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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7F92

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00108

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245434**

2.STATE VENDOR OR MEDICAID NO.
(L2) **568340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY HOME**
(L4) **1020 LARK STREET**
(L5) **ALEXANDRIA, MN** (L6) **56308**

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 **07/06/2017** (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 **83** (L18)

13.Total Certified Beds **83** (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
	83			
(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 :
Susan Bachleitner HFE NE II 06/25/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 08/31/2017 (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
02/01/1987
(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
07/18/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245434 July 25, 2017

Mr. Matthew Fischer, Administrator
Bethany Home
1020 Lark Street
Alexandria, MN 56308

Dear Mr. Fischer:

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

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

Effective June 13, 2017 the above facility is certified for or recommended for:

83 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 83 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 25, 2017

Mr. Matthew Fischer, Administrator
Bethany Home
1020 Lark Street
Alexandria, MN 56308

RE: Project Number S5434026

Dear Mr. Fischer:

On May 31, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 18, 2017. 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 July 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 14, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 18, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 13, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 18, 2017, effective June 13, 2017 and therefore remedies outlined in our letter to you dated May 31, 2017, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7F92

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(L5) **ALEXANDRIA, MN** (L6) **56308**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/18/2017** (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**
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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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___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)

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17. SURVEYOR SIGNATURE Date :
Susan Bachleitner, HFE NE II 06/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/17/2017 (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
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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02/01/1987
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25. LTC EXTENSION DATE:
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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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 31, 2017

Mr. Matthew Fischer, Administrator
Bethany Home
1020 Lark Street
Alexandria, MN 56308

RE: Project Number S5434026

Dear Mr. Fischer:

On May 18, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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 27, 2017, 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 27, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 18, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and

Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 18, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Please contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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
	245434	A. BUILDING _____ B. WING _____	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff provided a dignified experience for resident during incontinence cares for 1 of 1 residents (R234) when staff spoke in a undignified manner. Findings include: R234 initial care plan dated 5/3/17, indicated he had cerebral infarction, was aphasic (unable to communicate) and had impaired cognition. The care plan also indicated he needed total assist with grooming and elimination needs and his	F 241	Policy: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Per policy it is the expectation that all staff treat residents with dignity and respect. Staff shall speak respectfully to residents at all times including addressing the resident by his or her name or choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs.	6/13/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/07/2017

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
	245434	A. BUILDING _____ B. WING _____	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(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 241	Continued From page 1 fingernails were to be cleaned daily if dirty. During interview 5/17/17, at 12:23 p.m. family member (FM)-A stated she came to the facility the past weekend and found R234 with dry bowel movement (BM) on his hands and stomach. FM-A stated she put on his call light and two staff entered the room and she went into the hall. FM-A stated they were cleaning him up and one of the staff left the room to get more supplies and when she was returning to his room walking down the hall she stated "yeah he's a digger!" FM-A stated the staff member's voice was raised and other residents were within hearing range and resident room doors were open in the area. FM-A stated she did not know why she had to say that, it was really insensitive. FM-A stated if R234 knew what had been said about him, he would have been upset. During interview 5/18/17, at 9:54 a.m. with director of social services (SS)-A and short term rehab SS-B stated they were not aware a staff member had stated that and it is not at all the usual facility practice. SS-A and SS-B both stated this was unacceptable behavior. SS-A stated the staff had received training on privacy and dignity but there will definitely be some re-education on this. During observation 5/18/17, at 10:05 a.m. R234 was observed lying in bed watching television. R234 right hand was under the covers and his left hand was out, a brown substance was observed under the tips of his nails on the left hand. During interview 5/18/17, at 10:25 a.m. NA-A stated staff complete nail care on residents bath days and indicated it staff noticed something they	F 241	A. When the surveyor spoke to the LSW on 5-18-17 to inform her of this information in relation to dignity, immediate education was provided to staff in regards to the dignity Policy. This information was sent out on 5-18-17 in an email and via Point of Care notice. On5-22-17 the policy for Quality of Life Dignity was placed at all nurses stations, by all time clocks and in the break room for staff to review. B. All residents have the potential to be impacted by practices not in adherence to the policy and procedure. C. Education and review of the policy will be addressed with staff of Bethany home on 6-13-17 at an all staff meeting. Those staff that did not attend the meeting will be required to view the taped education and complete a post test. D. Auditing conversations of staff that occur in hallways, dining room and at the nurses desks will be completed daily at random times x 4 weeks. Immediate education and corrective action will be provided to any staff that does not follow the Quality of Life Dignity policy. The corrective action form will be included in the employee file. E. Completion date 6-13-17. Audit results will be reviewed at the monthly QAPI meeting in July and August where the team will determine if any additional education is required, and determine the future frequency of audits. Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(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 241	Continued From page 2 tried to clean it up. NA-A stated she did not get R234 ready this morning but had noticed the brown substance under his nails earlier that morning and did not know what the substance was. A facility policy revised November 2010, indicated "Residents shall be treated with dignity and respect at all times". The policy futher indicated staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the residents by his or her room number, diagnosis, or care needs.	F 241	Nursing or designee will be responsible.	
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 441		6/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING _____ B. WING _____	05/18/2017

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F 441	Continued From page 3 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 4 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a comprehensive infection control program to include analysis of collected data to prevent the potential spread of infection in the facility. This had the potential to affect all 71 residents of the facility, staff and visitors. Findings include: The facility had six units called Short Term Rehab North (SRN), Short Term Rehab South (SRS), Maple Lake (ML), Turtle Beach (TB), Darling Spring (DS), and Latoka Landing (LL). The facility provided a Facility Culture Trend (FCT) and review of January 2017 to March 2017, indicated the following: January 2017: SRN- listed five infections, three pneumonia and two urinary tract infections (UTI). The FCT indicated the date of onset, antibiotic order but lacked information to indicate if the infections were nosocomial (healthcare facility acquired) or community acquired, symptoms, resolved date or if treatment was effective. SRS- listed seven infections, one bilateral lower extremity infection, sinusitis, UTI, cellulitis, hematuria and two pneumonia. The FCT indicated the date of onset, antibiotic order but lacked information to indicate if the infections were nosocomial or community acquired,	F 441	MISSION OF PROGRAM: The infection prevention and control program exists to assure a safe, sanitary and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of communicable disease and infection. A. Although the facility was monitoring all areas of concern including nosocomial, community acquired signs and symptoms, resolved date or if treatment was effective via the infection report on each individual resident the results were not transposed onto the Facility Culture Trend data log. The log was updated on 6-1-17 to include all areas listed above, along with areas to include comments where education and interventions will be added, and an area for an analysis on a monthly basis and/or a PRN basis as needed to report trends, and potential areas of concern. B. All residents do have the potential to be effect by this practice. The new data log will contain all pertinent information so it can be analyzed effectively, therefore decreasing the chances of the spread of infections and increasing the wellness of all residents, staff, volunteers, visitors and other individuals. C. Education to all staff in regards to infection control and the importance of complete and accurate information on the Infection report sheet will be provided on 6	

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F 441	Continued From page 5 symptoms, resolved date or if treatment was effective. ML- listed four infections, right foot wound, pneumonia, infection to back and cystitis. The FCT indicated the date of onset, antibiotic order but lacked information to indicate if the infections were nosocomial or community acquired, symptoms, resolved date or if treatment was effective. TB- listed four infections, sinusitis, bronchitis, UTI and upper respiratory infection (URI) and aspiration pneumonia. The aspiration pneumonia was listed with diarrhea with emesis, fever and coughing. The FCT indicated the date of onset, antibiotic order, but lacked information to indicate if the infections were nosocomial or community acquired, resolution date of the infection or if treatment was effective. Also, there was no indication the facility had identified symptoms except for one resident. DS- listed two infections one infected left foot ulcer and sinusitis. The FCT indicated the date of onset, antibiotic order but lacked information to indicate if the infections were nosocomial or community acquired, symptoms, resolved date or if treatment was effective. The FCT indicated they would push fluids with residents with recurrent UTI and administer extra water with cranberry tabs. In addition, they indicated they would have the residents use tena wash cream for cleansing after peri cares which is on the long term care group sheets. LL- listed one infection URI. The FCT lacked information to indicate start date of antibiotic zpak and if the infection had been nosocomial or	F 441	-13-17 at the Bethany all staff meeting. Education was provided on June 9, 2017 to each nurse manager and the infection control nurse in regards to the new data log and the importance of surveillance and analysis. Each nurse manager will log their data in regards to infections as they occur and alert the infection control nurse of all new data entered, reporting to the infection control nurse of any highly contagious infections. The infection control nurse will review the data weekly and alert the nursing team of any areas of concern immediately, the Nurse Manager team will continue to review the infections weekly as a team, the infections will continue to be discussed at the IDT meeting weekly with the Medical Director, and will continue to present results to the QAPI committee monthly. D. The infection control nurse will audit the infection control log weekly x 6 weeks to assure that all pertinent information is being entered into the data log. The DON will audit the log weekly x 8 weeks to assure that the analysis of the data is complete and accurate. E. Completion date 6-13-17. Audit results will be reviewed at the July and August QAPI meeting where the team will determine if any additional education is required, and determine the future frequency of audits. Director of Nursing or designee will be responsible.	

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F 441	Continued From page 6 community acquired, symptoms, resolved date or if treatment was effective. February 2017: SRN- listed five infections one conjunctivitis (pink eye), UTI, cellulitis, pneumonia and yeast cystitis. The FCT indicated the date of onset, antibiotic order but lacked information to indicate if the infections were nosocomial or community acquired, symptoms, resolved date or if treatment was effective. SRS- listed four infections one cystitis, bronchitis, Methicillin Resistant Staphylococcus Aureus(MRSA) (a bacterium responsible for several difficult-to-treat infections) in a thigh infection. The cystitis did list a symptom of hematuria but the remaining listed no symptoms. The FCT indicated the date of onset, antibiotic order, but lacked information to indicate if the infections were nosocomial or community acquired, resolution date of the infection or if treatment was effective. Also there was no indication the facility had identified symptoms except for one resident. ML- listed two infections on bronchitis and one systematic inflammatory response syndrome (SIRS). The FCT indicated the date of onset, antibiotic order but lacked information to indicate if the infections were nosocomial or community acquired, symptoms, resolved date or if treatment was effective. TB- listed five infections two UTI, conjunctivitis, URI and cellulitis. The FCT indicated the date of onset, antibiotic order but lacked information to indicate if the infections were nosocomial or	F 441		

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F 441	Continued From page 7 community acquired, symptoms, resolved date or if treatment was effective. DS- one infection listed a URI symptoms were listed of wheezing, cough and altered lung sounds. The FCT indicated the date of onset, antibiotic order but lacked information to indicate if the infections were nosocomial or community acquired, resolved date or if treatment was effective. LL- listed seven infections, six of them were UTI and one ear infection. The FCT indicated the date of onset, antibiotic order but lacked information to indicate if the infections were nosocomial or community acquired, symptoms, resolved date or if treatment was effective. In addition the FCT lacked information to indicate a trend of UTI's in the unit and if the cause was investigated or if any training was provided to staff. March 2017: SRN- listed nine infections, three UTI, three pneumonia, one thrush (infection caused by the candida fungus, which is yeast), MRSA in sputum and chronic obstructive pulmonary disease exasperation. The FCT indicated the date of onset, antibiotic order but lacked information to indicate if the infections were nosocomial or community acquired, symptoms, resolved date or if treatment was effective. SRS- listed eight infections, four UTI, two pneumonia, cellulitis and one SIRS. The FCT lacked information to indicate the increase in UTI and failed to indicate if the cause was investigated. In addition the FCT failed to	F 441		

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F 441	Continued From page 8	F 441		

indicate if the infections were nosocomial or community acquired, symptoms, resolved date or if treatment was effective.

ML- listed eleven infections, six UTI, one pneumonia, wound infection to back, yeast infection, vaginitis and clostridium (c-dif), (a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon.) The FCT indicated the date of onset, antibiotic order but failed to indicate if the infections were nosocomial or community acquired, symptoms, resolved date or if treatment was effective. The FCT further failed to indicate the increase in UTI or investigate the cause.

TB- listed eight infections, one right wound and seven UTI's. One UTI was listed with a symptom of hematuria. The facility did not indicate a trend or indicate if an investigation was completed to attempt to identify the cause of the increase in UTI's. The FCT indicated the date of onset, antibiotic order but failed to indicate if the infections were nosocomial or community acquired, symptoms for all but one, resolved date or if treatment was effective.

DS- listed one infection URI, symptoms were listed as wheezing, cough and altered lung sounds. The FCT indicated the date of onset, antibiotic order but lacked to indicate if the infections were nosocomial or community acquired, resolved date or if treatment was effective.

LL- listed four infections, one pneumonia and 3 UTI's. The FCT indicated the date of onset, antibiotic order but failed to indicate if the

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F 441	Continued From page 9	F 441		

infections were nosocomial or community acquired, symptoms, resolved date or if treatment was effective.

April 2017:

SRN- listed six infections, one respiratory infection, necrotic toe, pneumonia, influenza A, bilateral lower extremity wound and left lower extremity wound. The FCT indicated the date of onset, antibiotic order but lacked to indicate if the infections were nosocomial or community acquired, resolved date or if treatment was effective.

SRS- listed eight infections, two urinary tract infections, two pneumonia, septicemia, diverticulitis, e coli (Escherichia coli) is the name of a germ, or bacterium, that lives in the digestive tracts of humans and animals) sepsis bacteremia and vulvectomy with infection.

ML- listed seven infections, three UTI, three pneumonia and one thrush. The FCT indicated the date of onset, antibiotic order but lacked to indicate if the infections were nosocomial or community acquired, resolved date or if treatment was effective. In addition the program lacked to indicate they still had ongoing UTI's on the unit.

TB- listed five infections, one UTI, wound infection with MRSA, E.coli with sepsis, wound infection and one URI with cough and temperature. The FCT indicated the date of onset, antibiotic order, but lacked to indicate if the infections were nosocomial or community acquired, resolution date of the infection or if treatment was effective. Also there was no

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F 441	Continued From page 10	F 441		

indication the facility had identified symptoms except for one resident.

DS- listed one infection, a UTI. The FCT indicated the date of onset, antibiotic order but lacked to indicate if the infections were nosocomial or community acquired, resolved date or if treatment was effective.

LL- listed two infections, one UTI and cellulitis. The FCT indicated the date of onset, antibiotic order but lacked to indicate if the infections were nosocomial or community acquired, resolved date or if treatment was effective.

During interview 5/17/17, at 11:56 a.m. registered nurse (RN)-A stated she is in charge of the infection control program, and the other nurse managers on the units monitor their individual unit infections and reported them to her. RN-A stated staff completed a Bethany Community Illness report for each resident when the resident developed an infection which list symptoms, start date, diagnosis, culture length of treatment and date illness resolved. RN-A stated she then added each resident to the FCT log, listing the infection and antibiotic but did not indicate on the FCT log if infections were nosocomial or community acquired, resolved or if treatment was effective. She indicated the Illness reports were filed in the residents charts and were not kept with the infection control program. RN-A stated she verbally reviewed with the nurses any potential trends in infections, and the facility met monthly for quality assurance and performance improvement (QAPI) and infections were discussed in QAPI.

During interview 5/18/17, at 1:23 p.m. the director

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of nursing (DON) stated RN-A was in charge of the infection control program and completed the tracking and trending, kept a log of the infections and antibiotic use. The DON further indicated staff was educated on general infection control processes and if there had been any specific education or monitoring it should be on the FCT.

Review of the FCT from 1/17 thru 4/17 did not reveal any specific infection control education had been completed, even though the facility had an increase in UTIs on specific units in the facility.

The facility Infection Prevention and Control Program policy, undated, indicated "The infection prevention and control program exists to assure a safe, sanitary and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of communicable disease and infection." The policy further indicated they would prevent, identify, report, investigate and control infections and communicable diseases in the facility for all residents, staff, volunteers, visitor and and other individuals. In addition the policy indicated they provide a surveillance to identify possible communicable diseases or infections before they spread in the facility.

Although the facility had a FCT which listed the infection and antibiotic, there was no identified analysis of the collected data to determine trends, symptoms of illness, when the infection resolved, or if they were potentially spreading in the facility. In addition, the only education/intervention the facility could provide was in January 2017 on the DS unit, which indicated the staff were pushing fluids with cranberry pills and using tena wash for peri care. The logs further lacked to indicate the

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F 441	Continued From page 12 increase in UTI.	F 441		

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	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**05/16/2017**

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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, State Fire Marshal Division. At the time of this survey, Bethany Home Building 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/09/2017

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

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@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. The Bethany Home facility was surveyed as 2 buildings as follows: Bethany Home was originally constructed in 1964 and has gone through several additions and has had one remodel in 2012. Building One, the long and short term care is mainly a two story building. It had a 3 story addition constructed in 2003, with nursing home care on the first level only. The entire structure is of type II (111) construction and the three story section is separated by two 2 hour fire barriers. One located along the assisted living and the other along the south end separating the 2 & 3 story sections. Building Two, the chapel area, was constructed in 2003 and is one level, type V (111) construction.	K 000		

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K 000	Continued From page 2 This building is separated with a 2 hour fire barrier from the main building. The buildings are fully sprinkled with a monitored fire alarm system. Smoke detectors are located in the corridors, spaces open to the corridors and in the resident rooms. Level one is separated by two smoke barriers and two 2 hour fire barriers creating 5 smoke compartments. Level two is separated by 4 two hour fire barriers and two smoke barriers creating 7 smoke compartments. The facility has a licensed capacity of 83 beds and had a census of 72 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1	K 321		6/9/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(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 321	Continued From page 3 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one hazardous room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter adjacent rooms and the corridor making it untenable and affect the quick and efficient exiting for an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 4:00 pm on 05-16-17 observation and staff interview review revealed the elevator equipment room on the main level adjacent to the kitchen did not have a self closing door. This deficient condition was confirmed by the Facility Maintenance Manager.	K 321	K 321 SS=D 1. A door self-closing device has been added to the elevator room on the main level adjacent to the kitchen to ensure compliance in accordance with the 2012 Life Safety Code and NFPA 101. 2. Completion date of 6-9-2017 3. Chad Flynn-Maintenance Manager is responsible for correction and ongoing monitoring	
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing	K 353		6/9/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(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 353	Continued From page 4 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 72 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 4:00 pm on 05-16-17 documentation review revealed in the last 12 months one quarterly sprinkler inspection report was missing and the 5 year obstruction inspection was not conducted. This deficient condition was confirmed by the	K 353	K 353 SS=F 1. A 5 year obstruction inspection was conducted by NOVA sprinkler Co. in addition a quarterly inspection was completed of the sprinkler system by NOVA Sprinkler Co to ensure compliance in accordance with the 2012 Life Safety Code and NFPA 25. 2. Completion Date of 6-5-2017 3. Chad Flynn-Maintenance Manager is responsible for correction and ongoing monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(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 353	Continued From page 5 Facility Maintenance Manager.	K 353		
K 372 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to maintain smoke dampers in accordance with The Standard for Fire Doors and Other Opening Protective's, NFPA 80 , 2010 edition section 19.4.1.1. This deficient practice could allow smoke to travel throughout smoke compartments affecting the exiting capabilities of all of the 72 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 4:00 pm on 05-16-17 documentation review revealed 10 fire dampers were not inspected during the 8/16 inspection cycle due to the lack of access panels. This deficient condition was confirmed by the Facility Maintenance Manager.	K 372	K 372 SS=F 1. Due to building upgrades and mechanical upgrades 10 fire dampers have been eliminated from use and building inspection report to ensure compliance with NFPA 80 2010 edition. 2. Completion date of 6-7-2017 3. Chad Flynn-Maintenance Manager is responsible for correction and ongoing monitoring	6/9/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(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 521 SS=C	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain proper exhaust throughout all resident wings as required by the 2012 Life Safety Code (NFPA 101) section 9.2.2 and NFPA 91 Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists and Noncombustible Particulate Solids. This deficient practice could negatively affect 59 of the 72 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 4:00 pm on 05-16-17 observation and staff interview review revealed the bath fans in the resident rooms on the 2nd floor were not operable. This deficient condition was confirmed by the Facility Maintenance Manager.	K 521	K 521 SS=C 1. 2nd floor resident room bath fans have been made operable due to new equipment, replacement of old motors, belts and fans. Additional wiring to roof mounted motors and fans was completed by Centrasota Electric to ensure compliance with 2012 Life Safety Code and NFPA 91. 2. Completion date of 6-9-2017 3. Chad Flynn-Maintenance Manager is responsible for correction and ongoing monitoring	6/9/17
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly	K 712		6/9/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(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 712	Continued From page 7 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 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to conduct fire drills at least quarterly on each shift under varied conditions as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 72 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 4:00 pm on 05-16-17 documentation review revealed the fire drills conducted in the last 12 months were not under various conditions. No drills were conducted in July and September and on the 2nd shift, two drills were conducted at 5:00 pm and on the 3rd shift, two drills were conducted at 1:00 am. This deficient condition was confirmed by the Facility Maintenance Manager.	K 712	K 712 SS=F 1. A fire drill schedule has been set up through cooperation of TELS monitoring system and education from Fire Marshall to be conducted monthly under varied conditions ongoing to ensure compliance with 2012 Life Safety Code and NFPA 101. 2. Completion date of 6-9-2017 3. Chad Flynn-Maintenance Manager is responsible for correction and ongoing monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **02 - SUB ACUTE** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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, State Fire Marshal Division. At the time of this survey, Bethany Home Building 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/09/2017

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
	245434	A. BUILDING **02 - SUB ACUTE** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@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. The Bethany Home facility was surveyed as 2 buildings as follows: Bethany Home was originally constructed in 1964 and has gone through several additions and has had one remodel in 2012. Building One, the long and short term care is mainly a two story building. It had a 3 story addition constructed in 2003, with nursing home care on the first level only. The entire structure is of type II (111) construction and the three story section is separated by two 2 hour fire barriers. One located along the assisted living and the other along the south end separating the 2 & 3 story sections. Building Two, the chapel area, was constructed in 2003 and is one level, type V (111) construction.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **02 - SUB ACUTE** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

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K 000	Continued From page 2 This building is separated with a 2 hour fire barrier from the main building. The buildings are fully sprinkled with a monitored fire alarm system. Smoke detectors are located in the corridors, spaces open to the corridors and in the resident rooms. Level one is separated by two smoke barriers and two 2 hour fire barriers creating 5 smoke compartments. Level two is separated by 4 two hour fire barriers and two smoke barriers creating 7 smoke compartments. The facility has a licensed capacity of 83 beds and had a census of 72 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		6/9/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **02 - SUB ACUTE** B. WING _____	**05/16/2017**

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K 353	Continued From page 3 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 72 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 4:00 pm on 05-16-17 documentation review revealed in the last 12 months one quarterly sprinkler inspection report was missing and the 5 year obstruction inspection was not conducted. This deficient condition was confirmed by the Facility Maintenance Manager.	K 353	K 353 SS=F 1. A 5 year obstruction inspection was conducted by NOVA sprinkler Co. in addition a quarterly inspection was completed of the sprinkler system by NOVA Sprinkler Co to ensure compliance in accordance with the 2012 Life Safety Code and NFPA 25. 2. Completion Date of 6-5-2017 3. Chad Flynn-Maintenance Manager is responsible for correction and ongoing monitoring	
K 372 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke	K 372		6/9/17

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K 372	Continued From page 4 barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to maintain smoke dampers in accordance with The Standard for Fire Doors and Other Opening Protective's, NFPA 80 , 2010 edition section 19.4.1.1. This deficient practice could allow smoke to travel throughout smoke compartments affecting the exiting capabilities of all of the 72 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 4:00 pm on 05-16-17 documentation review revealed 10 fire dampers were not inspected during the 8/16 inspection cycle due to the lack of access panels. This deficient condition was confirmed by the Facility Maintenance Manager.	K 372	K 372 SS=F 1. Due to building upgrades and mechanical upgrades 10 fire dampers have been eliminated from use and building inspection report to ensure compliance with NFPA 80 2010 edition. 2. Completion date of 6-7-2017 3. Chad Flynn-Maintenance Manager is responsible for correction and ongoing monitoring	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM, a coded announcement may be used	K 712		6/9/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **02 - SUB ACUTE** B. WING _____	**05/16/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(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 712	Continued From page 5 instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to conduct fire drills at least quarterly on each shift under varied conditions as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 72 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 4:00 pm on 05-16-17 documentation review revealed the fire drills conducted in the last 12 months were not under various conditions. No drills were conducted in July and September and on the 2nd shift, two drills were conducted at 5:00 pm and on the 3rd shift, two drills were conducted at 1:00 am. This deficient condition was confirmed by the Facility Maintenance Manager.	K 712	K 712 SS=F 1. A fire drill schedule has been set up through cooperation of TELS monitoring system and education from Fire Marshall to be conducted monthly under varied conditions ongoing to ensure compliance with 2012 Life Safety Code and NFPA 101. 2. Completion date of 6-9-2017 3. Chad Flynn-Maintenance Manager is responsible for correction and ongoing monitoring	