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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5VUH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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 **06/18/2014** (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 :
Bruce Melchert, HFE NE II — 06/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 8/15/2014 (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
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
06/13/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245532

July 1, 2014

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 May 28, 2014 the above facility is certified for or recommended for:

125 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 125 skilled nursing facility beds.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 1, 2014

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

RE: Project Number S5532024

Dear Ms. Bormann:

On May 9, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 24, 2014 . 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 18, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 16, 2014 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 April 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 28, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 24, 2014, effective May 28, 2014 and therefore remedies outlined in our letter to you dated May 9, 2014, 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
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245532	A. Building B. Wing	6/18/2014

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/22/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **05/22/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/22/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **05/22/2014**	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	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	BF/KJ	07/01/2014	32613	06/18/2014
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
4/24/2014			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245532	A. Building / B. Wing: 01 - MAIN BUILDING	6/16/2014

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0034	Correction Completed 05/28/2014	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 05/28/2014	ID Prefix Reg. # NFPA 101 LSC K0067	Correction Completed 05/28/2014
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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	07/01/2014	27200	06/16/2014
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?
4/22/2014	YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5VUH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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 **04/24/2014** (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:
X 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: **B*** (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):
See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Tim Rhonemus, HFE NE II — 06/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 06/09/2014 (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
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
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed 04/24/14, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 9, 2014

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

RE: Project Number S5532024

Dear Ms. Bormann:

On April 24, 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 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:

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

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

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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 3, 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 June 3, 2014 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 July 24, 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 October 24, 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 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) 215-0541

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245532	A. BUILDING _____ B. WING _____	04/24/2014

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 (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. Upon receipt of an acceptable ePOC 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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		5/22/14

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

Electronically Signed | 05/16/2014

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 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 _____	04/24/2014

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

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F 279	Continued From page 1 by: Based on interview and document review, the facility failed to develop a comprehensive care plan for falls prevention and medication monitoring for 2 of 19 residents (R132 and R43) who had a comprehensive assessment completed in the sample. Findings include: FALLS PREVENTION R43 had the diagnoses of dementia, depression psychosis and impulse control disorder. The quarterly Minimum Data Set (MDS), dated 1/28/14 indicated that R43 required extensive assistance with one staff for all activities of daily living (ADL), including assistance of one with transfers and ambulation secondary to balance issues. The Care Area Assessment (CAA), dated 10/31/13 indicated that R43 had the inability to steady himself without human assistance and had no safety awareness and was very impulsive, with self transfers and self ambulation. In the Stage 1 staff interview, on 4/22/14 at 8:00 a.m., registered nurse (RN)-B stated R43 had a fall on 4/08/14. RN-B stated that cause of the fall was that this resident received Milk of Magnesia (MOM - a stool laxative), experienced bowel urgency and attempted to toilet himself and fell in the bathroom at 2:30 a.m.. RN-B then stated that the R43's care plan was updated to include not to give MOM after 8:00 p.m. in the evening for a fall prevention intervention. A review of the nursing notes (NN) dated 04/09/2014 at 10:05 a.m., from RN-B documented the following: "Follow up from fall	F 279	F279 Develop Comprehensive Care Plans Corrective Action For Residents Affected By Deficient Practice: Care plan was updated for Resident #43 falls prevention intervention on 4/24/14. Care plan for Resident #132 use of Lovenox was updated on 4/23/14. On 5/7/14, the Lovenox for Resident #132 was discontinued. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed for residents who have had a fall in the past 30 days to verify that their fall prevention interventions are on their care plan. This audit included verifying residents who are on Lovenox were care planned. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: RN/LPN will update resident□s care plan as soon as a new falls p revention intervention or Anticoagulant medication has been added to their care. Licensed nursing staff will be educated on May 21st, 2014. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON/ADON or designee will do random audits of care plans looking at fall prevention interventions and Anticoagulant use. 8 chart audits will be done monthly X 4 months starting May 22nd, 2014. Audits	

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F 279	Continued From page 2 during the night. This resident's first fall since admission. He stated that he got medication to help his bowels and he had to go, didn't want to wait for help so got up on his own and was heading to the bathroom but lost his balance and fell. He denies pain or discomfort. Injuries of bruise and abrasion to left knee. ROM (range of motion) within normal limits. Plan is not to give MOM (bowel medication) after 8 p.m.. Writer also encouraged resident to use call light to ask for assistance." Review of R43's care plan (dated April 2014) identified a problem with Falls which was initiated on 11/04/13). There was no indication that this intervention of no MOM after 8:00 p.m., had been added to R43's plan of care as a fall prevention method. During interview on 04/24/14 at 8:15 a.m., RN-B verified the care plan did not address the last fall prevention intervention. RN-B further stated that she thought that it may have been placed in the communication book when it happened, but the staff should know. In review of the facility policy, entitled: Bethesda Heritage Center Care Planning Policy And Procedure (last revised 4/13), section 4 - "The plan of care is reviewed at least quarterly at each of the care conference. The care plan is revised by all disciplines as changes occur with the resident PRN (as needed)." MEDICATION MONITORING	F 279	will be reviewed at our monthly QAPI meetings. Completion Date: May 22nd, 2014	

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F 279	Continued From page 3 R132 admission and physician order sheet identified R132 was admitted to the facility for rehabilitation therapy on 1/9/14 after having fractured a hip. At the time of the admission R132 had a physician's order for the blood thinner Lovenox 0.4mg subcutaneous every day, a medication used to prevent blood clots from forming. A temporary care plan dated 1/9/14 identified the use of Lovenox and to watch for unusual bleeding. However, the care plan developed at the time of the initial care conference on 1/29/14 did not address the use of the Lovenox, the potential for bleeding and monitoring the resident for unusual bleeding. On 4/23/14 at 5:00 p.m. registered nurse-A (RN)-A reviewed the most current care plan and verified monitoring the resident for bleeding tendencies was not addressed on the care plan. RN-A also provided the surveyor with a copy of a temporary care plan which had been developed at the time of admission on 1/9/14. The temporary care plan addressed the Lovenox and to monitor for bleeding. When asked at 5:58 p.m. as to why the Lovenox was not carried over to the most current care plan, RN-A stated "I don't know why." On 4/24/14 at 8:00 a.m. RN-A approached the surveyor and stated R132's skin was monitored everyday for bruising. That since the resident required staff assistance for dressing and undressing R132's skin was looked at several times a day. Plus, the facility policy was for staff to report any bruises to the nurses. When mentioned again that it was not carried over from the temporary care plan to the permanent one,	F 279		

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F 279	Continued From page 4 RN-A had no comment.	F 279		
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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a fall interventions were documented so that staff could assure implantation for 1 of 1 residents (R43) who recently fell due to an ordered bowel protocol. R43 quarterly Minimum Data Set (MDS), dated 1/28/14 identifed diagnoses of dementia, depression psychosis and impulse control disorder. It also indicated that R43 required extensive assistance with one staff for all activities of daily living (ADL), including assistance of one with transfers and ambulation secondary to balance issues. The Care Area Assessment (CAA), dated 10/31/13 indicated that R43 had the inability to steady himself without human assistance and had no safety awareness and was very impulsive, with self transfers and self ambulation. R43's Bethesda heritage Care center Safety Risk Data Assessment (last reviewed 1/28/14) indicted that this resident utilized a wheelchair or walker	F 323	F323 Free of Accident Hazards/Supervision/Devices Corrective Action For Residents Affected By Deficient Practice: Care plan has been updated for Resident #43 falls prevention intervention. This intervention has been added to the MAR to alert all nursing staff. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed for residents who have had a fall in the past 30 days to verify that their fall prevention interventions are on their care plan and were properly communicated to staff. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: RN/LPN will update resident s care plan as soon as a new intervention has been added to their care. This change will be communicated to staff via the communication book or MAR as	5/22/14

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F 323	Continued From page 5 with 1 staff assist due to weakness and balance impairment. In the Stage 1 staff interview, on 4/22/14 at 8:00 a.m., the 3rd floor care manager (RN)-B stated that R43 had a fall on 4/08/14. RN-B stated that cause of the fall was that this resident received Milk of Magnesia (MOM - a laxative), experienced bowel urgency and attempted to toilet himself and fell in the bathroom at 2:30 a.m.. RN-B then stated that the R43's care plan was updated to include not to give MOM after 8:00 p.m. in the evening for a fall prevention intervention. A review of the nursing notes (IPN) dated 04/09/2014 at 10:05 a.m., made by RN-B documented the following: "Follow up from fall during the night. This resident's first fall since admission. He stated that he got medication to help his bowels and he had to go, didn't want to wait for help so got up on his own and was heading to the bathroom but lost his balance and fell. He denies pain or discomfort. Injuries of bruise and abrasion to left knee. ROM (range of motion) within normal limits. Plan is not to give MOM (bowel medication) after 8 p.m.. Writer also encouraged resident to use call light to ask for assistance." In review of R43's care plan (dated April 2014) and the problem for Falls (dated 11/04/13), there was no indication that this intervention of no MOM after 8:00 p.m., had been documented on R43's plan of care. In further review of R43's April 2014 medication administration record (MAR), the was documentation the MOM had been given on 4/8/14 at 11:30 p.m., and documentation the R43	F 323	applicable. Licensed nursing staff will be educated on May 21st, 2014. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON/ADON or designee will do random audits to ensure fall prevention intervention measures are communicated appropriately to staff following a fall. 4 chart audits will be done monthly X 4 months starting May 22nd, 2014. Audits will be reviewed at our monthly QAPI meetings. Completion Date: May 22nd, 2014	

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F 323	Continued From page 6 received "small results." However, this document lacked documentation updating and informing staff not to give MOM after 8:00 p.m.. In interview on 04/23/14 at 9:00 a.m., a licensed practical nurse (LPN)-B stated after review of the MAR, that there were no medications that were documented to be or not to be given at any specific time. LPN-B further stated that only medication she would make sure was given at a specific time was R43's aspirin, so that is was not taken on an empty stomach. On 4/23/14 4:06 p.m. (the shift that MOM had been given prior to R43's fall), LPN-A was asked if there were medications she gave on her shift, that had specific times to be given and/or not to give. After checking the MAR LPN-A shook her head and when the surveyor stated "so, nothing that you are aware of?", LPN-A stated "No". During interview on 04/24/14 at 8:15 a.m., RN-B verified they were not implementing the falls prevention protocol for R43, which was identified as part of the fall assessment intervention. RN-B further stated that she thought that it may have been placed in the communication book when it happened, but the staff should know. In review of the facility policy, entitled: Bethesda Heritage Center Care Planning Policy And Procedure (last revised 4/13), section 4 - "The plan of care is reviewed at least quarterly at each of the care conference. The care plan is revised by all disciplines as changes occur with the resident PRN (as needed)."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		5/22/14

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F 329	Continued From page 7 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure behavioral monitoring was completed for 1 of 3 residents (R132) who received an antipsychotic medication. Findings include: Admission notes on 1/9/14 identified R132 was admitted to the facility for rehabilitation therapy. According to the written history and physical	F 329	F329 Drug Regimen is Free From Unnecessary Drugs Corrective Action For Residents Affected By Deficient Practice: The appropriate diagnosis has been obtained for Resident #132 for his use of Abilify. The target behavior to be monitored has been changed to reflect his specific behavior. Identification Of Other Residents Having	

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F 329	Continued From page 8 document received from the hospital R132 had sustained a fractured hip, which could not be surgically repaired until a later date, and with a physician's order for the antidepressant Zoloft 50 milligrams (mg) every day. The physician ordered the antipsychotic medication Abilify, 5 mg on 1/31/14 for anxiety. However, the facility failed to monitor and document R132's anxiety to support continued use of the Abilify. A Suicide Assessment (dated 1/29/14) indicated R132 had asked a family member-A (FM-A) to bring in a gun, but denied having a plan to use the gun. The assessment revealed chronic pain related to the non-surgically repaired fractured hip, age and depression were associated suicide risk factors. Additional contributing factors included waiting more than two weeks for a surgery that could not be done at a local hospital, having the spouse drive in city traffic and the surgery itself. The assessment indicated R132 was anxious about these things and was agreeable to trying an anti-anxiety medication. The facility updated R132 physician with a fax dated 1/30/14, that identified R132 had anxiety and was telling staff that the stress of waiting (for surgery) was more than R132 could "take." The facility asked the physician "What would you like us to give him?" The physician's response was to order the anti-psychotic medication Abilify at a dose of 5 mg every day. A review of Abilify Monthly Behavior Monitoring sheets for 2/14, 3/14 and 4/14, identified staff were monitoring R132 for "sadness." There was no indication that staff were monitoring R132 for	F 329	the Potential To Be Affected By Deficient Practice: A facility audit was completed for residents who are on anti-psychotic medications to verify that appropriate diagnosis and indications for use are documented. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: RN obtained appropriate diagnosis from MD/NP for an Antipsychotic if one is not given by MD with order. Target behaviors will be individualized to reflect specific behaviors being monitored. Licensed nurses will be educated on this practice on May 21st , 2014. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON/ADON or designee will do random audits on Antipsychotic medications for appropriate diagnosis and target behavior to be monitored. 4 random audits will be done monthly X 4 months starting May 22nd, 2014. Audits will be reviewed monthly at our QAPI meeting. Completion Date: May 22nd, 2014	

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F 329	Continued From page 9 anxiety symptoms as identified on the 1/29/13 Suicide Assessment. The Abilify behavior sheets for these months revealed R132 had exhibited "sadness" on 2/7, 2/8 and 2/9/14, but all other dates for the months reviewed were blank. Also, there was no indication that R132 had been monitored for suicide ideation after completion of the 1/29/14 Suicide Assessment. On 4/23/14 at 4:30 p.m. registered nurse-A was asked for documentation regarding monitoring of behaviors to support the use of the Abilify, and monitoring of suicide ideation. RN-A stated the facility took suicide ideation "very seriously", but was not able to provide evidence of any monitoring for suicide ideation. When asked for documentation regarding monitoring of anxiety behaviors, RN-A stated that if the resident wasn't having any behaviors there would be no documentation. When asked if the facility was charting behaviors by exception, RN-A stated "Yes ma ' am." On 4/24/14 at 10:30 a.m. the consulting pharmacist was interviewed regarding behavior monitoring for R132. The consulting pharmacist stated he would expect the facility to be documenting on behaviors and side effects. The consulting pharmacist stated he did not have R132's information in front of him, but that the general expectation was to not chart by exception as that was not a "best practice." The pharmacist stated he preferred behaviors, whether they were happening or not to be documented. After informing the pharmacist how the facility was documenting behavior monitoring the pharmacist stated the resident's "stress could be documented better."	F 329		

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F 329	Continued From page 10 The facility's 8/2013 policy titled Behavior Management Process revealed that suicidal ideation required formal monitoring. The facility's 1/14 revised policy title Antipsychotic Medications Policy & Procedures revealed that residents receiving antipsychotic medications would have target behaviors monitored by nursing assistants and licensed staff and the behaviors would be "charted on only if behavior occurs." This policy also indicated that antipsychotic medication should only be used for specific conditions and neither anxiety or depression were listed as one of the specific conditions.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the consulting pharmacist failed to identify the facility was completing behavioral monitoring for 1 of 3 residents (R132) who received an antipsychotic medication. Findings include:	F 428	F428 Drug Regimen Review, Report Irregular, Act On Corrective Action For Residents Affected By Deficient Practice: MD orders reviewed for Resident #132 by the Pharmacy Consultant on May 15th, 2014. The appropriate diagnosis has been obtained	5/22/14

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F 428	Continued From page 11 Admission notes on 1/9/14 identified R132 was admitted to the facility for rehabilitation therapy. According to the written history and physical document received from the hospital R132 had sustained a fractured hip, which could not be surgically repaired until a later date, and with a physician's order for the antidepressant Zoloft 50 milligrams (mg) every day. A Suicide Assessment (dated 1/29/14), revealed R132 had asked a family member -A (FM-A) to bring in a gun, but denied having a plan to use the gun. The assessment further indicated R132 had been experiencing chronic pain related to the non-surgically repaired fractured hip, age and depression were associated suicide risk factors. Additional contributing factors included: waiting more than two weeks for a surgery that could not be done at a local hospital, having the spouse drive in city traffic and the surgery itself. The assessment indicated R132 was anxious about these things and was agreeable to trying an anti-anxiety medication. Nursing documentation in the P132's medical record (dated 1/30/14), indicated the physician was faxed information about the resident's anxiety and that R132 was telling staff that the stress of waiting (for surgery), and it was more than he could "take." The fax sent by the facility staff asked the physician "What would you like us to give him?" The physician's response (on 1/30/14) was an order for Abilify (antipsychotic medication) 5 milligrams (mg) for anxiety. A review of Abilify behavior monitoring sheets for 2/14, 3/14 and 4/14, revealed staff were to monitor R132 for "sadness." There was no	F 428	for his use of Abilify. The target behavior to be monitored has been changed to reflect his specific behavior. Identification Of Other Residents Having The Potential To Be Affected By Deficient Practice: A facility audit was completed for residents who are on anti-psychotic medications to verify that appropriate diagnosis and indications for use are documented. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: All resident□s medication regimes will be reviewed by Consultant Pharmacist on a monthly basis. Their recommendations will be given to MD/NP for their review. RN will obtain appropriate diagnosis from MD/NP for an Antipsychotic if one is not given by MD with order. Target behaviors will be individualized to reflect specific behaviors being monitored. Licensed nurses will be educated on this practice on May 22nd, 2014. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON/ADON or designee will do random audits on the completion of the monthly Pharmacy Consultant review and their recommendations are being responded to by the NP/MD. 4 random audits will be done monthly X 4 months starting May 22nd, 2014. Audits will be reviewed monthly at our QAPI meeting. Completion Date: May 22nd, 2014	

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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 428	Continued From page 12 indication that staff were monitoring R132 for anxiety symptoms as identified on the 1/29/13 Suicide Assessment. The Abilify behavior sheets for these months revealed R132 had exhibited "sadness" on 2/7, 2/8 and 2/9/14, but all other dates for the months reviewed were blank. Nor was there any indication R132 had been monitored for suicide ideation after completion of the 1/29/14 Suicide Assessment. The facility failed to monitor and document R132's anxiety to support continued use of the Abilify and the consulting pharmacist failed to address the lack of behavior monitoring during monthly drug regimen reviews conducted on 2/12/14, 3/12/14 and 4/11/14. On 4/23/14 at 4:30 p.m. registered nurse-A was asked for documentation regarding monitoring of behaviors to support the use of the Abilify, and monitoring of suicide ideation. RN-A stated the facility took suicide ideation "very seriously", but was not able to provide documentation regarding suicide ideation monitoring. When asked for documentation regarding monitoring of anxiety behaviors, RN-A stated that if the resident wasn't having any behaviors there would be no documentation. When asked if the facility was charting behaviors by exception, RN-A stated "Yes ma ' am." R132 was interviewed on 4/24/14 at 10:00 a.m., and was asked if he knew what an antipsychotic medication was and if he had ever taken this category of medication before. R132 stated he did not, and stated he took two pills for depression, one of which was a little blue pill (Abilify.)	F 428		

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 _____	04/24/2014

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F 428	Continued From page 13 On 4/24/14 at 10:30 a.m. the consulting pharmacist was interviewed regarding behavior monitoring for R132. The consulting pharmacist stated he would expect the facility to be documenting on behaviors and side effects. The consulting pharmacist stated he did not have R132's information in front of him, but that the general expectation was to not chart by exception as that was not a "best practice." The pharmacist stated he preferred behaviors, whether they were happening or not to be documented. After informing the pharmacist how the facility was documenting behavior monitoring the pharmacist stated the resident's "stress could be documented better." There was no comment as to why the lack of behavior monitoring had not been addressed during monthly drug regimen reviews. The pharmacist failed to identify the lack of behavior monitoring to support the continued use of the antipsychotic medication Abilify for R132, who had never received an antipsychotic medication. The facility's 8/2013 policy titled Behavior Management Process revealed that suicidal ideation required formal monitoring. The facility's 1/14 revised policy title Antipsychotic Medications Policy & Procedures revealed that residents receiving antipsychotic medications would have target behaviors monitored by nursing assistants and licensed staff and the behaviors would be "charted on only if behavior occurs." This policy also indicated that antipsychotic medication should only be used for specific conditions and neither anxiety or depression were listed as one of the specific conditions.	F 428		

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	245532	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/22/2014**

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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	TITLE	(X6) DATE
Electronically Signed		05/28/2014

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 survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245532	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/22/2014**

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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		

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K 000	Continued From page 2 The facility has a licensed capacity of 125 beds and had a census of 116 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 034 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain a clear and unobstructed exit stairway in accordance with NFPA 101 Life Safety Code (2000) section 7.2.2. This deficient practice could negatively affect the use of the exit stairway used by staff that would delay needed staff assistance to residents and visitors in the event of an emergency. Findings include: On facility tour between 10:00 AM and 1:00 PM on 04/22/2014, It was observed, that there were several boxes and other equipment being stored in the lower level of the central exit stairwell. This deficient practice is restricting the exit capacity and the capability for this stairwell as a required egress. This deficient practice was verified by the Maintenance Supervisor.	K 034	KO34 Corrective Action For The Deficiency: Boxes and newspapers were removed from exit stairwell on 4/22/14. Maintenance and housekeeping staff were re-educated on keeping the exit stairwells free from any boxes, newspapers, or other objects. A sign was placed in the stairwell stating No storage of any kind in this area. Facility will audit the stairwell weekly x 3 months to ensure stairwell is free from any objects. Audit will be reviewed by the Safety Committee monthly. Completion Date: May 28, 2014 Name and Title Of Person Responsible For Correction And Monitoring To Prevent Recurrence: Stanley Halvorson, Environmental Services Director and Ashley Bormann, Administrator	5/28/14

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K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed to conduct the required number of fire drills within the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 116 residents, visitors and staff. Findings include: On facility tour between 10:00 AM and 1:00 PM on 04/22/2014, during a documentation review of the available fire drill reports for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility had failed to conduct 1 of 12 fire drills. The facility failed to conduct a fire drill for the 3rd shift in the 3rd quarter of the calendar year. This deficient practice was verified by the Maintenance Supervisor.	K 050	KO50 Corrective Action For The Deficiency: To prevent reoccurrence, a revised flow sheet has been created and added to the maintenance book to ensure a fire drill is not missed. The administrator will approve the dates scheduled for fire drills in advance and ensure they are completed on that date. Completion Date: May 28, 2014 Name and Title Of Person Responsible For Correction And Monitoring To Prevent Recurrence: Stanley Halvorson, Environmental Services Director and Ashley Bormann, Administrator	5/28/14
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		5/28/14

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K 067	Continued From page 4 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of all 116 residents, staff and visitors in the event of a fire. Findings include: On facility tour between 10:00 AM and 1:00 PM on 04/22/2014, it was revealed during the review of facility's fire and smoke damper test and inspection documentation and was confirmed by interview with the Maintenance Supervisor, that the facility failed to provide documentation that the fire and smoke dampers had been tested/inspected within the last 4 years in accordance with NFPA 90(99) section 3-4.7. This deficient practice was verified by the Maintenance Supervisor.	K 067	KO67 Corrective Action For The Deficiency: The fire and smoke damper was inspected and tested on May 14th, 2014 by a licensed HVAC company. To prevent reoccurrence, a flow sheet has been added to the maintenance book stating when it was inspected and when it needs to be re-inspected. Completion Date: May 28, 2014 Name and Title Of Person Responsible For Correction And Monitoring To Prevent Recurrence: Stanley Halvorson, Environmental Services Director and Ashley Bormann, Administrator	