 2 of 5 residents (R5, R26) whose cares were observed. In addition, the facility failed to develop and implement and maintain an infection prevention and control program related to the surveillance log investigation, and analysis of staff diseases/infections in order to prevent, recognized and control, to the extent possible, the onset and spread of infections within the facility. This practice had the potential to affect all residents who resided in the facility. This has the potential to affect all 49 residents in the facility.	F 441	R26 was exposed to potential cross contamination during incontinent care. Resident was evaluated by the NP. Residents were evaluated for any harm that may have come from these deficient practices and interventions instituted as needed. Also, resident infections were reviewed and the infection tracking as per the infection control program was updated. Facility staff was educated and in-serviced on the importance of proper hand hygiene, removal of soiled linen and changing gloves at the appropriate intervals. Infection control logs were	

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F 441	Continued From page 46 Findings include: Linen Handling: R60's annual Minimum Data Set (MDS) dated 10/12/16, indicated R60 had Alzhiemer's and was frequently incontinent of bowl and Bladder. On 10/25/16, at 3:42 p.m. nursing assistant (NA)-C was observed coming out of R60's room carrying a bundle of soiled sheets. The soiled linens were held against NA-C's uniform NA-carried the linens to the utility room on 1st floor south. During inter view on 10/25/16, at 3:45 p.m. NA-C verified that R60 had been incontinent of urine and NA-C had striped the bed and made it. NA-C said she usually puts dirty sheets in a bag but did not do so this time During interview 10/27/16, at 9:14 a.m. licensed practical nurse (LPN)-A said linens were not to be held against a uniform even if they were clean. Registered nurse (RN)-A said that carrying linens against your uniform put all the residents at risk due to cross contamination. Handwashing: R5 received personal cares without appropriate hand washing on the morning of 10/27/16, at 10:00 a.m. During the observation of R5 receiving pericare by two nursing assistants (NA)-G and NA-H. NA-G applied and removed her gloves throughout the process and used an alcohol based hand rub (ABHR). NA-H applied her gloves as she entered the room and did not remove her gloves after she had removed the resident clothing and stool	F 441	updated to include employee tracking of infections and for resident infection identification, sign and symptoms, laboratory results and resolution date per new facility policy. Also, nursing staff were trained on the importance of a complete infection control program, its benefits, and how to properly conduct it. Infection Control Program: The facility is obtaining guidance in the development of a complete infection control program from APIC Minnesota □ Infectious Disease Epidemiology, Prevention and Control Division. This includes setting up a proper tracking of infections program, infectious organisms identified among residents, treatment modalities, facility locations for organisms, and how to properly isolate, cohabitate or separate, and infection control document management. Infection Control Practices: New policy and procedure was developed for proper management of potentially infective linens, hand washing, changing of gloves during procedures, and managing isolation for residents. Each nursing staff member who manages soiled linens, uses gloves, manages residents in isolation, and washes hands will receive training as stated above and then will be required to pass a return demonstration for the DON or her designee on all three practices. A passing score of perfect is required on all three measures before the nursing employee can graduate from the training program.	

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F 441	Continued From page 47 soiled incontinent product, provided pericare care and applied a barrier cream, redressed the resident and then went out into the hall and retrieved the resident's breakfast tray. After the tray was brought into the room, NA-H started to remove the cover from the breakfast. NA-H was then stopped and was asked to remove the soiled gloves and wash hands prior to serving the breakfast meal. R5's quarterly Minimum Data Set (MDS) dated 9/21/16, indicated R5 had moderate cognitive impairment and required extensive assistance with all activities of daily living, including extensive assistance with personal hygiene. On 10/27/16, at 10:15 a.m. NA-H confirmed she had left the soiled gloves on while she completed dressing R5 and moving items in/out the room. SHe acknowlegded she should have washed her hands. On 10/27/16, at 8:45 a.m. the DON was interviewed and stated that staff are trained to change their gloves between resident contact and wash their hands or to use ABHR after contact soiled items and bodily fluid. All staff received the training upon hire/orientation on proper hand washing techniques. R26: On 10/26/16, at 7:10 a.m. NA-D and NA-G entered R26's room. NA-G brought the standing lift into the room. NA-G said to NA-D "is it dumped out in there." pointing at the trash can next to R26's bed. NA-D put lift belt arround R26's waist. NA-G and NA-D applied gloves and then attached the belt to the standing lift. NA-G sprayed incontinence wipes with peri wash. NA-D	F 441	Unit managers will conduct audits once weekly x 4 weeks and then monthly thereafter of (5) staff members across at least (2) units for compliance with the training on hand washing, proper gloving, managing residents in isolation, and proper management of soiled linens. Where errors occur, new training and return demonstrations will be instituted. Reports on these audits will go to the DON who will report to the QA Committee monthly on this program. Completion date: December 15, 2016	

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F 441	Continued From page 48	F 441		

removed R26's incontinece brief. Incontinence brief was smeared with brown stool. NA-D used two wipes to wipe R26's bottom. There was a small amount of brown stool on the wipe. Without changing gloves NA-D applied incontinence brief to R26 and pulled up R26's pants. NA-D brought R26's wheelchair to the standing lift and NA-G lowered lowered R26 into the wheelchair. NA-G removed the waist belt and took the standing lift out of the room. NA-D with the same gloves on removed R26's splint, glasses and shirt. NA-D then buckled R26's seat belt, and put clean shirt on R26. NA-D then gave R26's his glasses and brushed his hair. NA-D while still wearing the same pair of gloves used to clean R26's bottom, put R26's splint on. wearing R26 left room. NA-D removed gloves and put on new gloves without washing hands. NA-D put R26's wet bed linens in a plastic bag. NA-D changed gloves and put new ones on without washing /sanitizing hands. NA-D put the trash bagthat was dripping yellow liquid into another plastic bag NA-D stated, "I do not know if it is [R26] or the night shift, but there is always urine in the bottom of the trash can every morning. NA-D took the trash can to utility room and poured out yellow liquid. Rinsed out trash can and wiped it out. and returned can to room.

During interview on 10/26/16, at 7:24 a.m. NA-D acknowleged that she did not change gloves from start of R26's incontince cares until she was cleaning up R26's wet linens. NA-D said, "you must have made me nervous." When NA-D was asked about glove usage and washing hands NA-D stated, "I only wash my hands when I am completely done because I can not get gloves on when my hands are wet. "

During interview on 10/26/16 at 10:00 a.m.

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F 441	Continued From page 49 LPN-D said staff are to change gloves after doing incontinece cares and wash their hands or use sanitizer every time they change their gloves. During interview on 10/27/16, director of nurses (DON) stated that staff are trained to change their gloves between resident contact and wash their hands or use antibacterial hand rub. DON said all staff are trained on hired and orientation on proper handwashing technique. The Hand Hygiene policy undated directed to staff to wash their hands for 10 to 15 seconds using antimicrobial soap and water after contact with bodily fluids. Monitoring of infections: On 10/27/16, at 8:45 a.m. the director of nursing (DON) stated that at the end of the month she would take the infection control report from the pharmacy and would highlight the infections and give it to the nurses on the the unit and along with the nurse managers and they were responsible for resolving the infection. The DON did not show or provide us with a tracking system she used with employee surveillance log which revealed who called in sick, she stated that depending on what they called in with she would tell them how many days they needed to be out. Review of the facility's infection control surveillance information logs revealed no tracking	F 441		

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F 441	Continued From page 50 or trending of staff illness and/or infection was evident on 10/27/16, at 3:00 p.m. The impact of staff illness/infection had not been tracked related it the impact on the facility's resident population. The DON was interviewed on 10/27/16, at 3:00 p.m. and she acknowledged she did not maintain a record of current infections control log of the current which were in her facility at that time which included type of infections, signs and symptoms, laboratory results and when the infection resolve.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe, functional, and sanitary living environment which included the roof, floors, dining rooms, shower rooms, exit doors and rooms (115, 121, 215). This had the potential to effect all 49 residents in the facility. Findings include: During the environmental tour with the administrator on 10/27/16, at 1:23 p.m. the Administrator confirmed there was not a maintenance department at the facility and he was in charge of maintenance.	F 465	Immediate roofing issues have been inspected and initial repairs were completed on November 25, 2016 with additional work to be completed as needed. After immediate repairs are made, roofing issues will be monitored and additional repairs will be made as necessary. Sections of flooring which may cause any immediate safety issues due to bubbling will be removed and replaced; this includes sections of the 1st floor main dining room, areas near rooms 217, 226 and 234 as well as sections by the 2	12/15/16

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F 465	Continued From page 51 -There was a roofing issue that caused ceiling tiles to be removed in areas throughout the facility and the ceiling to leak when it rained. Garbage cans had been placed in the hallway to catch the drip from the ceiling. -All floors in the facility should be cleaned, and the administrator indicated the floors should all be replaced. - The walls throughout the facility had wallpaper coming off of the wall with scrapes and black mars on the walls from wheelchairs. -The main dining room on the first floor had an area of carpet that was bubbling up near a table, which was confirmed by the administrator as a trip hazard. There was a black plastic wrapped around an air vent sealed with duct tape. The administrator was not aware of the black plastic and did not know the reason for the plastic. Additionally, a large crack in the wall coming down from the air conditioner and around the windows on the right side wall was observed and confirmed by the administrator. -The bathroom on the first floor had a crack along the wall and the tile and plaster was peeling off of the right side wall. -Room 115: The window in the room had a hole above the top of the frame. The Administrator confirmed the hole had been there for "awhile", and indicated it needed to repaired from the outside. Additionally, there were several areas where plaster was repaired but not painted to match the color of the wall. -Room 121 had a large brown stain on the carpet	F 465	South nursing station. Additionally, the floor in resident Room 121 will be replaced. The remainder of the flooring, which does not pose an immediate safety hazard will be brought to good working order in 2017. Walls will be repaired and painted as needed throughout the facility including walls and door jams. Plastic wall coverings may be used as appropriate for high traffic areas and corners. A comprehensive inspection of resident rooms and common areas was completed on October 28, 2016. Fire doors on both sides of 2nd floor dining room will have appropriate end caps re-installed. Main dining room: Tape and plastic will be removed from obsolete air conditioning unit and it will be sealed on the outside so that cold air will not flow in through this obsolete system. Unit will be cleaned and painted as needed. In addition, the wall on the east side will be patched and painted. First floor bathroom walls will be patched and painted. The vent cover will be replaced. Room 115 walls will be patched and painted. Room 121 will have flooring and baseboard replaced. Room will be painted.	

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(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
F 465	Continued From page 52 near the bed. Walls and baseboards in the room had black mars. -On the second floor both fire door push bar covers were covered in duct tape. The Administrator confirmed these needed to be replaced. -The carpet was coming up from the floor outside of room 217, 226 and 234 and outside the hallway nurse managers room to the second floor bathroom, which was confirmed by the Administrator as a trip hazard. -The second floor dining room had wallpaper missing and holes in the wallpaper. - Room 214 had large areas of plaster missing near the head of the bed from the side rail rubbing against the wall. During the tour on 10/27/16, at 1:23 p.m. the following concerns were identified and confirmed by the administrator.	F 465	Room 214 walls will be patched and painted. The Administrator and/or designee will perform monthly inspections of the facility to identify and repair any facility plant issues including but not limited to; flooring, walls, and equipment. Residents and families will be reminded to report facility plant issues to the administrator or designee at their respective family and resident council meetings. ED will report monthly to the QA Committee on this program and these monthly reviews. Completion Date: December 15, 2016	
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's administrator failed to effectively and	F 490	On 10/26/16 the Administrator completed an audit of the employee files and	12/15/16

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	245578	A. BUILDING _____ B. WING _____	10/27/2016

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BETHANY RESIDENCE AND REHABILITATION CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

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F 490	Continued From page 53 efficiently implement procedures that required completion of a background check for newly hired employees after January of 2016. This had the potential to affect all 49 residents recieving care in the facility. Findings include: The administrator was interviewed on 10/26/16, at 11:05 a.m. and stated several employees had not yet had background checks completed. He stated the facility had implemented the new State agency (SA) process (Net Study 2.0) and not all newly employed employees had fingerprinting and a background study conducted. The administrator verified this included employees actively providing care for residents who were not receiving direct supervision at this time. After completing a full audit of all employees, the administrator identified a total of 30 employees who had not yet had background checks completed. He verified the date when background checks stopped being completed as January 2016. The administrator verified it was the policy of the facility to conduct background checks at the time of hire and to verify the employee passed the check before scheduling the employee to have contact with residents. The administrator verified it was his responsibility to ensure background studies were conducted for all new staff. The director of nursing (DON) was interviewed on 10/26/16 at 1:00 p.m., and stated the administrator had updated her today that background checks had not been conducted. The DON stated she was not aware of that and had	F 490	identified that 30 employees did not have a background check. Once identified these employees were informed and instructed that they would: 3. Need to complete a background check, including fingerprints 4. Until receipt of cleared background check was received by the facility that they would need to work under direct supervision of a staff member who had a cleared background check. Staff immediately began to complete Net Study 2.0 background checks. By 11-11-16 all active staff members had a completed and cleared Net Study 2.0 background check. During this interval all staff without a background check who continued to work in the facility worked under direct supervision. Facility Administrator and Director of Nursing checked schedules to make sure appropriate staff were available to provide direct supervision to staff without background checks. All appropriate staff members, including department heads who hire staff members, and Human Resources managers were trained on the policies/procedures of background checks, current licensure and certification registration, and preventing or tracking expired licensure by 11-11-16. New hire policies and procedures have been reviewed and updated to include background checks, current licensure and	

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F 490	Continued From page 54 assumed that during the hiring process background checks were being completed according to the facility's policies.	F 490	certification registration, and preventing and tracking expired licensure. Additionally, the ED or designee will ensure that all new hires have background checks done as per policy. ED or designee will keep a list of professional licenses and a tickler system that will alert the ED and department managers when a license is up for renewal/and expiration. This will prompt the ED and department managers to verify with the licensed or certified employee that they are aware of their licensure renewal and are actively pursuing it. Notification of being removed from the work schedule will be given if pending updates are not forthcoming. This system will also prevent anyone from working in the facility without their required credentials. On an ongoing basis both the Administrator and the Department Managers must sign off on all new hires for each department verifying receipt of background study clearance letter. Administrator will appoint a designee to audit completion of background studies and to maintain ongoing compliance. Designee will also report finding and the success of the program to QA committee. Completion date: December 15, 2016	
F 496 SS=F	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification	F 496		12/15/16

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F 496	Continued From page 55 that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 34 nursing assistants (NA) was on the registry. This had the potential to effect all 49 residents in the facility. Findings include: Employee record was reviewed on 10/27/16, at	F 496	The nurse aide identified as not on the registry was removed from work and is pursuing correcting this problem. Employee was reinstated on 11/10/16 after resolving registry issues. All staff were reviewed for proper credentials to ensure compliance with	

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F 496	Continued From page 56 10:00 a.m., one nursing assistant (NA) was not on the registry. E-EEE had been rehired 7/31/15, and the verification that the NA was on the registry could not be found. The facility ran all the NA's on 10/26/16, and found E-EEE did not have a current registration. Review of the staffing schedules from 8/1/16 through 10/26/16, indicated E-EEE had worked on all units in the facility. The abuse policy titled "Vulnerable Adult Abuse Prevention Plan" dated 11/27/15, indicated that employment eligibility was verified by the state nurse aide registry for all currently certified nursing assistants to document successful completion of the required training and competency evaluation. Also to track nursing assistants against whom allegation of abuse, neglect, or theft have been substantiated. Professional certification and licensure was to be verified for all nurses according to the policy. The administrator was interviewed at 10:00 a.m. on 10/27/16, and verified E-EEE was not on the nursing assistant registry and had been taken off the schedule until registration was reinstated.	F 496	state and federal guidelines on nurse aides being qualified as per the registry and nurses as per state licensure. All personnel associated with personnel qualifications were in-serviced on the importance of reviewing and keeping abreast of credential updating and ensuring that nobody is on the units who is not qualified. On an ongoing basis both the Administrator and the Department Managers must sign off on all new hires for each department verifying proper credentialing for appropriate staff. This will act as a double check system to catch any who are not qualified through licensure errors or lack of licensure or other qualifying credentials. The sign-off sheet will contain the required credentials which will be circled and signed if valid. Lack of valid credential will bar any personnel from working the units. A tickler file has been developed for ED and department managers whereby they can keep track, based on the calendar of updating of credentials. Administrator will appoint a designee to update payroll system to include licensure expirations and to audit ongoing compliance monthly and with each new hire as they come in to the facility. Designee will also report finding to QA committee. Compliance date; December 15, 2016	

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F 503 SS=F	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter. If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility was providing laboratory testing without a certificate of waiver. This had the potential to affect all 49 residents in the facility. Findings include: On 10/27/16, at 2:36 p.m. when asked to provide a copy of the Certified Laboratory Improvement Agreement (CLIA) the director of nursing (DON) stated she was still trying to find it and would get	F 503	CLIA Waiver was re-requested on 10/27/2016. The CIA waiver certificate was received on 11/18/2016. The facility Administrator will calendar date for renewals on an auto-calendar system that will remind him before renewal is due. Administrator is responsible for ongoing compliance and will report to the QA	11/18/16

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F 503	Continued From page 58 back to the surveyor. -At 4:05 a.m. the facility consultant stated the facility CLIA certificate had expired and that the facility did not have one at the survey team had entered the facility and even until a copy was requested. -At 5:30 p.m. the facility provided a copy of CLIA certificate with expiration date of 8/31/16, yet continued to perform blood glucose testing via a glucometer for residents who required such testing. During further document review, it was revealed the certificate had been closed due to nonpayment of fees and the facility did not have a valid certificate. The facility had contacted the Department of Health to reactive it on 10/27/16, after the survey team had requested a copy.	F 503	Committee when the renewal is due and has been completed. Completion Date: November 18, 2016	
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to train employees upon hire regarding the facility's emergency procedures for 3 of 5 newly hired nursing assistants (NA)-FFF, NA-GGG, NA-HHH), reviewed during the extended survey. This had the potential to effect all 49 resident's currently residing in the facility.	F 518	F518 All staff will be re-trained on facility emergency procedures and instructed on responsibilities during various emergencies. These group training sessions will be conducted by the Administrator or his designee.	12/15/16

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F 518	Continued From page 59 Findings include: NA-FFF's employee file was reviewed. NA-FFF had a hire date of 6/4/12, and NA-FFF's employee record did not include training on emergency procedures. NA-GGG's employee file was reviewed. NA-GGG had a hire date of 6/4/12, and NA-GGG's employee record did not include training on emergency procedures. NA-HHH's employee file was reviewed. NA-HHH had a hire date of 3/25/14, and NA-FFF's employee record did not include training on emergency procedures. Interview with the facility consultant was interviewed on 10/27/16, at 9:24 a.m. and confirmed NA-FFF, NA-GGG and NA-HHH employee records did not include training on emergency procedures. The consultant went on to say that they had not been doing training on emergency procedures and the fire marshall had "already tagged them on that." An Employee Handbook dated 6/13/13, indicated on page 20 indicated "Employees should be prepared should disaster occur and it is imperative that employees, residents and visitors be protected in case of an emergency, and that operations continue with the least amount of disruption. The Handbook further indicated employees were "expected to respond effectively in the event of an emergeny and emergency drills."	F 518	Emergency policies and procedures have been reviewed and updated. A list of required emergency procedures has been developed and a check-off for each employee so those required on hire can be completed and those required to be done on an on-going basis can also be completed and evidence of this work shown through checking-off on the form which will remain in the employee file. On an ongoing basis both the Administrator and the Department Managers must sign off on all new hires for each department verifying proper training, including emergencies procedures was completed in orientation. The Human Resources Director will audit this program which is being conducted by the ED or his designee, to ensure through a review of files and emergency training provided that it is being managed as required. Any errors will be brought to the EDs attention immediately for correction. This audit will be done weekly x 4 and then monthly thereafter. The Administrators designee will report on this program monthly to the QA Committee. Completion date: December 15, 2016	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		12/15/16

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F 520	Continued From page 60 QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assurance (QA) committee recognized and developed an action plan to address the identified lack of employee screening upon hire. These practices had the potential to affect all 49 residents in the facility. Findings Include:	F 520	Facility has reviewed and updated its QA polices and procedures and has scheduled a Quality Assurance Committee Meeting for the month of December 2016 in which the ED, DON, and Medical Director will be present. The new policy and procedure for Quality Assurance includes a monthly QA Meeting for (6) months as the facility works to	

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F 520	Continued From page 61 The administrator was interviewed on 10/26/16, at 11:05 a.m. and stated that several employees had not completed background checks. He stated the facility implemented the new state agency (SA) process (Net Study 2.0) and that employees had not completed fingerprints and had a background study done. He verified the employees are working on the schedule and are not in direct supervision at this time. He acknowledged that information was not brought to the QA meeting. After completing a full audit of all employees, the administrator identified a total of 30 employees without background checks. He verified the date when background checks stopped being completed was January 2016. The administrator verified it was the policy of the facility to conduct background checks at the time of hire and to verify the employee passed the check before scheduled to have contact with residents. The administrator stated training should be done on hire, and that the director of nursing (DON) would do part of the training and he would do part. Training would have included protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. He verified the training had not been documented in the employee records for some employees. The DON was interviewed on 10/26/16, at 1:00 p.m., and stated the administrator had updated her today that no background checks had been done, she stated she was not aware of that, she assumed that during the hiring process the background check was completed according to	F 520	improve its quality following 2016 annual survey followed by a shift to quarterly if the ED deems the facility to have improved well-enough to move to the quarterly standard. Based on the new QA policy/procedure, all cited areas will be reviewed during each QA Committee meeting for the first (12) months with interventions being instituted immediately for problems that may develop with each program. This would include a review of the new background check program for new employees as well as all other tags cited in the 2016 annual recertification survey. QAPI Committee or projects will be included as part of the Quality Assurance Committee with a new QAPI project being selected monthly from those tags cited, covering (12) QAPI projects in the (12) month period. Background checks for new employees will be one of the selected QAPI projects. The Administrator has appointed a new designee to audit Quality Assurance Committee proceedings and QAPI projects including those for background checks for new employees. Completion Date: December 15, 2016	

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F 520	Continued From page 62 the facility's policy. A facility policy regarding quality assurance was requested but none was received.	F 520		

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	245578	A. BUILDING **01 - BETHANY COVENANT HOME** B. WING _____	**10/25/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on October 25, 2016. At the time of this survey, Bethany Residence and Rehab Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/27/2016

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.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Bethany Residence and Rehab Center is a 2-story building with no basement. The building was constructed in 1960 and was determined to be of Type II(222) construction. The building is has a full fire sprinkler system in accordance with NFPA 13, 1999 Ed.. The facility has a fire alarm system with smoke detection in the corridors, by the smoke barrier doors, resident rooms and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 66 beds and had a census of 54 at the time of the survey.	K 000		
K 011 SS=E	The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved	K 011		1/27/17

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	245578	A. BUILDING **01 - BETHANY COVENANT HOME** B. WING _____	**10/25/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418**

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K 011	Continued From page 2 self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to separate the independent and skilled nursing facilities in accordance with LCS (2000) Section 19.1.1.4.1. This deficient practice could affect all residents within the smoke compartment. Findings include: On a facility tour between the hours of 0930 and 1330 on October 25, 2016, observation revealed that the north tower entrance door, which is required to have a 1-1/2 hour fire rating, is cracked. This deficient practice was verified by the administrator at the time of inspection.	K 011	The door to the north tower entrance will be replaced with a 1 ½ hour fire rated door. Administrator will insure completion. Completion Date: On or before January 27, 2017.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of	K 029	A self-close mechanism was added to the 2 South soiled utility room door on October 26, 2016. Proper operation of	10/26/16

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K 029	Continued From page 3 NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1. This deficient practice could affect all residents within the smoke compartment. Findings include: On a facility tour between the hours of 0930 and 1330 on October 25, 2016, observation revealed that the east side soiled utility room door did not self-close. This deficient practice was verified by the administrator at the time of inspection.	K 029	self-closure was tested. Completion Date: October 26, 2016.	
K 033 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a fire resistance rating of at least one hour, arranged to provide a continuous path of escape. NFPA 101 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1. This deficient practice could affect all residents within the smoke compartment. Findings include: On facility tour between the hours of 0930 and 1330 on October 25, 2016, observation revealed that the second floor, south exit stairwell door, did not have a fire rated tag. This deficient practice was verified by the	K 033	The 2nd south stairwell exit door be replaced on or before January 27, 2016. Administrator will insure completion. Completion Date: On or before January 27, 2017.	1/27/17

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K 033	Continued From page 4 administrator at the time of the inspection.	K 033		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain their fire alarm system in accordance with NFPA 72, (99). This deficient practice could affect all 46 residents. Findings include: On a facility tour between the hours of 0930 and 1330 on October 25, 2016, observation revealed that the facility could not provide documentation for a current annual fire alarm inspection. The last inspection report on file was dated May 28, 2015. This deficient practice was verified by the administrator at the time of the inspection.	K 052	An Annual Fire Alarm System will be completed as soon as possible by the facility's contracted service provider. A new fire inspection log has been created and will be reviewed monthly by a designee appointed by the administrator. Designee will also report compliance to QAPI committee to insure compliance. Completion Date: On or before January 27, 2017.	1/27/17
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview it was revealed that the automatic sprinkler system is not maintained in accordance with NFPA 13	K 062	The company contracted to maintain the fire sprinkler system was notified and they will deliver sprinkler heads so that the	1/27/17

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K 062	Continued From page 5 Standard for the Installation of Sprinkler Systems (1999 edition). This deficient practice could affect all 46 residents. Findings include: On a facility tour between the hours of 0930 and 1330 on October 25, 2016, observation revealed that the facility did not have the required two of each type of sprinkler head, as a back-up. These deficient practices were verified by a administrator at the time of inspection.	K 062	facility will have on site 2 backup heads for each type of sprinkler head used in the facility. Administrator will insure compliance. Completion Date: On or before January 27, 2017.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide and maintain cooking facilities in accordance with the requirements of NFPA 101-2000 edition, Sections 19.3.2.6 and 9.2.3; NFPA 96-1998 edition. This deficient practice could affect and unknown number of staff in the kitchen. Findings include: On a facility tour between the hours of 0930 and 1330 on October 25, 2016, observation revealed that the facility did not have a K-class extinguisher in the kitchen, which is a required component of the wet chemical system that is installed. This deficient practice was verified by the administrator at the time of inspection.	K 069	A K-Class fire extinguisher was provided for the kitchen on October 28 2016. Completion Date: October 28, 2016.	10/28/16

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K 107 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did no provide required alarm and detection systems with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1. This deficient practice could affect all 46 residents. Findings include: On a facility tour between the hours of 0930 and 1330 on October 25, 2016, observation revealed that the facility did not have a remote annunciator for the back-up emergency generator. This deficient practice was verified by the administrator at the time of inspection.	K 107	A remote annunciator for the emergency generator system will be installed. Policies and Procedures related to the use of emergency generator will be reviewed and updated as needed. Staff will be trained on policies and procedures related to the emergency generator. Administrator will insure compliance. Completion Date: On or before January 27, 2017.	1/27/17
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110-1999 edition, Section 6-4. This deficient practice could affect all 46 residents. Findings include: 1. On a facility tour between the hours of 0930	K 144	An approved emergency generator contractor was on-site to provided training on how to proper perform weekly inspections and monthly run test. The first run test was performed on November 17, 2016. The administrator as well as one designee were trained on operation of emergency generator test and visual inspection. Log sheets were created to	11/17/16

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K 144	Continued From page 7 and 1330 on October 25, 2016, observation revealed that the facility could not provide documentation of weekly generator inspections. 2. On a facility tour between the hours of 0930 and 1330 on October 25, 2016, observation revealed that the facility could not provide documentation of monthly generator run tests. These deficient practices were verified by the administrator at the time of the inspection.	K 144	document inspections and run testing. Administrator will appoint designee to monitor compliance and report to QAPI. Completion Date: November 17, 2016 and ongoing.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to comply with NFPA 99 and NFPA 70 The National Electric Code. This deficient practice could affect all residents within the dining room. Findings include: On a facility tour between the hours of 0930 and 1330 on October 25, 2016, observation revealed that there was a missing electrical outlet cover in the dining room. This deficient practice was verified by the administrator at the time of inspection.	K 147	An electrical outlet cover was fabricated on October 26, 2016 and put in place in 2nd floor dining room for outlet above heating unit on east wall. Completion Date: October 26, 2016.	10/26/16