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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 20EU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00087

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245500**
2.STATE VENDOR OR MEDICAID NO.
(L2) **078040500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BETHANY**
(L4) **804 WRIGHT STREET**
(L5) **BRAINERD, MN** (L6) **56401**

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)

6. DATE OF SURVEY **09/21/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (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 **114** (L18)

13.Total Certified Beds **114** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	114			
(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 :
Theresa Gullingsrud, HFE NEII 09/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/24/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
01/01/1988
(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.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/22/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

CMS Certification Number (CCN): 245458

November 24, 2015

Ms. Linda Bump, Administrator
Essentia Health Virginia Care Cent
901 9th Street North
Virginia, Minnesota 55792

Dear Ms. Bump:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 1, 2015 the above facility is certified for:

114 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 114 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 24, 2015

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

RE: Project Number S5500025

Dear Mr. Cerney:

On August 6, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 30, 2015. 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 September 21, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 4, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 30, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 1, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 30, 2015, effective September 1, 2015 and therefore remedies outlined in our letter to you dated August 6, 2015, will not be imposed.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245500	A. Building B. Wing	9/21/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0252** Reg. # **483.15(h)(1)** LSC	Correction Completed **09/01/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **09/01/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/01/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/01/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/01/2015**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	09/24/2015	33562	09/21/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/30/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245500	A. Building B. Wing **01 - MAIN BUILDING**	9/4/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **07/29/2015**	ID Prefix	Correction Completed **07/29/2015**	ID Prefix	Correction Completed **09/01/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0017		LSC K0029		LSC K0038	
ID Prefix	Correction Completed **07/29/2015**	ID Prefix	Correction Completed **07/29/2015**	ID Prefix	Correction Completed **07/29/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0047		LSC K0052		LSC K0056	
ID Prefix	Correction Completed **07/29/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0073		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/mm	09/24/2015	27200	09/04/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/29/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

MDH
Minnesota
Department
of Health

Electronically delivered
December 1, 2015

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

Re: Reinspection Results - Project Number S5500025

Dear Mr. Cerney:

On September 21, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 30, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00087	A. Building B. Wing	9/21/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20302** Reg. # **MN State Statute 144.6503** LSC	Correction Completed **09/01/2015**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp. 1** LSC	Correction Completed **09/01/2015**	ID Prefix **21665** Reg. # **MN Rule 4658.1400** LSC	Correction Completed **09/01/2015**
ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp. 4** LSC	Correction Completed **09/01/2015**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/mm	09/24/2015	27200	09/21/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/30/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 20EU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00087

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245500**
2.STATE VENDOR OR MEDICAID NO.
(L2) **078040500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BETHANY**
(L4) **804 WRIGHT STREET**
(L5) **BRAINERD, MN** (L6) **56401**

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)

6. DATE OF SURVEY **07/30/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (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 **114** (L18)

13.Total Certified Beds **114** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	114			
(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 :
Rebecca Haberle, HFE NEII — 08/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 09/16/2015 (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
01/01/1988
(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.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 6, 2015

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

RE: Project Number S5500025

Dear Mr. Cerney:

On July 30, 2015, a standard 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 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), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 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 plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 8, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 8, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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 remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 Post Certification Revisit (PCR) 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 remedies will not be imposed. 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 October 30, 2015 (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 January 30, 2016 (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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(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.	F 000		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide housekeeping and maintenance services necessary to maintain clean and sanitary conditions for residents' personal wheelchairs for 2 of 2 resident (R55, R35) in the sample with soiled wheelchairs. Findings include: R55's wheelchair was observed dirty with dried debris and torn arm rest coverings and the facility failed to clean it.	F 252	1. Resident # 55 and 35¿s wheel chair¿s have been cleaned. Replacement parts for resident #55¿s wheel chair have been ordered. Resident #55 was evaluated by therapy and a different wheel chair was recommended and thus the wheel chair resident #55 was in was removed from service until the parts arrive. 2. All residents are at risk for being soiled and are at risk for being in need of repair. All wheel chair¿s were audited for cleanliness and to determine if they were	9/1/15

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

Electronically Signed | 08/14/2015

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F 252	Continued From page 1 R55's quarterly Minimum Data Set (MDS) dated 6/30/15, indicated R55 was diagnosed with dementia, had severe cognitive impairment and required extensive assistance for bed mobility, transferring and ambulation. On 7/29/15, at 9:00 a.m. nursing assistant (NA)-A was observed to transfer R55 into a Rock and Go (rocking) wheelchair. The chair's arm rests were observed encased with a cloth covering which was attached to the seat next to the wheels. The coverings were observed to have an area approximately 10 inches in diameter next to the wheels which were torn, shredded and worn through. The wheelchair frame under cushion was observed coated with thick, black and rust colored debris along with dried food debris. On 7/29/15, at 9:24 a.m. NA-A verified the wheelchair arm rest side panels were shredded and in need of repair and the wheelchair frame was in need of cleaning. On 7/30/15, at 8:25 a.m. registered nurse (RN)-A observed R55's wheelchair. She verified the side panels of the chair were in need of repair and the wheelchair frame was in need of cleaning. She stated the cleaning of the wheelchairs was to be completed by the night staff but the facility did not have a system which would indicate the last time the chair was cleaned. R35's wheelchair was observed with dried food debris and the facility failed to clean it. R35's quarterly MDS dated 6/24/15, indicated R35 had diagnoses of vascular dementia and Parkinson's disease, had severe cognitive impairment and required extensive staff assist for	F 252	in need of repair. Those identified as in need of repair or are in need of cleaning have been repaired and/or cleaned. 3. A new system has been put in place for cleaning the wheel chair¿s at least weekly on the night shift and checking for damage at that time. All Nursing staff educated on the new process on 8/12/2015, 8/14/2015, 8/19/2015, and/or 8/21/2015. All staff educated at that time on how to report wheel chair¿s in need of cleaning or repair. 4. Director of Nursing or Designee will randomly audit wheel chair cleanliness and repair a minimum of 3x/wk for 4 weeks with results to the QAPI committee for further recommendations.	

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F 252	Continued From page 2 transfers. On 7/29/15, at 8:29 a.m. R35's wheelchair was observed to have dried food debris down the left side of the wheelchair, the seat cushion had dried debris embedded in it and the bottom support frames as well as both wheel spokes had a build up of dried debris. On 7/30/15, at 9:17 a.m. RN-A verified R35's wheelchair was dirty and in need of cleaning. RN-A also stated the wheelchairs were cleaned on the night shift to allow drying time prior to the residents needing them in the morning. On 7/30/15, at 9:15 a.m. the director of nursing (DON) verified the wheelchair was in need of cleaning and repair. She stated the facility did not have a policy regarding wheelchair cleaning and repair but stated a cleaning schedule would be developed and implemented.	F 252		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356		9/1/15

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F 356	Continued From page 3 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately post the per shift hours worked for nursing staff directly responsible for resident care which had the potential to affect 85 of 85 residents residing in the facility. Findings include: During the initial tour on 7/27/15, at 6:15 p.m. the nurse staffing posting was reviewed and noted to be dated 7/16/15. On 7/30/15, at 3:30 p.m. the director of nursing (DON) verified the posting should have been for the current date and not 7/16/15. On 7/30/15, at 3:36 p.m. the staff coordinator stated the daily staffing posting should have been changed every day and posted on the station 2	F 356	1.The posted nurse staffing information has been posted daily. 2.All residents are at risk for being affected by the posted nurse staffing information not being posted daily. 3.A new system has been put in place to post the nurse staffing information daily. Staff educated on the need to update the sheet at the beginning of each shift with update with changes as needed. All Nursing staff educated on the new process on 8/12/2015, 8/14/2015, 8/19/2015, and/or 8/21/2015. 4.Staffing coordinator and nursing managers to audit compliance a minimum of 3x/wk for 4 weeks with results to the QAPI committee for further recommendations.	

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F 356	Continued From page 4 bulletin board. The staff coordinator verified the posting was not accurate. The facility policy Nursing Staff Daily Posting Requirements dated 12/14, indicated the facility would post the staffing and resident census daily at the beginning of each shift and update as appropriate (for each shift).	F 356		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431		9/1/15

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F 431	Continued From page 5 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper narcotic storage and security for 1 of 5 medication carts (300 wing cart) reviewed. Findings include: On 7/30/15, at 10:56 a.m. the 300 wing medication cart was observed locked, however, the narcotic drawer which had a key lock on the top of the drawer was found unlocked. Licensed practical nurse (LPN)-A confirmed the narcotic drawer was unlocked and it should have been locked. The contents of the medications in the 300 wing unlocked narcotic drawer included: · Oxycontin 10 milligram (mg) (pain medication) - 20 tablets · Oxycontin 20 mg - 32 tablets · Oxycodone (pain medication) a variety of doses - 48 tablets · Fentanyl 75 microgram (mcg) / hour (pain medication) - 1 patch · Norco 5/325mg (pain medication) - 104 tablets · Methadone 10 mg - 2 tablets On 7/30/15, at 11:18 a.m. the director of nursing (DON) confirmed narcotic medications should be	F 431	1.The narcotic lock boxes located on the nurses carts have been locked appropriately. 2.All residents are at risk for being affected by narcotic boxes not being locked appropriately. Audits completed initially and verified narcotic counts are accurate and boxes locked appropriately. 3.All Nursing staff educated on the proper way to secure narcotis. They were educated on this at mandatory in-services held on 8/12/2015, 8/14/2015, 8/19/2015, and 8/21/2015. 4.Director of Nursing or designee to audit for compliance of ensuring locked boxes are locked appropriately for a minimum of 3x/wk for 4 weeks with results to the QAPI committee for further recommendations.	

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F 431	Continued From page 6 double locked. The medication cart and the narcotic drawer within the medication cart should have both been locked. The Acquisition, Receiving, Dispensing and Storage of Medications policy dated 6/2014, indicated controlled medications along with other medications subject to possible abuse should be stored in a separate, locked, fixed compartment.	F 431		
F 441 SS=D	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 (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	F 441		9/1/15

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F 441	Continued From page 7 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 observation, interview and document review, the facility failed to ensure appropriate hand washing was performed during the provision of personal cares for 2 of 4 residents (R55, R35) observed during personal care for which hand washing was indicated. Findings include: Hand Hygiene: R55's quarterly Minimum Data Set (MDS) dated 6/30/15, indicated R55 was diagnosed with dementia, had severe cognitive impairment and required extensive assistance for bed mobility, transferring and personal hygiene. On 7/29/15, at 9:13 a.m. R55 was observed seated on the toilet. Nursing assistant (NA)-A was observed to donned gloves and assist R55 with perineal cares after R55 had a bowel movement while on the toilet. NA-A was observed to remove her gloves prior to assisting R55 to pull up his pants and transfer into a wheelchair. - At 9:17 a.m. R55 asked to brush his teeth.	F 441	1.Resident # 55 and #35¿s NAR¿s were educated on the importance of proper infection control practices during perineal and oral cares. 2.All residents who require assistance with incontinence products and oral cares are at risk of being affected by the same deficient practice. 3.Mandatory nursing staff education will take place on 8/12/2015, 8/14/2015, 8/19/2015 and 8/21/2015 and will cover education on proper perineal and oral cares. The importance of proper infection control techniques for glove use, handwashing, linen handeling, and brief removal will be stressed. 4.DON/designee will complete random visual audits of perineal care, oral cares, linen handeling and brief removal to ensure that appropriate infection control techniques are being utilized. 3x/wk for 4 wks. The results will be forwarded to the QAPI committee for further recommendation.	

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F 441	Continued From page 8	F 441		

NA-A donned a pair of gloves and assisted R55 with the toothbrush and toothpaste application. NA-A was not observed to wash her hands prior to donning the gloves and assisting R55 with oral care set up. R55 was observed to brush his own teeth, however, NA-A touched R55's toothbrush, toothpaste, emesis basin and a glass of water during the oral cares.
-At 9:20 a.m. NA-A removed the second pair of gloves and straightened up R55's room. She then carried the garbage and dirty linens to the soiled utility room. NA-A was not observed to wash her hands in between providing perineal care and oral care or after providing personal cares and leaving the room.

At 9:25 a.m. NA-A was observed to wash her hands in the soiled utility room. NA-A verified she had not washed her hands between perineal cares and oral cares. She also verified she had not washed her hands until she had disposed of the soiled linens and garbage in the utility room.

On 7/30/15, at 2:55 p.m. registered nurse (RN)-A stated she would expect staff to not only change gloves but to wash their hands between performing perineal cares and oral cares.

On 7/30/15, at 3:00 p.m. the director of nursing stated she would expect staff to wash their hands in between perineal cares and oral cares.

R35's soiled linens were not handled properly in order to prevent the spread of infection.

R35's quarterly MDS dates 6/24/15, indicated R35 was diagnosed with vascular dementia and Parkinson's disease. The MDS also indicated R35 had severe cognitive impairment and

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F 441	Continued From page 9 required extensive staff assist for transfers and hygiene. On 7/29/15, at 8:29 a.m. NA-A was observed providing R35 personal cares. With gloves on, NA-A was observed to place a wet towel and wet wash cloth soiled with feces on R35's floor, remove the gloves and continue with providing R35's cares. Once R35 was in the wheelchair, NA-A put gloves on and picked up the soiled linen off the floor and brought it to the soiled utility room and put them in the receptacle. NA-A then washed hands with soap and water. On 7/29/15, at 8:43 a.m. NA-A stated soiled linens should not be placed on the floor. On 7/30/15, at 10:26 a.m. the DON stated staff should have used linen bags to put the soiled linen in and not on the resident floor. The DON also stated staff should wash their hands between taking soiled gloves off and putting on clean gloves. The facility policy Perineal Care dated 11/13, indicated staff should wash hands or use hand sanitizer after removing soiled gloves. Then put on clean gloves to put on clean pad and/or clothing. The policy directed staff to remove and dispose of linen and bedding appropriately, however, lacked direction as to where to put the soiled linen while completing resident cares. The Hand Hygiene and Handwashing policy dated 6/2014, directed the staff to wash their hands after providing personal cares involving contact with bodily fluids.	F 441		
F 465	483.70(h)	F 465		9/1/15

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F 465 SS=E	Continued From page 10 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, interview and document review, the facility failed to provide appropriate maintenance to 4 of 35 resident rooms (217, 301, 303, 305, and 330) observed in disrepair. Findings include: On 7/30/15, at 8:17 a.m. the director of maintenance (DM) stated each resident room and their bathroom were checked monthly for needed repairs. The DM confirmed the last walk through was conducted the end of June 2015. the DM confirmed the maintenance staff utilized the Resident Room Inspection Report as a checklist when conducting the walk arounds. The DM stated each unit had a work order book that they utilized to inform the maintenance staff of items that needed repair or attention. On 7/30/15, at 8:20 a.m. the DM confirmed there were no outstanding work orders for the 200 wing. On 7/30/15, at 8:26 a.m. the maintenance technician confirmed there were no outstanding work orders for the 300 wing. On 7/30/15, from 8:20 a.m. to 8:41 a.m. a tour of the facility was completed with the DM and the	F 465	1.Rooms 217, 301, 303, 305, & 330 have had the gouged/scraped walls repaired, filled in gouges and scrapes and repainted the scuff marks. 2.All rooms have the potential to be damaged. 3.All staff will be educated to be watchful for indication of damage/abuse to walls and resident surroundings. Housekeeping and nursing staff will notify Maintenance by written maintenance request form of any issues they observe that need attention. 4.In addition to Housekeeping and Nursing staff monitoring for damage/abuse to walls, Maintenance director or designee will do a formal audit 3x/wk for 4 weeks to check for needed repairs and/or paint. This information will be brought to the QAPI Committee for future auditing needs.	

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F 465	Continued From page 11 following was identified: The DM verified the following resident room concerns: · The bathroom wall in room 217, had a gouge on the wall by the toilet measuring 18 inches in length and approximately ½ inch at its widest point with sheet rock exposed · The bathroom wall in room 301, had a 16 inch scrape where the paint was chipped off · The bathroom wall in room 303, had a black scuff mark measuring two feet · The bathroom walls in room 305, had two gouge marks each measuring approximately two feet · The exterior door to room 330, had several gouges and chips of wood out of the lower portion of the door The Resident Room Inspection Report [undated] included inspection of the bedroom doors and bathroom walls. The Monthly Routines log [undated] indicated resident room inspection had been completed monthly, with the last inspection in June 2015. No policy related to routine maintenance inspections was provided.	F 465		

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	245500	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/29/2015**

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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 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. At the time of this survey Good Samaritan Society Bethany 01 Main Building 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 (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/14/2015

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 Or by e-mail to: Marian.Whitney@state.mn.us or 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 The facility was inspected as one building. Good Samaritan Society Bethany is a 1-story building without a basement. The building was constructed at six different times. The original building was constructed in 1969, is 1- story and was determined to be of Type II(000) construction. In 1974, two, 1-story additions were constructed, one to the south west and one to the east side of the original building, that were determined to be of Type II(111) construction and are separated with 2- hour fire barriers form the existing building. In 1980 an 1- story addition was constructed to the south and east of the 1974 south addition, was determined to be Type II (111) construction and is separated with a 2- hour fire barrier. In 1983 a small 1- story connecting link was added to the south of the 1980 addition to connect the facility to an apartment building and was determined to be Type V (000) construction. This link is not separated from the facility but a	K 000		

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K 000	Continued From page 2 2-hour fire barrier is between the link and the apartment building. In 1994 the Physical Therapy 1- story addition was added to the north of the original building and was determined to be Type II (111) construction. In 1998 an 1- story addition was constructed to the north of the 1960 building and 1974 addition, was determined to be Type V(111) construction and is separated by a 2-hour fire barrier. The main level is divided into 11 smoke zones by 30 minute and 90 minute fire barriers. The entire building is protected by a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with quick response heads in the 1998 addition and standard response heads in all other areas. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system, in common areas and in all sleeping rooms that is installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for automatic fire department notification. Other hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 124 beds and had a census of 109 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 017		7/29/15

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K 017	Continued From page 3 Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had penetrations located in the ceiling tile located in the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting residents, staff and visitors. Findings include: On facility tour between 9:30 AM to 1:30 PM on 07/29/2015, observations revealed, that there is a 1/2 inch wide by 20 inch long gap between the	K 017	The grid work outside room 637 that had been hit and had been pushed out of place was replaced and the grid was secured. The environmental services director will be responsible for correction and monitoring to prevent reoccurrence of this deficiency.	

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K 017	Continued From page 4 ceiling tiles in the corridor located outside of resident room 637 This deficient condition was verified by the Maintenance Supervisor (RN).	K 017		
K 029 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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 observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include:	K 029	The environmental services director filled in a small hole with joint compound. The non-fire rated foam was removed from the conduit and replaced with fire rated caulk. The environmental services director will be responsible for correction and monitoring to prevent reoccurrence of this deficiency.	7/29/15

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K 029	Continued From page 5 On facility tour between 9:30 AM to 1:30 PM on 07/29/2015, observation revealed, that the following conditions were found affecting communication/server storage room: 1. There is a 1/2 inch wide by 3/4 inch long penetration in the corridor wall on the inside communication/server storage room, and 2. The facility used a non-fire rated foam compound to fill in gaps and openings in and around the electrical conduit that is located in the Communication/server storage room. This deficient practices was confirmed by the Maintenance Supervisor (RN).	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a hard surfaced path to the public way for 1 of several means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, 7.2.1.6.1(d), 7.7.2 (1) and the 2007 MN State Fire Code, Appendix I. The deficient practice could affect residents, staff, and visitors.	K 038	The facility will be pouring concrete sidewalks to these doors in order to provide a hard path to the public way. The environmental services director will be responsible for correction and monitoring to prevent reoccurrence of this deficiency.	9/1/15

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K 038	Continued From page 6 Findings include: On facility tour between 9:30 AM to 1:30 PM on 07/29/2015, observation revealed that the exit discharge for the emergency exit that is located in the connecting link between station 5 and 6 did not have a hard path to the public way. This deficient practices was confirmed by the Maintenance Supervisor (RN).	K 038		
K 047 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide 1 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. The deficient practice could affect residents, staff and visitors, if the lack of properly illuminated exit sign prevented a means of egress from being utilized in a timely manner in an emergency situation. Findings include: On facility tour between 9:30 AM to 1:30 PM on 07/29/2015, it was observed that the exit light that is located in the Physical Therapy room is inoperative.	K 047	The environmental services director immediately replaced the exit fixture in the physical therapy room. The environmental services director will be responsible for correction and monitoring to prevent reoccurrence of this deficiency.	7/29/15

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K 047	Continued From page 7 This deficient practices was confirmed by the Maintenance Supervisor (RN).	K 047		
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting residents, staff, and visitors of the facility. Findings include:	K 052	The smoke diffuser located by room 511 was relocated per the fire marshals suggestion. The environmental services director will be responsible for correction and monitoring to prevent reoccurrence of this deficiency.	7/29/15

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K 052	Continued From page 8 On facility tour between 9:30 AM to 1:30 PM on 07/29/2015, observations revealed that there was a smoke detector located by resident room 511 that had been installed within 36 inches of a HVAC diffuser. This deficient practices was confirmed by the Maintenance Supervisor (RN).	K 052		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that	K 056	The escutcheon rings were replaced and secured. All of the building was audited to ensure all escutcheon rings were secured. The pillows were removed from the top of the station 5&6 short term care wings linen closets. Laundry staff educated on the proper codes regarding sprinkler diffusers.	7/29/15

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K 056	Continued From page 9 would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 9:30 AM to 1:30 PM on 07/29/2015, observations have revealed that the following deficient practices were found to be affecting the facility's fire sprinkler system: 1. There are numerous escutcheon rings missing throughout the facility, and 2. there are pillows in the station 5 and 6 short term care wing's linen closets that are within 18 inches of the sprinkler diffuser. This deficient practices was confirmed by the Maintenance Supervisor (RN).	K 056	The environmental services director will be responsible for correction and monitoring to prevent reoccurrence of this deficiency.	
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain combustible decoration in accordance with NFPA Life Safety Code 101 (00) section 19.7.5.4. The failure to treat and maintain the combustible decorations throughout the facility in accordance with NFPA Life Safety Code 101 (00) could allow smoke and fire to rapidly migrate through the corridors and negatively affect the egress capability in the event of an emergency for residents, visitors and staff of the facility.	K 073	The decorations and hangings on the residents room doors were removed and the residents and their families were educated about the need to keep the residents doors free of items that are not fire retardant. All door hangers were removed from the residents doors to prevent reoccurrence. The environmental services director will be responsible for correction and	7/29/15

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K 073	Continued From page 10 Findings include: On facility tour between 9:30 AM to 1:30 PM on 07/29/2015, observations revealed that the facility could not verify if the decoration that are hanging on resident room doors are fire retardant of if they have been treated with any type of approved fire retardant treatment. This deficient practices was confirmed by the Maintenance Supervisor (RN).	K 073	monitoring to prevent reoccurrence of this deficiency.	

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 6, 2015

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5500025

Dear Mr. Cerney:

The above facility was surveyed on July 27, 2015 through July 30, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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	00087	A. BUILDING: _____ B. WING _____	07/30/2015

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GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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	00087	A. BUILDING: _____ B. WING _____	07/30/2015

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 27, 28, 29, 30, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		9/1/15

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2 302	Continued From page 3 Based on interview and document review, the facility failed to ensure all direct care staff received the required Alzheimer's disease training for 3 of 6 nursing employees (NA-B, NA-C and NA-D) reviewed for the required Alzheimer's training. Findings include: On 7/30/15, at 3:25 p.m. staff training related to Alzheimer's was reviewed with registered nurse (RN)-B and the following was noted: -NA-B was hired on 5/22/08. NA-B's training transcript indicated she had not completed the required Alzheimer training in 2014-2015. -NA-C was hired on 1/5/2009. NA-C's training transcript indicated he had not completed the required Alzheimer training in 2014-2015. -NA-D was hired on 1/2/2008. NA-D's training transcript indicated she had not completed the required Alzheimer's training in 2014-2015. On 7/30/15, at 3:40 p.m. RN-B stated she had been working in staff training and development for five months. She stated she had recently identified Alzheimer's training as a required training for the staff and had sent out a memo to the staff encouraging them to complete an online training for Alzheimer's. She verified the above staff members had not completed the training as required. Review of the memorandum number 2014-319, subject dated "2015 required Annual Training Topics for All Settings" directed all staff to	2 302	corrected	

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2 302	Continued From page 4 complete an annual training entitled Dementia Management and care of the Cognitively Impaired. SUGGESTED METHOD OF CORRECTION: The staff development coordinator or designee could review and revise the policies related to Alzheimer's training and provide education to the staff. The quality assurance committee could develop a system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand washing was performed during the provision of personal cares for 2 of 4 residents (R55, R35) observed during personal care for which hand washing was indicated. Findings include: Hand Hygiene: R55's quarterly Minimum Data Set (MDS) dated	21375	corrected	9/1/15

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21375	Continued From page 5	21375		

6/30/15, indicated R55 was diagnosed with dementia, had severe cognitive impairment and required extensive assistance for bed mobility, transferring and personal hygiene.

On 7/29/15, at 9:13 a.m. R55 was observed seated on the toilet. Nursing assistant (NA)-A was observed to donned gloves and assist R55 with perineal cares after R55 had a bowel movement while on the toilet. NA-A was observed to remove her gloves prior to assisting R55 to pull up his pants and transfer into a wheelchair.
- At 9:17 a.m. R55 asked to brush his teeth. NA-A donned a pair of gloves and assisted R55 with the toothbrush and toothpaste application. NA-A was not observed to wash her hands prior to donning the gloves and assisting R55 with oral care set up. R55 was observed to brush his own teeth, however, NA-A touched R55's toothbrush, toothpaste, emesis basin and a glass of water during the oral cares.
-At 9:20 a.m. NA-A removed the second pair of gloves and straightened up R55's room. She then carried the garbage and dirty linens to the soiled utility room. NA-A was not observed to wash her hands in between providing perineal care and oral care or after providing personal cares and leaving the room.

At 9:25 a.m. NA-A was observed to wash her hands in the soiled utility room. NA-A verified she had not washed her hands between perineal cares and oral cares. She also verified she had not washed her hands until she had disposed of the soiled linens and garbage in the utility room.

On 7/30/15, at 2:55 p.m. registered nurse (RN)-A stated she would expect staff to not only change gloves but to wash their hands between

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21375	Continued From page 6 performing perineal cares and oral cares. On 7/30/15, at 3:00 p.m. the director of nursing stated she would expect staff to wash their hands in between perineal cares and oral cares. R35's soiled linens were not handled properly in order to prevent the spread of infection. R35's quarterly MDS dates 6/24/15, indicated R35 was diagnosed with vascular dementia and Parkinson's disease. The MDS also indicated R35 had severe cognitive impairment and required extensive staff assist for transfers and hygiene. On 7/29/15, at 8:29 a.m. NA-A was observed providing R35 personal cares. With gloves on, NA-A was observed to place a wet towel and wet wash cloth soiled with feces on R35's floor, remove the gloves and continue with providing R35's cares. Once R35 was in the wheelchair, NA-A put gloves on and picked up the soiled linen off the floor and brought it to the soiled utility room and put them in the receptacle. NA-A then washed hands with soap and water. On 7/29/15, at 8:43 a.m. NA-A stated soiled linens should not be placed on the floor. On 7/30/15, at 10:26 a.m. the DON stated staff should have used linen bags to put the soiled linen in and not on the resident floor. The DON also stated staff should wash their hands between taking soiled gloves off and putting on clean gloves. The facility policy Perineal Care dated 11/13, indicated staff should wash hands or use hand	21375		

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21375	Continued From page 7 sanitizer after removing soiled gloves. Then put on clean gloves to put on clean pad and/or clothing. The policy directed staff to remove and dispose of linen and bedding appropriately, however, lacked direction as to where to put the soiled linen while completing resident cares. The Hand Hygiene and Handwashing policy dated 6/2014, directed the staff to wash their hands after providing personal cares involving contact with bodily fluids. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee would review and revise the policy and procedures related to infection control concerns while performing perinal cares and provide education to staff members. A monitoring system could be developed to ensure staff are providing cares as directed and report the results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide housekeeping	21665	corrected	9/1/15

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21665	Continued From page 8 and maintenance services necessary to maintain clean and sanitary conditions for residents' personal wheelchairs for 2 of 2 resident (R55, R35) in the sample with soiled wheelchairs. Findings include: R55's wheelchair was observed dirty with dried debris and torn arm rest coverings and the facility failed to clean it. R55's quarterly Minimum Data Set (MDS) dated 6/30/15, indicated R55 was diagnosed with dementia, had severe cognitive impairment and required extensive assistance for bed mobility, transferring and ambulation. On 7/29/15, at 9:00 a.m. nursing assistant (NA)-A was observed to transfer R55 into a Rock and Go (rocking) wheelchair. The chair's arm rests were observed encased with a cloth covering which was attached to the seat next to the wheels. The coverings were observed to have an area approximately 10 inches in diameter next to the wheels which were torn, shredded and worn through. The wheelchair frame under cushion was observed coated with thick, black and rust colored debris along with dried food debris. On 7/29/15, at 9:24 a.m. NA-A verified the wheelchair arm rest side panels were shredded and in need of repair and the wheelchair frame was in need of cleaning. On 7/30/15, at 8:25 a.m. registered nurse (RN)-A observed R55's wheelchair. She verified the side panels of the chair were in need of repair and the wheelchair frame was in need of cleaning. She stated the cleaning of the wheelchairs was to be completed by the night staff but the facility did not	21665		

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21665	Continued From page 9 have a system which would indicate the last time the chair was cleaned. R35's wheelchair was observed with dried food debris and the facility failed to clean it. R35's quarterly MDS dated 6/24/15, indicated R35 had diagnoses of vascular dementia and Parkinson's disease, had severe cognitive impairment and required extensive staff assist for transfers. On 7/29/15, at 8:29 a.m. R35's wheelchair was observed to have dried food debris down the left side of the wheelchair, the seat cushion had dried debris embedded in it and the bottom support frames as well as both wheel spokes had a build up of dried debris. On 7/30/15, at 9:17 a.m. RN-A verified R35's wheelchair was dirty and in need of cleaning. RN-A also stated the wheelchairs were cleaned on the night shift to allow drying time prior to the residents needing them in the morning. On 7/30/15, at 9:15 a.m. the director of nursing (DON) verified the wheelchair was in need of cleaning and repair. She stated the facility did not have a policy regarding wheelchair cleaning and repair but stated a cleaning schedule would be developed and implemented. SUGGESTIVE METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of the importance of clean and sanitary resident personal care equipment. The DON or designee,	21665		

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21665	Continued From page 10 could coordinate with maintenance and housekeeping staff to set up a cleaning schedule and conduct periodic audits of resident wheelchairs to ensure cleanliness is maintained. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21665		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate maintenance to 4 of 35 resident rooms (217, 301, 303, 305, and 330) observed. Findings include: On 7/30/15, at 8:17 a.m. the director of maintenance (DM) stated each resident room and their bathroom were checked monthly for needed repairs. The DM confirmed the last walk through was conducted the end of June 2015. the DM confirmed the maintenance staff utilized the Resident Room Inspection Report as a checklist when conducting the walk arounds. The DM stated each unit had a work order book that they utilized to inform the maintenance staff of items	21695	corrected	9/1/15

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21695	Continued From page 11 that needed repair or attention. On 7/30/15, at 8:20 a.m. the DM confirmed there were no outstanding work orders for the 200 wing. On 7/30/15, at 8:26 a.m. the maintenance technician confirmed there were no outstanding work orders for the 300 wing. On 7/30/15, from 8:20 a.m. to 8:41 a.m. a tour of the facility was completed with the DM and the following was identified: The DM verified the following resident room concerns: · The bathroom wall in room 217, had a gouge on the wall by the toilet measuring 18 inches in length and approximately ½ inch at its widest point with sheet rock exposed · The bathroom wall in room 301, had a 16 inch scrape where the paint was chipped off · The bathroom wall in room 303, had a black scuff mark measuring two feet · The bathroom walls in room 305, had two gouge marks each measuring approximately two feet · The exterior door to room 330, had several gouges and chips of wood out of the lower portion of the door The Resident Room Inspection Report [undated] included inspection of the bedroom doors and bathroom walls. The Monthly Routines log [undated] indicated resident room inspection had been completed monthly, with the last inspection in June 2015.	21695		

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21695	Continued From page 12 No policy related to routine maintenance inspections was provided. SUGGESTED METHOD OF CORRECTION: The maintenance director and administrator could review and revise the cleaning /maintenance schedules for the facility. They could provide education to the staff members and establish a monitoring system to ensure compliance. They could report the results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		