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: 70II
Facility ID: 00167

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

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

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

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

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

6. DATE OF SURVEY 09/13/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10. THE FACILITY IS CERTIFIED AS:

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

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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. .

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 09/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/19/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS
Posted 1/7/14 70II ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/09/2013
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5578 December 19, 2013

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

Dear Mr. Sondegaard:

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

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

Effective September 4, 2013, the above facility is certified for:

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

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring

Telephone #: (651)201-4117 Fax #: (651)215-9697
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

September 20, 2013

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

RE: Project Number S5578023

Dear Mr. Sondegaard:

On August 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 1, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 13, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 5, 2013 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 urvey, completed on August 1, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 4, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 1, 2013, effective September 4, 2013 and therefore remedies outlined in our letter to you dated August 12, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: 612-201-4124 Fax: 651-215-9697

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245578	A. Building B. Wing	9/13/2013

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0167 Reg. # 483.10(g)(1) LSC	08/22/2013	ID Prefix F0176 Reg. # 483.10(n) LSC	09/04/2013	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	09/04/2013
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	09/04/2013	ID Prefix F0309 Reg. # 483.25 LSC	09/04/2013	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	09/04/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	09/20/2013	18623	09/13/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/1/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245578	01 - BETHANY COVENANT HOME	9/5/2013

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0018	**09/04/2013**	ID Prefix Reg. # **NFPA 101** LSC K0038	**09/04/2013**	ID Prefix Reg. # **NFPA 101** LSC K0050	**09/04/2013**
ID Prefix Reg. # **NFPA 101** LSC K0051	**09/04/2013**	ID Prefix Reg. # **NFPA 101** LSC K0052	**08/22/2013**	ID Prefix Reg. # **NFPA 101** LSC K0072	**08/22/2013**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	09/20/2013	28120	09/05/2013
CMS RO				

Followup to Survey Completed on: 7/31/2013

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: 70II
Facility ID: 00167

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/01/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Angela Richey, HFE NE II 08/29/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 09/08/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00131** (L31)

30. REMARKS
Posted 09/09/2013 CO. 70II

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 24-5578

At the time of the standard survey completed August 1, 2013, 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. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5186

August 12, 2013

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

RE: Project Number S5578023

Dear Mr. Sondegaard:

On August 1, 2013, 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;**
>
> **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;**

<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:

Gayle Lantto
Minnesota Department of Health
PO Box 64900
Saint Paul Minnesota 55164-0900

Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 21, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 21, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. 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 PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 1, 2013 (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 February 1, 2014 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

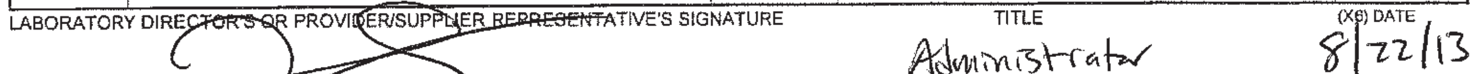
cc: Licensing and Certification File 5578s13.rtf

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
	245578	A. BUILDING ____ B. WING ____	08/01/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute deficiency, or that the scope and severity regarding the deficiency are correctly applied. Please accept this Plan of Correction as our credible allegation of compliance. Our compliance will be achieved by the date identified on the Plan of Correction.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the most recent state survey results in a manner that the 61 residents and visitors to the facility would not have to request them from staff. Findings include: During the initial tour on 7/29/13, at 12:03 p.m. an observation revealed that the posted survey results were dated 6/2/11. The most current	F 167	Accepted 8-29-13	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8/22/13

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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	245578	A. BUILDING ______ B. WING ______	08/01/2013

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F 167	Continued From page 1 survey that should have been posted was dated 5/10/12. The director of social services verified the posted survey results were from 6/2/11. The administrator was interviewed on 7/30/13, at 2:11 p.m. and verified the posted survey results were still 6/2/11 versus the most current survey results. The administrator stated the most current survey results were kept at the front desk, and would be shown to anyone if they asked to see them. Review of the undated Survey Posting Policy indicated, "It is the policy of Bethany Care Center to provide a copy of the most recently conducted survey to all residents, staff and guests." The undated Survey Posting Procedure indicated "Upon completion of each survey a copy will be posted in a place readily available to all residents, staff and guests in an easily identifiable location."	F 167	Policy and Procedure reviewed and updated Annual survey from 2013 posted in the 3 ring binder. DON to monitor. Date of completion: 8/22/~~13~~/2013 ✓	8-22-13
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R51) reviewed for self-administration of medications, was assessed to safely self-administer oral or topical medications in an accurate and safe manner. Findings include:	F 176		

RECEIVED
AUG 26 2013
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

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F 176	Continued From page 2	F 176		

R51 was interviewed on 7/29/13, at 5:30 p.m. and during the interview a white paper soufflé cup containing many tablet medications was observed stored on the floor under the bed. Two white tablets and one yellowish colored capsule were also observed on the carpeting of the floor at the bedside. R51 stated she stated she "must have dropped them on the floor," when asked if she was aware there were medications in a cup under the bed. The resident then retrieved the two tablets and capsule from the floor and placed them on the bed. R51 stated the surveyor "did not need to notify the nurse" and said that instead, she would notify the nurse. R51 left the cup of medications under the bed.

On 7/29/13, at 5:32 p.m. the registered nurse (RN)-D was notified a cup of medications was stored under R51's bed. RN-D confirmed he was the nurse assigned to R51 and stated he had not given R51 any medications since the start of his shift. The RN explained R51 did not like taking her medications, especially inhalers, but he usually "waits with the resident to make sure she takes all her medications." RN-D confirmed R51 did not self-administer her oral medications and medications should not have been stored under the bed. The RN speculated, "Maybe she's trying to hide them? She plays games sometimes." He said he would immediately go and retrieve the cup of medications, find out which medications they were, and determine when they were given to R51. RN-D further stated, "She doesn't get medication from me until 8:00 p.m. They may have come from a previous shift."

R51's quarterly MDS dated 5/1/13, revealed the resident was cognitively intact and independent with all activities of daily living (ADLs). The

Provider's Plan of Correction (F 176):

Policy and Procedure reviewed and updated.

Education provided to all Licensed staff and TMA's regarding proper medication administration, procedure for self-administration of medication.

DON to monitor and staff education to be completed by 9/4/2013.✓

Handwritten: audits will include SAM [illegible] completed, added & POC reassessment [illegible]. [illegible] audits [illegible] 4 wks then [illegible] for [illegible] [illegible]

[illegible handwriting]

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F 176	Continued From page 3	F 176		

Assessment of Self-Administration of Medications dated 4/22/13, indicated R51 wished to self-administer nebulizers (a machine used to dispense inhaled medications). The word "medications" was crossed out with one line and the word "nebulizers" was written underneath. The assessment indicated R51 was assessed for her ability to safely self-administer her nebulizer medications. A hand written note to the side read, "Nurse will be setting up the Neb [nebulizer machine] for Res. [resident]" The assessment did not include assessment of R51's oral and topical medications.

The care plan dated 10/5/12, identified R51 had chronic obstructive pulmonary disease and congestive heart failure. The care plan had a hand written note dated 4/22/13, which directed, "Ok to self admin [administer] neb after nurse set up." The care plan did not address safe self-administration of oral or topical medications.

Although R51 had not been assessed as safe to self-administer topical medications, physician orders included keeping topical medications at the bedside and to self-administer them. Physician's Orders did not include self-administration of oral medications. Orders dated 7/25/13, indicated R51 was to apply Carrington Moist Barrier cream and triamcinolone cream 0.1% to skin; both were ordered to apply two times daily as needed. The order was dated 5/11/13, and directed, "*May keep at bedside* (May Self Administer)." R51's Physician's Orders directed, "(May Self Administer)" the Duoneb 2.5-0.5 mg/ml (milligrams per milliliter) one vial per neb every four hours as needed.

On 7/30/13, at 9:50 a.m. the director of nursing

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F 176	Continued From page 4 (DON) verified she was notified immediately of the medications stored under R51's bed. "I have a list of the medications in my office." The DON verified R51 could not self-administer medications safely and the nurse who dispensed the medications should have either waited in the room with R51 until the medications were taken, waited until the resident could take the medications, or mark a refusal (on the medication administration record (MAR). At the time, DON provided a blank MAR print out, the medications which were in the soufflé cup were highlighted on the form. The medications observed to be stored under R51's bed were: 1) one budeprion XL 150 mg tablet (antidepressant); 2) one multivitamin tablet (a dietary supplement); 3) one Lasix 40 mg tablet (a diuretic medication); 4) one isosorbide mononitrate ER 60 mg tablet (vasodilator); 5) one losartan potassium 50 mg tablet (for hypertension); 6) three metoprolol succinate ER 25 mg tables (beta blocker); 7) two sertraline HCl 100 mg tablets (an antidepressant drug); 8) one omeprazole 40 mg capsule (for esophageal reflux); 9) one ziprasidone HCl 60 mg tablet (antipsychotic). The July 2013 MAR indicated all the above medications were initialed as dispensed by a licensed nurse on the morning of 7/29/13. On 7/30/13, at 2:40 p.m. DON stated she spoke with R51 regarding the medications and stated she learned the resident had placed the medications aside to take them later and "forgot." DON stated she did not know the medications were found by the surveyor under R51's bed and would have to talk with R51 to determine why	F 176		

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F 176	Continued From page 5 they were placed there. DON stated R51 was not assessed to safely self-administer medications and explained R51 was the type of resident who said, "It's okay to leave the medications" and then forget to take them. The Resident Self-Administration Policy dated as last revised on 6/12, identified, "It is the policy of Bethany Care Center to allow residents to self-administer medications and treatments per their request, if the resident is competent to perform such tasks." The procedure directed: "1) LN [licensed nurse] will conduct a self-administration assessment with resident to determine competency. 2) If assessment shows that resident is competent to self-administer medications and/or treatments and the IDT [interdisciplinary team] agrees, an order will be obtained from the MD [medical doctor]." Although the policy directed to assess the resident and obtain a physician's order if the resident was competent to safely self-administer their medications; the policy lacked direction to further ensure resident safety with medication self-administration, such as set-up of medications for self-administration, safe storage of medications such as at the bedside and securing of medications such as in a locked container. The policy lacked direction for documentation of medications which were stored at the bedside and self-administered, such as with as needed creams. The policy lacked direction for care planning of self-administration of medications, and follow-up or periodic re-evaluation of the resident's ability to safely self-administer medications.	F 176		
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

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F 253 SS=C	Continued From page 6 MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not maintain a clean environment. This had the potential to affect all 61 residents residing in the facility. Findings include: Environmental concerns were observed and verified by the administrator during the environmental tour on 8/1/13, at 2:00 p.m. 1) The carpet in the first floor television/bird cage room had a tear measuring 12 inches in length and there were multiple stains on the carpet. 2) The door guard on the door leading into the first floor television/bird cage room was in disrepair, bulging out at the edge of the door guard. 3) The large glass window in the television/bird cage room was permanently fogged over. 4) R51's room was cluttered and had opened food containers everywhere. 5) R12's room had a fourteen inch long scrape along the room door at level of bathroom door handle. 6) The walls on the second floor had greater than ten areas of peeling wallpaper. The new wallpaper had been applied to the old wallpaper with no preparation of the surface underneath the new wallpaper.	F 253	Contractor has been engaged to replace or repair carpet tears. Door guards have been ordered to replace all existing door guards that appear to be in disrepair. Resident R51's room cleaned and organized. R12's door to be repaired. Second floor will be replaced by paint. Blinds to be replaced in 2nd floor dining room. All paint patchwork to be completed. Bathroom work in 230 to be completed. Call light box in 233 repaired. Administrator to monitor. Date of completion: 9/4/2013	

Going to audit [illegible] for [illegible]

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F 253	Continued From page 7 7) The carpeting in the hallway on the second floor just outside room 2S10 had a tear measuring 16 inches. 8) The second floor dining room had ten vertical blinds laying on the window sill that were heavily soiled with green, beige and black substance. 9) The second floor dining room had a wooden cupboard with multiple gouges and there was a recliner in the area. 10) The two south resident hallway had torn carpeting measuring 2 by 6 inches. 11) Room 213 had peeling paint on the doorway threshold from previous taping. 12) Room 222-A had paint peeling off of the wall underneath the window sill. 13) Rooms 234-B and 231-A had wooden dressers with drawers that would not close. 14) Room 230-A bathroom tiles were covered with old glue and one tile was missing. 15) Room 233 call light box was hanging loose from the wall. 16) The second floor dining room ceiling had a 4 by 3 foot area cut out of the finished ceiling that was concrete near an air conditioning unit. The administrator explained it was a recurrent leak from the roof after rain. When interviewed on 8/1/13 at 2:30 p.m. the administrator said that he acted as the maintenance person and that one of the housekeepers assisted in the maintenance needs of the facility. The administrator explained that the facility system for repairs included a maintenance log on the nurses stations and staff can enter environmental concern on the log. The housekeeper then initialed off on the log as tasks are completed. The administrator added that audits of the facility were completed weekly. The administrator said when the ceiling leaked after	F 253		

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F 253	Continued From page 8 rain, a contractor came to the facility, however, documentation of recommendations for permanent repair were not provided when requested. hen interviewed on 8/1/13 at 3:35 p.m. the director of nursing said that the roof did leak and needed to be replaced. The facility policy titled, Routine Maintenance Policy, dated 6/12 indicated that it was the policy of Bethany Care Center to provide a clean and safe environment for residents, staff and guests. Routine maintenance would be part of maintaining this standard. Maintenance personnel would maintain a maintenance log and keep up to date on maintenance requests. The facility maintenance logs for June and July 2013 were reviewed. The logs included requests for wallpaper repairs, vertical blinds repairs, water stains from roof leak repairs and painting repairs. On 7/29/13, at 6:30 p.m. the second floor dining room resident refrigerator was observed to contain house supplements, thickened juice, left over lunch trays, and soda. All the shelves and base of the refrigerator was covered in yellow, orange and brown sticky substances that had not been cleaned. On 7/30/13, at 9:17 a.m. the administrator reported the housekeeper was responsible for cleaning the second floor snack refrigerator. The administrator confirmed the refrigerator was not cleaned routinely as expected by facility policy. Resident Refrigerator Temperature Logs policy and procedure (undated) identified all refrigerator units should have been cleaned daily or as needed.	F 253	Contractor has been engaged to replace or repair carpet tears. Door guards have been ordered to replace all existing door guards that appear to be in disrepair. Resident R51's room cleaned and organized. R12's door to be repaired by 9/1/13. Second floor will be replaced by paint. Blinds to be replaced in 2nd floor dining room. All paint patchwork to be completed by 9/1/2013. Bathroom work in 230 to be completed by 9/1/2013. Call light box in 233 repaired. Administrator to monitor.	

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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 by: Based on observation, interview and document review, the facility failed to develop a plan of care related to pain for 1 of 4 residents (R3) with identified pain. Findings include: R3 was observed on 7/31/13, at 8:02 a.m. when a nursing assistant (NA)-D entered R3's room to provide morning cares. The resident was lying in bed and looked at NA-D to assure she had her attention. R3 then rubbed her right leg up and down the thigh. NA-D asked R3 if she was in	F 279	Care plan was corrected for the resident R3. Policy and Procedure reviewed and updated. Education for Licensed staff and non-licensed staff regarding pain management, what to do and when and who to report the information to and why. Review of policy and procedures for pain and symptom management. Along with review of importance to make sure that when transcribing medication orders for more than one medication of the same type that there are specific directions of when to use which one. Along with education to include when to use which type of pain medication to reach the goal of that specific resident.	

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Continued From page 10

pain, to which R3 shook her head, "yes." NA-D told R3, "I'll let the nurse know when we are done." R3 proceeded to furrow her eye brows (known to indicate pain). Although the resident was fully dressed, the pans did not match and were tight fitting. With the resident's permission, the NA proceeded to change the resident's pants. During this procedure NA-D's back was facing R3's head and upper torso, as the resident mouthed "ow--ow" with facial grimacing, and arched her back off the bed throughout the procedure. NA-D continued to move R3's legs and hips while pulling up her pants, providing incontinence care, and changing a brief. At 8:11 a.m. a licensed practical nurse (LPN)-B entered the room. NA-D reported to LPN-B that R3 was having pain. LPN-B left the room to get pain medication, NA-D proceeded to assist R3 to a sitting position, then standing, and pivoted her to her wheelchair from the bed. R3 exhibited facial grimacing with the movement. At 8:30 a.m. R3 received of Oxycodone 5 milligrams (mg) for pain.

The Diagnosis Report (last revised on 4/1/13), identified R3 had diagnoses including malignant neoplasm (cancer) of head, face and neck, and had returned from the hospital on 6/26/13 after surgical repair of a fractured hip.

The Admission Data Collection and Documentation document (dated 6/26/13) identified R3 as alert, oriented and had pain in her left hip with movement for, "about a half hour," after the movement occurred. The document indicated R3 had verbal expression of pain and nonverbal expressions of pain exhibited by grimacing with transfers. The current treatment was Oxycodone 5 mg every six hours as needed

F 279

Audits to be done for all residents to make sure that all current residents have a care plan including problem, goal and interventions for pain.

Audit done on all new admissions that pain screen is done on admission, day 3 pain assessment is complete and pain is addressed on admission temporary care plan.

Audits to be done for 10 random residents q week for 4 weeks, then 10 random residents q 2 weeks for 1 month and then 10 random residents monthly for 4 months to ensure continued compliance of policy and procedures.

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F 279	Continued From page 11 and ice packs. It noted the pain was relieved by/with medications and positioning and was aggravated by movement. The Health Conditions Pain Assessment document completed by a registered nurse (RN) -B dated 7/10/13, indicated R3 received a schedule pain medication regimen, as needed pain medication or was offered and declined, and non-medication intervention for pain. The document identified R3 had occasional pain or hurting in the last five days in her right leg. The document noted R3 rated the intensity of her worst pain in the last five days as mild. R3's physician orders dated 7/25/13 indicated Oxycodone solution 5 milligrams (mg) as needed every six hours for moderate pain was ordered on 6/26/13. In addition, R3 had Ibuprofen 200 mg ordered every six hours as needed for pain. R3's plan of care revised 6/19/13, directed staff to provide adequate time for R3 to formulate and express thoughts. The plan of care did not address the plan for pain management. On 8/1/13, at 10:00 a.m. RN-B stated she and the assistant director of nursing were responsible for developing/updating the care based on the assessment. RN-B reviewed R3's care plan and verified R3's it did not address pain or pain management. RN-B confirmed R3 was recently readmitted from the hospital after having a left femoral neck fracture repaired. RN-B confirmed a plan of care regarding R3's pain should have been developed.	F 279	Audits to include completion of pain assessment per policy and procedure, pain screening completed per policy and procedure. Pain problem on plan of care, measurable goal along with interventions appropriate for each of these residents. DON to monitor. Date of ~~initiation:~~ Correction 9-4-13 ~~8/22/13/2013~~ ~~Date of completion of audits:~~ ~~2/28/20~~14 [initials]	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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
	245578	A. BUILDING ______ B. WING ______	08/01/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pain management was provided and an evaluation as to the intensity prior to administering as needed medication to determine appropriate interventions for 1 of 4 residents (R3) with identified pain. Findings include: R3 was observed on 7/31/13, at 8:02 a.m. when a nursing assistant (NA)-D entered R3's room to provide morning cares. The resident was lying in bed and looked at NA-D to assure she had her attention. R3 then rubbed her right leg up and down the thigh. NA-D asked R3 if she was in pain, to which R3 shook her head, "yes." NA-D told R3, "I'll let the nurse know when we are done." R3 proceeded to furrow her eye brows (known to indicate pain). Although the resident was fully dressed, the pans did not match and were tight fitting. With the resident's permission, the NA proceeded to change the resident's pants. During this procedure NA-D's back was facing R3's head and upper torso, as the resident mouthed "ow--ow" with facial grimacing, and arched her back off the bed throughout the procedure. NA-D continued to move R3's legs	F 309	Policy and Procedure reviewed and updated. Education for Licensed staff and non-licensed staff regarding pain management, what to do and when and who to report the information to and why. Review of policy and procedures for pain and symptom management. Along with review of importance to make sure that when transcribing medication orders for more than one medication of the same type that there are specific directions of when to use which one. Education to include when to use which type of pain medication to reach the goal of that specific resident. Audits to be done for all residents to make sure that all current residents have a care plan including problem, goal and interventions for pain.	

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F 309	Continued From page 13 and hips while pulling up her pants, providing incontinence care, and changing a brief. At 8:11 a.m. a licensed practical nurse (LPN)-B entered the room. NA-D reported to LPN-B that R3 was having pain. LPN-B left the room to get pain medication, NA-D proceeded to assist R3 to a sitting position, then standing, and pivoted her to her wheelchair from the bed. R3 exhibited facial grimacing with the movement. At 8:30 a.m. R3 received of Oxycodone 5 milligrams (mg) for pain. The LPN did not obtain information on the extent to R3's pain prior to administering the pain medication. In addition, no other non-pharmaceuticals interventions were provided/offered upon identifying the pain. On 7/31/13, at 10:22 a.m. R3 was lying in bed in her room. R3 explained NA-B had assisted her to dress and she reported she was having pain that was worse in her hip after a fall with fracture. The resident indicated, maybe she needed a doctor to address her pain. R3 reported the pain medication she was given today helped a, "little bit." R3 thought she may need to have something scheduled for pain when she got up in the morning, as she rated her pain on a scale of 0 to at a 6, or moderate, (with 0 being no pain and 10 being the worst pain) that morning with cares and transferring to the chair. On 7/31/13, at 11:45 a.m. NA-B confirmed R3 reported to him that she had a lot of pain in her right leg. NA-B stated he told LPN-B at 8:00 a.m., "right after he helped her get dressed." On 7/31/13, at 11:47 a.m. LPN-B stated R3's pain was first reported to her as she entered R3's room when NA-D was assisting R3 with morning	F 309	Audit done on all new admissions that pain screen is done on admission, day 3 pain assessment is complete and pain is addressed on admission temporary care plan. Audits to be done for 10 random residents q week for 4 weeks, then 10 random residents q 2 weeks for 1 month and then 10 random residents monthly for 4 months to ensure continued compliance of policy and procedures.	

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F 309	Continued From page 14 cares. LPN-B stated if NA-B had reported R3's complaint of pain, she would have given the pain medications, and waited for the medication to take effect prior to allowing staff to complete cares. LPN-B confirmed she did not evaluate R3's pain level and used "nursing judgement," to determine whether to give the Oxycodone or the ibuprofen. LPN-B confirmed there was no evaluation completed or pain scale used to determine why Oxycodone was given versus the ibuprofen. LPN-B confirmed R3 would have been able to describe her pain using a pain scale such as 0-10. The Diagnosis Report (last revised on 4/1/13), identified R3 had diagnoses including malignant neoplasm (cancer) of head, face and neck, and had returned from the hospital on 6/26/13 after surgical repair of a fractured hip. The Admission Data Collection and Documentation document (dated 6/26/13) identified R3 as alert, oriented and had pain in her left hip with movement for, "about a half hour," after the movement occurred. The document indicated R3 had verbal expression of pain and nonverbal expressions of pain exhibited by grimacing with transfers. The current treatment was Oxycodone 5 mg every six hours as needed and ice packs. It noted the pain was relieved by/with medications and positioning and was aggravated by movement. The Health Conditions Pain Assessment document completed by a registered nurse (RN) -B dated 7/10/13, indicated R3 received a schedule pain medication regimen, as needed pain medication or was offered and declined, and non-medication intervention for pain. The	F 309	Audits to include completion of pain assessment per policy and procedure, pain screening completed per policy and procedure. Pain problem on plan of care, measurable goal along with interventions appropriate for each of these residents. DON to monitor. Date of ~~initiation:~~ [handwritten: complete] ~~8/22/13/2013~~ [handwritten: 9-4-13 ✓] ~~Date of completion~~ of audits: ~~3/28/2014~~ [handwritten initials]	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 15 document identified R3 had occasional pain or hurting in the last five days in her right leg. The document noted R3 rated the intensity of her worst pain in the last five days as mild. R3's physician orders dated 7/25/13 indicated Oxycodone solution 5 milligrams (mg) as needed every six hours for moderate pain was ordered on 6/26/13. In addition, R3 had Ibuprofen 200 mg ordered every six hours as needed for pain. R3's plan of care revised 6/19/13, directed staff to provide adequate time for R3 to formulate and express thoughts. Medication administration record for the month of 7/13, identified R3 received the Oxycodone 15 times total in 31 days. R3 also received Ibuprofen 11 times in 31 days. R3's falls care plan revised 6/30/13, identified R3 had a fall on 6/21/13, that resulted in a a femoral neck fracture that was surgically repaired. The care plan noted R3 returned from hospital with orders for physical therapy and occupational therapy and required more assist due to recent fracture. The plan of care did not address the plan for pain management. On 7/31/13, at 8:24 a.m. NA-D stated R3 would occasionally slap staff to get their attention when she was having too much pain with cares. NA-D confirmed she was faced away from the R3 during cares and did not see her non-verbal signs of mouthing "ow" or grimacing. NA-D state used when a resident reported pain staff should have let the nurse know immediately and not provide cares until the pain was manageable. NA-D confirmed the nurse was not notified prior to assisting the resident. On 8/1/13, at 10:00 a.m. RN-B stated she and the	F 309		

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F 309	Continued From page 16 assistant director of nursing were responsible for developing/updating the care based on the assessment. RN-B reviewed R3's care plan and verified R3's it did not address pain or pain management. RN-B confirmed R3 was recently readmitted from the hospital after having a left femoral neck fracture repaired. RN-B confirmed a plan of care regarding R3's pain should have been developed. During interview on 8/1/13, at 9:39 a.m. the administrator stated, "If a resident was exhibiting signs or symptoms of pain, the staff should stop what they are doing ensuring the resident was in a safe environment, and let the nurse know immediately." The administrator reported staff should not continue with cares if a resident voiced or was exhibiting outward signs of pain. The facility's Pain Management policy dated 6/12, identified; a pain assessment would be completed upon admission and with a new complaint of pain. The primary source of assessment was the resident, the same pain assessment scoring measurement should have been assessed every time the assessment is completed. Establishing a baseline for pain assessment was of primary importance. An assessment needs to be completed before treatment can be initiated. Included in the assessment would be effectiveness of the intervention, how long relief was obtained and how long relief lasted. The effectiveness of the medication for pain control on an as needed basis was assessed after each time the medication was administered.	F 309		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 17 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper storage of medications on two of three medication	F 431	Policy and Procedure reviewed and updated Education provided to all Licensed staff Audit of all 3 storage units q week for 8 weeks and then q 2weeks for 1 month and then monthly for 3 months. DON to monitor. ~~Date of initiation:~~ ~~8/22/13/2013~~ complete 9-4-13 ~~Date of completion~~ of audits: ~~2/28/2014~~ [illegible]	

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F 431	Continued From page 18 storage units, having the potential to affect twenty-five residents on the first floor unit. During observation of the Two North medication room on 7/31/13, at 9:29 a.m. a vial of Lantus insulin for R78 was labeled with an open date of 7/1/13. During an interview with a licensed practical nurse (LPN)-A on 7/31/13, at 9:39 a.m., she stated she thought Lantus insulin expired 30 days after opening. LPN-A was shown the orange label affixed to the insulin vial that directed to discard vials within 28 days of opening. LPN-A verified the open insulin vial was expired and needed to be discarded. During observation of the first floor medication room refrigerator on 7/31/13, at 10:05 a.m. a box of stock Bisacodyl suppositories was found frozen in a sheet of ice in a tray directly below the freezer. During interview with a registered nurse (RN)-E on 7/31/13, at 10:15 a.m. she verified the suppositories were not meant to be frozen. Review of the facility Storage of Medications policy dated 12/12, indicated outdated, contaminated or deteriorated medications were immediately removed from stock, disposed of according to facility procedures for medication destruction and reordered from pharmacy if a current order existed.	F 431		

F 5578022

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	245578	A. BUILDING 01 - BETHANY COVENANT HOME B. WING	07/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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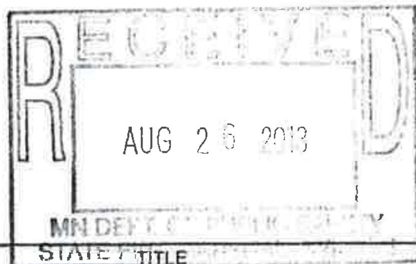
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Bethany Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute deficiency, or that the scope and severity regarding the deficiency are correctly applied. Please accept this Plan of Correction as our credible allegation of compliance. Our compliance will be achieved by the date identified on the Plan of Correction.  RECEIVED AUG 26 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 08.01.2013 DC: 09.10.2013

POC ok 8-28-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/20/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING 01 - BETHANY COVENANT HOME B. WING ________	07/31/2013

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K 000	Continued From page 1 Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Bethany Care Center is a 2-story building with no basement. The building was constructed in 1960 and was determined to be of Type II(222) construction. The building is currently installing a fire sprinkler system in accordance with NFPA 13, 1999 Ed. and is expected to have the work completed by August 13, 2013. The facility has a fire alarm system with smoke detection in the corridors, by the smoke barrier doors, resident rooms and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 66 beds and had a census of 62 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=D	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	K 018		

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K 018	Continued From page 2 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 interview, the facility had corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the residents. Findings include: During facility tour between 9:30 AM and 11:30 AM on 07/31/2013, observation revealed that the linen closet near Room 234 did not positively latch when closed. This deficient practice was verified by the Administrator at the time of the inspection.	K 018	Linen closet will be repaired. Audits will be added to weekly maintenance round to check that all doors latch shut. Administrator to monitor. Date of completion: 9/4/2013	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 038	Continued From page 3 Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 07/31/2013, observation revealed that the delayed egress controlled stairway doors on the second floor do not have the required signage indicating their usage. This deficient practice was verified by the administrator at the time of the inspection.	K 038	Delayed egress doors will have required signage. Administrator to monitor. Date of completion: 9/4/2013	
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	K 050		

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	245578	A. BUILDING 01 - BETHANY COVENANT HOME B. WING ______	07/31/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 4 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide quarterly drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect all residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 07/31/2013, record review revealed that there was no fire drill for the second quarter of 2013. This deficient practice was verified by the administrator at the time of the inspection.	K 050	Fire drills will be held each month on varying shifts and tracked in the fire drill section of the Life Safety Code Documentation manual. Administrator to monitor. Date of completion: 9/4/2013	
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm	K 051		

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
	245578	A. BUILDING **01 - BETHANY COVENANT HOME** B. WING ______	**07/31/2013**

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

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K 051	Continued From page 5 system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and review, the facility failed to document testing of the DACT in accordance with NFPA 101 Section19.3.4. This deficient practice could effect all residents. Findings include: During facility tour between 9:30 AM and 10:30 AM on 07/31/2013, record review revealed that there was no documentation of the monthly DACT testing for multiple months within the last year. This deficient practice was verified by the administrator at the time of the inspection.	K 051	Facility has contracted with a provider to do test facility's DACT in accordance with the regulation. Appropriate paperwork will be maintained for compliance in the Life Safety Code Documentation manual. Administrator to monitor. Date of completion: 9/4/2013	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		

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	245578	A. BUILDING 01 - BETHANY COVENANT HOME B. WING	07/31/2013

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K 052	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72, (99). This deficient practice could affect the residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 07/31/2013, record review revealed that the last annual fire alarm inspection was conducted on 05/03/2012. This deficienct practice was verified by the administrator at the time of the inspection.	K 052	Annual fire alarm inspection completed 8/14/2013. Administrator to monitor. Date of completion: 8/22/2013	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of	K 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 072	Continued From page 7 patients in an emergency situation. Findings include: On facility tour between 9:30 AM and 11:30 AM on 07/31/2013, observation revealed that there are housekeeping supplies being stored the the egress stairwells. This deficient practice was verified by the Maintenance Director at the time of the inspection.	K 072	All items removed from egress stairwells. Audits added to weekly maintenance rounds to ensure compliance with regulation. Administrator to monitor. Date of completion: 8/22/2013	