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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 5NP1
Facility ID: 00312

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245532**

2.STATE VENDOR OR MEDICAID NO.
(L2) **803742600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHESDA HERITAGE CENTER**
(L4) **1012 EAST THIRD STREET**
(L5) **WILLMAR, MN** (L6) **56201**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/26/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **125** (L18)

13.Total Certified Beds **125** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	125			
(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 :
Kathy Serie, HFE NE II 06/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 07/13/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/10/1989
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/12/2015
(L33)

Posted 07/15/2015 Co.

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245532
July 13, 2015

Ms. Ashley Bormann, Administrator
Bethesda Heritage Center
1012 East Third Street
Willmar, Minnesota 56201

Dear Ms. Bormann:

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 June 12, 2015 the above facility is certified for or recommended for:

125 Skilled Nursing Facility/Nursing Facility Beds

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 13, 2015

Ms. Ashley Bormann, Administrator
Bethesda Heritage Center
1012 East Third Street
Willmar, Minnesota 56201

RE: Project Number S5532025

Dear Ms. Bormann:

On May 20, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 7, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 26, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 15, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 7, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 12, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 7, 2015, effective June 12, 2015 and therefore remedies outlined in our letter to you dated May 20, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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

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
245532	A. Building B. Wing	6/26/2015

Name of Facility	Street Address, City, State, Zip Code
BETHESDA HERITAGE CENTER	1012 EAST THIRD STREET WILLMAR, MN 56201

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 F0242 Reg. # 483.15(b) LSC	06/12/2015	ID Prefix F0356 Reg. # 483.30(e) LSC	06/12/2015	ID Prefix F0441 Reg. # 483.65 LSC	06/12/2015
ID Prefix F0492 Reg. # 483.75(b) LSC	06/12/2015	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 BF/KJ	Date: 07/13/2015	Signature of Surveyor: 03048	Date: 06/26/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/7/2015			

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
245532	A. Building / B. Wing: **01 - MAIN BUILDING**	6/15/2015

Name of Facility	Street Address, City, State, Zip Code
BETHESDA HERITAGE CENTER	1012 EAST THIRD STREET WILLMAR, MN 56201

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 K0018	**06/12/2015**	ID Prefix Reg. # **NFPA 101** LSC K0056	**06/12/2015**	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	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/KJ	07/13/2015	34764	06/15/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 5/6/2015

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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 5NP1

Facility ID: 00312

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245532**

2. STATE VENDOR OR MEDICAID NO. (L2) **803742600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHESDA HERITAGE CENTER**
(L4) **1012 EAST THIRD STREET**
(L5) **WILLMAR, MN** (L6) **56201**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/07/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **125** (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
(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 :
Bruce Melchert, HFE NE II 06/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 06/10/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/10/1989
(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.
03001
(L31)

30. REMARKS

Posted 06/12/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 20, 2015

Ms. Ashley Bormann, Administrator
Bethesda Heritage Center
1012 East Third Street
Willmar, Minnesota 56201

RE: Project Number S5532025

Dear Ms. Bormann:

On May 6, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**
>
> **Informal Dispute Resolution - your right to request an informal reconsideration to dispute the**

attached deficiencies.

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

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 June 16, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 16, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 6, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 6, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245532	A. BUILDING ______ B. WING ______	**05/06/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HERITAGE CENTER	**1012 EAST THIRD STREET** **WILLMAR, MN 56201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accommodate bathing preferences for 1 of 3 residents (R83), reviewed for bathing choices. Findings include: R83's admission Minimum Data Set (MDS) dated 3/15/2015 identified the resident had a Brief Interview for Mental Status (BIMS) score of 14	F 242	Corrective Action For Residents Affected By Deficient Practice: R83 bathing preference has been added to the bath list and care plan. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed to ensure bathing preference is listed on bath list and care plan.	6/12/15

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

Electronically Signed — 05/28/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245532	A. BUILDING ______ B. WING ______	05/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HERITAGE CENTER	**1012 EAST THIRD STREET WILLMAR, MN 56201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 1	F 242		

(cognitively intact). The MDS identified R83 required one person assistance with bathing and it was very important to choose between a tub bath, shower, bed bath, or sponge bath.

R83's Nursing Admission Assessment, dated 3/13/15, indicated taking a tub bath in the morning was very important to her. R83's care plan, dated 4/2/15, directed staff to ensure R83's daily preferences will be followed. The care plan indicated R83's preference was to "choose a tub bath in the morning." The nursing assistant assignment sheet, undated, identified R83 required extensive assist of 1 staff for bathing, but did not indicate that she had a bathing preference.

On 5/6/2015 at 7:30 a.m., R83 was observed in wheelchair exiting shower room, propelled by staff, returning to her room. There was no bath tub in this bathing room.

During interview on 5/6/2015 at 7:48 a.m., R83 stated she had a shower earlier this morning. R83 also said she liked [tub] baths, however, the facility only had a shower on the TCU (transitional care unit). R83 stated when she was admitted to the facility, she told staff she liked baths, but it has never been brought up since and has always received a shower. R83 stated the previous facility she was in gave her a bath in the whirlpool, and it felt good. R83 stated, "Maybe the new place will have one."

During an interview on 5/6/2015 at 8:10 a.m., nursing assistant (NA)-D stated the TCU unit has a shower only, but no bath tub. NA-D said, if a resident wanted a bath instead of a shower, they would have "to use the tub on the 3rd floor."

Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: RN/LPNs will update bath list and care plan if bathing preference has changed at any time. CNAs will provide residents¿ bathing request unless resident requests differently. Training and re-education was provided to all nursing staff by June 10, 2015 regarding residents¿ right to make choices regarding bathing preferences.

How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON, ADON, or designee will do random audits of bath lists and care plan looking at residents¿ bathing preferences. DON, ADON, or designee will also complete resident interviews regarding whether or not staff have honored their bathing preference. 8 chart audits and 8 resident interviews will be done monthly for 4 months beginning June 12, 2015. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.

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F 242	Continued From page 2 NA-D also stated, if a resident preferred to have a tub bath, the nurse would let the nursing assistants know, or put it on the care sheet. NA-D further stated there was only one staff on the unit and it was "harder to give baths in the a.m. " During an interview on 5/6/2015 at 8:16 a.m., registered nurse (RN)-C stated, "I can't promise a tub bath, there is not one on this floor." RN-C said, if a resident preferred a tub bath, "We write it in the book for the nursing assistants." In regard to how often residents can bathe, RN-C stated, when census is low, residents can have two baths, "but we guarantee one bath a week." During an interview on 5/6/2015 at 12:04 p.m., the director of nursing (DON) stated upon admission, staff ask if residents want a tub or shower, if they prefer day or evening, and, if resident requests more than one a week, "They work that into the schedule." The DON also stated residents were again asked about preferences if there was a room change, and also during care conferences. The DON was not sure if bathing preferences were documented anywhere. During a subsequent interview on 5/7/15 at 10:23 a.m., RN-C stated R83 should have been offered a tub bath, "per her preference." A facility policy regarding resident choices was requested, but not provided.	F 242		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:	F 356		6/12/15

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F 356	Continued From page 3 o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the daily staff posting included the actual hours worked for each category of nursing staff. This had the potential to affect all 103 current residents in the facility, along with interested family members and visitors.	F 356	Corrective Action For Residents Affected By Deficient Practice: Nurse Staffing Posting form was updated to include specific start and end times of each shift. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: This had the potential to affect	

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F 356	Continued From page 4 Findings include: During initial tour of the facility on 5/4/15 at 1:02 p.m., the facility's staff posting document entitled, BETHESDA HERITAGE CENTER STAFFING HOURS PER SHIFT, was hanging on a bulletin board at the end of the entrance way. The staff posting included the facility name, date, census, number of staff, and the total number of hours worked by each category of nursing staff. The posting identified "Day Shift, Evening Shift, and Night Shift" without designated start and end times for each shift. The posting did not identify the actual hours worked by the employees. During interview on 5/5/15, at 10:45 a.m. the scheduling coordinator (SC)-A stated, "I have just been putting total hours on the schedule, I did not know that the actual hours had to be itemized." During interview on 5/7/15, at 2:16 p.m. the director of nursing (DON) stated, "We thought we had everything covered on the staff posting by having day shift, evening shift, and night shift listed." The DON said, moving forward, "we will list shift start and stop times on the posting." A facility policy regarding the staff posting was requested, but none was provided.	F 356	all 103 current residents in the facility, along with interested family members and visitors. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: Nurse Staffing Posting form and policy has been revised. Training was provided with Staffing Coordinator on revised form and policy on May 6, 2015. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON, ADON, or designee will do random audits to ensure nurse staffing hours form is completed correctly. 4 audits will be done monthly for 4 months beginning June 12, 2015. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		6/12/15

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	245532	A. BUILDING ______ B. WING ______	05/06/2015

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F 441	Continued From page 5 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure infection control practices were consistently followed during disposal of soiled laundry down 1 of 1 laundry chutes in the facility. This had the potential to affect all 103 residents	F 441	Corrective Action For Residents Affected By Deficient Practice: Signage was placed above laundry chute door on each floor stating ¿All linen must be placed in a bag before putting in the laundry chute. Bag	

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F 441	Continued From page 6 residing in the facility. Findings include: During observation on 5/6/2015 between 7:00 a.m. and 8:45 a.m., nursing assistants (NA)-B and NA-C were providing routine morning cares to fourth-floor residents on the east wing of the facility. As resident cares were completed, NA-B and NA-C carried numerous bags from resident rooms, and placed them into a lined, portable hamper lined with a clear plastic bag. The clear, plastic bag contained soiled bed linens, clothing items, wash cloths and towels, all coming from resident rooms after providing cares. Mixed in with the bags in the hamper cart were a night gown, dark stockings, and several small, face towels, all of which were unbagged. At 8:27 a.m.,nursing assistant (NA)-B opened the laundry chute door, located in the east wing hallway, and NA-C grabbed two of the plastic bags filled with resident laundry from the nearby hamper to place the bags down the chute. One of the bags dropped immediately down the chute. A second bag was overfilled and untied, and as NA-C pushed it through the door, half of the bag's contents dropped down the chute with the bag, and the remaining contents including bed linens, a pillow case and clothing items, spilled onto the floor in front of the chute door. NA-C immediately picked up the items from the floor, and sent them down the chute. NA-C unloaded the remaining bags from the hamper, as well as the unbagged clothing and linen items, and placed them down the chute. In an interview on 5/6/2015 at 8:30 a.m., NA-C acknowledged one of the bags of laundry opened up and spilled on the floor. NA-C said using the	F 441	must be tied¿ Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: This had the potential to affect all 103 current residents residing in the facility. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: Linen handling policy was reviewed. Nursing, housekeeping, and laundry personnel were re-trained on linen handling policy and procedure by June 10, 2015. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON, ADON, or designee will do random audits to ensure soiled linen is handled appropriately. 10 audits will be done monthly for 4 months beginning June 12, 2015. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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F 441	Continued From page 7	F 441		

chute was how the dirty laundry got down to get washed, and that laundry and linen "was supposed to be in a bag."

Meanwhile, NA-B assisted a resident in a room across the hall from the the laundry chute. At 8:35 a.m., NA-B exited a resident's room, across the hall from the laundry chute. NA-B carried from the room a resident's pajamas, another article of clothing, a towel, and a small wash cloth in her hands. NA-B then walked to the laundry chute door, opened it, and tossed the laundry items down the chute. All of the items in her arms were unbagged.

In an interview on 5/6/2015 at 8:54 a.m. NA-B stated the laundry chutes is were dirty, resident laundry was disposed. NA-B said she did place "towels, PJs, and wash cloths" down the chute without a bag. NA-B said the "linens and dirty laundry need to be bagged" and then stated, "sometimes they are not bagged."

During observation of the laundry facilities on 5/6/2015 at 12:15 p.m., a large bag, filled with clothing protectors, emerged from the laundry chute, and missed the sorting cart, landing instead on the floor. Seconds later, two more clothing protectors came down the chute, along with a white hand towel, all unbagged, and landed in the cart.

In an interview on 5/6/2015 at 12:19 p.m., laundry assistant (LA)-A stated that dirty laundry items come into the laundry area "by way of the chute, it's connected to all floors." LA-A said the chute was stainless, and it had been in use "as long as I have been here, " and further that all items came to the laundry this way, including resident

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F 441	Continued From page 8	F 441		

"clothing, bedding, linens, soaker pads, clothing protectors and towels." LA-A said "most of the items that come down the chute were bagged," and then added, "but not all." LA-A said she thought if laundry items were not visibly soiled, like resident clothing, or wash cloths, that they "would not have to be bagged." LA-A went on to state, that items that were soiled with BM (bowel movement) were rinsed out on the floor by the aides, then "re-bagged before they were sent down the chute." LA-A was not sure if the laundry chute was regularly cleaned, or who was responsible to clean it.

In an interview on 5/7/2015 at 9:00 a.m., registered nurse (RN)-B stated, in regard to the laundry chutes, "All soiled laundry items should be bagged, but I'm not sure that happens."

During an interview on 5/7/2015 at 12:36 p.m., the assistant director of nursing (ADON) stated there was "no explanation" as to why soiled laundry items were not bagged when sent down the laundry chute. The ADON stated it was "facility protocol" to bag all items, including clothing protectors, resident laundry, soiled clothing, towels, everything, before sending them down the laundry chute. The ADON said there was no way of knowing what items sent down the chute were soiled or contaminated, and therefore everything needed to be bagged. "Everything, always," the ADON said. The ADON stated this practice was "an infection control concern," and that all items going down the laundry chute, "were to be bagged."

A facility policy regarding the appropriate handling of soiled linen was requested, but none was provided.

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F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a Medicare beneficiary, who requested a review of her medicare non-coverage, was not charged for services while the decision was pending for 1 of 1 residents (R163) reviewed for liability notices. Findings include: R163 received a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) on 3/11/15, indicating her Medicare-covered, skilled services were ending on 3/13/15. R163 requested an appeal of this determination, and the nursing facility submitted her request to Medicare for further review. R163's billing statements, dated 3/23/15, 3/31/15, and 4/30/15, indicated R163 was charged for services from 3/14/15 through 5/31/15, although the Medicare determination had not been made at the time of the billing statements. During an interview on 5/7/15, at 12:04 p.m., the accounts receivable manager (ACM) stated, "I billed [R163] for the co-insurance amount on day 21 through day 30, at $157.50 per day of the	F 492	Corrective Action For Residents Affected By Deficient Practice: Accounts Receivable Manager will no longer bill R163 until we receive the determination from Medicare appeal. Identification Of Other Residents Having The Potential To Be Affected By Deficient Practice: The facility has no other outstanding requests for reviews/appeals of Medicare non-coverage, so no other residents were affected. The deficient practice has the potential to affect all Medicare-eligible residents. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: A facility policy was developed following CMS guidelines regarding demand bills. Training with Accounts Receivable Manager on new policy and billing practices was provided on June 8, 2015. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Administrator	6/12/15

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F 492	Continued From page 10 demand bill." Further, the ACM said, "On day 31, I billed her at the regular room rate through the remainder of April and for the month of May." The ACM also stated, she was under the understanding the facility could bill for co-insurance and thought the demand bill was for thirty days at a time. The ACM said, "I thought I could bill [R163] at the regular rate after the 30 days, so that is what I did." A facility policy on demand bill was requested, but not provided.	F 492	will audit demand bill requests monthly to verify if there were any demand bills and that the policy was followed. The audit will be presented to the facility Quality Assurance committee for a period of four months to verify that compliance has been attained.	

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

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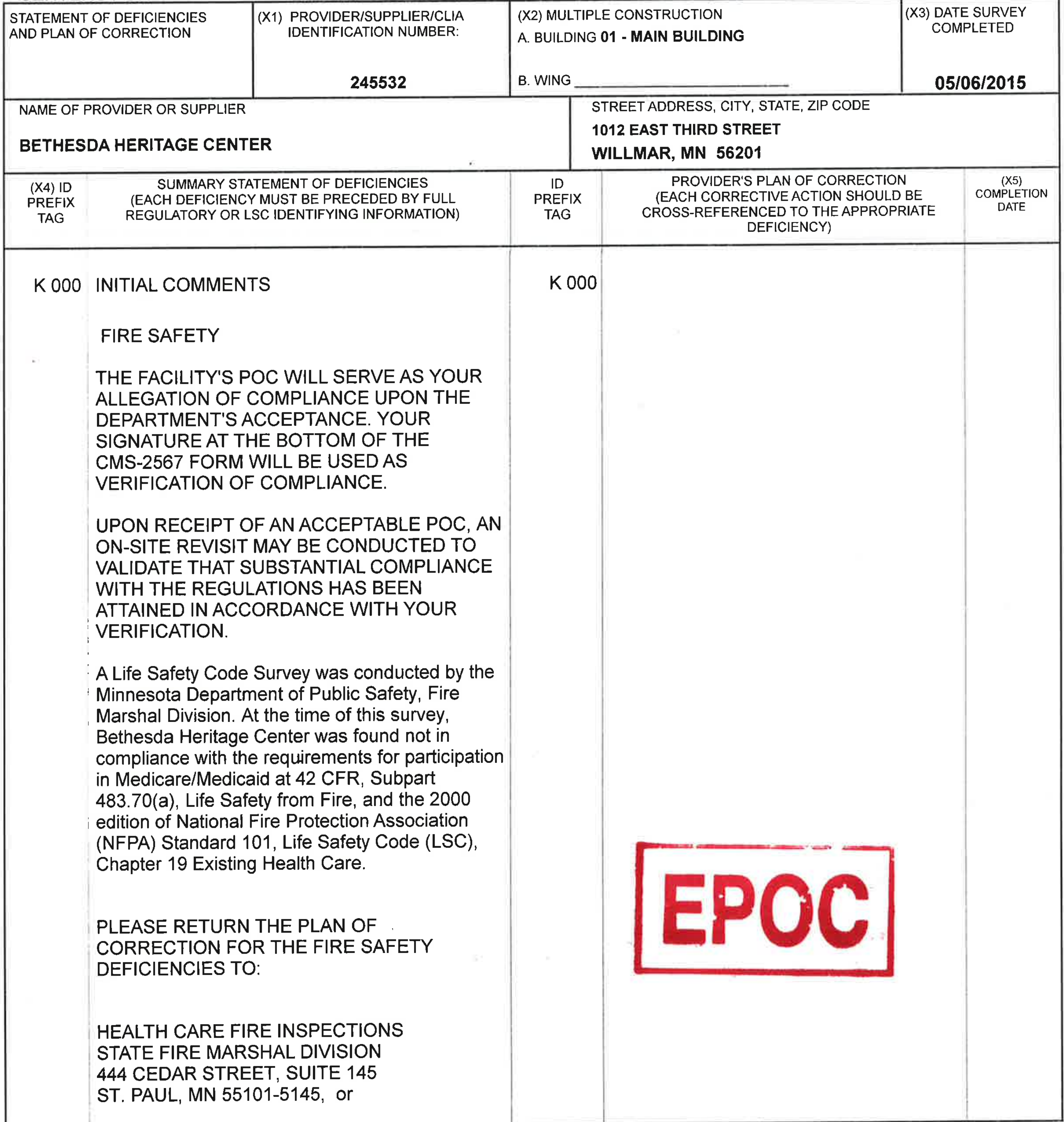

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	245532	A. BUILDING **01 - MAIN BUILDING** B. WING ______	**05/06/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT 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, Fire Marshal Division. At the time of this survey, Bethesda Heritage Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 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: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/28/2015

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HERITAGE CENTER	**1012 EAST THIRD STREET** **WILLMAR, MN 56201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By e-mail to: 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. Bethesda Heritage Center is a 4-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1957 and was determined to be of Type II(222) construction. In 1999, additions were added to the east and west which were determined to be of Type II(222)construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a complete fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification.	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245532	A. BUILDING **01 - MAIN BUILDING** B. WING ________	**05/06/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 The facility has a licensed capacity of 125 beds and had a census of 103 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain one or more corridor doors in the means of egress, in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.3.6.3. In a fire emergency, this	K 018	Corrective Action For Residents Affected By Deficient Practice: Resident rooms 108, 118, 214 were repaired so the door positively latches into its frame.	6/12/15

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

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	245532	A. BUILDING **01 - MAIN BUILDING** B. WING ______	**05/06/2015**

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K 018	Continued From page 3 deficient practice could adversely affect 50 of 103 residents, staff and visitors. FINDINGS INCLUDE: On 05/06/2015 at 09:00am to 1:30pm , observation revealed the corridor door from resident rooms 118 & 214 did not positively latch into its frame, as the door leaf was warped at the bottom. Room 108 was not a single action latch. These findings were verified with the facility Maintenance director (PS) at the time of discovery.	K 018	Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: In a fire emergency, this deficient practice could adversely affect 50 of 103 residents, staff, and visitors. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: A facility audit tool was developed to be completed monthly by maintenance personnel to verify that resident corridor doors are positively latching. Maintenance personnel were educated on the audit process by June 10, 2015. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: The corridor door audit will be audited by the Administrator monthly. The results of the audit will be presented to the facility Quality Assurance committee for a period of four months to verify that compliance has been maintained.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the	K 056		6/12/15

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	245532	A. BUILDING **01 - MAIN BUILDING** B. WING ______	**05/06/2015**

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K 056	Continued From page 4 building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Observations indicated that the automatic sprinkler system has not been maintained in accordance with NFPA 13 Standard for the Installation of Sprinkler System 1999 edition section 5-5.6. This deficient practice may allow a fire to grow uncontrolled which will negatively impact all the residents, visitors and staff. Findings include: Observations during the facility tour on May 6, 2015, between 9am and 1:30PM, revealed that storage in the following areas were within 18 inches of the sprinkler heads within the rooms; 1) Patient rooms 318, 319, 324, and 329. The Facilities Maintenance Director (PS) Verified these findings during the facility tour.	K 056	Corrective Action For Residents Affected By Deficient Practice: Storage within 18 inches of the sprinkler head in resident rooms 318, 319, 324, and 329 were removed. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: All facility residents, visitors, and staff have the potential to be affected by the deficient practice. A facility audit was completed to ensure all resident rooms have no storage within 18 inches of the sprinkler heads. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: A facility audit tool was developed to be completed monthly by maintenance personnel to verify that all resident rooms have no storage within 18 inches of the sprinkler heads. Maintenance personnel were educated on the audit process by June 10, 2015. Education regarding appropriate storage was provided to residents at their neighborhood resident council meetings. Education regarding storage was also provided to families in attendance at the family council meeting on June 9, 2015. How The Facility Will Monitor Performance To Make Sure That	

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K 056	Continued From page 5	K 056	Solutions Are Sustained: The resident room inspection for storage within 18 inches of a sprinkler head will be audited by the Administrator monthly. The results of the audit will be presented to the facility Quality Assurance committee for a period of four months to verify that compliance has been maintained.	

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
May 20, 2015

Ms. Ashley Bormann, Administrator
Bethesda Heritage Center
1012 East Third Street
Willmar, Minnesota 56201

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5532025

Dear Ms. Bormann:

The above facility was surveyed on May 4, 2015 through May 6, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

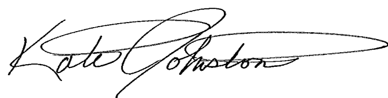
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338.

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,



Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: 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
	00312	A. BUILDING: ______ B. WING ______	05/06/2015

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/28/15

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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On May 4-7, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. On May 4-7th, 2015 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 Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and	21375		6/12/15

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21375	Continued From page 3 sanitary environment. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure infection control practices were consistently followed during disposal of soiled laundry down 1 of 1 laundry chutes in the facility. This had the potential to affect all 103 residents residing in the facility. Findings include: During observation on 5/6/2015 between 7:00 a.m. and 8:45 a.m., nursing assistants (NA)-B and NA-C were providing routine morning cares to fourth-floor residents on the east wing of the facility. As resident cares were completed, NA-B and NA-C carried numerous bags from resident rooms, and placed them into a lined, portable hamper lined with a clear plastic bag. The clear, plastic bag contained soiled bed linens, clothing items, wash cloths and towels, all coming from resident rooms after providing cares. Mixed in with the bags in the hamper cart were a night gown, dark stockings, and several small, face towels, all of which were unbagged. At 8:27 a.m.,nursing assistant (NA)-B opened the laundry chute door, located in the east wing hallway, and NA-C grabbed two of the plastic bags filled with resident laundry from the nearby hamper to place the bags down the chute. One of the bags dropped immediately down the chute. A second bag was overfilled and untied, and as NA-C pushed it through the door, half of the bag's contents dropped down the chute with the bag, and the remaining contents including bed linens, a pillow case and clothing items, spilled onto the floor in front of the chute door. NA-C immediately	21375	Corrected	

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21375	Continued From page 4	21375		

Continued From page 4

picked up the items from the floor, and sent them down the chute. NA-C unloaded the remaining bags from the hamper, as well as the unbagged clothing and linen items, and placed them down the chute.

In an interview on 5/6/2015 at 8:30 a.m., NA-C acknowledged one of the bags of laundry opened up and spilled on the floor. NA-C said using the chute was how the dirty laundry got down to get washed, and that laundry and linen "was supposed to be in a bag."

Meanwhile, NA-B assisted a resident in a room across the hall from the the laundry chute. At 8:35 a.m., NA-B exited a resident's room, across the hall from the laundry chute. NA-B carried from the room a resident's pajamas, another article of clothing, a towel, and a small wash cloth in her hands. NA-B then walked to the laundry chute door, opened it, and tossed the laundry items down the chute. All of the items in her arms were unbagged.

In an interview on 5/6/2015 at 8:54 a.m. NA-B stated the laundry chutes is were dirty, resident laundry was disposed. NA-B said she did place "towels, PJs, and wash cloths" down the chute without a bag. NA-B said the "linens and dirty laundry need to be bagged" and then stated, "sometimes they are not bagged."

During observation of the laundry facilities on 5/6/2015 at 12:15 p.m., a large bag, filled with clothing protectors, emerged from the laundry chute, and missed the sorting cart, landing instead on the floor. Seconds later, two more clothing protectors came down the chute, along with a white hand towel, all unbagged, and landed in the cart.

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21375	Continued From page 5	21375		

In an interview on 5/6/2015 at 12:19 p.m., laundry assistant (LA)-A stated that dirty laundry items come into the laundry area "by way of the chute, it's connected to all floors." LA-A said the chute was stainless, and it had been in use "as long as I have been here, " and further that all items came to the laundry this way, including resident "clothing, bedding, linens, soaker pads, clothing protectors and towels." LA-A said "most of the items that come down the chute were bagged," and then added, "but not all." LA-A said she thought if laundry items were not visibly soiled, like resident clothing, or wash cloths, that they "would not have to be bagged." LA-A went on to state, that items that were soiled with BM (bowel movement) were rinsed out on the floor by the aides, then "re-bagged before they were sent down the chute." LA-A was not sure if the laundry chute was regularly cleaned, or who was responsible to clean it.

In an interview on 5/7/2015 at 9:00 a.m., registered nurse (RN)-B stated, in regard to the laundry chutes, "All soiled laundry items should be bagged, but I'm not sure that happens."

During an interview on 5/7/2015 at 12:36 p.m., the assistant director of nursing (ADON) stated there was "no explanation" as to why soiled laundry items were not bagged when sent down the laundry chute. The ADON stated it was "facility protocol" to bag all items, including clothing protectors, resident laundry, soiled clothing, towels, everything, before sending them down the laundry chute. The ADON said there was no way of knowing what items sent down the chute were soiled or contaminated, and therefore everything needed to be bagged. "Everything, always," the ADON said. The ADON stated this

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21375	Continued From page 6 practice was "an infection control concern," and that all items going down the laundry chute, "were to be bagged." A facility policy regarding the appropriate handling of soiled linen was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could re-educate the staff on appropriate handling, bagging and disposal of linen and laundry. The designee could verify staff have received the infection-control education, and also perform additional audits to verify staff compliance with the training. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is	21830		6/12/15

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
BETHESDA HERITAGE CENTER	**1012 EAST THIRD STREET WILLMAR, MN 56201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00312	A. BUILDING: ______ B. WING ______	05/06/2015

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the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to accommodate bathing preferences for 1 of 3 residents (R83), reviewed for bathing choices.

Corrected

Findings include:

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R83's admission Minimum Data Set (MDS) dated 3/15/2015 identified the resident had a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). The MDS identified R83 required one person assistance with bathing and it was very important to choose between a tub bath, shower, bed bath, or sponge bath.

R83's Nursing Admission Assessment, dated 3/13/15, indicated taking a tub bath in the morning was very important to her. R83's care plan, dated 4/2/15, directed staff to ensure R83's daily preferences will be followed. The care plan indicated R83's preference was to "choose a tub bath in the morning." The nursing assistant assignment sheet, undated, identified R83 required extensive assist of 1 staff for bathing, but did not indicate that she had a bathing preference.

On 5/6/2015 at 7:30 a.m., R83 was observed in wheelchair exiting shower room, propelled by staff, returning to her room. There was no bath tub in this bathing room.

During interview on 5/6/2015 at 7:48 a.m., R83 stated she had a shower earlier this morning. R83 also said she liked [tub] baths, however, the facility only had a shower on the TCU (transitional care unit). R83 stated when she was admitted to the facility, she told staff she liked baths, but it has never been brought up since and has always received a shower. R83 stated the previous facility she was in gave her a bath in the whirlpool, and it felt good. R83 stated, "Maybe the new place will have one."

During an interview on 5/6/2015 at 8:10 a.m., nursing assistant (NA)-D stated the TCU unit has

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a shower only, but no bath tub. NA-D said, if a resident wanted a bath instead of a shower, they would have "to use the tub on the 3rd floor." NA-D also stated, if a resident preferred to have a tub bath, the nurse would let the nursing assistants know, or put it on the care sheet. NA-D further stated there was only one staff on the unit and it was "harder to give baths in the a.m. "

During an interview on 5/6/2015 at 8:16 a.m., registered nurse (RN)-C stated, "I can't promise a tub bath, there is not one on this floor." RN-C said, if a resident preferred a tub bath, "We write it in the book for the nursing assistants." In regard to how often residents can bathe, RN-C stated, when census is low, residents can have two baths, "but we guarantee one bath a week."

During an interview on 5/6/2015 at 12:04 p.m., the director of nursing (DON) stated upon admission, staff ask if residents want a tub or shower, if they prefer day or evening, and, if resident requests more than one a week, "They work that into the schedule." The DON also stated residents were again asked about preferences if there was a room change, and also during care conferences. The DON was not sure if bathing preferences were documented anywhere.

During a subsequent interview on 5/7/15 at 10:23 a.m., RN-C stated R83 should have been offered a tub bath, "per her preference."

A facility policy regarding resident choices was requested, but not provided.

SUGGESTED METHOD OF CORRECTION:
The administrator or designee could re-educate

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21830	Continued From page 11 staff on soliciting and assessment of resident preferences, and conduct audits to ensure resident choices are obtained, care planned and provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		