Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 27, 2024

Administrator
Bethesda
901 Southeast Willmar Avenue
Willmar, MN 56201

RE: CCN: 245427
Cycle Start Date: January 24, 2024

Dear Administrator:

On March 13, 2024, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 27, 2024

Administrator
Bethesda
901 Southeast Willmar Avenue
Willmar, MN 56201

Re: Reinspection Results
Event ID: 3PX112

Dear Administrator:

On March 13, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 24, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 2, 2024

Administrator
Bethesda
901 Southeast Willmar Avenue
Willmar, MN 56201

RE: CCN: 245427
Cycle Start Date: January 24, 2024

Dear Administrator:

On January 24, 2024, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nikki Stassen, BSN, RN
Regional Operations Supervisor
St. Cloud Team A
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Nicole.Sassen@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 April 24, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by July 24, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
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
	245427	A. BUILDING _____ B. WING _____	C 01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

(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
E 000	Initial Comments On 1/22/24 thru 1/24/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73 was conducted during a standard recertification survey. The facility was NOT in compliance. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		2/23/24

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

Electronically Signed | 02/09/2024

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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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide emergency generator testing in accordance with the 2012 Edition of Life Safety Code (NFPA 101), section 9.1.3.1, and the 2010 Edition of NFPA 110, Standard for Emergency and Standby Power Systems. Findings include: The Life Saftey Code Surveyor (State Fire Marshal - SFM) informed the Certification and Licensing Team of the following: On 01/23/2024 between 09:00 AM and 1:00 PM, it was revealed by a review of available documentation and an interview with the Maintenance Director that the weekly generator checks for the the month of April 2023 had incorrect dates making it appear that weekly checks were not conducted during that month. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	E 041	Corrective Action for Residents Affected by Deficient Practice: Facilities Director immediately reviewed emergency generator testing documentation after identified by State Fire Marshal to identify root cause of concern. Emergency generator testing record has been updated to reflect accurate dates. Identification of Other Residents Having the Potential to be Affected by Deficient Practice: Emergency generator testing documentation was reviewed for other buildings. All documentation was reflected accurately and confirmed weekly generator checks were completed. Measures or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur: Training and re-education will be provided to all staff responsible for emergency generator testing on procedure and accurate documentation beginning February 2024 and will be completed by completion date. How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is Being Corrected and Will Not Recur: Administrator will audit both generator books monthly X 4 months beginning February 2024. These audits will be	

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E 041	Continued From page 4	E 041	presented to the facility Quality Assurance committee to verify that compliance has been attained.	
F 000	INITIAL COMMENTS On 1/22/2024 thru 1/24/2024, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H#: H54278871C / MN#: MN00098865 H#: H54278872C / MN#: MN00098294 H#: H54278876C / MN#: MN00097816 H#: H54278877C / MN#: MN00097205 H#: H54278875C / MN#: MN00097210 H#: H54278874C / MN#: MN00095892 H#: H54278927C / MN#: MN00094392 H#: H54278870C / MN#: MN00090463 H#: H54278869C / MN#: MN00090326 H#: H54278895C / MN#: MN00097462 and MN#: MN00097385 H#: H54278873C / MN#: MN00094544 H#: H54278868C / MN#: MN00090822 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to	F 000		

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F 000	Continued From page 5 validate substantial compliance with the regulations has been attained.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene care (i.e., nail care, shaving) was provided for 2 of 3 residents (R55 and R101) reviewed for activities of daily living (ADLs) and who was dependent on staff for their daily care and grooming needs. Findings include: R55's significant change Minimum Data Set (MDS) dated 12/19/23, identified R55 was cognitively intact, and was independent with activities of daily living (i.e., nail care). R55's Admission Record (face sheet) listed primary diagnosis of hepatic encephalopathy (advanced liver dysfunction) and malignant neoplasm of right breast. R55's last documented ADLs Care Area Assessment (CAA) dated 11/13/23, documented only the following: "Maintain current level of functioning". R55's care plan last revised 12/28/23, identified R55 had an ADL self-care deficit due to weakness, liver cirrhosis, and cancer. R55's care	F 677	Corrective Action for Residents Affected by Deficient Practice: Resident #55 fingernails were clipped and filed on 1/24/24 when staff was made aware by MDH. Resident #101 fingernails were clipped and filed, and facial hair was trimmed and shaved on 1/24/24 when staff were made aware by MDH. Identification of Other Residents Having the Potential to be Affected by Deficient Practice: A facility audit will be completed on all residents to ensure routine fingernail care has been provided and fingernails are appropriate length, if resident is independent ensure they have access to a personal nail clippers. Audit will include ensuring resident/resident representative preferences are appropriately documented in care plan. A facility audit will be completed on all male residents to ensure all male residents' facial hair preferences from resident/resident representative are appropriately documented in care plan	2/23/24

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F 677	Continued From page 6 plan further documented under the approach of "Grooming", R55 was independent and "prefers to have beautician/barber to maintain facial hair". During observation and interview of R55 on 1/22/24 at 3:19 p.m., resident was lying in bed watching TV. R55 was noted to have a full beard from ear to ear and down his neck. It was also noted R55's finger nails on both hands / all fingers were long. R55's finger nails appeared to be between 1/8 inches (in) to approximately 1/4 in on residents thumbs and index fingers. R55 stated he has a barber keep his beard trimmed when he has his hair cut. R55 stated he used to keep his own nails trimmed, however does not have nail trimmers to do so. When asked if staff have offered to trim them for him, R55 stated "no". During multiple observations on 1/23/24 from 8:00 a.m. through 5:00 p.m. and 1/24/24 from 8:00 a.m. though 1:30 p.m., R55 was observed in his room with nails the same length, still uncut. During observation and interview on 1/24/24 at 1:24 p.m. registered nurse (RN)-A asked R55 what he felt about his finger nails, to which R55 stated "yeah, they are pretty long. I normally have them cut a lot shorter than they are now." RN-A informed R55 she would have one of the nursing assistants come down clip and file his nails. RN-A stated the facility staff should be performing nail care after a resident's shower or bath. R101's admission Minimum Data Set (MDS) dated 1/01/24, identified R101 was severely cognitively impaired, and required partial to moderate assistance with activities of daily living.	F 677	and groomed to their preference, also to ensure a personal razor is available for routine use. Measures or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur: The Morning and Evening Cares Policy and Procedure and Bathing Policy and Procedure was reviewed and revised. All nursing staff will be educated on routine personal hygiene care specific to fingernail care and shaving. Nursing staff who are responsible for the admission process will be educated on discussing fingernail care and facial hair preferences with all residents upon admission. Social services staff will be educated on the updated policy and procedure. Training and re-education will be provided to all nursing and social services staff beginning February 2024 and will be completed by the completion date. How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is Being Corrected and Will Not Recur: DON, ADON, or designee will complete 8 random audits on residents' fingernail care monthly X 4 months beginning February 2024. Director of Social Services or designee will complete 8 random audits on male residents' facial hair monthly X 4 months beginning February 2024. These audits	

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F 677	Continued From page 7 R101 had the primary diagnosis of cerebral infarction due to embolism of the left cerebral artery (stroke). R101's last documented ADLs Care Area Assessment (CAA) dated 1/05/24, documented R101 had concerns with a change in cognitive status, communication issues, a decline in mood and vision problems. These included physical coordination, balance and visual impairments. R101's care plan last revised 1/15/24, identified R101 had an ADL self-care deficit due to functional mobility, "At times, resident may require assistance that is not at their usual performance". R101's care plan further documented, under the approach of "Personal Hygiene", R55 was partial/moderate assist. During observation and interview on 1/22/24 at 3:34 p.m., R101 was observed to have an unkept/untrimmed beard, from ear to ear and down all sides of his neck. When R101 was asked if he preferred his facial hair long and down his neck, R101 stated "No". When asked if he had been offered to have it shaved, R101 stated "No". Although R 101 answered surveyor's interview questions reasonably appropriately, due to the facility's assessment of R101 being severely cognitively impaired, and telephone interview was performed on 1/22/24 at 5:40 p.m. During the telephone interview family member (FAM)-A stated R101 was admitted to the facility on 12/26/23 after being hospitalized for stroke. FAM-A stated while R101 was in the hospital, staff there did not shave resident. FAM-A stated during the nursing home admission process, life	F 677	will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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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 677	Continued From page 8 preferences were asked, however, not in regards to shaving. FAM-A stated, R101 would not be upset/embarrassed, however R101 has never had more that a 2-3 day facial stubble before shaving. FAM-A stated no one from the facility had reached out to him in regards to R101's facial hair preference. FAM-A is unaware if family had brought a shaver in for R101's use. During morning care observation on 1/24/24 at 7:42 a.m., nursing assistant (NA)-A was setting R101 up with a prepared wash cloth and towel, with which R101 was able to wash and dry face with verbal cueing. Once dressed, NA-A transferred R101 from bed to wheel chair (wc) with use of a transfer belt and standard walker. NA-A informed resident she would be setting him up in the bathroom to brush his teeth. After R101 finished brushing his teeth, resident looked in the mirror and stated, "are you going to shave me?" NA-A stated, "I didn't know you wanted to be shaved. Do you want it trimmed?" R101 stated, "It just looks wrong." NA-A stated they would look at that after breakfast, and then wheeled R101 from his room to the dining area. During an interview on 1/24/24 at 8:02 a.m., NA-A was asked about the conversation she and R101 had in regards to shaving. NA-A stated, "No, he has never asked me that before. He has been here for several weeks and this is the first time I have heard him asked to be shaved." When asked if she would be shaving R101 after breakfast, NA-A stated, "I don't think I will, until I ask his family first." In an observation and interview on 1/24/24 at 1:35 p.m., registered nurse (RN)-A asked R101 about the facial hair and how he feels about it.	F 677		

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	245427	A. BUILDING _____ B. WING _____	C 01/24/2024

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F 677	Continued From page 9 R101 stated "are you going to shave it?" RN asked "[R101], what is your preference on your beard and mustache?" R101 responded, "I really only want stubble." RN informed R101 she would have someone to help him. After leaving the room, RN-A stated social services covers life preferences (i.e.: grooming preferences) at the time of admission. During an interview on 1/24/24 at 2:52 p.m., social services representative (SS)-A stated they normally do not bring up the shaving during admission process, stating "If we see they have a toiletry bag, we will asked. Sometime we will bring it up on women, but rarely the men, or if family brings it up." SS-A further stated with R101's cognitive status at the time of admission, the facility maybe should have covered with family or when the family brought it up. In review of the facility's policy, entitled: Morning and Evening Cares Policy and Procedure (last revised 2/2020), instructed facility direct care staff, under Morning cares: "8. Assist resident with shaving as needed. Performed with an electric razor, shaving is part of the male's usual daily care and female's care as needed if applicable. Besides reducing bacterial growth on the face, shaving promotes resident comfort by removing whiskers that can itch and irritate the skin and produces an unkempt appearance." This policy did not mention or document the frequency of providing resident nailcare.	F 677		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		2/23/24

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F 761	Continued From page 10 §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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 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 oberservation, interview and document review, the facility failed to ensure medication carts were properly secured for 2 of 4 medication carts located outside of the locked unit. Findings include: On 1/22/24, at 6:50 p.m. D hall medication cart was observed sitting across from nursing office unlocked with keys hanging from second drawer on left side of cart. No staff member was located	F 761	Corrective Action for Residents Affected by Deficient Practice: Re-education provided to all nursing staff to ensure medications are properly secured. Identification of Other Residents Having the Potential to be Affected by Deficient Practice: A facility audit will be completed on all medication carts and cubbies to ensure all	

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F 761	Continued From page 11 in the area. On 1/22/24, at 6:53 p.m. trained medication aide (TMA)-A returned to the cart. When interviewed TMA-A stated he had left the keys in the lock, he should have locked the cart and taken the keys with so nobody could get into the narcotic drawer. On 1/23/24 at 2:58 p.m. observed G/H hall cart unattended and unlcoked. Five residents went past cart but did not attempt to open the cart. At 1/23/24, 3:08 p.m. a unidentified male staff member approached cart, obtained straw from top of cart, cart remained unlocked. At 1/23/24, at 3:11 p.m. regisetered nurse (RN)-B approached medication cart, moved down the hallway. When interviewed RN-B stated he was not aware the cart was unlocked, stated there was a good policy on locking the carts and he tried to do good. During interview on 1/24/24, at 2:06 p.m. director of nursing (DON) stated expectation was to lock medication carts when walking away from the cart or going out of view to prevent potential of others getting in to the cart. Facility policy Administration of Medications dated 4/23 indicated all drugs must be stored in locked compartments. Facility policy Pharmacy Services dated 9/21 indicated Controlled medications are stored under double lock. The medication nurse maintains posession of the key.	F 761	drugs are properly secured. Measures or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur: The The Administration of Medications and the Pharmacy Services policies were reviewed and revised. Training and re-education will be provided to all staff responsible for passing medications beginning February 2024 and will be completed by completion date. How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is Being Corrected and Will Not Recur: DON, ADON, or designee will complete 8 random monthly audits X 4 months beginning February 2024 to ensure all medications are properly secured. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	
F 851 SS=F	Payroll Based Journal	F 851		2/23/24

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F 851	Continued From page 12 CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including,	F 851		

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F 851	Continued From page 13 but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 4), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include: Payroll Based Journal (PBJ) Casper Report 1705 identified the following dates triggered: 9/2/23, 9/3/23, 9/4/23, 9/9/23, 9/10/23, 9/15/23, 9/16/23, 9/17/23, 9/23/23, 9/24/23 and 9/30/23 for failure to have licensed nurse coverage 24 hours per day.	F 851	Corrective Action for Residents Affected by Deficient Practice: Facility identified root cause of September PBJ reporting error, and immediately re-submitted September PBJ reporting. Identification of Other Residents Having the Potential to be Affected by Deficient Practice: All residents had the potential to be affected by deficient practice, corrective action was addressed in section above. Measures or Systemic Changes Made to	

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F 851	Continued From page 14 Daily staff schedules on the above-mentioned dates identified licensed nursing staff including registered nurses had worked and therefore the data submitted in the PBJ to CMS was inaccurate. During interview on 1/23/23 at 12:23 p.m., administrator stated financial director submits the information for the PBJ reporting. Administrator stated the financial director, who was responsible for submitting data, was not available for interview on this date. Administrator confirmed that the information that was submitted for fiscal year Quarter 4 2023 was inaccurate. A facility policy was requested and was not received.	F 851	Ensure the Deficient Practice Will Not Recur: PBJ reporting process has been re-assigned to Payroll and Benefits Specialist and Director of HR. Payroll and Benefits Specialist will submit accurate data in uniform format specified by CMS by required deadline. Director of HR will review data format and accuracy prior to the required deadline. Re-education on the CMS PBJ reporting requirements will be provided to all staff who are responsible for PBJ reporting process beginning February 2024 and will be completed by completion date. Facility PBJ reporting policy was created and implemented and will be reviewed annually. How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is Being Corrected and Will Not Recur: Administrator will audit CMS PBJ reporting for the next four quarters. This data will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 921		2/23/24

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F 921	Continued From page 15 by: Based on observation, interview and document review, the facility failed to provide a safe and sanitary environment. This had the potential to affect all 186 residents. During observations in the facility kitchen on 01/22/24 at 11:18 a.m., seven of fourteen exhaust hood filter panels were noted to have areas of one quarter to one-inch-thick grease imbedded with dust hanging over a double convection oven, a stationary kettle filled with water and no lid as well as a 2-burner natural gas stock pot range. When interviewed on 1/22/24 at 11:30 a.m., the dietary manager (DM) stated cleaning of the exhaust hood filter panels was done monthly or when needed by maintenance and provided a document entitled Main Kitchen Hood Cleaning 2023 with staff initials and last dated 12/19/23. When interviewed on 01/22/24 at 1:40 p.m., the maintenance director (MD) stated the exhaust hood filter panels "looked hairy" and had last been cleaned 12/19/23. The MD stated normally maintenance would remove the panels, degrease, and run them through the dishwasher The MD agreed they should have been cleaned sooner but the maintenance department had been busy with the facility new construction. When interviewed on 1/24/24 at 9:30 a.m., the DM stated the panels had been "looking pretty bad a couple of weeks ago" and had verbally communicated the need for cleaning to the MD because sometimes the panels get greasy and dusty more quickly requiring more frequent cleaning than monthly. The DM stated it was important to keep the exhaust hood filter panels	F 921	Corrective Action for Residents Affected by Deficient Practice: Exhaust hood filter panels were cleaned on 1/22/24 after staff were made aware by MDH. Identification of Other Residents Having the Potential to be Affected by Deficient Practice: Identified range hood is the only range hood in main kitchen. A facility audit of all neighborhood range hoods for cleanliness will be completed. Measures or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur: Facility policy Cleaning Guidelines and Main Kitchen Hood Cleaning checklist was reviewed and revised. Training and re-education will be provided to all facility staff responsible for cleaning exhaust hood filter panels beginning February 2024 and will be completed by February 23rd 2024. How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is Being Corrected and Will Not Recur: Culinary Director or designee will complete 8 random audits to ensure exhaust hood filter panels are clean monthly X 4 months beginning February 2024. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been obtained.	

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F 921	Continued From page 16 clean to prevent fires, and to keep dust from falling into food during preparation. The facility policy Cleaning Guidelines dated 7/2023, identified "The hood filters are a part of the maintenance asset maintenance schedule" and outlined the procedure for cleaning them.	F 921		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 2, 2024

Administrator
Bethesda
901 Southeast Willmar Avenue
Willmar, MN 56201

Re: State Nursing Home Licensing Orders
Event ID: 3PX111

Dear Administrator:

The above facility was surveyed on January 22, 2024 through January 24, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Nikki Stassen, BSN, RN
Regional Operations Supervisor
St. Cloud Team A
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: Nicole.Sassen@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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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: On 1/22/24 thru 1/24/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey and NO licensing orders were issued. H#: H54278871C / MN#: MN00098865 H#: H54278872C / MN#: MN00098294 H#: H54278876C / MN#: MN00097816 H#: H54278877C / MN#: MN00097205 H#: H54278875C / MN#: MN00097210 H#: H54278874C / MN#: MN00095892 H#: H54278927C / MN#: MN00094392 H#: H54278870C / MN#: MN00090463 H#: H54278869C / MN#: MN00090326 H#: H54278895C / MN#: MN00097462 and MN#: MN00097385 H#: H54278873C / MN#: MN00094544 H#: H54278868C / MN#: MN00090822 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing	2 000		

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2 000	Continued From page 2 orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene care (i.e., nail care, shaving)	2 920	"Corrected"	2/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00792	A. BUILDING: _____ B. WING _____	C 01/24/2024

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BETHESDA	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

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2 920	Continued From page 3 was provided for 2 of 3 residents (R55 and R101) reviewed for activities of daily living (ADLs) and who was dependent on staff for their daily care and grooming needs. Findings include: R55's significant change Minimum Data Set (MDS) dated 12/19/23, identified R55 was cognitively intact, and was independent with activities of daily living (i.e., nail care). R55's Admission Record (face sheet) listed primary diagnosis of hepatic encephalopathy (advanced liver dysfunction) and malignant neoplasm of right breast. R55's last documented ADLs Care Area Assessment (CAA) dated 11/13/23, documented only the following: "Maintain current level of functioning". R55's care plan last revised 12/28/23, identified R55 had an ADL self-care deficit due to weakness, liver cirrhosis, and cancer. R55's care plan further documented under the approach of "Grooming", R55 was independent and "prefers to have beautician/barber to maintain facial hair". During observation and interview of R55 on 1/22/24 at 3:19 p.m., resident was lying in bed watching TV. R55 was noted to have a full beard from ear to ear and down his neck. It was also noted R55's finger nails on both hands / all fingers were long. R55's finger nails appeared to be between 1/8 inches (in) to approximately 1/4 in on residents thumbs and index fingers. R55 stated he has a barber keep his beard trimmed when he has his hair cut. R55 stated he used to keep his own nails trimmed, however does not have nail trimmers to do so. When asked if staff	2 920		

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2 920	Continued From page 4 have offered to trim them for him, R55 stated "no". During multiple observations on 1/23/24 from 8:00 a.m. through 5:00 p.m. and 1/24/24 from 8:00 a.m. though 1:30 p.m., R55 was observed in his room with nails the same length, still uncut. During observation and interview on 1/24/24 at 1:24 p.m. registered nurse (RN)-A asked R55 what he felt about his finger nails, to which R55 stated "yeah, they are pretty long. I normally have them cut a lot shorter than they are now." RN-A informed R55 she would have one of the nursing assistants come down clip and file his nails. RN-A stated the facility staff should be performing nail care after a resident's shower or bath. R101's admission Minimum Data Set (MDS) dated 1/01/24, identified R101 was severely cognitively impaired, and required partial to moderate assistance with activities of daily living. R101 had the primary diagnosis of cerebral infarction due to embolism of the left cerebral artery (stroke). R101's last documented ADLs Care Area Assessment (CAA) dated 1/05/24, documented R101 had concerns with a change in cognitive status, communication issues, a decline in mood and vision problems. These included physical coordination, balance and visual impairments. R101's care plan last revised 1/15/24, identified R101 had an ADL self-care deficit due to functional mobility, "At times, resident may require assistance that is not at their usual performance". R101's care plan further documented, under the approach of "Personal	2 920		

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2 920	Continued From page 5 Hygiene", R55 was partial/moderate assist. During observation and interview on 1/22/24 at 3:34 p.m., R101 was observed to have an unkept/untrimmed beard, from ear to ear and down all sides of his neck. When R101 was asked if he preferred his facial hair long and down his neck, R101 stated "No". When asked if he had been offered to have it shaved, R101 stated "No". Although R 101 answered surveyor's interview questions reasonably appropriately, due to the facility's assessment of R101 being severely cognitively impaired, and telephone interview was performed on 1/22/24 at 5:40 p.m. During the telephone interview family member (FAM)-A stated R101 was admitted to the facility on 12/26/23 after being hospitalized for stroke. FAM-A stated while R101 was in the hospital, staff there did not shave resident. FAM-A stated during the nursing home admission process, life preferences were asked, however, not in regards to shaving. FAM-A stated, R101 would not be upset/embarrassed, however R101 has never had more that a 2-3 day facial stubble before shaving. FAM-A stated no one from the facility had reached out to him in regards to R101's facial hair preference. FAM-A is unaware if family had brought a shaver in for R101's use. During morning care observation on 1/24/24 at 7:42 a.m., nursing assistant (NA)-A was setting R101 up with a prepared wash cloth and towel, with which R101 was able to wash and dry face with verbal cueing. Once dressed, NA-A transferred R101 from bed to wheel chair (wc) with use of a transfer belt and standard walker. NA-A informed resident she would be setting him up in the bathroom to brush his teeth. After R101	2 920		

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2 920	Continued From page 6 finished brushing his teeth, resident looked in the mirror and stated, "are you going to shave me?" NA-A stated, "I didn't know you wanted to be shaved. Do you want it trimmed?" R101 stated, "It just looks wrong." NA-A stated they would look at that after breakfast, and then wheeled R101 from his room to the dining area. During an interview on 1/24/24 at 8:02 a.m., NA-A was asked about the conversation she and R101 had in regards to shaving. NA-A stated, "No, he has never asked me that before. He has been here for several weeks and this is the first time I have heard him asked to be shaved." When asked if she would be shaving R101 after breakfast, NA-A stated, "I don't think I will, until I ask his family first." In an observation and interview on 1/24/24 at 1:35 p.m., registered nurse (RN)-A asked R101 about the facial hair and how he feels about it. R101 stated "are you going to shave it?" RN asked "[R101], what is your preference on your beard and mustache?" R101 responded, "I really only want stubble." RN informed R101 she would have someone to help him. After leaving the room, RN-A stated social services covers life preferences (i.e.: grooming preferences) at the time of admission. During an interview on 1/24/24 at 2:52 p.m., social services representative (SS)-A stated they normally do not bring up the shaving during admission process, stating "If we see they have a toiletry bag, we will asked. Sometime we will bring it up on women, but rarely the men, or if family brings it up." SS-A further stated with R101's cognitive status at the time of admission, the facility maybe should have covered with family or when the family brought it up.	2 920		

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2 920	Continued From page 7 In review of the facility's policy, entitled: Morning and Evening Cares Policy and Procedure (last revised 2/2020), instructed facility direct care staff, under Morning cares: "8. Assist resident with shaving as needed. Performed with an electric razor, shaving is part of the male's usual daily care and female's care as needed if applicable. Besides reducing bacterial growth on the face, shaving promotes resident comfort by removing whiskers that can itch and irritate the skin and produces an unkempt appearance." This policy did not mention or document the frequency of providing resident nailcare. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.	21610		2/23/24

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21610	Continued From page 8 This MN Requirement is not met as evidenced by: Based on oberservation, interview and document review, the facility failed to ensure medication carts were properly secured for 2 of 4 medication carts located outside of the locked unit. Findings include: On 1/22/24, at 6:50 p.m. D hall medication cart was observed sitting across from nursing office unlocked with keys hanging from second drawer on left side of cart. No staff member was located in the area. On 1/22/24, at 6:53 p.m. trained medication aide (TMA)-A returned to the cart. When interviewed TMA-A stated he had left the keys in the lock, he should have locked the cart and taken the keys with so nobody could get into the narcotic drawer. On 1/23/24 at 2:58 p.m. observed G/H hall cart unattended and unlcoked. Five residents went past cart but did not attempt to open the cart. At 1/23/24, 3:08 p.m. a unidentified male staff member approached cart, obtained straw from top of cart, cart remained unlocked. At 1/23/24, at 3:11 p.m. regisetered nurse (RN)-B approached medication cart, moved down the hallway. When interviewed RN-B stated he was not aware the cart was unlocked, stated there was a good policy on locking the carts and he tried to do good. During interview on 1/24/24, at 2:06 p.m. director of nursing (DON) stated expectation was to lock medication carts when walking away from the cart	21610	"Corrected"	

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21610	Continued From page 9 or going out of view to prevent potential of others getting in to the cart. Facility policy Administration of Medications dated 4/23 indicated all drugs must be stored in locked compartments. Facility policy Pharmacy Services dated 9/21 indicated Controlled medications are stored under double lock. The medication nurse maintains posession of the key. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on medication storage on mobile carts; then provide education to direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21610		
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 a safe and sanitary environment. This had the potential to affect all 186 residents. During observations in the facility kitchen on 01/22/24 at 11:18 a.m., seven of fourteen exhaust	21665	"Corrected"	2/23/24

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21665	Continued From page 10 hood filter panels were noted to have areas of one quarter to one-inch-thick grease imbedded with dust hanging over a double convection oven, a stationary kettle filled with water and no lid as well as a 2-burner natural gas stock pot range. When interviewed on 1/22/24 at 11:30 a.m., the dietary manager (DM) stated cleaning of the exhaust hood filter panels was done monthly or when needed by maintenance and provided a document entitled Main Kitchen Hood Cleaning 2023 with staff initials and last dated 12/19/23. When interviewed on 01/22/24 at 1:40 p.m., the maintenance director (MD) stated the exhaust hood filter panels "looked hairy" and had last been cleaned 12/19/23. The MD stated normally maintenance would remove the panels, degrease, and run them through the dishwasher The MD agreed they should have been cleaned sooner but the maintenance department had been busy with the facility new construction. When interviewed on 1/24/24 at 9:30 a.m., the DM stated the panels had been "looking pretty bad a couple of weeks ago" and had verbally communicated the need for cleaning to the MD because sometimes the panels get greasy and dusty more quickly requiring more frequent cleaning than monthly. The DM stated it was important to keep the exhaust hood filter panels clean to prevent fires, and to keep dust from falling into food during preparation. The facility policy Cleaning Guidelines dated 7/2023, identified "The hood filters are a part of the maintenance asset maintenance schedule" and outlined the procedure for cleaning them. The administrator or designee, could educate	21665		

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21665	Continued From page 11 staff regarding the importance of a safe and clean environment. The administrator or designee, could coordinate with dietary and maintenance to conduct periodic audits of the kitchen and eqipment to ensure a safe and clean environment is maintained to the extent possible. The period for correction is twenty-one (21) days.	21665		

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	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/23/2024**

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BETHESDA	**901 SOUTHEAST WILLMAR AVENUE** **WILLMAR, MN 56201**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/23/2024. At the time of this survey, Building 01 of Bethesda Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/09/2024

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 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building 01 of Bethesda Nursing Home is a one-story building with a full basement that was constructed as type II (111) in 1979. In 1994 two gazebos of type II (111) construction were added to the original building at the common areas adjacent to the east and west resident wings. In 1999 a link was constructed between the memory care wings, which was constructed as type II (111). In 2014	K 000		

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K 000	Continued From page 2 two additions were added off the south ends of the two North/South wings that were constructed as type V (111), one was a six-bed addition, and the other was a dining area, and one 36 bed single story with a partial basement of type V (111) was added on the east end. Due to the lack of a 2-hour fire barrier between the two types of construction, building 01 was downgraded to a Type V (111) as allowed by NFPA 101 (12) section 8.2.1.3 (3). The building is fully sprinkled per NFPA 13 and has a fire alarm system with smoke detectors in the corridors and spaces open to the corridors. The facility has a capacity of 244 beds and had a census of 186 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an egress corridor per NFPA 101 (2012 edition), Life Safety Code, section 7.1.10.1. This deficient finding could have a widespread impact on the residents within the facility.	K 211	Corrective Action for The Deficiency: All items stored in the egress corridor in F hall has been removed to ensure egress is free of all obstructions. Measures to Ensure the Deficiency does not Recur: Training and re-education on	2/23/24

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K 211	Continued From page 3 Findings include: On 01/23/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that wheeled equipment, resident beds, furnishings from resident rooms and other items were being stored in the egress corridor in F Hall. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 211	keeping egress free of all obstructions will be provided to all staff. How Facility will Monitor Performance to Ensure Solutions are Sustained: Facility Director and Administrator will complete weekly audits for 4 months beginning in February of 2024 of E & F halls to ensure egress is free of all obstructions monthly. Name and Title of Person Responsible for Correction and Monitoring to Prevent Recurrence: Ross Brandt, Facilities Director and Baillee Krieger, Administrator	
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings	K 223	Corrective Action for The Deficiency: All combustible supplies will be removed from rooms 410, 414, 415, 416, 417, 419, and 420.	2/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE** **WILLMAR, MN 56201**

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K 223	Continued From page 4 could have a widespread impact on the residents within the facility. Findings include: On 01/23/2024 between 9:00am and 1:00pm, it was revealed by observation that the following rooms were being used for storage of combustible supplies and did not have self-closing devices on the doors: rooms 410, 414, 415, 416, 417, 419, and 420. An interview with Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 223	Measures to Ensure the Deficiency does not Recur: Training and re-education on not storing combustible supplies in resident rooms will be provided to all staff. How Facility will Monitor Performance to Ensure Solutions are Sustained: Facility Director and Administrator will complete weekly audits for 4 months beginning in February of 2024 of E & F hall resident rooms to ensure combustible supplies are not stored. Name and Title of Person Responsible for Correction and Monitoring to Prevent Recurrence: Ross Brandt, Facilities Director and Baillee Krieger, Administrator	
K 918 SS=B	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start	K 918		2/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

(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
K 918	Continued From page 5 and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test their Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.4, 8.3.4.1, 8.4.1, 8.4.9, 8.4.9.1, and 8.4.9.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/23/2024 between 09:00 AM and 1:00 PM, it was revealed by a review of available documentation and an interview with the Maintenance Director that the weekly generator checks for the month of April 2023 had incorrect dates making it appear that weekly checks were	K 918	Corrective Action for The Deficiency: Facilities Director immediately reviewed emergency generator testing documentation after identified by State Fire Marshal to identify root cause of concern. Emergency generator testing record has been updated to reflect accurate dates. Emergency generator testing documentation was reviewed for other buildings. All documentation was reflected accurately and confirmed weekly generator checks were completed. Measures to Ensure the Deficiency does not Recur: Training and re-education will be provided to all staff responsible for emergency generator testing on procedure and accurate documentation beginning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE** **WILLMAR, MN 56201**

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K 918	Continued From page 6 not conducted during that month. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 918	February 2024 and will be completed by completion date. How Facility will Monitor Performance to Ensure Solutions are Sustained: Administrator will audit both generator books monthly X 4 months beginning February 2024. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained. Name and Title of Person Responsible for Correction and Monitoring to Prevent Recurrence: Ross Brandt, Facilities Director and Baillee Krieger, Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **02 - MEMORY UNIT** B. WING _____	**01/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

(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
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/23/2024. At the time of this survey, Building 02 of Bethesda Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 02/09/2024

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
	245427	A. BUILDING **02 - MEMORY UNIT** B. WING _____	**01/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

(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
K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building 02 of Bethesda Nursing Home consists of one structure of type II (111) construction that was added on in 2014. It is a three-story 84-bed unit that is separated from the original building by a 2-hour fire barrier. The building is fully sprinkled and has a fire alarm system with smoke detectors in the resident rooms, corridors, and spaces open to the corridors.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **02 - MEMORY UNIT** B. WING _____	**01/23/2024**

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BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

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K 000	Continued From page 2 The facility has a capacity of 244 beds and had a census of 186 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order	K 923		2/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **02 - MEMORY UNIT** B. WING _____	**01/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 923	Continued From page 3 of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2 and 11.6.5.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/23/24 between 09:30 AM and 12:30 PM, it was revealed by observation that the oxygen cylinders being stored in the oxygen room located on the first floor south oxygen room did not have the empty cylinders segregated from full cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	Corrective Action for The Deficiency: Oxygen cylinders on 1S were segregated by full and empty cylinders on 1/23/24 when staff were made aware by State Fire Marshal. Measures to Ensure the Deficiency does not Recur: Training and re-education on oxygen cylinder segregation will be provided to all nursing staff who would manage oxygen cylinders beginning February 2024 and will be completed by completion date. Education will be provided to oxygen vendors on appropriate amount of oxygen cylinders that can be stored in each area. How Facility will Monitor Performance to Ensure Solutions are Sustained: Director of Nursing or designee will complete 8 random audits to ensure oxygen cylinders are segregated monthly X 4 months beginning February 2024. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been obtained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **02 - MEMORY UNIT** B. WING _____	**01/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

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K 923	Continued From page 4	K 923	Name and Title of Person Responsible for Correction and Monitoring to Prevent Recurrence: Director of Nursing, Crystal Moran	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **03 - CHAPEL EXPANSION/15 BED ADDITION** B. WING _____	**01/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/23/2024. At the time of this survey, Bethesda Nursing Home Building 03 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Building 03 of Bethesda Nursing Home is a 100 square foot chapel expansion and a raised ceiling constructed in 2018 as a Type V (111). In 2023 a 15-bed addition and remodel that added two neighborhood kitchens was completed and is constructed as a Type V (111). The building is fully sprinkled per NFPA 13 and has a fire alarm system with smoke detectors in the corridors and spaces open to the corridors. The facility has a capacity of 244 beds and had a census of 186 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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