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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5LSC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00167

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

2.STATE VENDOR OR MEDICAID NO.
(L2) **936670200**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/04/2012**

6. DATE OF SURVEY **08/22/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Mandatory Denial of Payment for New Admissions (DoPNA) is rescinded, effective 08/22/2014.

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 08/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 08/29/2014 (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
09/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/29/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5578

Electronically Delivered: August 29, 2014

Mr. Jon Sondegaard, Administrator
Bethany Care Center
2309 Hayes Street Northeast
Minneapolis, Minnesota 55418

Dear Mr. Sondegaard:

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 August 18, 2014, the above facility is certified for:

56 - Skilled Nursing Facility/Nursing Facility Beds
10 - Nursing Facility II Beds

Your facility's Medicare approved area consists of all 66 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: August 29, 2014

Mr. Jon Sondegaard, Administrator
Bethany Care Center
2309 Hayes Street Northeast
Minneapolis, Minnesota 55418

RE: Project Number S5578024

Dear Mr. Sondegaard:

On August 8, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 13, 2014. (42 CFR 488.422)

On August 8, 2014 this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 5, 2014. (42 CFR 488.417 (b))

Additionally, it was recommended to the CMS Region V Office that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 5, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on June 5, 2014 and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on July 22, 2014. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On August 22, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on July 22, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 18, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 22, 2014, as of August 22, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 22, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of August 8, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 5, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 5, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 5, 2014, is to be rescinded.

In our letter of August 8, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 5, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 22, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 08/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F000	INITIAL COMMENTS An onsite resurvey was conducted on August 22, 2014, to determine compliance with Federal deficiencies issued during a post recertification survey exited on July 22, 2014. The facility was found to have no deficienices.	F000		

(X5) COMPLETE DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Electronically Signed 8/29/14	08/29/2014

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 08/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2000	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 August 22, 2014, surveyors of this Department's staff visited the above provider and all orders issued on the re-survey exited July 22, 2014, were determined to be corrected. Please refer to the State Form (CMS2567B) for status of the corrected orders.	2000		

Minnesota Department of Health	TITLE	(X6) DATE
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Electronically Signed	08/29/2014

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
245578	A. Building B. Wing	8/22/2014

Name of Facility	Street Address, City, State, Zip Code
BETHANY CARE CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**08/22/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	**08/22/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	08/28/2014	32982	08/22/2014
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
6/5/2014	

AH Form Approved
8/28/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00167	A. Building B. Wing	8/22/2014

Name of Facility	Street Address, City, State, Zip Code
BETHANY CARE CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. LSC	08/22/2014	ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. LSC	08/22/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	08/28/2014	32982	08/22/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/5/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5LSC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00167

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

2.STATE VENDOR OR MEDICAID NO.
(L2) **936670200**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/04/2012**

6. DATE OF SURVEY **07/21/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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: **X** * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Mandatory Denial of Payment for New Admissions (DoPNA) is effective 09/05/2014

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 08/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 08/19/2014 (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
09/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/29/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5392

August 8, 2014

Mr. Jon Sondegaard, Administrator
Bethany Care Center
2309 Hayes Street Northeast
Minneapolis, MN 55418

RE: Project Number S5578024

Dear Mr. Sondegaard:

On June 24, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on June 5, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On July 22, 2014, the Minnesota Department of Health and on July 24, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on June 5, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our extended survey, completed on June 5, 2014. The deficiencies not corrected are as follows:

F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

In addition, at the time of this revisit, we identified the following deficiency:

F0280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required.

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

- State Monitoring effective August 13, 2014. (42 CFR 488.422)

Additionally, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 13, 2014.

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

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 5, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

- Include signature of provider and date.

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

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

Failure to submit an acceptable PoC 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 PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 5, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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
245578	A. Building B. Wing	7/22/2014

Name of Facility	Street Address, City, State, Zip Code
BETHANY CARE CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **07/22/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **07/22/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **07/22/2014**	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	GD/AK	08/08/2014	32982	07/22/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/5/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245578	A. Building B. Wing **01 - BETHANY COVENANT HOME**	7/24/2014

Name of Facility	Street Address, City, State, Zip Code
BETHANY CARE CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0017	**07/18/2014**	ID Prefix Reg. # **NFPA 101** LSC K0144	**07/18/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	08/08/2014	28120	07/24/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/4/2014

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00167	A. Building B. Wing	7/22/2014

Name of Facility	Street Address, City, State, Zip Code
BETHANY CARE CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

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 **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **07/22/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **07/22/2014**	ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **07/22/2014**
ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **07/22/2014**	ID Prefix **21025** Reg. # **MN Rule 4658.0615** LSC	Correction Completed **07/22/2014**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	Correction Completed **07/22/2014**
ID Prefix **21565** Reg. # **MN Rule 4658.1325 Subp.** LSC	Correction Completed **07/22/2014**	ID Prefix **21610** Reg. # **MN Rule 4658.1340 Subp.** LSC	Correction Completed **07/22/2014**	ID Prefix **21665** Reg. # **MN Rule 4658.1400** LSC	Correction Completed **07/22/2014**
ID Prefix **23010** Reg. # **MN Rule 4658.4635 A** LSC	Correction Completed **07/22/2014**	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	GD/AK	08/08/2014	32982	07/22/2014
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
6/5/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 07/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A post certification revisit was conducted by the Minnesota Department of Health on July 21 through July 22, 2014. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable 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}	This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute deficiency, or that the scope and severity regarding the deficiency are correctly applied. Please accept this Plan of Correction as our credible allegation of compliance. Our compliance will be achieved by the date identified on the Plan of Correction.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	POC accepted as of 8/21/14	

RECEIVED
AUG 18 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	8/13/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 07/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was revised with an intervention which had been developed to prevent skin breakdown for 1 of 3 residents (R5) reviewed for the development of a stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). Findings include: R5 was observed on 7/22/14, at 9:23 a.m. dressed and with a pair of white tennis shoes on. R5 was seated in his wheelchair (W/C) in the dining room (DR) table eating breakfast with staff seated next to him assisting. -At 9:56 a.m. observed R5 still in the DR at the table facing the window then propelled himself around and faced the television across the room still observed wearing a pair of white tennis shoes no footrest on W/C at the time. - At 10:00 a.m. R5 was observed participating in a sing a long activity continued to move his feet back and forth on the same spot. -At 10:23 a.m. observed nursing assistant (NA)-A and another nursing assistant going in R5's room with a Hoyer lift (mechanical lift used for transferring) and shut the door. -At 10:25 R5 was observed lying in bed as both NA's repositioned R5 and removed the lift sheet then NA-A took R5's shoes and socks off. -At 10:27 a.m. licensed practical nurse (LPN)-A was observed checking both R5's feet and indicated R5's left foot second, third and fourth toes had scabs were getting smaller down the	F 280	Assignment sheet, care plan and NAR's all informed regarding changes in resident's care to make sure that he does not wear shoes at any time. Sign also placed at bed and wife updated and did remove all shoes from room. Added nursing order on treatment sheets that LN check q shift that resident does not have shoes on. Audit of treatment sheet, care plan and NAR sheet will be done weekly for 12 weeks. Then monthly for 3 months. DON, ADON and MDS Coordinator to monitor. Date of Completion: 8/18/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 07/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 280	Continued From page 2 toes. LPN-A then looked at the left great toe which appeared slightly raised and had a soft bulgy tissue on top of area, slightly red and appeared to have fluid and indicated it was a fluid filled blister asked surveyor to touch area. LPN-A stated usually when R5 was starting to have skin issues on his toes it started with a blister and he was going to update the provider on the skin concern. LPN-A then looked at R5's right foot second toe and stated he had two pinpoint scabs to the side and the scab on the same hammer toe stated "Not so dark as the other scabs" surrounding area was pink and intact. When interviewed on 7/22/14, at 10:07 a.m. NA-A stated she had given R5 a bed bath that morning and had gotten R5 up to his W/C around 8:30 a.m. right before breakfast. NA-A verified R5 was wearing white tennis shoes. When asked if R5 was not supposed to wear the shoes NA-A stated "I don't think so" as she verified looking through the NAR List #5 dated 7/18/14, did not address R5 was not supposed to wear shoes as ordered. The Pressure Ulcer Care Area Assessment (CAA) dated 1/23/14, indicated R5 was at risk for pressure ulcers. In addition, the activities of daily living (ADL) CAA indicated R5 required extensive assist with bed mobility, transfers, W/C propelling, dressing, and personal hygiene. R5's diagnoses included Parkinson's, paralysis agitans and osteoporosis obtained from the quarterly Minimum Data Set (MDS) dated 4/16/14. The MDS indicated R5 was at risk for pressure ulcers, had unhealed pressure ulcer stage one or higher which was unstageable, had eschar (black, brown or tan tissue that adheres firmly to the wound bed or ulcer edges) and R5	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 07/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 3 had an ulcer care treatment. In addition, the MDS indicated R5 required extensive physical assist of one staff for dressing and personal hygiene. Additionally, R5's MDS Brief Interview of Mental Status (BIMS-tool used to measure cognition) was seven which indicated severe cognitive impairment. Care plan dated 1/24/14, identified R5 was at risk for skin breakdown related to impaired mobility. Care plan goal "[R5] will not develop any skin breakdown." Care plan directed daily observation by NA's during cares, complete skin assessment weekly by licensed nurse and dressing changes to open areas on toes until healed. The care plan did not indicate R5 was not supposed to wear shoes to keep pressure off his toes. Podiatry Visit note dated 4/4/14, identified R5 had acquired deformity of toe, peripheral vascular disease (PVD), bunion, callus and difficulty walking. Treatment Notes indicated " Patient is advised to follow up in 9-10 weeks or as needed. I recommend [Discontinue] D/C [patient] pt wearing shoes, to take pressure off top toes ..." Physician order dated 7/8/14, indicated "NO SHOES ON- Need to take pressure off top of toes." Bethany Care Center Weekly Skin Checklist dated 7/15/14, indicated R5 had dry scabbed areas to both feet with toes circled and had an open lesion on his abdomen. The Checklist dated 7/8/14, indicated R5 had dark scabs on toes and open area on his abdomen. Copy of Investigative Skin Flowsheet Updated dated 7/15/14, indicated R5's right second toe	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 07/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 4 had healed, left second toe was unstageable , wound bed was covered with 100% scab; area was healing with peri-wound healthy; left third toe was healed; left fourth toe remained healed and left outer ankle remained healed. In addition the Flowsheet indicated all areas continued to improve and "resident no longer wears shoes and this has been helpful to assist in healing and resident will continue to wear only socks. " When interviewed on 7/22/14, at 12:24 p.m. the director of nursing (DON) stated R5's open areas on the toes had healed up last week and had just put a note in today 7/22/14. DON also indicated "We had rounded up all his shoes and sent them home with his wife and am not sure how he got them again as we had identified this was a problem." DON further stated her expectation was the care plan and NAR List should have been updated to reflect R5 was not supposed to wear shoes after going through the care plan and verified the intervention for "NO SHOES ON-Need to take pressure off top of toes." was missing in the entire care plan. When interviewed on 7/22/14, at 1:03 p.m. registered nurse (RN)-A stated everyone was responsible for updating the care plan and when she completed the MDS's she would also update the care plan including anything that was had written since the last review. RN-A further stated she was involved during weekly wound rounds at the facility and since R5's MDS was in progress she would have caught the intervention for not supposed to wear his shoes as she knew he was not supposed to wear his shoes. When asked who was responsible for updating the NAR List, RN-A indicated RN-B was responsible. Skin Protocol Policy, revised 06/14, indicated it	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 07/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 5 was the facility policy each resident received skin care to maintain and prevent skin breakdown. However the policy did indicate during weekly pressure ulcer rounds the team would reviewed the care plan and all other documentation matched to ensure the staff were aware of interventions in place to prevent skin issues.	F 280		
(F 314) SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an intervention which had been developed and had been implemented for 1 of 3 residents (R5) when R5 first developed a stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). Findings include: On 7/22/14, at 9:23 a.m. R5 was observed dressed up with a pair of black ankle socks and a pair of white tennis shoes seated on his	(F 314)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 07/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 314)	Continued From page 6 wheelchair (W/C) in the dining room (DR) table eating breakfast with staff seated next to him assisting. -At 9:56 a.m. observed R5 still in the DR at the table facing the window then propelled himself around and faced the television across the room still observed wearing a pair of white tennis shoes no footrest on W/C at the time. - At 10:00 a.m. R5 was observed participating in a sing a long activity continued to move his feet back and forth on the same spot. -At 10:23 a.m. observed nursing assistant (NA)-A and another NA was going in R5's room with a Hoyer lift (mechanical lift used for transferring) and shut the door. -At 10:25 R5 was observed lying in bed as both NA's repositioned R5 and removed the lift sheet then NA-A took R5's shoes and socks off. -At 10:27 a.m. licensed practical nurse (LPN)-A was observed checking both R5's feet and indicated R5's left foot second, third and fourth toes had scabs were getting smaller down the toes. LPN-A then looked at the left great toe which appeared slightly raised and had a soft bulgy tissue on top of area, slightly red and appeared to have fluid and indicated it was a fluid filled blister asked surveyor to touch area. LPN-A stated usually when R5 was starting to have skin issues on his toes it started with a blister and he was going to update the provider on the skin concern. LPN-A then looked at R5's right foot second toe and stated he had two pinpoint scabs to the side and the scab on the same hammer toe stated "Not so dark as the other scabs" surrounding area was pink and intact. When interviewed on 7/22/14, at 10:07 a.m. NA-A stated she had given R5 a bed bath in the morning and had gotten R5 up to his W/C around	(F 314)	Reviewed & updated policy & procedure for skin & pressure ulcer. Reviewed & updated skin assessment on EMR. Staff educated with new/updated policy & procedure. Audits of pressure areas, checking prevention was/is address, wkly measurements are done, Policy is being followed; Braden, Tissue Tolerance, notification of areas to DR. & family. Audit to be conducted on all residents with stage 1 or > pressure ulcers in house wkly for 6 weeks then q 2 weeks for 2 months , then monthly for 3 months. Mtg held wkly with IDT wound team, the following will be reviewed & updated prn- careplan, NAR assign. sheet, investigative flow sheet. DON, ADON and MDS Coordinator to monitor. Date of Completion: 8/18/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY CARE CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 7 8:30 a.m. right before breakfast. NA-A went over with surveyor and verified R5 was wearing white tennis shoes. When asked if R5 was not supposed to wear the shoes NA-A stated "I don't think so" as she verified looking through the NAR (nursing assistant/registered) List #5 dated 7/18/14, which did not address if R5 was supposed to wear shoes. The Pressure Ulcer Care Area Assessment (CAA) dated 1/23/14, indicated R5 was at risk for pressure ulcers. In addition the activities of daily living (ADL)CAA indicated R5 required extensive assist with bed mobility, transfers, W/C propelling, dressing, and personal hygiene. Care plan dated 1/24/14, identified R5 was at risk for skin breakdown related to impaired mobility. Care plan goal "[R5] will not develop any skin breakdown." Care plan directed daily observation by NA's during cares, complete skin assessment weekly by licensed nurse and dressing changes to open areas on toes until healed. The care plan did not indicate R5 was not supposed to wear shoes to keep pressure off his toes. Podiatry Visit note dated 4/4/14, identified R5 had acquired deformity of toe, peripheral vascular disease (PVD), bunion, callus and difficulty walking. Treatment Notes indicated "Patient is advised to follow up in 9-10 weeks or as needed. I recommend [Discontinue] D/C [patient] pt wearing shoes, to take pressure off top toes ..." R5's diagnoses included Parkinson's, paralysis agitans and osteoporosis obtained from the quarterly Minimum Data Set (MDS) dated 4/16/14. The MDS indicated R5 was at risk for pressure ulcers, had unhealed pressure ulcer	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	R 07/22/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 314)	Continued From page 8 stage one or higher which was unstageable, had eschar (black, brown or tan tissue that adheres firmly to the wound bed or ulcer edges) and R5 had an ulcer care treatment. In addition the MDS indicated R5 required extensive physical assist of one staff for dressing and personal hygiene. Additionally R5's MDS Brief Interview of Mental Status (BIMS-tool used to measure cognition) was seven which indicated severe cognitive impairment. Physician order dated 7/8/14, indicated "NO SHOES ON- Need to take pressure off top of toes." Bethany Care Center Weekly Skin Checklist dated 7/15/14, indicated R5 had dry scabbed areas to both feet with toes circled and had an open lesion on his abdomen. The Checklist dated 7/8/14, indicated R5 had dark scabs on toes and open area on his abdomen. Copy of Investigative Skin Flowsheet Updated dated 7/15/14, indicated R5's right second toe had healed, left second toe was unstageable, wound bed was covered with 100% scab; area was healing with periwound healthy; left third toe was healed; left fourth toe remained healed and left outer ankle remained healed. In addition, the Flowsheet indicated all areas continued to improve and "resident no longer wears shoes and this has been helpful to assist in healing and resident will continue to wear only socks." The Treatment Administration Record (TAR) dated June 2014, and July 2014, both directed "NO SHOES ON - NEED TO TAKE PRESSURE OFF TOPICALLY OF TOES FYI" Review of the facility plan of correction Audit for pressure Ulcers undated revealed audits had	(F 314)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 314}	Continued From page 9 been completed for 7/9/14, and 7/17/14, but R5's pressure areas had only been audited on 7/9/14, and indicated preventative interventions had been put in place. When interviewed on 7/22/14, at 12:24 p.m. the director of nursing (DON) stated R5's open areas on the toes had healed up last week and had just put a note in today 7/22/14. DON also indicated "We had rounded up all his shoes and sent them home with his wife and am not sure how he got them again as we had identified this was a problem." DON further stated her expectation was the care plan and NAR List should have been updated to reflect R5 was not supposed to wear shoes after going through the care plan and verified the intervention for "NO SHOES ON-Need to take pressure off top of toes." was missing in the entire care plan. -At 12:26 p.m. as surveyor was conversing with DON registered nurse (RN)-B seated across the desk stated she had checked and had verified the NAR List was not updated to reflect R5 was not supposed to wear shoes. -At 12:28 p.m. when DON and surveyor were coming out of R5's room to the hallway approaching the medication cart came LPN-A and indicated to DON R5 had a fluid filled like blister on his left great toe and he was going to update the doctor. When interviewed on 7/22/14, at 1:03 p.m. RN-A stated everyone was responsible for updating the care plan and when she completed the MDS's she would also update the care plan including anything that was had written since the last review. RN-A further stated she was involved during weekly wound rounds at the facility and since R5's MDS was in progress she would have caught the intervention for not supposed to wear	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 314}	Continued From page 10 his shoes as she knew he was not supposed to wear his shoes. When asked who was responsible for updating the NAR List, RN-A indicated RN-B was responsible. Skin Protocol Policy, revised 6/14, indicated it was the facility policy each resident received skin care to maintain and prevent skin breakdown. However, the policy did indicate during weekly pressure ulcer rounds the team would reviewed the care plan and all other documentation matched to ensure the staff were aware of interventions in place to prevent skin issues.	{F 314}		

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Per Gloria, never hand delivered (AK 8/29/14)

Mr. Jon Sondegaard, Administrator
Bethany Care Center
2309 Hayes Street Northeast
Minneapolis, MN 55418

Re: Project # S5578024

Dear Mr. Sondegaard:

On July 22, 2014, 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 June 5, 2014.

State licensing orders issued pursuant to the survey completed on June 5, 2014 and found corrected at the time of this July 22, 2014 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on June 5, 2014, found not corrected at the time of this July 22, 2014 revisit and subject to penalty assessment are as follows:

- **20900 -- S/S: -- MN Rule 4658.0525 Subp. 3 -- Rehab - Pressure Ulcers - $350.00**

The details of the violations noted at the time of this revisit completed on July 22, 2014 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $350.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

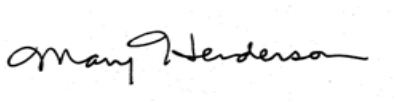
Also, at the time of this reinspection completed on July 22, 2014 additional violations were cited as follows:

- **20570 -- S/S: -- MN Rule 4658.0405 Subp. 4 -- Comprehensive Plan Of Care; Revision**

They are delineated on the attached Minnesota Department of Health Statement of Deficiencies - Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, when all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St Paul, Minnesota 55164-0900.

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.

Sincerely,



Mary Henderson, Program Assurance Supervisor
Minnesota Department of Health
Compliance Monitoring Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4115 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically Delivered: August 29, 2014

Mr. Jon Sondegaard, Administrator
Bethany Care Center
2309 Hayes Street Northeast
Minneapolis, Minnesota 55418

Re: Project # S5578024

Dear Mr. Sondegaard:

On July 22, 2014, 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 June 5, 2014.

State licensing orders issued pursuant to the survey completed on June 5, 2014 and found corrected at the time of this July 22, 2014 revisit, are listed on the enclosed Revisit Report Form.

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The details of the violations noted at the time of this revisit completed on July 22, 2014 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

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The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
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When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Also, at the time of this reinspection completed on July 22, 2014 additional violations were cited as follows:

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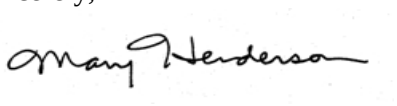
Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,



Mary Henderson, Program Assurance Supervisor
Minnesota Department of Health
Compliance Monitoring Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4115 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

PRINTED: 08/08/2014
FORM APPROVED
Minnesota Department of Health

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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: A post certification revisit was conducted by the Minnesota Department of Health on July 21 through July 22, 2014. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance.	{2 000}		

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

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{2 000}	Continued From page 1 Upon receipt of an acceptable 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.	{2 000}		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was revised with an intervention which had been developed to prevent skin breakdown for 1 of 3 residents (R5) reviewed for the development of a stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). Findings include: R5 was observed on 7/22/14, at 9:23 a.m.	2 570		

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2 570	Continued From page 2 dressed and with a pair of white tennis shoes on. R5 was seated in his wheelchair (W/C) in the dining room (DR) table eating breakfast with staff seated next to him assisting. -At 9:56 a.m. observed R5 still in the DR at the table facing the window then propelled himself around and faced the television across the room still observed wearing a pair of white tennis shoes no footrest on W/C at the time. - At 10:00 a.m. R5 was observed participating in a sing a long activity continued to move his feet back and forth on the same spot. -At 10:23 a.m. observed nursing assistant (NA)-A and another nursing assistant going in R5's room with a Hoyer lift (mechanical lift used for transferring) and shut the door. -At 10:25 R5 was observed lying in bed as both NA's repositioned R5 and removed the lift sheet then NA-A took R5's shoes and socks off. -At 10:27 a.m. licensed practical nurse (LPN)-A was observed checking both R5's feet and indicated R5's left foot second, third and fourth toes had scabs were getting smaller down the toes. LPN-A then looked at the left great toe which appeared slightly raised and had a soft bulgy tissue on top of area, slightly red and appeared to have fluid and indicated it was a fluid filled blister asked surveyor to touch area. LPN-A stated usually when R5 was starting to have skin issues on his toes it started with a blister and he was going to update the provider on the skin concern. LPN-A then looked at R5's right foot second toe and stated he had two pinpoint scabs to the side and the scab on the same hammer toe stated "Not so dark as the other scabs" surrounding area was pink and intact. When interviewed on 7/22/14, at 10:07 a.m. NA-A stated she had given R5 a bed bath that morning and had gotten R5 up to his W/C around 8:30	2 570		

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2 570	Continued From page 3 a.m. right before breakfast. NA-A verified R5 was wearing white tennis shoes. When asked if R5 was not supposed to wear the shoes NA-A stated "I don't think so" as she verified looking through the NAR List #5 dated 7/18/14, did not address R5 was not supposed to wear shoes as ordered. The Pressure Ulcer Care Area Assessment (CAA) dated 1/23/14, indicated R5 was at risk for pressure ulcers. In addition, the activities of daily living (ADL) CAA indicated R5 required extensive assist with bed mobility, transfers, W/C propelling, dressing, and personal hygiene. R5's diagnoses included Parkinson's, paralysis agitans and osteoporosis obtained from the quarterly Minimum Data Set (MDS) dated 4/16/14. The MDS indicated R5 was at risk for pressure ulcers, had unhealed pressure ulcer stage one or higher which was unstageable, had eschar (black, brown or tan tissue that adheres firmly to the wound bed or ulcer edges) and R5 had an ulcer care treatment. In addition, the MDS indicated R5 required extensive physical assist of one staff for dressing and personal hygiene. Additionally, R5's MDS Brief Interview of Mental Status (BIMS-tool used to measure cognition) was seven which indicated severe cognitive impairment. Care plan dated 1/24/14, identified R5 was at risk for skin breakdown related to impaired mobility. Care plan goal "[R5] will not develop any skin breakdown." Care plan directed daily observation by NA's during cares, complete skin assessment weekly by licensed nurse and dressing changes to open areas on toes until healed. The care plan did not indicate R5 was not supposed to wear shoes to keep pressure off his toes.	2 570		

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2 570	Continued From page 4 Podiatry Visit note dated 4/4/14, identified R5 had acquired deformity of toe, peripheral vascular disease (PVD), bunion, callus and difficulty walking. Treatment Notes indicated " Patient is advised to follow up in 9-10 weeks or as needed. I recommend [Discontinue] D/C [patient] pt wearing shoes, to take pressure off top toes ..." Physician order dated 7/8/14, indicated "NO SHOES ON- Need to take pressure off top of toes." Bethany Care Center Weekly Skin Checklist dated 7/15/14, indicated R5 had dry scabbed areas to both feet with toes circled and had an open lesion on his abdomen. The Checklist dated 7/8/14, indicated R5 had dark scabs on toes and open area on his abdomen. Copy of Investigative Skin Flowsheet Updated dated 7/15/14, indicated R5's right second toe had healed, left second toe was unstageable , wound bed was covered with 100% scab; area was healing with peri-wound healthy; left third toe was healed; left fourth toe remained healed and left outer ankle remained healed. In addition the Flowsheet indicated all areas continued to improve and "resident no longer wears shoes and this has been helpful to assist in healing and resident will continue to wear only socks. " When interviewed on 7/22/14, at 12:24 p.m. the director of nursing (DON) stated R5's open areas on the toes had healed up last week and had just put a note in today 7/22/14. DON also indicated "We had rounded up all his shoes and sent them home with his wife and am not sure how he got them again as we had identified this was a problem." DON further stated her expectation was the care plan and NAR List should have been updated to reflect R5 was not supposed to	2 570		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 5 wear shoes after going through the care plan and verified the intervention for "NO SHOES ON-Need to take pressure off top of toes." was missing in the entire care plan. When interviewed on 7/22/14, at 1:03 p.m. registered nurse (RN)-A stated everyone was responsible for updating the care plan and when she completed the MDS's she would also update the care plan including anything that was had written since the last review. RN-A further stated she was involved during weekly wound rounds at the facility and since R5's MDS was in progress she would have caught the intervention for not supposed to wear his shoes as she knew he was not supposed to wear his shoes. When asked who was responsible for updating the NAR List, RN-A indicated RN-B was responsible. Skin Protocol Policy, revised 06/14, indicated it was the facility policy each resident received skin care to maintain and prevent skin breakdown. However the policy did indicate during weekly pressure ulcer rounds the team would reviewed the care plan and all other documentation matched to ensure the staff were aware of interventions in place to prevent skin issues.	2 570		
{2 900}	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop	{2 900}		

PRINTED: 08/08/2014
FORM APPROVED
Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00167	A. BUILDING: _____ B. WING _____	R 07/22/2014

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

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{2 900}	Continued From page 6 pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an intervention which had been developed and had been implemented for 1 of 3 residents (R5) when R5 first developed a stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). Findings include: On 7/22/14, at 9:23 a.m. R5 was observed dressed up with a pair of black ankle socks and a pair of white tennis shoes seated on his wheelchair (W/C) in the dining room (DR) table eating breakfast with staff seated next to him assisting. -At 9:56 a.m. observed R5 still in the DR at the table facing the window then propelled himself around and faced the television across the room still observed wearing a pair of white tennis shoes no footrest on W/C at the time. - At 10:00 a.m. R5 was observed participating in a sing a long activity continued to move his feet back and forth on the same spot. -At 10:23 a.m. observed nursing assistant (NA)-A and another NA was going in R5's room with a	{2 900}		

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(2 900)	Continued From page 7 Hoyer lift (mechanical lift used for transferring) and shut the door. -At 10:25 R5 was observed lying in bed as both NA's repositioned R5 and removed the lift sheet then NA-A took R5's shoes and socks off. -At 10:27 a.m. licensed practical nurse (LPN)-A was observed checking both R5's feet and indicated R5's left foot second, third and fourth toes had scabs were getting smaller down the toes. LPN-A then looked at the left great toe which appeared slightly raised and had a soft bulgy tissue on top of area, slightly red and appeared to have fluid and indicated it was a fluid filled blister asked surveyor to touch area. LPN-A stated usually when R5 was starting to have skin issues on his toes it started with a blister and he was going to update the provider on the skin concern. LPN-A then looked at R5's right foot second toe and stated he had two pinpoint scabs to the side and the scab on the same hammer toe stated "Not so dark as the other scabs" surrounding area was pink and intact. When interviewed on 7/22/14, at 10:07 a.m. NA-A stated she had given R5 a bed bath in the morning and had gotten R5 up to his W/C around 8:30 a.m. right before breakfast. NA-A went over with surveyor and verified R5 was wearing white tennis shoes. When asked if R5 was not supposed to wear the shoes NA-A stated "I don't think so" as she verified looking through the NAR (nursing assistant/registered) List #5 dated 7/18/14, which did not address if R5 was supposed to wear shoes. The Pressure Ulcer Care Area Assessment (CAA) dated 1/23/14, indicated R5 was at risk for pressure ulcers. In addition the activities of daily living (ADL)CAA indicated R5 required extensive assist with bed mobility, transfers, W/C	(2 900)		

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{2 900}	Continued From page 8 propelling, dressing, and personal hygiene. Care plan dated 1/24/14, identified R5 was at risk for skin breakdown related to impaired mobility. Care plan goal "[R5] will not develop any skin breakdown." Care plan directed daily observation by NA's during cares, complete skin assessment weekly by licensed nurse and dressing changes to open areas on toes until healed. The care plan did not indicate R5 was not supposed to wear shoes to keep pressure off his toes. Podiatry Visit note dated 4/4/14, identified R5 had acquired deformity of toe, peripheral vascular disease (PVD), bunion, callus and difficulty walking. Treatment Notes indicated "Patient is advised to follow up in 9-10 weeks or as needed. I recommend [Discontinue] D/C [patient] pt wearing shoes, to take pressure off top toes ..." R5's diagnoses included Parkinson's, paralysis agitans and osteoporosis obtained from the quarterly Minimum Data Set (MDS) dated 4/16/14. The MDS indicated R5 was at risk for pressure ulcers, had unhealed pressure ulcer stage one or higher which was unstageable, had eschar (black, brown or tan tissue that adheres firmly to the wound bed or ulcer edges) and R5 had an ulcer care treatment. In addition the MDS indicated R5 required extensive physical assist of one staff for dressing and personal hygiene. Additionally R5's MDS Brief Interview of Mental Status (BIMS-tool used to measure cognition) was seven which indicated severe cognitive impairment. Physician order dated 7/8/14, indicated "NO SHOES ON- Need to take pressure off top of toes."	{2 900}		

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{2 900}	Continued From page 9 Bethany Care Center Weekly Skin Checklist dated 7/15/14, indicated R5 had dry scabbed areas to both feet with toes circled and had an open lesion on his abdomen. The Checklist dated 7/8/14, indicated R5 had dark scabs on toes and open area on his abdomen. Copy of Investigative Skin Flowsheet Updated dated 7/15/14, indicated R5's right second toe had healed, left second toe was unstageable, wound bed was covered with 100% scab; area was healing with periwound healthy; left third toe was healed; left fourth toe remained healed and left outer ankle remained healed. In addition, the Flowsheet indicated all areas continued to improve and "resident no longer wears shoes and this has been helpful to assist in healing and resident will continue to wear only socks." The Treatment Administration Record (TAR) dated June 2014, and July 2014, both directed "NO SHOES ON - NEED TO TAKE PRESSURE OFF TOPICALLY OF TOES FYI" Review of the facility plan of correction Audit for pressure Ulcers undated revealed audits had been completed for 7/9/14, and 7/17/14, but R5's pressure areas had only been audited on 7/9/14, and indicated preventative interventions had been put in place. When interviewed on 7/22/14, at 12:24 p.m. the director of nursing (DON) stated R5's open areas on the toes had healed up last week and had just put a note in today 7/22/14. DON also indicated "We had rounded up all his shoes and sent them home with his wife and am not sure how he got them again as we had identified this was a problem." DON further stated her expectation was the care plan and NAR List should have been updated to reflect R5 was not supposed to wear shoes after going through the care plan and verified the intervention for "NO SHOES ON-	{2 900}		

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{2 900}	Continued From page 10 Need to take pressure off top of toes." was missing in the entire care plan. -At 12:26 p.m. as surveyor was conversing with DON registered nurse (RN)-B seated across the desk stated she had checked and had verified the NAR List was not updated to reflect R5 was not supposed to wear shoes. -At 12:28 p.m. when DON and surveyor were coming out of R5's room to the hallway approaching the medication cart came LPN-A and indicated to DON R5 had a fluid filled like blister on his left great toe and he was going to update the doctor. When interviewed on 7/22/14, at 1:03 p.m. RN-A stated everyone was responsible for updating the care plan and when she completed the MDS's she would also update the care plan including anything that was had written since the last review. RN-A further stated she was involved during weekly wound rounds at the facility and since R5's MDS was in progress she would have caught the intervention for not supposed to wear his shoes as she knew he was not supposed to wear his shoes. When asked who was responsible for updating the NAR List, RN-A indicated RN-B was responsible. Skin Protocol Policy, revised 6/14, indicated it was the facility policy each resident received skin care to maintain and prevent skin breakdown. However, the policy did indicate during weekly pressure ulcer rounds the team would reviewed the care plan and all other documentation matched to ensure the staff were aware of interventions in place to prevent skin issues.	{2 900}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5LSC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00167

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

2.STATE VENDOR OR MEDICAID NO.
(L2) **936670200**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/04/2012**

6. DATE OF SURVEY **06/05/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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
	56	10		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sandra Nelson, HFE NE II 07/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 07/25/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS
Posted 07/29/2014 Co.

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

Certified Mail # 7013 2250 0001 6356 5156

June 24, 2014

Mr. Jon Sondegaard, Administrator
Bethany Care Center
2309 Hayes Street Northeast
Minneapolis, Minnesota 55418

RE: Project Number S5578024

Dear Mr. Sondegaard:

On June 5, 2014, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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;

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3792
Fax: (651) 201-3790

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 July 15, 2014, 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 July 15, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the

facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC 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 PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 September 5, 2014 (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 December 5, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	06/05/2014

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

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F 000	INITIAL COMMENTS The facility's plan of correction (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 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	This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute deficiency, or that the scope and severity regarding the deficiency are correctly applied. Please accept this Plan of Correction as our credible allegation of compliance. Our compliance will be achieved by the date identified on the Plan of Correction.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident (R4) who was observed self-administering medications was deemed safe to do so. Findings include: R4 was observed in her room on 6/4/14, at 7:01 a.m. The resident held a pill in her fingers and put the pill to her mouth with one hand, while holding a small paper souffle cup in her other hand. Eye drops were placed in a container on the bedside table in front of R4. When the surveyor greeted R4 the resident stated, "I am taking my medications." When asked about the container	F 176		

RECEIVED
JUL - 9 2014
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

7-9-14 Corrected Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	7/2/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	06/05/2014

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F 176	Continued From page 1 holding the eye drops R4 explained, "The nurse left the eye drops there." There were no staff present in the room. R4's Self-administration of Medications assessment (SAM) dated 7/2/13, indicated R4 wished to only self-administer nebulizer treatments. The current physician orders for R4 indicated the resident had diagnoses including vascular dementia, and did not include an order allowing the resident to self-administer medications. R4's Minimum Data Set (MDS) dated 3/16/14, showed R4 had a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. The resident's care plan dated 3/27/14, directed staff to give medications as ordered and self-medication assessment per facility policy. On 6/4/14, at 1:24 p.m. a registered nurse (RN)-F explained that nursing assessments could be found in resident records under the "assessments" tab, and or were in the computerized charting. No SAM assessment for medications other than the nebulizer was found in the chart and/or computer for R4. On 6/4/14, at 1:45 p.m. a licensed practical nurse (LPN)-A stated R4 did not routinely take her own medications, but that morning LPN-A had just left R4 in her room with her medications and eye drops to get something quick and then went right back into the resident's room. LPN-A stated R4 did not even want the nurse to leave her alone with her medication, and would tell someone R4 with her medications alone and reported the next day if a nurse left her with "even one pill."	F 176	Policy and Procedure reviewed and updated. All licensed Staff reeducated regarding policy and procedure. Audits of Medication pass will be conducted 3 times a week to include all 3 shifts for 2 weeks then 2 times a week for 2 weeks and then weekly for 4 weeks, then monthly for 3 months. DON, ADON and MDS Coordinator to monitor Date of completion: 7/11/2014	

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F 176	Continued From page 2 On 6/5/14, at 1:30 p.m. the director of nursing (DON) stated she expected her nurses to stay with the resident while administering medications and/or treatments if the resident did not have an assessment, physician's order, and care plan for SAM. Resident Self-Administration Policy directed staff to "allow residents to self-administer medications and treatments per their request, if the resident is competent to perform such tasks." Under Resident Self-Administration Procedure step 1 read, "LN [licensed nurse] will conduct a self-administration assessment located in the assessment section of the electronic medical record with resident to determine competency, the ability to store medications and then to document." Step 5 of the Resident Self-Administration Procedure noted "residents will not be allowed to self-administer medication or store medications at bedside if it was not deemed to be safe after self-administration assessment completed and reviewed by IDT" [interdisciplinary team].	F 176		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care as	F 282		

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F 282	Continued From page 3 directed in the plan of care for 1 of 3 residents (R48) reviewed for activities of daily living (ADLs). Findings include: R48's lower front teeth were observed to be dirty during all encounters. On 6/3/14, 6/4/14, and 6/5/14; whitish matter/substances were observed in the corners of R48's mouth and eyes. On 6/3/14 and 6/4/14; R48 had no socks on and on 6/5/14, R48's left heel was awkwardly not placed in left shoe. The Diagnosis Information section of the electronic admission record indicated R48 had diagnoses to include: Alzheimer's disease, essential and unspecified forms of tremor, vascular dementia, chronic kidney disease, and pain in joint (forearm). The annual Minimum Data Set (MDS) dated 11/13/2013, indicated R48 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated significant cognitive impairment. The Care Area Assessment (CAA) dated 11/23/2013, identified R48 had impaired ability to communicate or to make ideas and wants understood. The care plan dated 5/23/2014, identified R48 had a ADL self-care performance deficit and required assistance with personal hygiene. The care plan directed staff to assist R48 with mouth cares and other ADLs. The nursing assistant care sheet dated 6/2/14, indicated R48 needed assistance by 1 staff for dressing and grooming. On 6/3/14, at 10:16 a.m. R48 was observed sitting alone in the day room. Streaks of whitish matter/substances that looked like dried tears and dried saliva were observed in the corners of	F 282	Reviewed care plan of resident (48) for accuracy. Reviewed and updated policy and procedures Staff educated with new/updated policy and procedures for ADL's, importance of following the care plan and their group assignment sheet. Audits for ADL's of random residents completed to assess that NAR's are following the individual resident's plan of care. Audit to be conducted on 20% of residents on all three shifts for 4 weeks, then 10% of residents on all three shifts for 4 weeks. Then 5% of residents on all three shifts for 16 weeks. DON, ADON and MDS Coordinator responsible for monitoring Date of completion: 7/11/2014	

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F 282	Continued From page 4 R48's eyes and mouth. R48 was also observed to have facial hairs which were approximately 1 centimeter in length. When R48 opened her mouth to talk, R48's lower teeth were obviously dirty. On 6/4/14, at 9:35 a.m. R48 was observed with five other residents in the coffee and chat activity at the apartment dining room. R48 had dry white matter/substances around the corners of her eyes and mouth, and still had the facial hairs. - At 1:50 p.m. R48 was sitting in a chair at the front lobby holding a magazine and flipping the pages. When talking, R48's lower teeth were observed to be yellowish dirty and whitish streaks observed in the corners of her eyes and mouth. When surveyor asked R48 if she was helped from bed that morning, she stated "yeah" then moved lower extremities forward and slightly pulled pants on right leg to show that no socks were worn. When asked if she liked to wear socks, R48 nodded and continued to talk. On 6/4/14, at 1:58 p.m. nursing assistant (NA)-D stated she helped R48 to get up that morning and stated R48 cannot perform ADLs independently but needed cueing and assistance. NA-D stated R48 would not ask for needs so staff need to go ask and help R48 every time. -At 2:06 p.m. registered nurse (RN)-C stated R48 needed reminders about daily cares. RN-C stated R48 can do things herself like washing face but just needed stand-by assist and cueing. On 6/5/14, at 7:50 a.m. R48 was observed walking in the dining room, heel of left foot was out from her shoe, in an awkward appearance.	F 282		

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F 282	Continued From page 5 R48's lower teeth were still dirty as observed when mouth was opened to talk in response to surveyor's greeting. On 6/5/2014, at 1:34 p.m. when R48 was asked how it felt having facial hairs and how it felt having left heel not placed well in shoe, R48 did not seem to comprehend the questions. R48 started talking about things that were totally unrelated to the questions being asked. The facility's Adequate and Proper Nursing Care Policy dated 6/2012, directed staff to provide proper care to residents, to include assistance with or supervision of shaving as needed to keep them clean and well-groomed, and assistance with oral hygiene to keep mouth and teeth clean.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure weights were monitored as ordered for 1 of 1 resident (R20) reviewed for dialysis. Findings include:	F 309		

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F 309	Continued From page 6 R20's Admission Record dated 6/5/14, included diagnoses of chronic kidney disease stage III (moderate), unspecified disorder of kidney and ureter, congestive heart failure, and abnormal weight gain. R20 scored an eight on a Brief Interview for Mental Status (BIMS) assessment dated 1/22/14, indicating moderately impaired cognition. On 6/4/14, at 8:36 a.m. a licensed practical nurse (LPN)-A stated R20 would be returning from dialysis after 1:00 p.m. and attended dialysis weekly on Mondays, Wednesdays, and Fridays. On 6/4/14, at 1:19 p.m. R20 was observed seated in his wheelchair in his room. On 6/4/14, at 1:45 p.m. LPN-A stated when R20 returned from dialysis, the staff was provided and envelope of information from the dialysis center including the resident's daily weight records. On 6/5/14, at 12:36 p.m. LPN-A verified R20's weights from dialysis were not on the visit sheet returned to facility upon R20's return from dialysis on 6/4/14. LPN-A also stated it was on the "list to do today" to call the dialysis center for R20's 6/4/14 weight. LPN-A also verified on the 6/14 Treatment Administration Record (TAR), R20's dialysis weight was not initialed off by staff, nor were the dry weights from dialysis recorded on both 6/2 and 6/4/14. LPN-A also stated it was the nurse's responsibility to initial the TAR for the dry weight upon R20's return to facility from dialysis and the nurse's responsibility to enter the weight into the computer. On 6/5/14, at 1:30 p.m. the director of nursing (DON) stated she expected the nurses to follow physician orders and record weights for residents returning from dialysis. The DON also stated if	F 309	Reviewed and updated policy and procedure for dialysis specifically monitoring of dry wts. Reeducated licensed nursing staff with updated policy and procedure Audit dialysis patients for documentation from dialysis unit on resident's dry wts (wt prior to run). Audits will be completed on all dialysis residents; 3x/wk for 2 wks, then 1x/wk for 2 wks, then q 2wks for 4wks, then monthly for 4months. DON, ADON and MDS Coordinator to monitor Date of completion: 7/11/2014	

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F 309	Continued From page 7 the weights did not come back on the visit referral sheets from dialysis, she expected the nurse would call the dialysis center upon resident's return to the facility to obtain the information and then record it. The physician order started 11/18/13, directed staff to record dry weight from dialysis every Monday Wednesday and Friday. The dialysis visit referral sheets which came back with R20 from dialysis dated 5/30/14, 5/21/14, 5/19/14, 5/14/14, and 4/16/14 included the dry weight for R20. The other May and April visit referral sheets for R20's dialysis on Monday, Wednesday, and Fridays did not include the dry weights. On the Weights and Vitals Summary the weights for R20 were recorded only on 5/30, 5/29, 5/22, 5/12, 5/01, 4/24, 4/17, 4/16, 4/11, 4/10, and 4/3/14. The only dated initials by nursing staff for recorded dry weights from dialysis on the TARs for R20 for 6/14, 5/14, and 4/414 were on 5/23/14, and 4/11/14. The other dialysis dates on the 6/14, 5/14, and 4/14 TARs were blank (not initialed by nursing staff). R20's care plan dated 5/6/14, indicated a potential for dehydration related to fluid restriction. The goal was for the resident to show no signs or symptoms of dehydration. Interventions included staff recording the resident's weight before breakfast, monitor those weights, and weigh per facility policy/physician order. The facility Dialysis Policy (last revised 6/12) noted it was the facility's policy to meet resident's needs who received dialysis. Number four listed under Dialysis Procedure on the Dialysis policy directed staff to "send referral paperwork with	F 309		

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F 309	Continued From page 8 resident to dialysis with any pertinent information regarding their care. Dialysis will communicate with Bethany staff on any concerns related to dialysis run or any changes." Number six listed under Dialysis Procedure on the policy directed staff to "coordinate with dialysis center to make sure nursing staff are monitoring fluid restrictions/labs/access sites/weights as ordered by physician/dialysis center."	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate grooming and services were provided for 1 of 3 residents (R48) reviewed for activities of daily living (ADLs). Findings include: R48's lower front teeth were observed to be dirty during observations on 6/3, 6/4, and 6/5/14. Whitish matter was also observed in the corners of the resident's mouth and eyes. In addition, on 6/3 and 6/4/14 R48 was not wearing socks, and on 6/5/14 the resident's left heel was not properly placed into the left shoe. The Diagnosis Information section of the electronic admission record indicated R48 had diagnoses including Alzheimer's disease. The	F 311		

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F 311	Continued From page 9 annual Minimum Data Set (MDS) dated 11/13/13, revealed the resident's Brief Interview for Mental Status (BIMS) showed a score of 3 or significant cognitive impairment. The Care Area Assessment (CAA) dated 11/23/13, identified R48 had impaired ability to communicate or to make ideas and wants understood. The care plan dated 5/23/14, identified R48 had an ADL self-care performance deficit and required assistance with personal hygiene. The care plan directed staff to assist R48 with mouth cares and other ADLs. The nursing assistant (NA) care sheet dated 6/2/14, indicated R48 needed assistance of one staff for dressing and grooming. On 6/3/14, at 10:16 a.m. R48 was observed sitting alone in the day room. Streaks of whitish matter like dried tears in appearance as well as dried saliva at the corners of the resident's mouth were noted. R48 also had facial hair approximately one centimeter in length. When the resident opened her mouth to talk, her lower teeth were observed to be unclean. On 6/4/14, at 9:35 a.m. R48 was observed with five other residents in the Coffee and Chat activity in the dining room. Again dry white matter was observed around the resident's eyes and mouth, and the facial hair was still present. At 1:50 p.m. R48 was seated in a chair at the front lobby looking through a magazine. When the resident spoke, her lower teeth were observed to be yellowish and unclean, and white streaks were noted in the corners of the resident's eyes and mouth. When asked if staff had helped her get ready that morning, the resident replied, "Yeah" and then moved her lower extremities forward	F 311	Reviewed care plan of resident (48) for accuracy. Reviewed and updated policy and procedures Staff educated with new/updated policy and procedures for ADL's, review of ADL's and grooming expectations. Audits for ADL's of random residents completed to assess that NAR's are following the individual resident's plan of care. Audit to be conducted on 20% of residents on all three shifts for 4 weeks, then 10% of residents on all three shifts for 4 weeks. Then 5% of residents on all three shifts for 16 weeks. DON, ADON and MDS Coordinator to monitor Date of completion: 7/11/2014	

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F 311	Continued From page 10 and slightly pulled pants on right leg revealing she was wearing no socks. When asked if she preferred wearing socks, the resident nodded. On 6/4/14, at 1:58 p.m. NA-D reported she had assisted R48 with morning cares. NA-D explained that R48 could not independently request help or perform ADLs, but needed cueing and assistance from staff every day. At 2:06 p.m. a registered nurse (RN)-C stated R48 needed reminders to perform daily cares, and could do things such as wash her own face with standby assistance and cueing. On 6/5/14, at 7:50 a.m. R48 was observed walking in the dining room. The heel on her left foot was not placed properly in her shoe. The resident's mouth and teeth were again unclean when she spoke. At 1:34 p.m. when asked clarifying questions, the resident was unable to comprehend the conversation as evidenced by answering in unrelated topics. The facility's Adequate and Proper Nursing Care Policy dated 6/12, directed staff to provide proper care to residents, to include assistance with or supervision of shaving as needed to keep them clean and well-groomed, and assistance with oral hygiene to keep mouth and teeth clean.	F 311		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314		

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F 314	Continued From page 11 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify causative factors, and implement interventions, to minimize the risk for skin breakdown for 1 of 2 residents (R63) reviewed for pressure ulcers. This resulted in actual harm for R63 who acquired an avoidable stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle) to the right hip, and a stage II (partial thickness loss of dermis presenting as a shallow open ulcer) pressure ulcer to the left shoulder while in the facility. Findings include: R63's Admission Record dated 6/27/13, indicated diagnoses including hip fracture and dementia. The quarterly Minimum Data Set (MDS) dated 3/5/14, indicated R63 was at risk for pressure ulcers, had no unhealed pressure ulcers, required extensive assist of one staff for bed mobility, transfers and toilet use as well as a Brief Interview of Mental Status (BIMS) score of five (moderate to severe cognitive impairment). This MDS also indicated R63 had pressure relieving devices for bed and chair, but was not on a turning and repositioning program. During continuous observations on 6/4/14, from 7:02 a.m. until 7:35 a.m. R63 was observed in bed on back. At 7:35 a.m. NA-E entered R63's room and asked if ready to get up. R63 responded "no" and NA-E stated when R63 says no she comes back after breakfast. NA-E did not	F 314	Reviewed and updated policy and procedure for skin and pressure ulcer Review and update skin assessment on EMR. Staff educated with new/updated policy and procedure. Audits of pressure areas, checking that prevention was/is address, weekly measurements are done, Policy is being followed; Braden, Tissue Tolerance, notification of areas to physician and family. Audit to be conducted on all residents with stage 1 or > pressure ulcers in house 5x/wk for 2 weeks, then q wk for 6 weeks, then monthly for 4 months. DON, ADON and MDS Coordinator to monitor Date of completion: 7/11/2014	

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	245578	A. BUILDING _____ B. WING _____	06/05/2014

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F 314	Continued From page 12 reposition R63. R63 remained on his/her back during continuous observations from 7:35 a.m. until 8:44 a.m. At 8:44 a.m. NA-E entered the room and woke R63 up. R63 stated "dig a hole and throw me in it." NA-E stated when R63 "is doing that, I don't get [R63] up." NA-E provided incontinent cares and rolled R63 from side to side. R63 was off back for less than one minute on each side. An intact dressing was observed to the right hip. NA-E stated she had to get a bigger incontinent product for R63 so it wouldn't put pressure on the "sore." While NA-E was providing incontinent cares, a four cm x four cm open area was noted to the back of the left shoulder and blood was observed on R63's gown. R63 was left on his back after the cares were completed. R63 remained on back in bed until 9:41 a.m. when NA-E responded to R63's call for help, assisted R63 to dress and transfer into the wheelchair. The Pressure Ulcer Care Area Assessment (CAA) dated 6/7/13, revealed R63 was at risk for pressure ulcers and had fragile skin which was prone to bruising. A Braden Scale For Predicting Pressure Sore Risk dated 3/5/14, indicated R63 was at risk for skin breakdown. No assessment was conducted to determine an appropriate turning and repositioning schedule for the resident. A Care Conference Note dated 3/20/14, indicated R63 had intact skin with no areas of concern. However, the care plan dated 3/22/13, did indicate R63 was at risk for alteration in skin integrity. The care plan was updated 5/15/14, to identify an open area to the resident's right hip. The original goal was for R63 to be free from	F 314		

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F 314	Continued From page 13 pressure ulcers, or other alterations in skin integrity, and had been revised 5/15/14 to include, open area to right hip will heal. Care plan interventions included: assist R63 to reposition in wheel chair or bed every two hours and as needed (prn), pressure relieving cushion for wheel chair, pressure relieving mattress while in bed. The interventions were updated on 5/15/14, to include a treatment for the pressure ulcer. No other revisions to the care plan were noted. The NA (nursing assistant) List (for resident care) dated 6/2/14, identified R63 had an open area on the right hip and directed staff to position R63 on the left side or back and reposition every two hours. A Bethany Care Center Weekly Skin Checklist dated 3/22/14, indicated R63 had no pressure ulcers present. The Checklist dated 4/5/14, indicated R63 had an open area to the right hip and that Allevyn (a wound dressing) and skin prep were applied as ordered. The Checklist dated 4/12/14, identified an open area to the right hip, however no actions were noted. The Checklist dated 4/19/14, indicated R63 had an open area to the right hip and that the Allevyn dressing was changed as ordered. A Progress Note dated 4/1/14, indicated R63 had a 4.0 cm (centimeter) by 3.5 cm reddened area noted on the right hip and that R63 had been scratching at the area. An Investigative Skin Flowsheet Updated dated 4/3/14, revealed R63 had a stage II pressure ulcer to the right hip which measured 5.7 cm by 4.5 cm with zero depth. The instructions directed to complete the flowsheet on discovery of a skin issue and weekly until healed. The summary of status section noted a reddened area had been noted on 4/2/14, which was superficially opened and slightly larger on 4/3/14. Documentation	F 314		

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F 314	Continued From page 14 indicated the area was located on the trochanter and on the side (right) R63 preferred to lay on. Additionally, the note indicated the interdisciplinary team felt the area was related to pressure. The Treatment Administration Record (TAR) dated April 2014, included an intervention for staff to measure and document the wound every week on Thursday. Documentation on the TAR indicated the wound had been measured on 4/10/14, that the director of nursing (DON) had measured the wound on 4/17/14, and there was no signature to indicate whether or not it had been completed on 4/24/14. The medical record lacked evidence of any assessment of the wound other than the measurements for 4/10, 4/17 and 4/24/14. The TAR also indicated staff were to monitor the red area on the resident's right hip until resolved and were supposed to update the nurse practitioner (NP) with any complications, which was signed off as having occurred daily. A physician progress note dated 4/8/14, did not address whether the physician was aware of the open area to the right hip. A NP note dated 5/8/14, indicated a right ischial tuberosity (IT) wound had progressed in three weeks from a red area to a stage II-III, very foul smelling, green purulent drainage. The NP's note later indicated R63 had a stage II-IV IT wound and the dressing was changed from Allevyn to Aquacel and Flagyl (an antifungal) was added for odor to be changed twice day. A Health Status Note dated 5/11/14, indicated the wound "seems to be better" and "does not have such a foul odor as it did a few days ago." An Investigative Skin Flowsheet Updated dated 5/13/14, indicated R63 had a stage IV pressure ulcer to the right hip which measured 4.3 cm by	F 314		

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F 314	Continued From page 15 2.8 cm and was 2.8 cm deep. The note indicated the wound bed was covered with 90% slough and had undermining over the entire circumference of the wound. It was again noted R63 preferred to lay on the right side and needed to be encouraged to lay on left side or back. R63 was identified as not being able to off load independently. The bed was noted as turned to accommodate lying on left side or back and an alternating air mattress had been put on the bed the prior week. The TAR dated May 2014, directed to measure and document wound every week on Thursday. For 5/1/14, 5/15/14, and 5/22/14 the TAR indicated the DON had measured the wound, however for 5/8/14 and 5/29/14, the TAR was not signed to indicate this had been completed. In addition, the medical record lacked evidence the wound had been assessed along with measurements when taken, and included only subjective data regarding the wound status. Although not all measurements and/or assessment had been recorded, the TAR dated May 2014, also indicated staff were to monitor the red area on the right hip until resolved, and update the nurse practitioner (NP) with any complications, which had been signed off as having occurred daily. A physician's order dated 5/15/14, directed "x-ray today of right hip and OK for wound nurse to evaluate and treat". The x-ray report dated 5/15/14, indicated there were pockets of gas within the soft tissue adjacent to the right proximal femur which could be related to an open wound, necrotizing infection or developing abscess. The x-ray also noted there was a possibility of early osteomyelitis (a bone infection), and that the hip alignment was appropriate with no evidence of hardware failure.	F 314		

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F 314	Continued From page 16 A Health Status Note dated 5/15/14, indicated a call was placed to Twin Cities Wound and Ostomy for them to come out and see R63 at the facility. A Health Status Note dated 5/16/14, indicated the right hip x-ray results were called to the physician and a physician's order dated 5/16/14, indicated R63 had been started on Augmentin (an antibiotic) twice a day for 10 days for osteomyelitis. A Health Status Note dated 5/16/14, indicated occupational therapy (OT) would evaluate R63 for wheelchair positioning although the open area was on the hip. Following the evaluation, the notes indicated OT had issued R63 a "better fit/more comfortable cushion" and indicated R63 had complained of a "sore bottom." A Health Status Note dated 5/19/14, indicated the right hip wound looked much better and appeared to be healing. The note indicated the wound was not as deep as it was a week ago. A physician's progress note dated 5/20/14, indicated R63 had a stage IV IT wound, noted the x-ray showed gas in the wound with concern for osteomyelitis, and directed wound registered nurse (RN) to see and to watch for systemic infection. A Health Status Note dated 5/20/14, indicated the physician had seen R63's wound and would wait and have the wound nurse address if any treatment changes needed to be done. Observations 6/4/14 at 2:14 p.m. the DON and registered nurse (RN)-F were observed providing	F 314		

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F 314	Continued From page 17 wound care for R63. R63 was observed on his/her left side when entered room and rolled to left side with the DON's assistance. The DON washed her hands, applied gloves and removed the pressure ulcer dressing. The wound was observed as a deep cavity with strings of yellow slough in the wound bed. The DON stated a large amount of escar had come out of the wound. The DON also stated R63 had a nail in the left hip from a former hip fracture and she didn't think the pressure ulcer wound have gotten "that bad so fast" if just pressure. The DON removed her gloves, washed her hands and applied new gloves before applying wound cleanser to a four by four gauze pad. The DON used the four by four gauze to cleanse the wound bed and the skin surrounding the wound bed. The DON removed her gloves, cleansed her hands with hand sanitizer, applied new gloves and applied skin prep to the surrounding skin. The DON then again removed her gloves, cleansed her hands with hand sanitizer, applied new gloves and measured the wound. The wound was measured as a length of 4 cm, width of 2.6 cm, depth of 1.9 cm with undermining from nine o'clock to eleven o'clock and slough from three o'clock to seven o'clock. Crushed Flagyl was poured into the wound bed and an Aquacel dressing was cut into three strips and packed into the wound bed using a Q-tips. A gauze dressing was placed over the wound, covered with another dressing and secured with tape. R63 slept through the dressing change and did not have any observed indicators of pain. Interview on 6/5/14, at 9:08 a.m. NA-E stated she was aware R63 had a pressure ulcer on the right hip and it was identified on the assignment sheet. NA-E stated she was not aware of any new	F 314		

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F 314	Continued From page 18 interventions for R63. When interviewed on 6/5/14, at 9:10 a.m. RN-C stated the pressure ulcer on R63's hip started within the last two months as a "little red area, like he was scratching it". RN-C stated R63 "loved to sleep on that side" and that the bed had been turned around to encourage R63 to sleep on the other side. RN-C stated an alternating pressure mattress was initiated on 5/6/14. RN-C stated the MDS nurse was responsible to complete a Braden and TTT, but RN-C stated she didn't think a new one had been done for R63. RN-C also stated she didn't think the wound nurse had come out yet because of insurance issues. When interviewed on 6/5/14, at 9:20 a.m. RN-C stated she thought an open area on R63's shoulder was from a skin tear. When the open area was observed by RN-C, she stated the area on the posterior shoulder looked like a new pressure ulcer from laying on his/her back. RN-C verified the open area on the shoulder was over a bony prominence. RN-F was interviewed on 6/5/14, at 10:29 a.m. and stated she had completed a Braden and TTT with the quarterly and annual MDS. RN-F verified new assessments had not been completed when R63 developed the new pressure ulcer. RN-F stated she thought the pressure ulcer was related to an old hip fracture but the x-ray did not show that. RN-F stated the pressure ulcer started out looking like a red area or bruise and got bad very quickly. RN-F stated the original wound could have been a deep tissue injury.	F 314		

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F 314	Continued From page 19 When interviewed on 6/5/14, at 10:49 a.m. the DON stated the pressure ulcer on R63's right hip was "very superficial initially and progressed really fast." The DON stated the Allevyn dressing was used for the wound at first, but that she'd later spoken to the NP and gotten an order for an x-ray to rule out osteomyelitis. The DON stated the NP had come and looked at the wound before starting the Aquacell dressing, and the Flagyl. Interventions identified by the DON included: modifying the dressing, switching the bed around so R63 would lay on the other hip, and an evaluation of the wheelchair for any pressure issues. The DON stated no pressure issues were found from the wheelchair evaulation. The DON also stated she had assessed the wound, but verified no other assessments had been completed. The DON stated the wound nurse had not come out because "insurance would not cover it." The DON stated the rationale for the wound nurse had been for her to debride the slough, but since slough had already come out, the wound nurse was not needed. During this interview, the DON verified the new area on R63's left shoulder was also a pressure ulcer. The DON stated the alternating pressure mattress was placed on R63's bed "two to three weeks ago." When interviewed on 6/5/14, at 11:06 a.m. RN-C stated R63 had a stage II pressure ulcer to the left posterior shoulder which measured 3.4 cm x 1.5cm. The DON was interviewed on 6/5/14, at 1:40 p.m. and stated that although they normally conduct a Tissue Tolerance Testing (a test used to test tissue perfusion), none had been completed for R63 when the open areas occurred.	F 314		

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F 314	Continued From page 20 The facility's Skin Protocol Policy, dated 12/94 and revised 06/12, identified care for a stage II pressure ulcer to include keep off the area and chart daily. For a stage IV pressure ulcer, keep pressure off ulcer, debride necrotic tissue and chart at least daily. For reduction of pressure; full position changes at least every two hours, small shifts in weight every 20 to 30 minutes, protect trochanters with 30 degree turns and pillows. The facility Pressure Ulcer Task Force Policy, dated 3/95 and revised 9/13, indicated a resident who enters the facility does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, the pressure ulcers were unavoidable. The procedure indicated wound rounds would be completed every week for wounds that are stage II-IV to measure wounds, document on wound flow sheet and wound documentation in the electronic medical record (EMR), and to follow up with the NP/physicians to assess whether current treatments are appropriate or not. The policy indicated all documentation would be done on a weekly basis by a licensed nurse using the Pressure and Vascular Wound Flow sheet in the EMR. The policy also indicated the resident's family and NP/physicians would be updated on a routine basis.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure half side rails were assessed for use and maintained in a safe and functional manner for 1 of 3 residents (R40) reviewed for accidents. In addition, the facility failed to ensure a toilet armrest was stable and secure for 2 of 2 residents (R8, R62) bathroom. Findings include: R40 was not assessed for the safe use of half side rails and the half side rail was observed to be loose on the bed. The quarterly Minimum Data Set (MDS) dated 5/14/14, for R40 included a Brief Interview of Mental Status (BIMS) score of seven (moderate cognitive impairment) and indicated R40 was independent with bed mobility and transfers. The ADL (activities of daily living) Functional/Rehabilitation Potential, and Falls Care Area Assessment (CAA) dated 2/20/14, did not identify or assess the use of half side rails for R40. A Fall Risk Assessment dated 5/14/14, included a score of thirteen and indicated scores above ten represented a HIGH RISK for falls. The Summary Notes section did not identify nor assess the safe use of half side rails for R40 and indicate R40 held onto furniture in room to ambulate. The care plan dated 8/16/13, indicated R40 used a half position rail to maintain independence with bed mobility and assist with transfers in and out of bed. The at risk for falls care plan noted R40 fell on 12/18/13, while trying to move a blanket on the bed. The NAR List dated 6/2/14, indicated	F 323	Maintenance staff replaced entire bed and put on a new side rail for Resident 40. Toilet arm rest replaced with new armrest for Residents 8 and 62. Reviewed and updated policies and procedures for Assistive Devices. Reviewed and re-educated Maintenance staff on policy and procedure. Maintenance staff will audit Assistive Devices weekly for 1 month, then monthly thereafter. Administrator and Maintenance staff to monitor Date of completion: 7/11/2014	

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F 323	Continued From page 22 R40 had two half assist rails. The Treatment Record dated June 2014, included "OK FOR ½ SIDE RAILS FOR BED MOBILITY." A Progress Notes dated 3/17/14, noted R40 was found on the floor at 9:30 p.m. The note further indicated R40 was stepping backwards and sat partially on the bed, caught herself some but fell anyway. A Care Conference Note dated 5/29/14, did not identify side rails used for R40. During observations on 6/3/14, at 9:24 a.m. half side rails were noted on both upper ends of R40's bed. The half side rail on the right side of the bed away from the wall was loose and moved away from the mattress when pulled. On 6/4/14, at 7:17 a.m. R40 was observed sitting in a wheel chair next to the bed with the half side rail up on the right side of the bed. The half side rail was again noted to be loose. When interviewed at 7:20 a.m. R40 reported she used the half side rail to get up from bed. Upon interview on 6/4/14, at 9:24 a.m. nursing assistant (NA)-E stated R40 was independent with cares and only required staff assistance with showers. When interviewed on 6/4/14, at 2:50 p.m. the director of nursing (DON) verified the side rail was loose and maintenance would need to tighten it. The DON stated maintenance checked the fit of side rails on safety rounds. During the environmental tour on 6/5/14, from	F 323		

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F 323	Continued From page 23 10:00a.m.to 10:45 a.m., the administrator stated the side rail for R40 had been "swapped out yesterday." When interviewed on 6/5/14, at 1:33 p.m. maintenance (M)-A stated she was not aware the side rail for R40 was loose until it was reported to her on 6/4/14. M-A stated she checks side rails only if nursing reports a problem and does not keep logs of any checks made. The DON was interviewed on 6/5/14, at 1:40 p.m. and stated side rail assessments are not completed unless the side rail is a restraint and audits are not completed unless there is a problem. The facility Side Rail policy dated 01/98 and revised 06/12, did not address assessing the safe use of a side rail and did not address how/when the side rail would be checked for safe use. During observations on 6/2/14, at 3:35 p.m. the toilet armrest in the bathroom for R8 and R62 was observed to be very loose. During the environmental tour on 6/5/14, from 10:00a.m. to 10:45 a.m., the administrator verified the toilet armrest was loose and would need to be tightened or replaced. The Admission Record dated 6/5/14, for R62 included diagnoses of pain in joint pelvic region and thigh and muscle weakness. R62's care plan indicated she was independent with toileting and was at risk for falls. The Admission Record dated 6/5/14, for R8 included diagnoses of personal history of fall and	F 323		

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F 323	Continued From page 24 lower limb amputation. R8's care plan indicated she was able to use the toilet independently and was at risk for falls. The facility Grab Bar Policy dated 6/5/13, did not address how grab bars would be monitored for safe use.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food in a sanitary manner and failed to ensure food preparation equipment was clean to minimize the possibility of food borne illness. This had the potential to affect 60 of 64 residents who were served food out of the kitchen. In addition, the facility failed to ensure milk (a potentially hazardous food) was held at a safe temperature to minimize the risk for foodborne illness for 4 of 4 residents (R11, R35, R58, R65) who ate in the first floor small dining area. Findings include:	F 371		

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F 371	Continued From page 25 On 6/2/14, from 5:11 p.m. to 6:03 p.m. six glasses of milk were observed on the table in the small dining room on first floor for R11, R35, R58, R65 and for two apartment residents. At 6:03 p.m. the registered dietitian (RD) was asked to check the temperature of the milk in the glass for R65. The temperature of the milk was 50 degrees Fahrenheit (F). When interviewed at 6:05 p.m. R65 reported he liked his milk "ice cold." On 6/5/14, at 7:50 a.m. glasses of milk for R11, R35, R58, R65 were again observed on the dining room tables. When interviewed on 6/5/14, at 7:50 a.m. dietary aide (DA)-A stated he put beverages including milk on the tables around 7:15 a.m. and DA-B had put the beverages on the table that morning. Upon interview on 6/5/14, at 7:53 a.m. DA-B stated she had put the milk on the tables at 7:10 a.m. On 6/5/14, at 7:56 a.m. the administrator was asked to check the temperature of the milk for R11. The temperature of the milk was 50 degrees. When interviewed on 6/5/14, at 11:50 a.m. the RD stated milk should be forty-one degrees or less. The RD stated staff shouldn't be setting the milk out too early and "probably need to look at a new way of doing things." The Handling Cold Foods for Trayline policy dated 1/31/14, directed proper cold food temperatures will be maintained during meal service.	F 371	Policies and procedures updated. Dietary Staff educated on changes to the policies. Reviewed resident preferences with residents at Resident Council meeting on June 25th. Cleaning audits will be completed once weekly for 3 months then monthly six months. Milk temperature audits will be completed weekly for one month then monthly for six months. Administrator and Dietitian to monitor Date of completion: 7/11/2014	

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F 371	Continued From page 26 The supper dining service was observed on 6/2/14, from 5:45 - 6:15 p.m. in the main kitchen directly outside the first floor dining room. Meal service included hamburgers, chicken tenders, potato salad, lettuce leaf and tomato wedges. The following was noted: At 5:45 p.m., R20 was observed handling and touching his menu choice card out in the dining room. At 5:47 p.m., cook (C)-A was observed wearing a pair of disposable gloves on both hands while serving food from behind a steam table. C-A was observed opening the oven door, obtaining a tray of chicken tenders, pouring them into a steam table container, obtained a thermometer to check the temperature of the chicken tenders, touched a black magic marker to record the temperature, took the gloves off, put on new gloves without washing her hands. At 5:50 p.m., C-A obtained an alcohol wipe to clean the thermometer, checked the temperature of the pureed and mechanical soft meats, recorded the temperature using the black magic marker, obtained a heated plate, touched a menu card which had been placed on the top steam table counter, and with the same soiled gloves placed a lettuce leaf on the plate, used a scoop to place potato salad on the lettuce leaf and placed a tomato wedge next to the lettuce. With the same soiled gloves, C-A opened the dessert refrigerator door to place juice inside, came back to the steam table, grabbed a clean plate, touched and turned the menu choice cards to face the aides serving the residents and spread more menu choice cards on the top steam table counter. C-A then obtained a hamburger bun, opened it with the same soiled gloved hands, placed it on the	F 371		

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F 371	Continued From page 27 plate, used tongs to place hamburger on bun, rested right hand on top of steam table. Repeatedly during the meal service C-A touched menu choice cards and with the same soiled gloves placed lettuce leaves, tomato wedges and/or hamburger buns on the plates when requested. During an interview on 6/2/14 at 6:18 p.m., the RD stated "the menu cards are placed on the tables before residents come into the dining room and dietary staff handle the menu cards, but there is potential for the residents to touch them also." She further stated she did not know why tongs were not used to place lettuce, tomato on the plates and agreed that there was potential for contamination by touching the menu cards and and other surfaces without changing gloves. Review of the undated facility Bare Hand Contact with Food and Use of Plastic Gloves policy outlined "single use gloves shall be used for only one task...and discarded when damaged or soiled, or when interruptions occur in the operation" and that "anytime a contaminated surface is touched, the gloves must be changed". Equipment sanitation procedures were not followed for the steel backsplash behind the convection oven. During a tour on 6/4/14 at 1:30 p.m. with the dietary intern (DI), the steel backsplash located directly behind the convection oven was observed to have a buildup of a brown, greasy type substance with a heavy buildup of dust particles attached to the greasy substance. This area was approximately 2 feet wide by 1 foot in length above and to the left side of the oven. An exhaust	F 371		

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F 371	Continued From page 28 container connected to the back of the convection oven was covered with the same brown, greasy substance with a heavy buildup of dust particles attached to it. Uncovered muffin pans were in close proximity of this brown greasy, dusty buildup. The DI could not provide when this was last cleaned and verified it was not clean. During an interview on 6/5/14 at 10:58 a.m., RD stated she was not sure when the backsplash was last cleaned, but it is her or the head cook's responsibility to check to make sure the cleaning tasks are completed. RD verified the brown greasy substance with accumulated dust particles on the steel backsplash and convection oven exhaust container was not clean. Review of the facility "monthly cleaning schedule AM cook" indicated the steel backsplash behind the ovens was to be cleaned the 2nd and 4th Sun of the month and was last cleaned on 5/24/14. Review of the facility Cleaning and Sanitation of Dining and Food Service Areas policy dated 3/13/14, outlined "the food service staff will maintain the cleanliness and sanitation of the dining and food service areas".. and that "staff will be held accountable for cleaning assignments."	F 371		
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	F 431		

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F 431	Continued From page 29 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 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 medications were stored at the correct temperature for 3 of 3 residents (R4, R68, R88) reviewed during medication storage. Findings include: During observation of the second floor North medication room on 6/5/14, at 9:35 a.m., the	F 431	Mechanics checked of refrigerator and refrigerator was functioning appropriately. Reviewed and updated policy and procedure. Staff reeducated regarding policy and procedure for need to monitor refrigerators for proper temperature and what to do when temperature is not with in parameters. Audit refrigerator temperatures are within proper parameters and that nursing staff are aware of what to do if the temperature is not within parameters set up by policy and procedure. Audits will be conducted 3 x/wk for 4 weeks, then 1x/wk for 4 weeks, then monthly for 4 months. DON, ADON and MDS Coordinator to monitor. Date of completion: 7/11/2014	

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F 431	Continued From page 30	F 431		

thermometer in the medication refrigerator read 25 degrees. The temperature was verified by licensed practical nurse (LPN)-A to read 25 degrees. Medications stored in the refrigerator were glucagon, two boxes of bisacodyl suppositories, a brown paper bag of lab tests not yet done, one bottle of normal saline, a bottle of liquid ativan labeled with R68's name, one third full, with a refilled date of 4/14/14, three liquid vials of Aranesp labeled with R88's name with a refilled date of 5/31/14, and Latanoprost eyedrops labeled with R4's name with a refilled date of 5/31/14. LPN-A verified these medications in the refrigerator. LPN-A also verified the temperature documented on the Refrigerator Temperature Log for 6/5/14, read 28 degrees and 6/4/14, read 30 degrees, and 6/3/14, read 30 degrees. Documentation on the Refrigerator Temperature Log was missing on 4/17/14, 4/18/14, 4/25/14, 4/27/14, 4/28/14, 4/29/14, 4/30/14, 5/01/14, 5/02/14, and 5/17/14. The Refrigerator Temperature Logs included temperatures out of the correct range on 4/1/14, 46 degrees, 4/2/14, 46 degrees, 4/3/14, 46 degrees, 4/8/14, 48 degrees, 4/9/14, 48 degrees, 4/10/14, 48 degrees, 4/12/14, 48 degrees, 4/13/14, 48 degrees, 4/14/14, 48 degrees, 4/16/14, 26 degrees, 4/21/14, 48 degrees, 5/12/14, 50 degrees, 5/25/14, illegible temperature. LPN-A also verified at the bottom of the Refrigerator Temperature Log that temperatures to be checked daily and maintain temp (35-45 F).

On 6/5/14, at 9:43 a.m., LPN-A stated the night nurse checks the refrigerator temperature every night and documents it on the temperature log. She stated when asked by surveyor the refrigerator temperature should be between 36 and 40 degrees. She also stated if the

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F 431	Continued From page 31 temperature is not in that range, nursing should have the refrigerator checked out and if malfunctioning let maintenance and administrator know to replace. On 6/5/14, at 10:24 a.m. registered nurse (RN)-A stated the nurses should be aware of the medication refrigerator temperature range and if the temperature is not within the range the nurse should adjust the temperature of the refrigerator to correct. RN-A also stated if the nurse thinks there is an issue or something is wrong, the nurse should notify RN-A or director of nursing (DON) to get a new refrigerator. On 6/5/14, at 10:31 a.m. the consultant pharmacist (CP) stated liquid Ativan, liquid Aranesp, and Latanoprost eyedrops should be stored between 36 to 46 degrees. CP stated outside the range of 36 to 46 degrees there would be no stability of the medication and would not be able to guarantee the concentration and/or effectiveness of the medications. Individual inserts of the Ativan, Aranesp, and Latanoprost provided by CP showed each medication should be stored at a temperature between 36 degrees and 46 degrees. On 6/5/14, at 10:44 a.m. LPN-A stated a new thermometer had just been put in the medication refrigerator on two North. On 6/5/14, at 12:36 p.m. LPN-A stated R88 received the Aranesp injections once a week and verified on the medication administration record (MAR) R88 received an Aranesp injection on 6/4/14, in the morning. LPN-A also stated R88 received Aranesp injections for anemia related to chronic renal failure. LPN-A also verified the	F 431		

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F 431	Continued From page 32 Latanoprost eyedrops were given to R4 daily in the morning and needed to be refrigerated. The Admission Record for R4 dated 6/5/14, included a diagnoses of Glaucoma. The June 2014, MAR noted R4 received Latanoprost sol 0.005% 1 drop to each eye every morning. The Admission Record for R68 dated 6/5/14, included diagnoses of depressive disorder and failure to thrive. The June 2014, MAR noted R68 received liquid Ativan 0.5 mg (0.25 ml) orally 2 times daily and Ativan to be kept in fridge. The Admission Record for R88 dated 6/5/14, included diagnoses of renal failure, thrombocytopenia, and other abnormal blood chemistry. The June 2014 and May 2014, MAR showed R88 received an Aranesp injection of 100 mcg sub-IQ every Wednesday starting 5/2/14, due to anemia associated with chronic kidney failure and to keep medication in the fridge. On 6/5/14, at 1:30 p.m. the DON stated she expected her nurses to follow the refrigerator temperature policy when checking the temperature of the medication refrigerators daily. The DON also stated she expected the nurses to recheck the refrigerator temperature after adjusting the thermostat per policy. The Temperature of Refrigerators Policy dated last revision 06/12, stated it is the policy of Bethany Care Center to monitor temperatures in medication refrigerators to maintain proper temperatures in order to preserve medications used for residents. Temperature Refrigerator Procedure states 1. Check temperature every day and document on refrigerator temperature log, 2.	F 431		

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F 431	Continued From page 33 If temperature is > [greater than] 45 degrees or < [less than] 35, adjust thermostat accordingly and recheck in 1 hr., 3. If temperature remains > than 45 or < than 35, notify maintenance and move refrigerator items to another refrigerator on another unit until refrigerator is able to be fixed or replace. The Storage of Medications dated Revision 12/12, stated it is the policy of Bethany Care Center to ensure accurate, safe and timely administration of our drugs to our residents, and to ensure safe storage of supplies. Number six of policy stated Medications requiring "refrigeration" are kept at temperatures ranging from 36-46 degrees F (Fahrenheit) in a refrigerator not accessible to residents.	F 431		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light system was functional for 3 of 35 residents (R23, R39, R28) reviewed. Findings include: The care plan for R23 dated 3/21/14, included a Brief Interview of Mental Status (BIMS) score of 15/15 which indicated R23 was cognitively intact. The at risk for falls care plan for R23 dated 1/9/13, directed "make sure call light is within	F 463		

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F 463	Continued From page 34 reach." At 9:21 a.m. the call light for R23 was activated and did not light up outside the room. The care plan for R39 dated 5/5/14, included a BIMS score of 13/15 which indicated mild cognitive impairment. The at risk for falls care plan dated 7/25/13, directed "answer call light quickly." During observations on 6/3/14, at 9:26 a.m. the call light for R39 was activated and also did not light up outside of the room. During interview at this time, nursing assistant (NA)-D verified the call light did not work outside of the room for R23 and R39 but did light up at the nursing station (on another unit). The care plan for R28 dated 12/12/12, indicated R28 was alert and oriented to place and person but not always time. During observations on 6/3/14, at 1:17 p.m. the call light for R28 was activated and did not light up outside the room and did not sound at the nursing station. NA-E verified the call light was not working. The facility environmental tour was conducted on 6/5/14, from 10:00 a.m. to 10:45 a.m. with the administrator. The administrator verified the call lights for R23, R39 and R28 did not light up outside the room when activated and needed to be replaced. When interviewed on 6/5/14, at 1:33 p.m. maintenance (M) - A stated call lights are checked with new admissions, when someone moves out, periodically and no logs were kept. M-A stated "it's an old building; they [the call lights] go out all the time." M-A stated "downstairs is always a problem" and she relies on staff to report problems to her. M-A reported she was unaware the call lights for R23, R39 and R28 were not working.	F 463	Policy and procedure updated. Maintenance staff educated on the changes to the policy. Call light bulbs were replaced. Maintenance will check call lights weekly for 4 weeks and monthly thereafter. Administrator and Maintenance staff to monitor. Date of completion: 7/11/2014	

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F 463	Continued From page 35 The DON was interviewed on 6/5/14, at 1:40 p.m. and stated audits of call lights are not completed unless there is a problem. The facility Call Light Maintenance Policy dated 6/5/13, directed "Upon discharge or room change call lights will be checked by housekeeping when they do a room turn to ensure functionality. Maintenance staff will test call lights monthly and replace bulbs or cords as needed. Nursing staff will notify maintenance as necessary."	F 463		

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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) 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: On 6/2/14 through 6/5/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	RECEIVED JUL - 9 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION 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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/2/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00167	A. BUILDING: _____ B. WING _____	06/05/2014

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2 000	Continued From page 1 Certification Program, P.O. Box 64900, Saint Paul, MN 55164-0900	2 000	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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care as	2 565		

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2 565	Continued From page 2 directed in the plan of care for 1 of 3 residents (R48) reviewed for activities of daily living (ADLs). Findings include: R48's lower front teeth were observed to be dirty during all encounters. On 6/3/14, 6/4/14, and 6/5/14; whitish matter/substances were observed in the corners of R48's mouth and eyes. On 6/3/14 and 6/4/14; R48 had no socks on and on 6/5/14, R48's left heel was awkwardly not placed in left shoe. The Diagnosis Information section of the electronic admission record indicated R48 had diagnoses to include: Alzheimer's disease, essential and unspecified forms of tremor, vascular dementia, chronic kidney disease, and pain in joint (forearm). The annual Minimum Data Set (MDS) dated 11/13/2013, indicated R48 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated significant cognitive impairment. The Care Area Assessment (CAA) dated 11/23/2013, identified R48 had impaired ability to communicate or to make ideas and wants understood. The care plan dated 5/23/2014, identified R48 had a ADL self-care performance deficit and required assistance with personal hygiene. The care plan directed staff to assist R48 with mouth cares and other ADLs. The nursing assistant care sheet dated 6/2/14, indicated R48 needed assistance by 1 staff for dressing and grooming. On 6/3/14, at 10:16 a.m. R48 was observed sitting alone in the day room. Streaks of whitish matter/substances that looked like dried tears and dried saliva were observed in the corners of R48's eyes and mouth. R48 was also observed to	2 565		

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2 565	Continued From page 3 have facial hairs which were approximately 1 centimeter in length. When R48 opened her mouth to talk, R48's lower teeth were obviously dirty. On 6/4/14, at 9:35 a.m. R48 was observed with five other residents in the coffee and chat activity at the apartment dining room. R48 had dry white matter/substances around the corners of her eyes and mouth, and still had the facial hairs. - At 1:50 p.m. R48 was sitting in a chair at the front lobby holding a magazine and flipping the pages. When talking, R48's lower teeth were observed to be yellowish dirty and whitish streaks observed in the corners of her eyes and mouth. When surveyor asked R48 if she was helped from bed that morning, she stated "yeah" then moved lower extremities forward and slightly pulled pants on right leg to show that no socks were worn. When asked if she liked to wear socks, R48 nodded and continued to talk. On 6/4/14, at 1:58 p.m. nursing assistant (NA)-D stated she helped R48 to get up that morning and stated R48 cannot perform ADLs independently but needed cueing and assistance. NA-D stated R48 would not ask for needs so staff need to go ask and help R48 every time. -At 2:06 p.m. registered nurse (RN)-C stated R48 needed reminders about daily cares. RN-C stated R48 can do things herself like washing face but just needed stand-by assist and cueing. On 6/5/14, at 7:50 a.m. R48 was observed walking in the dining room, heel of left foot was out from her shoe, in an awkward appearance. R48's lower teeth were still dirty as observed when mouth was opened to talk in response to	2 565		

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2 565	Continued From page 4 surveyor's greeting. On 6/5/2014, at 1:34 p.m. when R48 was asked how it felt having facial hairs and how it felt having left heel not placed well in shoe, R48 did not seem to comprehend the questions. R48 started talking about things that were totally unrelated to the questions being asked. The facility's Adequate and Proper Nursing Care Policy dated 6/2012, directed staff to provide proper care to residents, to include assistance with or supervision of shaving as needed to keep them clean and well-groomed, and assistance with oral hygiene to keep mouth and teeth clean. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures to ensure residents care plans are followed . The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Forty (40) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out	2 830		

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2 830	Continued From page 5 of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure weights were monitored as ordered for 1 of 1 resident (R20) reviewed for dialysis. Findings include: R20's Admission Record dated 6/5/14, included diagnoses of chronic kidney disease stage III (moderate), unspecified disorder of kidney and ureter, congestive heart failure, and abnormal weight gain. R20 scored an eight on a Brief Interview for Mental Status (BIMS) assessment dated 1/22/14, indicating moderately impaired cognition. On 6/4/14, at 8:36 a.m. a licensed practical nurse (LPN)-A stated R20 would be returning from dialysis after 1:00 p.m. and attended dialysis weekly on Mondays, Wednesdays, and Fridays. On 6/4/14, at 1:19 p.m. R20 was observed seated in his wheelchair in his room. On 6/4/14, at 1:45 p.m. LPN-A stated when R20 returned from dialysis, the staff was provided and envelope of information from the dialysis center including the resident's daily weight records. On 6/5/14, at 12:36 p.m. LPN-A verified R20's weights from dialysis were not on the visit sheet returned to facility upon R20's return from dialysis	2 830		

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2 830	Continued From page 6 on 6/4/14. LPN-A also stated it was on the "list to do today" to call the dialysis center for R20's 6/4/14 weight. LPN-A also verified on the 6/14 Treatment Administration Record (TAR), R20's dialysis weight was not initialed off by staff, nor were the dry weights from dialysis recorded on both 6/2 and 6/4/14. LPN-A also stated it was the nurse's responsibility to initial the TAR for the dry weight upon R20's return to facility from dialysis and the nurse's responsibility to enter the weight into the computer. On 6/5/14, at 1:30 p.m. the director of nursing (DON) stated she expected the nurses to follow physician orders and record weights for residents returning from dialysis. The DON also stated if the weights did not come back on the visit referral sheets from dialysis, she expected the nurse would call the dialysis center upon resident's return to the facility to obtain the information and then record it. The physician order started 11/18/13, directed staff to record dry weight from dialysis every Monday Wednesday and Friday. The dialysis visit referral sheets which came back with R20 from dialysis dated 5/30/14, 5/21/14, 5/19/14, 5/14/14, and 4/16/14 included the dry weight for R20. The other May and April visit referral sheets for R20's dialysis on Monday, Wednesday, and Fridays did not include the dry weights. On the Weights and Vitals Summary the weights for R20 were recorded only on 5/30, 5/29, 5/22, 5/12, 5/01, 4/24, 4/17, 4/16, 4/11, 4/10, and 4/3/14. The only dated initials by nursing staff for recorded dry weights from dialysis on the TARs for R20 for 6/14, 5/14, and 4/414 were on 5/23/14, and 4/11/14. The other dialysis dates on the 6/14, 5/14, and 4/14 TARs were blank (not initialed by nursing staff).	2 830		

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2 830	Continued From page 7 R20's care plan dated 5/6/14, indicated a potential for dehydration related to fluid restriction. The goal was for the resident to show no signs or symptoms of dehydration. Interventions included staff recording the resident's weight before breakfast, monitor those weights, and weigh per facility policy/physician order. The facility Dialysis Policy (last revised 6/12) noted it was the facility's policy to meet resident's needs who received dialysis. Number four listed under Dialysis Procedure on the Dialysis policy directed staff to "send referral paperwork with resident to dialysis with any pertinent information regarding their care. Dialysis will communicate with Bethany staff on any concerns related to dialysis run or any changes." Number six listed under Dialysis Procedure on the policy directed staff to "coordinate with dialysis center to make sure nursing staff are monitoring fluid restrictions/labs/access sites/weights as ordered by physician/dialysis center." SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures to ensure residents receiving dialysis receive the care and services ordered by the physician. The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Forty (40) days.	2 830		

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2 900	Continued From page 8	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify causative factors, and implement interventions, to minimize the risk for skin breakdown for 1 of 2 residents (R63) reviewed for pressure ulcers. This resulted in actual harm for R63 who acquired an avoidable stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle) to the right hip, and a stage II (partial thickness loss of dermis presenting as a shallow open ulcer) pressure ulcer to the left shoulder while in the facility. Findings include: R63's Admission Record dated 6/27/13, indicated diagnoses including hip fracture and dementia. The quarterly Minimum Data Set (MDS) dated 3/5/14, indicated R63 was at risk for pressure	2 900		

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2 900	Continued From page 9 ulcers, had no unhealed pressure ulcers, required extensive assist of one staff for bed mobility, transfers and toilet use as well as a Brief Interview of Mental Status (BIMS) score of five (moderate to severe cognitive impairment). This MDS also indicated R63 had pressure relieving devices for bed and chair, but was not on a turning and repositioning program. During continuous observations on 6/4/14, from 7:02 a.m. until 7:35 a.m. R63 was observed in bed on back. At 7:35 a.m. NA-E entered R63's room and asked if ready to get up. R63 responded "no" and NA-E stated when R63 says no she comes back after breakfast. NA-E did not reposition R63. R63 remained on his/her back during continuous observations from 7:35 a.m. until 8:44 a.m. At 8:44 a.m. NA-E entered the room and woke R63 up. R63 stated "dig a hole and throw me in it." NA-E stated when R63 "is doing that, I don't get [R63] up." NA-E provided incontinent cares and rolled R63 from side to side. R63 was off his/her back for less than one minute on each side. An intact dressing was observed to the right hip. NA-E stated she had to get a bigger incontinent product for R63 so it wouldn't put pressure on the "sore." While NA-E was providing incontinent cares, a four cm x four cm open area was noted to the back of the left shoulder and blood was observed on R63's gown. R63 was left on his back after the cares were completed. R63 remained on back in bed until 9:41 a.m. when NA-E responded to R63's call for help, assisted R63 to dress and transfer into the wheelchair. The Pressure Ulcer Care Area Assessment (CAA) dated 6/7/13, revealed R63 was at risk for	2 900		

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2 900	Continued From page 10 pressure ulcers and had fragile skin which was prone to bruising. A Braden Scale For Predicting Pressure Sore Risk dated 3/5/14, indicated R63 was at risk for skin breakdown. No assessment was conducted to determine an appropriate turning and repositioning schedule for the resident. A Care Conference Note dated 3/20/14, indicated R63 had intact skin with no areas of concern. However, the care plan dated 3/22/13, did indicate R63 was at risk for alteration in skin integrity. The care plan was updated 5/15/14, to identify an open area to the resident's right hip. The original goal was for R63 to be free from pressure ulcers, or other alterations in skin integrity, and had been revised 5/15/14 to include, open area to right hip will heal. Care plan interventions included: assist R63 to reposition in wheel chair or bed every two hours and as needed (prn), pressure relieving cushion for wheel chair, pressure relieving mattress while in bed. The interventions were updated on 5/15/14, to include a treatment for the pressure ulcer. No other revisions to the care plan were noted. The NA (nursing assistant) List (for resident care) dated 6/2/14, identified R63 had an open area on the right hip and directed staff to position R63 on the left side or back and reposition every two hours. A Bethany Care Center Weekly Skin Checklist dated 3/22/14, indicated R63 had no pressure ulcers present. The Checklist dated 4/5/14, indicated R63 had an open area to the right hip and that Allevyn (a wound dressing) and skin prep were applied as ordered. The Checklist dated 4/12/14, identified an open area to the right hip, however no actions were noted. The Checklist dated 4/19/14, indicated R63 had an open area to the right hip and that the Allevyn dressing was changed as ordered.	2 900		

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2 900	Continued From page 11 A Progress Note dated 4/1/14, indicated R63 had a 4.0 cm (centimeter) by 3.5 cm reddened area noted on the right hip and that R63 had been scratching at the area. An Investigative Skin Flowsheet Updated dated 4/3/14, revealed R63 had a stage II pressure ulcer to the right hip which measured 5.7 cm by 4.5 cm with zero depth. The instructions directed to complete the flowsheet on discovery of a skin issue and weekly until healed. The summary of status section noted a reddened area had been noted on 4/2/14, which was superficially opened and slightly larger on 4/3/14. Documentation indicated the area was located on the trochanter and on the side (right) R63 preferred to lay on. Additionally, the note indicated the interdisciplinary team felt the area was related to pressure. The Treatment Administration Record (TAR) dated April 2014, included an intervention for staff to measure and document the wound every week on Thursday. Documentation on the TAR indicated the wound had been measured on 4/10/14, that the director of nursing (DON) had measured the wound on 4/17/14, and there was no signature to indicate whether or not it had been completed on 4/24/14. The medical record lacked evidence of any assessment of the wound other than the measurements for 4/10, 4/17 and 4/24/14. The TAR also indicated staff were to monitor the red area on the resident's right hip until resolved and were supposed to update the nurse practitioner (NP) with any complications, which was signed off as having occurred daily. A physician progress note dated 4/8/14, did not address whether the physician was aware of the open area to the right hip. A NP note dated 5/8/14, indicated a right ischial tuberosity (IT) wound had progressed in three weeks from a red area to a stage II-III, very foul smelling, green	2 900		

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2 900	Continued From page 12 purulent drainage. The NP's note later indicated R63 had a stage II-IV IT wound and the dressing was changed from Allevyn to Aquacel and Flagyl (an antifungal) was added for odor to be changed twice day. A Health Status Note dated 5/11/14, indicated the wound "seems to be better" and "does not have such a foul odor as it did a few days ago." An Investigative Skin Flowsheet Updated dated 5/13/14, indicated R63 had a stage IV pressure ulcer to the right hip which measured 4.3 cm by 2.8 cm and was 2.8 cm deep. The note indicated the wound bed was covered with 90% slough and had undermining over the entire circumference of the wound. It was again noted R63 preferred to lay on the right side and needed to be encouraged to lay on left side or back. R63 was identified as not being able to off load independently. The bed was noted as turned to accommodate lying on left side or back and an alternating air mattress had been put on the bed the prior week. The TAR dated May 2014, directed to measure and document wound every week on Thursday. For 5/1/14, 5/15/14, and 5/22/14 the TAR indicated the DON had measured the wound, however for 5/8/14 and 5/29/14, the TAR was not signed to indicate this had been completed. In addition, the medical record lacked evidence the wound had been assessed along with measurements when taken, and included only subjective data regarding the wound status. Although not all measurements and/or assessment had been recorded, the TAR dated May 2014, also indicated staff were to monitor the red area on the right hip until resolved, and update the nurse practitioner (NP) with any complications, which had been signed off as having occurred daily.	2 900		

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2 900	Continued From page 13 A physician's order dated 5/15/14, directed "x-ray today of right hip and OK for wound nurse to evaluate and treat". The x-ray report dated 5/15/14, indicated there were pockets of gas within the soft tissue adjacent to the right proximal femur which could be related to an open wound, necrotizing infection or developing abscess. The x-ray also noted there was a possibility of early osteomyelitis (a bone infection), and that the hip alignment was appropriate with no evidence of hardware failure. A Health Status Note dated 5/15/14, indicated a call was placed to Twin Cities Wound and Ostomy for them to come out and see R63 at the facility. A Health Status Note dated 5/16/14, indicated the right hip x-ray results were called to the physician and a physician's order dated 5/16/14, indicated R63 had been started on Augmentin (an antibiotic) twice a day for 10 days for osteomyelitis. A Health Status Note dated 5/16/14, indicated occupational therapy (OT) would evaluate R63 for wheelchair positioning although the open area was on the hip. Following the evaluation, the notes indicated OT had issued R63 a "better fit/more comfortable cushion" and indicated R63 had complained of a "sore bottom." A Health Status Note dated 5/19/14, indicated the right hip wound looked much better and appeared to be healing. The note indicated the wound was not as deep as it was a week ago. A physician's progress note dated 5/20/14, indicated R63 had a stage IV IT wound, noted the x-ray showed gas in the wound with concern for	2 900		

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2 900	Continued From page 14 osteomyelitis, and directed wound registered nurse (RN) to see and to watch for systemic infection. A Health Status Note dated 5/20/14, indicated the physician had seen R63's wound and would wait and have the wound nurse address if any treatment changes needed to be done. On 6/4/14 at 2:14 p.m. the DON and registered nurse (RN)-F were observed providing wound care for R63. R63 was observed on his/her left side when entered room and rolled to left side with the DON's assistance. The DON washed her hands, applied gloves and removed the pressure ulcer dressing. The wound was observed as a deep cavity with strings of yellow slough in the wound bed. The DON stated a large amount of escar had come out of the wound. The DON also stated R63 had a nail in the left hip from a former hip fracture and she didn't think the pressure ulcer wound have gotten "that bad so fast" if just pressure. The DON removed her gloves, washed her hands and applied new gloves before applying wound cleanser to a four by four gauze pad. The DON used the four by four gauze to cleanse the wound bed and the skin surrounding the wound bed. The DON removed her gloves, cleansed her hands with hand sanitizer, applied new gloves and applied skin prep to the surrounding skin. The DON then again removed her gloves, cleansed her hands with hand sanitizer, applied new gloves and measured the wound. The wound was measured as a length of 4 cm, width of 2.6 cm, depth of 1.9 cm with undermining from nine o'clock to eleven o'clock and slough from three o'clock to seven o'clock. Crushed Flagyl was poured into the wound bed and an Aquacel dressing was cut into three strips and packed into the wound bed using a Q-tips. A gauze dressing was placed over the wound,	2 900		

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2 900	Continued From page 15 covered with another dressing and secured with tape. R63 slept through the dressing change and did not have any observed indicators of pain. Upon interview on 6/5/14, at 9:08 a.m. NA-E stated she was aware R63 had a pressure ulcer on the right hip and it was identified on the assignment sheet. NA-E stated she was not aware of any new interventions for R63. When interviewed on 6/5/14, at 9:10 a.m. RN-C stated the pressure ulcer on R63's hip started within the last two months as a "little red area, like he was scratching it". RN-C stated R63 "loved to sleep on that side" and that the bed had been turned around to encourage R63 to sleep on the other side. RN-C stated an alternating pressure mattress was initiated on 5/6/14. RN-C stated the MDS nurse was responsible to complete a Braden and TTT, but RN-C stated she didn't think a new one had been done for R63. RN-C also stated she didn't think the wound nurse had come out yet because of insurance issues. When interviewed on 6/5/14, at 9:20 a.m. RN-C stated she thought an open area on R63's shoulder was from a skin tear. When the open area was observed by RN-C, she stated the area on the posterior shoulder looked like a new pressure ulcer from laying on his/her back. RN-C verified the open area on the shoulder was over a bony prominence. RN-F was interviewed on 6/5/14, at 10:29 a.m. and stated she had completed a Braden and TTT with the quarterly and annual MDS. RN-F verified new assessments had not been completed when R63 developed the new pressure ulcer. RN-F stated she thought the pressure ulcer was related	2 900		

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2 900	Continued From page 16 to an old hip fracture but the x-ray did not show that. RN-F stated the pressure ulcer started out looking like a red area or bruise and got bad very quickly. RN-F stated the original wound could have been a deep tissue injury. When interviewed on 6/5/14, at 10:49 a.m. the DON stated the pressure ulcer on R63's right hip was "very superficial initially and progressed really fast." The DON stated the Allevyn dressing was used for the wound at first, but that she'd later spoken to the NP and gotten an order for an x-ray to rule out osteomyelitis. The DON stated the NP had come and looked at the wound before starting the Aquacell dressing, and the Flagyl. Interventions identified by the DON included: modifying the dressing, switching the bed around so R63 would lay on the other hip, and an evaluation of the wheelchair for any pressure issues. The DON stated no pressure issues were found from the wheelchair evaulation. The DON also stated she had assessed the wound, but verified no other assessments had been completed. The DON stated the wound nurse had not come out because "insurance would not cover it." The DON stated the rationale for the wound nurse had been for her to debride the slough, but since slough had already come out, the wound nurse was not needed. During this interview, the DON verified the new area on R63's left shoulder was also a pressure ulcer. The DON stated the alternating pressure mattress was placed on R63's bed "two to three weeks ago." When interviewed on 6/5/14, at 11:06 a.m. RN-C stated R63 had a stage II pressure ulcer to the left posterior shoulder which measured 3.4 cm x	2 900		

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2 900	Continued From page 17 1.5cm. The DON was interviewed on 6/5/14, at 1:40 p.m. and stated that although they normally conduct a Tissue Tolerance Testing (a test used to test tissue perfusion), none had been completed for R63 when the open areas occurred. The facility's Skin Protocol Policy, dated 12/94 and revised 06/12, identified care for a stage II pressure ulcer to include keep off the area and chart daily. For a stage IV pressure ulcer, keep pressure off ulcer, debride necrotic tissue and chart at least daily. For reduction of pressure; full position changes at least every two hours, small shifts in weight every 20 to 30 minutes, protect trochanters with 30 degree turns and pillows. The facility Pressure Ulcer Task Force Policy, dated 3/95 and revised 9/13, indicated a resident who enters the facility does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, the pressure ulcers were unavoidable. The procedure indicated wound rounds would be completed every week for wounds that are stage II-IV to measure wounds, document on wound flow sheet and wound documentation in the electronic medical record (EMR), and to follow up with the NP/physicians to assess whether current treatments are appropriate or not. The policy indicated all documentation would be done on a weekly basis by a licensed nurse using the Pressure and Vascular Wound Flow sheet in the EMR. The policy also indicated the resident's family and NP/physicians would be updated on a routine basis. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures to ensure residents who are admitted without a pressure ulcer do not develop a pressure ulcer while in the facility. The DON or	2 900		

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2 900	Continued From page 18 designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Forty (40) days.	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate grooming and services were provided for 1 of 3 residents (R48) reviewed for activities of daily living (ADLs).	2 915		

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2 915	Continued From page 19 Findings include: R48's lower front teeth were observed to be dirty during observations on 6/3, 6/4, and 6/5/14. Whitish matter was also observed in the corners of the resident's mouth and eyes. In addition, on 6/3 and 6/4/14 R48 was not wearing socks, and on 6/5/14 the resident's left heel was not properly placed into the left shoe. The Diagnosis Information section of the electronic admission record indicated R48 had diagnoses including Alzheimer's disease. The annual Minimum Data Set (MDS) dated 11/13/13, revealed the resident's Brief Interview for Mental Status (BIMS) showed a score of 3 or significant cognitive impairment. The Care Area Assessment (CAA) dated 11/23/13, identified R48 had impaired ability to communicate or to make ideas and wants understood. The care plan dated 5/23/14, identified R48 had an ADL self-care performance deficit and required assistance with personal hygiene. The care plan directed staff to assist R48 with mouth cares and other ADLs. The nursing assistant (NA) care sheet dated 6/2/14, indicated R48 needed assistance of one staff for dressing and grooming. On 6/3/14, at 10:16 a.m. R48 was observed sitting alone in the day room. Streaks of whitish matter like dried tears in appearance as well as dried saliva at the corners of the resident's mouth were noted. R48 also had facial hair approximately one centimeter in length. When the resident opened her mouth to talk, her lower teeth were observed to be unclean. On 6/4/14, at 9:35 a.m. R48 was observed with	2 915		

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2 915	Continued From page 20 five other residents in the Coffee and Chat activity in the dining room. Again dry white matter was observed around the resident's eyes and mouth, and the facial hair was still present. At 1:50 p.m. R48 was seated in a chair at the front lobby looking through a magazine. When the resident spoke, her lower teeth were observed to be yellowish and unclean, and white streaks were noted in the corners of the resident's eyes and mouth. When asked if staff had helped her get ready that morning, the resident replied, "Yeah" and then moved her lower extremities forward and slightly pulled pants on right leg revealing she was wearing no socks. When asked if she preferred wearing socks, the resident nodded. On 6/4/14, at 1:58 p.m. NA-D reported she had assisted R48 with morning cares. NA-D explained that R48 could not independently request help or perform ADLs, but needed cueing and assistance from staff every day. At 2:06 p.m. a registered nurse (RN)-C stated R48 needed reminders to perform daily cares, and could do things such as wash her own face with standby assistance and cueing. On 6/5/14, at 7:50 a.m. R48 was observed walking in the dining room. The heel on her left foot was not placed properly in her shoe. The resident's mouth and teeth were again unclean when she spoke. At 1:34 p.m. when asked clarifying questions, the resident was unable to comprehend the conversation as evidenced by answering in unrelated topics. The facility's Adequate and Proper Nursing Care Policy dated 6/12, directed staff to provide proper care to residents, to include assistance with or supervision of shaving as needed to keep them	2 915		

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2 915	Continued From page 21 clean and well-groomed, and assistance with oral hygiene to keep mouth and teeth clean. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures to ensure residents receive needed grooming assistance. The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Forty (40) days.	2 915		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food in a sanitary manner and failed to ensure food preparation equipment was clean to minimize the possibility of food borne illness. This had the potential to affect 60 of 64 residents who were served food out of the kitchen. Findings include: The supper dining service was observed on 6/2/14, from 5:45 - 6:15 p.m. in the main kitchen directly outside the first floor dining room. Meal	21015		

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21015	Continued From page 22 service included hamburgers, chicken tenders, potato salad, lettuce leaf and tomato wedges. The following was noted: At 5:45 p.m., R20 was observed handling and touching his menu choice card out in the dining room. At 5:47 p.m., cook (C)-A was observed wearing a pair of disposable gloves on both hands while serving food from behind a steam table. C-A was observed opening the oven door, obtaining a tray of chicken tenders, pouring them into a steam table container, obtained a thermometer to check the temperature of the chicken tenders, touched a black magic marker to record the temperature, took the gloves off, put on new gloves without washing her hands. At 5:50 p.m., C-A obtained an alcohol wipe to clean the thermometer, checked the temperature of the pureed and mechanical soft meats, recorded the temperature using the black magic marker, obtained a heated plate, touched a menu card which had been placed on the top steam table counter, and with the same soiled gloves placed a lettuce leaf on the plate, used a scoop to place potato salad on the lettuce leaf and placed a tomato wedge next to the lettuce. With the same soiled gloves, C-A opened the dessert refrigerator door to place juice inside, came back to the steam table, grabbed a clean plate, touched and turned the menu choice cards to face the aides serving the residents and spread more menu choice cards on the top steam table counter. C-A then obtained a hamburger bun, opened it with the same soiled gloved hands, placed it on the plate, used tongs to place hamburger on bun, rested right hand on top of steam table. Repeatedly during the meal service C-A touched menu choice cards and with the same soiled gloves placed lettuce leaves, tomato wedges and/or hamburger buns on the plates when	21015		

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21015	Continued From page 23 requested. During an interview on 6/2/14 at 6:18 p.m., the RD stated "the menu cards are placed on the tables before residents come into the dining room and dietary staff handle the menu cards, but there is potential for the residents to touch them also." She further stated she did not know why tongs were not used to place lettuce, tomato on the plates and agreed that there was potential for contamination by touching the menu cards and and other surfaces without changing gloves. Review of the undated facility Bare Hand Contact with Food and Use of Plastic Gloves policy outlined "single use gloves shall be used for only one task...and discarded when damaged or soiled, or when interruptions occur in the operation" and that "anytime a contaminated surface is touched, the gloves must be changed". Equipment sanitation procedures were not followed for the steel backsplash behind the convection oven. During a tour on 6/4/14 at 1:30 p.m. with the dietary intern (DI), the steel backsplash located directly behind the convection oven was observed to have a buildup of a brown, greasy type substance with a heavy buildup of dust particles attached to the greasy substance. This area was approximately 2 feet wide by 1 foot in length above and to the left side of the oven. An exhaust container connected to the back of the convection oven was covered with the same brown, greasy substance with a heavy buildup of dust particles attached to it. Uncovered muffin pans were in close proximity of this brown greasy, dusty buildup. The DI could not provide when this was last cleaned and verified it was not clean.	21015		

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21015	Continued From page 24 During an interview on 6/5/14 at 10:58 a.m., RD stated she was not sure when the backsplash was last cleaned, but it is her or the head cook's responsibility to check to make sure the cleaning tasks are completed. RD verified the brown greasy substance with accumulated dust particles on the steel backsplash and convection oven exhaust container was not clean. Review of the facility "monthly cleaning schedule AM cook" indicated the steel backsplash behind the ovens was to be cleaned the 2nd and 4th Sun of the month and was last cleaned on 5/24/14. Review of the facility Cleaning and Sanitation of Dining and Food Service Areas policy dated 3/13/14, outlined "the food service staff will maintain the cleanliness and sanitation of the dining and food service areas".. and that "staff will be held accountable for cleaning assignments." SUGGESTED METHOD OF CORRECTION: The RD or designee could develop policies and procedures to ensure kitchen equipment is kept clean and staff do not have bare hand contact with ready to eat foods. The RD or designee could educate all appropriate staff on these policies and procedures. The RD or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Forty (40) days.	21015		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade)	21025		

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21025	Continued From page 25 or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure milk (a potentially hazardous food) was held at a safe temperature to minimize the risk for foodborne illness for 4 of 4 residents (R11, R35, R58, R65) who ate in the first floor small dining area. Findings include: On 6/2/14, from 5:11 p.m. to 6:03 p.m. six glasses of milk were observed on the table in the small dining room on first floor for R11, R35, R58, R65 and for two apartment residents. At 6:03 p.m. the registered dietitian (RD) was asked to check the temperature of the milk in the glass for R65. The temperature of the milk was 50 degrees Fahrenheit (F). When interviewed at 6:05 p.m. R65 reported he liked his milk "ice cold." On 6/5/14, at 7:50 a.m. glasses of milk for R11, R35, R58, R65 were again observed on the dining room tables. When interviewed on 6/5/14, at 7:50 a.m. dietary aide (DA)-A stated he put beverages including milk on the tables around 7:15 a.m. and DA-B had put the beverages on the table that morning. Upon interview on 6/5/14, at 7:53 a.m. DA-B stated she had put the milk on the tables at 7:10	21025		

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	00167	A. BUILDING: _____ B. WING _____	06/05/2014

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21025	Continued From page 26 a.m. On 6/5/14, at 7:56 a.m. the administrator was asked to check the temperature of the milk for R11. The temperature of the milk was 50 degrees. When interviewed on 6/5/14, at 11:50 a.m. the RD stated milk should be forty-one degrees or less. The RD stated staff shouldn't be setting the milk out too early and "probably need to look at a new way of doing things." The Handling Cold Foods for Trayline policy dated 1/31/14, directed proper cold food temperatures will be maintained during meal service. SUGGESTED METHOD OF CORRECTION: The RD or designee could develop policies and procedures to ensure potentially hazardous foods are held at the proper temperature to avoid food borne illness. The RD or designee could educate all appropriate staff on these policies and procedures. The RD or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Forty (40) days.	21025		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease	21426		

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21426	Continued From page 27 Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening was completed for 4 of 5 residents (R6, R48, R51 and R68) from the census sample reviewed for TB screening; facility did not ensure TB screening was completed for 2 of 5 new employees (C and E) reviewed for TB screening; and facility did not ensure 3 of 5 new employees (C, D, and E) reviewed for TB screening, were examined by a physician after chest x-ray and positive tuberculosis skin testing (TST). Findings include: Employees: A review of the file for registered nurse (RN)-G revealed a hire date of 3/11/14. The file lacked evidence of an Employee Tuberculosis Screening. A review of the file for other employee F revealed a hire date of 3/25/14. The file lacked evidence of an Employee Tuberculosis Screening.	21426		

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21426	Continued From page 28 A review of the file for nursing assistant (NA)-F revealed a hire date of 3/25/14. The file lacked evidence of an Employee Tuberculosis Screening. A chest x-ray report dated 10/4/10, indicated NA-F had a diagnosis of latent tuberculosis with no signs of active pulmonary disease but lacked documentation of a medical evaluation to rule out infectious TB disease. A review of the file for NA-G revealed a hire date of 5/14/14. The Employee Tuberculosis Screening indicated NA-G had a history of a positive tuberculin skin test (TST). A chest x-ray dated 1/13/09, indicated NA-G had pulmonary masses in the left lung which needed to be confirmed clinically but lacked documentation of a medical evaluation to rule out infectious TB disease. A review of the file for NA-H revealed a hire date of 5/27/14. The file lacked evidence of an Employee Tuberculosis Screening. A chest x-ray report dated 11/4/09, indicated there were no findings of active tuberculosis but lacked documentation of a medical evaluation to rule out infectious TB disease. When interviewed on 6/5/14, at 3:05 p.m. RN-A stated she was not aware a medical evaluation was required with/after a chest x-ray. RN-A verified NA-F, NA-G and NA-H did not have documentation of a medical evaluation to rule out infectious TB disease following a chest x-ray. Upon interview on 6/5/14, at 3:55 p.m. the director of nursing (DON) verified an Employee Tuberculosis Screening was not completed for RN-G, NA-F, NA-H, and other employee F. The facility Tuberculosis policy dated 6/12, directed to " monitor all staff who has a positive mantoux for symptoms of disease. " The policy	21426		

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21426	Continued From page 29 lacked direction to complete an Employee Tuberculosis Screening for all new employees and to ensure a medical evaluation was completed with/following a chest x-ray for employees with a history of a positive TST. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures to ensure residents and employees are receiving TB screening according to the CDC guidelines and Minnesota Rules. The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Forty (40) days.	21426		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident (R4) who was observed self-administering medications was deemed safe to do so. Findings include:	21565		

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21565	Continued From page 30 R4 was observed in her room on 6/4/14, at 7:01 a.m. The resident held a pill in her fingers and put the pill to her mouth with one hand, while holding a small paper souffle cup in her other hand. Eye drops were placed in a container on the bedside table in front of R4. When the surveyor greeted R4 the resident stated, "I am taking my medications." When asked about the container holding the eye drops R4 explained, "The nurse left the eye drops there." There were no staff present in the room. R4's Self-administration of Medications assessment (SAM) dated 7/2/13, indicated R4 wished to only self-administer nebulizer treatments. The current physician orders for R4 indicated the resident had diagnoses including vascular dementia, and did not include an order allowing the resident to self-administer medications. R4's Minimum Data Set (MDS) dated 3/16/14, showed R4 had a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. The resident's care plan dated 3/27/14, directed staff to give medications as ordered and self-medication assessment per facility policy. On 6/4/14, at 1:24 p.m. a registered nurse (RN)-F explained that nursing assessments could be found in resident records under the "assessments" tab, and or were in the computerized charting. No SAM assessment for medications other than the nebulizer was found in the chart and/or computer for R4. On 6/4/14, at 1:45 p.m. a licensed practical nurse (LPN)-A stated R4 did not routinely take her own medications, but that morning LPN-A had just left	21565		

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21565	Continued From page 31 R4 in her room with her medications and eye drops to get something quick and then went right back into the resident's room. LPN-A stated R4 did not even want the nurse to leave her alone with her medication, and would tell someone R4 with her medications alone and reported the next day if a nurse left her with "even one pill." On 6/5/14, at 1:30 p.m. the director of nursing (DON) stated she expected her nurses to stay with the resident while administering medications and/or treatments if the resident did not have an assessment, physician's order, and care plan for SAM. Resident Self-Administration Policy directed staff to "allow residents to self-administer medications and treatments per their request, if the resident is competent to perform such tasks." Under Resident Self-Administration Procedure step 1 read, "LN [licensed nurse] will conduct a self-administration assessment located in the assessment section of the electronic medical record with resident to determine competency, the ability to store medications and then to document." Step 5 of the Resident Self-Administration Procedure noted "residents will not be allowed to self-administer medication or store medications at bedside if it was not deemed to be safe after self-administration assessment completed and reviewed by IDT" [interdisciplinary team]. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures to ensure residents are assessed to safely self administer medications before doing so. The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop	21565		

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21565	Continued From page 32 monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Forty (40) days.	21565		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were stored at the correct temperature for 3 of 3 residents (R4, R68, R88) reviewed during medication storage. Findings include: During observation of the second floor North medication room on 6/5/14, at 9:35 a.m., the thermometer in the medication refrigerator read 25 degrees. The temperature was verified by licensed practical nurse (LPN)-A to read 25 degrees. Medications stored in the refrigerator were glucagon, two boxes of bisacodyl suppositories, a brown paper bag of lab tests not yet done, one bottle of normal saline, a bottle of liquid ativan labeled with R68's name, one third full, with a refilled date of 4/14/14, three liquid vials of Aranesp labeled with R88's name with a refilled date of 5/31/14, and Latanoprost eyedrops labeled with R4's name with a refilled date of	21610		

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21610	Continued From page 33 5/31/14. LPN-A verified these medications in the refrigerator. LPN-A also verified the temperature documented on the Refrigerator Temperature Log for 6/5/14, read 28 degrees and 6/4/14, read 30 degrees, and 6/3/14, read 30 degrees. Documentation on the Refrigerator Temperature Log was missing on 4/17/14, 4/18/14, 4/25/14, 4/27/14, 4/28/14, 4/29/14, 4/30/14, 5/01/14, 5/02/14, and 5/17/14. The Refrigerator Temperature Logs included temperatures out of the correct range on 4/1/14, 46 degrees, 4/2/14, 46 degrees, 4/3/14, 46 degrees, 4/8/14, 48 degrees, 4/9/14, 48 degrees, 4/10/14, 48 degrees, 4/12/14, 48 degrees, 4/13/14, 48 degrees, 4/14/14, 48 degrees, 4/16/14, 26 degrees, 4/21/14, 48 degrees, 5/12/14, 50 degrees, 5/25/14, illegible temperature. LPN-A also verified at the bottom of the Refrigerator Temperature Log that temperatures to be checked daily and maintain temp (35-45 F). On 6/5/14, at 9:43 a.m., LPN-A stated the night nurse checks the refrigerator temperature every night and documents it on the temperature log. She stated when asked by surveyor the refrigerator temperature should be between 36 and 40 degrees. She also stated if the temperature is not in that range, nursing should have the refrigerator checked out and if malfunctioning let maintenance and administrator know to replace. On 6/5/14, at 10:24 a.m. registered nurse (RN)-A stated the nurses should be aware of the medication refrigerator temperature range and if the temperature is not within the range the nurse should adjust the temperature of the refrigerator to correct. RN-A also stated if the nurse thinks there is an issue or something is wrong, the nurse should notify RN-A or director of nursing (DON) to	21610		

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21610	Continued From page 34 get a new refrigerator. On 6/5/14, at 10:31 a.m. the consultant pharmacist (CP) stated liquid Ativan, liquid Aranesp, and Latanoprost eyedrops should be stored between 36 to 46 degrees. CP stated outside the range of 36 to 46 degrees there would be no stability of the medication and would not be able to guarantee the concentration and/or effectiveness of the medications. Individual inserts of the Ativan, Aranesp, and Latanoprost provided by CP showed each medication should be stored at a temperature between 36 degrees and 46 degrees. On 6/5/14, at 10:44 a.m. LPN-A stated a new thermometer had just been put in the medication refrigerator on two North. On 6/5/14, at 12:36 p.m. LPN-A stated R88 received the Aranesp injections once a week and verified on the medication administration record (MAR) R88 received an Aranesp injection on 6/4/14, in the morning. LPN-A also stated R88 received Aranesp injections for anemia related to chronic renal failure. LPN-A also verified the Latanoprost eyedrops were given to R4 daily in the morning and needed to be refrigerated. The Admission Record for R4 dated 6/5/14, included a diagnoses of Glaucoma. The June 2014, MAR noted R4 received Latanoprost sol 0.005% 1 drop to each eye every morning. The Admission Record for R68 dated 6/5/14, included diagnoses of depressive disorder and failure to thrive. The June 2014, MAR noted R68 received liquid Ativan 0.5 mg (0.25 ml) orally 2 times daily and Ativan to be kept in fridge.	21610		

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21610	Continued From page 35 The Admission Record for R88 dated 6/5/14, included diagnoses of renal failure, thrombocytopenia, and other abnormal blood chemistry. The June 2014 and May 2014, MAR showed R88 received an Aranesp injection of 100 mcg sub-IQ every Wednesday starting 5/2/14, due to anemia associated with chronic kidney failure and to keep medication in the fridge. On 6/5/14, at 1:30 p.m. the DON stated she expected her nurses to follow the refrigerator temperature policy when checking the temperature of the medication refrigerators daily. The DON also stated she expected the nurses to recheck the refrigerator temperature after adjusting the thermostat per policy. The Temperature of Refrigerators Policy dated last revision 06/12, stated it is the policy of Bethany Care Center to monitor temperatures in medication refrigerators to maintain proper temperatures in order to preserve medications used for residents. Temperature Refrigerator Procedure states 1. Check temperature every day and document on refrigerator temperature log, 2. If temperature is > [greater than] 45 degrees or < [less than] 35, adjust thermostat accordingly and recheck in 1 hr., 3. If temperature remains > than 45 or < than 35, notify maintenance and move refrigerator items to another refrigerator on another unit until refrigerator is able to be fixed or replace. The Storage of Medications dated Revision 12/12, stated it is the policy of Bethany Care Center to ensure accurate, safe and timely administration of our drugs to our residents, and to ensure safe storage of supplies. Number six of policy stated Medications requiring "refrigeration" are kept at temperatures ranging from 36-46	21610		

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21610	Continued From page 36 degrees F (Fahrenheit) in a refrigerator not accessible to residents. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures to ensure medications are stored per manufacturer recommendations. The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Forty (40) 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 ensure half side rails were assessed for use and maintained in a safe and functional manner for 1 of 3 residents (R40) reviewed for accidents. In addition, the facility failed to ensure a toilet armrest was stable and secure for 2 of 2 residents (R8, R62) bathroom. Findings include: R40 was not assessed for the safe use of half side rails and the half side rail was observed to be loose on the bed. The quarterly Minimum Data Set (MDS) dated 5/14/14, for R40 included a Brief Interview of Mental Status (BIMS) score of seven (moderate	21665		

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21665	Continued From page 37 cognitive impairment) and indicated R40 was independent with bed mobility and transfers. The ADL (activities of daily living) Functional/Rehabilitation Potential, and Falls Care Area Assessment (CAA) dated 2/20/14, did not identify or assess the use of half side rails for R40. A Fall Risk Assessment dated 5/14/14, included a score of thirteen and indicated scores above ten represented a HIGH RISK for falls. The Summary Notes section did not identify nor assess the safe use of half side rails for R40 and indicate R40 held onto furniture in room to ambulate. The care plan dated 8/16/13, indicated R40 used a half position rail to maintain independence with bed mobility and assist with transfers in and out of bed. The at risk for falls care plan noted R40 fell on 12/18/13, while trying to move a blanket on the bed. The NAR List dated 6/2/14, indicated R40 had two half assist rails. The Treatment Record dated June 2014, included "OK FOR ½ SIDE RAILS FOR BED MOBILITY." A Progress Notes dated 3/17/14, noted R40 was found on the floor at 9:30 p.m. The note further indicated R40 was stepping backwards and sat partially on the bed, caught herself some but fell anyway. A Care Conference Note dated 5/29/14, did not identify side rails used for R40. During observations on 6/3/14, at 9:24 a.m. half side rails were noted on both upper ends of R40's bed. The half side rail on the right side of the bed away from the wall was loose and moved away	21665		

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21665	Continued From page 38 from the mattress when pulled. On 6/4/14, at 7:17 a.m. R40 was observed sitting in a wheel chair next to the bed with the half side rail up on the right side of the bed. The half side rail was again noted to be loose. When interviewed at 7:20 a.m. R40 reported she used the half side rail to get up from bed. Upon interview on 6/4/14, at 9:24 a.m. nursing assistant (NA)-E stated R40 was independent with cares and only required staff assistance with showers. When interviewed on 6/4/14, at 2:50 p.m. the director of nursing (DON) verified the side rail was loose and maintenance would need to tighten it. The DON stated maintenance checked the fit of side rails on safety rounds. During the environmental tour on 6/5/14, from 10:00a.m.to 10:45 a.m., the administrator stated the side rail for R40 had been "swapped out yesterday." When interviewed on 6/5/14, at 1:33 p.m. maintenance (M)-A stated she was not aware the side rail for R40 was loose until it was reported to her on 6/4/14. M-A stated she checks side rails only if nursing reports a problem and does not keep logs of any checks made. The DON was interviewed on 6/5/14, at 1:40 p.m. and stated side rail assessments are not completed unless the side rail is a restraint and audits are not completed unless there is a problem. The facility Side Rail policy dated 01/98 and revised 06/12, did not address assessing the safe use of a side rail and did not address how/when	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00167	A. BUILDING: _____ B. WING _____	06/05/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 39 the side rail would be checked for safe use. During observations on 6/2/14, at 3:35 p.m. the toilet armrest in the bathroom for R8 and R62 was observed to be very loose. During the environmental tour on 6/5/14, from 10:00a.m. to 10:45 a.m., the administrator verified the toilet armrest was loose and would need to be tightened or replaced. The Admission Record dated 6/5/14, for R62 included diagnoses of pain in joint pelvic region and thigh and muscle weakness. R62's care plan indicated she was independent with toileting and was at risk for falls. The Admission Record dated 6/5/14, for R8 included diagnoses of personal history of fall and lower limb amputation. R8's care plan indicated she was able to use the toilet independently and was at risk for falls. The facility Grab Bar Policy dated 6/5/13, did not address how grab bars would be monitored for safe use. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures to ensure side rails are assessed for safe use and side rails and grab bars are maintained for safety. The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Forty (40) days.	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00167	A. BUILDING: _____ B. WING _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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23010	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses' station. A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights must be provided at corridor intersections. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light system was functional for 3 of 35 residents (R23, R39, R28) reviewed. Findings include: The care plan for R23 dated 3/21/14, included a Brief Interview of Mental Status (BIMS) score of 15/15 which indicated R23 was cognitively intact. The at risk for falls care plan for R23 dated 1/9/13, directed "make sure call light is within reach."	23010		

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23010	Continued From page 41 At 9:21 a.m. the call light for R23 was activated and did not light up outside the room. The care plan for R39 dated 5/5/14, included a BIMS score of 13/15 which indicated mild cognitive impairment. The at risk for falls care plan dated 7/25/13, directed "answer call light quickly." During observations on 6/3/14, at 9:26 a.m. the call light for R39 was activated and also did not light up outside of the room. During interview at this time, nursing assistant (NA)-D verified the call light did not work outside of the room for R23 and R39 but did light up at the nursing station (on another unit). The care plan for R28 dated 12/12/12, indicated R28 was alert and oriented to place and person but not always time. During observations on 6/3/14, at 1:17 p.m. the call light for R28 was activated and did not light up outside the room and did not sound at the nursing station. NA-E verified the call light was not working. The facility environmental tour was conducted on 6/5/14, from 10:00 a.m. to 10:45 a.m. with the administrator. The administrator verified the call lights for R23, R39 and R28 did not light up outside the room when activated and needed to be replaced. When interviewed on 6/5/14, at 1:33 p.m. maintenance (M) - A stated call lights are checked with new admissions, when someone moves out, periodically and no logs were kept. M-A stated "it's an old building; they [the call lights] go out all the time." M-A stated "downstairs is always a problem" and she relies on staff to report problems to her. M-A reported she was unaware the call lights for R23, R39 and R28 were not working. The DON was interviewed on 6/5/14, at 1:40 p.m. and stated audits of call lights are not completed	23010		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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23010	Continued From page 42 unless there is a problem. The facility Call Light Maintenance Policy dated 6/5/13, directed "Upon discharge or room change call lights will be checked by housekeeping when they do a room turn to ensure functionality. Maintenance staff will test call lights monthly and replace bulbs or cords as needed. Nursing staff will notify maintenance as necessary." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop policies and procedures to ensure call lights are functional. The administrator or designee could educate all appropriate staff on these policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Forty (40) days.	23010		

PROJECT_NUM
FACILITY_NAME

ASE-Q Onsite PCR SURVEY – Team Coordinator Checklist

Following the exit, email the following information to the supervisor processing the package:

- **Facility name**
- **HFID #**
- **Project #**
- **Event ID #**
- **PCR Exit date**
- **Corrected?**
- **Number of tags found not corrected or new deficiencies**
- **Status of licensing orders (if applicable)**

Team Coordinator to create PCR folder in the QIS pool (example – Valley View PCR 072211)

- **Within the new folder create 3 sub-folders**
  - **Admin**
  - **Scan Docs**
  - **Worksheets**

Ensure all surveyors have copied the CE Pathways to the Worksheets folder

<u>Turn in package papers in the following order:</u>

1. **Revisit Sample Matrix**

****<u>Each surveyor</u> is responsible for turning in papers supporting a deficiency to administrative support staff for scanning**

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

Surveyor Notes Worksheet

Facility Name: Draft 2567 Facility ID: Bethany CC

Surveyor Name/ID:

Care Area(s)/Activity:

Enter the time, source, and documentation.

Date and Time	Source and Documentation
	THIS IS A DRAFT STATEMENT OF DEFICIENCIES These are preliminary findings. This is not the final 2567 report. A completed and finalized Statement of Deficiencies will be provided. This preliminary information is provided to inform and assist facilities in correcting deficient practices. Based on observation, interview and document review the following deficiencies were noted during the standard survey of 6/2/14___ to __6/5/14.
F176 D	Facility failed to ensure 1 of 1 residents (R4) did not self administer medications unless assessed to safely do so.
F282 D	Facility failed to follow the care plan for 1 of 3 residents (R48) reviewed for activities of daily living.
F309 D	Facility failed to monitor weights as ordered for 1 of 1 residents (R20) reviewed for dialysis.
F311 D	Facility failed to assist 1 of 3 residents (R48) reviewed for grooming.
F314 G	Facility failed to ensure 1 of 2 residents (R63) did not develop a stage IV pressure ulcer. This resulted in actual harm.
F323 D	Facility failed to ensure a siderail was maintained in a safe manner for 1 of 3 residents (R40) and failed to ensure a toilet armrest was stable for 2 of 2 residents (R8, R62) reviewed for accidents.
F371 E	Facility failed to safety serve food in a sanitary manner and failed to ensure food preparation equipment was clean to minimize the possibility of food borne illness. This had the potential to affect 60 of 64 residents who were served food out of the kitchen. In addition facility failed to ensure milk was served at a safe temperature for 4 of 4 residents (R35, R58, R11, R65) in the first floor dining area.
F431 D	Facility failed to ensure medications were stored at the correct temperature for 3 of 3 residents (R4, R68, R88) reviewed during medication storage.
F463 E	Facility failed ensure a call light system was functional for 3 of 35 residents (R28, R39, R23) reviewed during the environmental tour.
MN rule 144A.04 sub4	Facility did not ensure symptom screening was completed for 4 of 5 residents (R51, R6, R48, R68). In addition, the facility failed to ensure medical evaluation was completed for 3 of 5 employees with positive tuberculin skin test.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING 01 - BETHANY COVENANT HOME B. WING _____	06/04/2014

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Bethany Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok JB 7-16-14 RECEIVED JUL - 9 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 7-15-14

EXIT: 6-5-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7/2/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING **01 - BETHANY COVENANT HOME** B. WING _____	**06/04/2014**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Bethany Care Center is a 2-story building with no basement. The building was constructed in 1960 and was determined to be of Type II(222) construction. The building is has a full fire sprinkler system in accordance with NFPA 13, 1999 Ed.. The facility has a fire alarm system with smoke detection in the corridors, by the smoke barrier doors, resident rooms and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 66 beds and had a census of 63 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=F	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 017		

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K 017	Continued From page 2 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 observation and interview, the facility has not maintained the corridors in accordance with NFPA 101 (2000 edition), Chapter 19, Section 19.3.6.1. This could affect the residents. Findings include: On facility tour between 9:30 AM and 10:30 AM on 06/04/2014, observation revealed that there are numerous penetrations in the corridors above the suspended ceiling that are no properly firestopped. These penetrations include fire sprinkler piping, fire alarm wiring, nurse call wiring and telecomm wiring. This deficient practice was verified by the administrator at the time of the inspection.	K 017	Administrator contacted third party contractor to properly fire stop all the penetrations from corridors to hallway. Administrator and Maintenance staff to monitor. Date of completion: 7/18/2014	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and interview, the facility's emergency generators do not comply with NFPA 99 Health Care Facilities (1999 edition) nor NFPA 110 Standard for Standby Power Systems (1998 edition). This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 10:30 AM on 06/04/2014, record review revealed that there is no documentation of the weekly or monthly generator testing for the year 2013. This deficient practice was verified by the administrator at the time of the inspection.	K 144	Generator testing records will be kept in compliance with facility policy and procedures. Administrator will audit monthly for six months Administrator and Maintenance staff to monitor. Date of completion: 7/18/2014	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5156

June 24, 2014

Mr. Jon Sondegaard, Administrator
Bethany Care Center
2309 Hayes Street Northeast
Minneapolis, Minnesota 55418

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5578024

Dear Mr. Sondegaard:

The above facility was surveyed on June 2, 2014 through June 5, 2014 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, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3792
Fax: (651) 201-3790

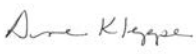
We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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.

Please feel free to call me with any questions.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00167	A. BUILDING: _____ B. WING _____	06/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 6/2/14 through 6/5/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	RECEIVED JUL - 9 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION 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.	