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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BJMZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00913

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245295**

2.STATE VENDOR OR MEDICAID NO.
(L2) **493226900**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHEL CARE CENTER**
(L4) **420 MARSHALL AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55102**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/27/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **131** (L18)

13.Total Certified Beds **131** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	131			
(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 :
Susanne Reuss, Supervisor 06/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/30/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/12/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5295

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 05/08/14. On 06/27/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on 06/26/14, the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 05/08/14, effective 06/16/14. Refer to the CMS-2567B for both health and life safety code.

Effective 06/16/14, the facility is certified for 131 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5295

Electronically Delivered: June 30, 2014

Ms. Jennifer Schoenecker, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, Minnesota 55102

Dear Ms. Schoenecker:

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 16, 2014, the above facility is certified for:

131 - beds from Paradise Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 131 beds from Paradise skilled nursing facility beds.

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

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: June 30, 2014

Ms. Jennifer Schoenecker, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, Minnesota 55102

RE: Project Number S5295023

Dear Ms. Schoenecker:

On May 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 8, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 27, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 26, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 8, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 16, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 8, 2014, effective June 16, 2014 and therefore remedies outlined in our letter to you dated May 16, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Feel free to contact me if you have questions regarding this electronic notice.

Sincerely,

Anne Kleppe

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245295	A. Building B. Wing	6/27/2014

Name of Facility	Street Address, City, State, Zip Code
BETHEL CARE CENTER	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **06/16/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **06/16/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **06/16/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/16/2014**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **06/16/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/16/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/16/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/16/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **06/16/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	06/30/2014	16022	06/27/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/8/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245295	01 - MAIN BUILDING 01	6/26/2014

Name of Facility	Street Address, City, State, Zip Code
BETHEL CARE CENTER	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 06/16/2014	ID Prefix Reg. # NFPA 101 LSC K0033	Correction Completed 06/16/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	06/30/2014	12424	06/26/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/7/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BJMZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00913

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245295**

2.STATE VENDOR OR MEDICAID NO.
(L2) **493226900**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHEL CARE CENTER**
(L4) **420 MARSHALL AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55102**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/08/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **131** (L18)

13.Total Certified Beds **131** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	131			
(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 :
Mary Heim, HPR-Social Work Specialist 05/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5295

At the time of the standard survey completed 05/08/14, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are 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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: May 16, 2014

Ms. Jennifer Schoenecker, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, Minneosta 55102

RE: Project Number S5295023

Dear Ms. Schoenecker:

On May 8, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

<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:

Susanne Reuss, Supervisor
Metro A Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
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 June 17, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 17, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 8, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 8, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

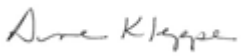
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions about this electronic notice.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	05/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL CARE CENTER	**420 MARSHALL AVENUE SAINT PAUL, MN 55102**

(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. If 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 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 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	F 279		6/16/14

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

Electronically Signed | 05/26/2014

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F 279	Continued From page 1 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop non-pharmacological interventions for sleep for 2 of 3 (R96, R26) residents reviewed for medications prescribed for insomnia. Findings include: The facility failed to develop non-pharmacological interventions for sleep to complement the use of a medication prescribed for insomnia, for R96. R96's Order Summary Report, dated 3/31/14 and 4/30/14 directed staff to administer "Trazodone HCL Tablet 75 mg by mouth at bedtime related to insomnia unspecified." A review of R96's current care plan, last reviewed 3/28/14 directed staff "I do usually take a short nap during the day and am able to sleep well at night when I take my sleeping medication. I do have a diagnosis of insomnia" Interventions included : "Staff administer sleeping medications per NP/MD [nurse practitioner/medical doctor] order." No non-pharmacological interventions for sleep were included on the care plan. On 5/8/14 at 12:10 p.m., RN-A explained the facility tried to create a peaceful environment conducive to sleep by offering snacks, dimming the lights and keeping the noise level low. RN-A confirmed no non-pharmacological interventions specific to R96 were on R96's care plan.	F 279	Immediate corrective action: The care plan for residents R26 and R96 were updated on 5/20/14 and 5/22/14 to include non-pharmacological interventions for sleep. Action as it applies to others: The care plan for all residents who receive medications for sleep will be reviewed to ensure they include non-pharmacological interventions to promote restful sleep. The Policy and Procedure for the care planning process was reviewed and remains current. All nursing staff will be reeducated on the policy for the development of resident individualized care plans by 6/16/14. Date of completion: 6/16/14 Recurrence will be prevented by: Random weekly chart audits will be conducted on each unit to ensure residents who receive medications for sleep have care planned non-pharmacological interventions to promote restful sleep. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by:	

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F 279	Continued From page 2 R26 was receiving medication for sleep and did not have specific non-pharmacological interventions for sleep and the effectiveness of these interventions included in the resident's plan of care. Record review on 5/7/14 revealed a physician's order for trazodone (an anti-depressant also used to treat insomnia) 75 milligrams by mouth at bedtime for insomnia, dated 4/3/14. The medication administration record for this resident showed that this medication was given every day since it was ordered. The current care plan, dated 5/7/14, contained a focus that read, "I do have difficulties sleeping at night sometimes..." The non-pharmacological interventions for evening sleep for this resident read, "Staff promote [R26]'s usual HS [hour of sleep] routine, and relaxation when preparing for bed." There was no more detail provided for this intervention, and no documentation of effectiveness. When interviewed on 5/8/14, at 10:30 a.m. registered nurse (RN)-D, was asked if there was documentation of detailed non-pharmacological sleep interventions in the record. She stated that those interventions should be listed on the care plan.	F 279	Ongoing compliance will be monitored by the Director of Nursing and/or designee	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		6/16/14

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F 280	Continued From page 3 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to review and revise the plan of care for 1 of 3 residents (R76) reviewed for dental needs and 1 of 3 residents reviewed for personal hygiene and grooming (R66). Findings include: R76 dental needs were not identified in the plan of care. Interview on 5/8/14 at 8:50 with the nurse manager, (RN)-A revealed R76 was admitted in September 2011 and had diagnoses including unspecified cerebrovascular disease. Resident was nonverbal and unable to communicate her needs other than with her eyes or facial expressions. Interview with family (F)-A on 5/6/14 at 3:17 p.m.	F 280	Immediate corrective action: The care plan for R66 was revised on 5/20/14 to include hair care. The care plan for resident R76 was revised on 5/21/14 for dental needs. R76 was re-assessed for pain or discomfort on 5/21/14. Action as it applies to others: All resident care plans will be reviewed to ensure current hair care and dental needs are care planned according to each resident□s individual preference. The policy and procedure for the care planning process was reviewed and remains current. All nursing staff will be re-educated on the policy for the Care Planning Process by 6/16/14.	

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F 280	Continued From page 4 revealed that R76 could possibly have some pain from her teeth. F-A indicated she was unsure if R76 had pain. F-A reported R76 had not seen a dentist and was not able to indicate whether or not she had pain. F-A was concerned about teeth not getting cleaned all the time and possible odors at times. Observation of oral cares on 5/7/14 at 9:23 a.m. revealed nursing assistant (NA)-B performed oral care using toothettes. R76's teeth were cleaned on all sides along the gum lines. It was unclear if R76 was experiencing discomfort. R76's forehead was wrinkled during procedure. She did not open her mouth so staff could clean her tongue and get the upper inner sides of the teeth. The teeth appeared to have yellowish debris on them. The quarterly minimum data set (MDS) dated 2/18/14 indicated no concerns, under the oral/dental section. The nursing completed oral/dental assessment dated 4/28/14, indicated the resident had her own teeth, in fair condition, no signs or symptoms of oral pain or discomfort noted. The oral mucosa was moist and pink. The resident needed total assist with oral care twice a day (bid). The section about dental care was left blank. The plan of care (CP) dated 3/17/14, indicated the resident needed assist with oral care, had her own teeth in fair condition, and breath was malodorous which required frequent oral cares. The staff was directed to provide daily oral care twice a shift due to bad breath and to monitor for mouth irritation or pain. Arrange routine and emergent dental treatment. The CP also indicated F-A originally declined dental services because she would have to pay for it. It was unclear what	F 280	Date Of Completion: 6/16/14 Recurrence will be prevented by: Random weekly chart audits will be conducted on each unit to ensure hair care and dental needs are care planned according to resident choice. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing and/or designee	

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F 280	Continued From page 5 F-A's preferences regarding dental visits were now that R76 was enrolled in medical assistance. Interview on 5/8/14 at 8:50 with the social worker, (LSW)-A revealed R76 had not been seen by the dentist. When, R76 had her insurance benefits switched to medical assistance (MA) in 7/2013, the dental consent was not signed. LSW-A indicated she usually had the resident/family sign dental consents when they go onto MA. However she did not do that for R76. LSW-A filled out the consent, dated, 5/8/14. LSW-A later reported she called F-A on 5/8/14 and discovered she would like R76 to have a dental appointment scheduled. LSW-A agreed the care plan should have reflected the dental needs of R76. R66 did not have an accurately revised care plan related to assistance with hair hygiene and grooming. Review of the resident's plan of care, on 5/7/14, revealed a focus regarding bathing that read, "I usually refuse my shower or bed baths." The only entry in the plan of care related to her hair described the resident as liking to wear her hair short. There was no documentation in the plan of care regarding the refusal of shampooing of her hair. The admission Minimum Data Set for this resident, dated 3/11/14, described the resident as requiring extensive assistance of at least two staff for personal hygiene and totally dependent on staff for bathing. During resident observation 5/6/14, at 10:12 a.m. the resident was lying in her bed with hair that	F 280		

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F 280	Continued From page 6 appeared oily. When interviewed at the same time, the resident denied any concerns regarding her grooming or hygiene. The facility form that documented functional assistance provided to the resident showed that this resident had received a bath on 4/14/14, 4/18/14, 4/21/14, 4/28/14, 5/2/14, and 5/5/14. When interviewed on 5/7/14, at 1:20 p.m. registered nurse (RN)-D stated that the resident usually cooperated with either a bed bath or shower. She explained that when the resident got a shower that automatically included a hair shampoo, but when the resident took bed baths, her hair was shampooed only once weekly. She also stated that this resident did not use the services of the beauty shop and the facility staff provided all of her hair hygiene and grooming. During interview on 5/8/14, at 10:45 a.m. nursing assistant (NA)-C stated that R66 was generally cooperative with a bed bath, but did not like to be lifted out of bed with a mechanical lift for a shower. He was not sure how often her hair had been shampooed with the bed bath, but he did remember assisting with shampooing her hair in the past. When interviewed on 5/8/14, at 10:45 a.m. R66 stated that she had just received a shower and shampoo from staff and that both felt very good. When asked if she had any concerns related to the process, equipment, products, or staff related to bathing and shampooing in the facility, she stated, again, that she had no concerns and she had felt comfortable in the shower that day.	F 280		

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F 312	Continued From page 7	F 312		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not provide services for hair care necessary to maintain good grooming for 1 of 3 residents (R66) reviewed for activities of daily living. Findings include: During resident observation 5/6/14, at 10:12 a.m. the resident was lying in her bed with hair that appeared oily. When interviewed at the same time, the resident denied any concerns regarding her grooming or hygiene. The admission Minimum Data Set for this resident, dated 3/11/14, described the resident as requiring extensive assistance of at least two staff for personal hygiene and totally dependent on staff for bathing. The facility form that documented functional assistance provided to the resident showed that this resident had received a bath on 4/14/14, 4/18/14, 4/21/14, 4/28/14, 5/2/14, and 5/5/14. Review of the resident's plan of care, on 5/7/14, revealed a focus regarding bathing that read, "I	F 312	Immediate corrective action: Personal grooming and hair hygiene was provided immediately for resident R66. Action as it applies to other residents: All residents will be interviewed to ensure their personal preferences are honored regarding personal grooming and hair hygiene. The policy and procedure for Nursing Care Standards was reviewed and remains current. All Nursing Staff will be re-educated on the policy for Nursing Care Standards by 6/16/14. Recurrence will be prevented by: Random weekly audits will be conducted on each unit to ensure residents receive personal grooming and hair hygiene according their individual preferences. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. Date of Completion: 6/16/14	6/16/14

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F 312	Continued From page 8 usually refuse my shower or bed baths." The only entry in the plan of care related to her hair described the resident as liking to wear her hair short. There was no documentation in the plan of care regarding the refusal of shampooing of her hair. When interviewed on 5/7/14, at 1:20 p.m. registered nurse (RN)-D stated that the resident usually cooperated with either a bed bath or shower. She explained that when the resident got a shower that automatically included a hair shampoo, but when the resident took bed baths, her hair was shampooed only once weekly. She also stated that this resident did not use the services of the beauty shop and the facility staff provided all of her hair hygiene and grooming. During interview on 5/8/14, at 10:45 a.m. nursing assistant (NA)-C stated that R66 was generally cooperative with a bed bath, but did not like to be lifted out of bed with a mechanical lift for a shower. He was not sure how often her hair had been shampooed with the bed bath, but he did remember assisting with shampooing her hair in the past. When interviewed on 5/8/14, at 10:45 a.m. R76 stated she had just received a shower and shampoo from staff and that both felt very good. When asked if she had any concerns related to the process, equipment, products, or staff related to bathing and shampooing in the facility, she stated, again, that she had no concerns and she had felt comfortable in the shower that day.	F 312	The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing and/or designee	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		6/16/14

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F 329	Continued From page 9 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents reviewed for unnecessary medications received the necessary care and services; monitoring of heart rate and blood pressure for R96, non-pharmacological interventions for sleep for R26 and R96 and sleep monitoring for R74. Findings include: The facility failed to monitor systolic blood	F 329	Immediate corrective action: Monitoring of Systolic blood pressure and heart rate were implemented for resident R96 on 5/21/14 ; Non-pharmacological interventions for sleep were implemented for resident R26 on 5/20/14; and sleep monitoring was implemented for resident R74 on 5/21/14. Action as it applies to other residents: All residents receiving antihypertensive or	

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F 329	Continued From page 10 pressure and heart rate as ordered by the physician related to administration of a hypertension medication, and develop non-pharmacological interventions for sleep to complement the use of a medication prescribed for insomnia. [Systolic blood pressure measures the pressure in the arteries when the heart beats (when the heart muscle contract). Heart rate is the number of times your heart beats per minute.] The Order Summary Report, dated 3/31/14 and 4/30/14, directed staff "Metoprolol Tartrate Tablet Give 25 mg [milligrams] two times a day related to unspecified essential hypertension (401.9) Hold for systolic BP [blood pressure] less than 100 or heart rate less than 60." [Metoprolol Tartrate is a medication used to treat hypertension, high blood pressure.] A review of the medication and treatment administration records for April and May 2014 indicated R96's heart rate and blood pressure were documented five times in April and once in May. A review of the weights and vitals summaries for both heart and blood pressure indicated the heart rate and blood pressure were documented on the same five days in April and one day in May as the medication and treatment administration records. On 4/10/14 R42's systolic blood pressure was 95. The Metoprolol Tartrate was marked as administered for both doses that day. On 5/7/14 at 10:15 a.m., a floor nurse (LPN)-A reported there were not spaces to record heart rate and blood pressure in the electronic medication administration record for each administration of Metoprolol Tartrate.	F 329	medications for sleep will be reviewed to ensure monitoring is in place according to facility policy and acceptable standards of nursing practice. The policy and procedure for Medication Monitoring has been reviewed and remains current. All Staff will be re-educated on the policy for Medication Monitoring by 6/16/14. Date Of Completion: 6/16/14 Recurrence will be prevented by: Random weekly audits will be conducted on each unit to ensure residents who receive antihypertensive or sleep medications have monitoring in place according to facility policy. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing and/or designee	

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F 329	Continued From page 11 On 5/7/14 at 10:17 a.m. a floor nurse (RN)-B reported staff should be monitoring heart rate and blood pressure before each administration of Metoprolol Tartrate. RN-B reported she would add an order and space to record heart rate and blood pressure in the electronic medication administration record. On 5/7/14 at 10:20 a.m. the nurse manager, (RN)-A explained she thought the order was to monitor but not document blood pressure and heart rate. She believed staff were monitoring heart rate and blood pressure prior to each administration of Metoprolol Tartrate. On 5/8/14 at noon, the consultant pharmacist (CP) explained the facility should be documenting heart rate and blood pressure prior to each dose of Metoprolol Tartrate administered. R96's Order Summary Report, dated 3/31/14 and 4/30/14 directed staff to administer "Trazodone HCL Tablet 75 mg by mouth at bedtime related to insomnia unspecified." [Trazodone HCL is a anti-depressant medication that is also used to treat difficulty with sleeping.] A review of R96's current care plan, last reviewed 3/28/14 directed staff "I do usually take a short nap during the day and am able to sleep well at night when I take my sleeping medication. I do have a diagnosis of insomnia" Interventions included : "Staff administer sleeping medications per NP/MD [nurse practitioner/medical doctor] order." No non-pharmacological interventions for sleep or summary of effectiveness of non-pharmacological interventions were on the care plan.	F 329		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 12 On 5/8/14 at 12:10 p.m., RN-A explained the facility tried to create a peaceful environment conducive to sleep by offering snacks, dimming the lights and keeping the noise level low. RN-A confirmed no non-pharmacological interventions specific to R96 were on his care plan. R26 was receiving medication for sleep and did not have specific non-pharmacological interventions for sleep and the effectiveness of these interventions included in this resident's plan of care. Record review on 5/7/14 revealed a physician's order for trazodone (an anti-depressant also used to treat insomnia) 75 milligrams by mouth at bedtime for insomnia, dated 4/3/14. The medication administration record for this resident showed that this medication was given every day since it was ordered. The current care plan, dated 5/7/14, contained a focus that read, "I do have difficulties sleeping at night sometimes..." The non-pharmacological interventions for evening sleep for this resident read, "Staff promote [R26]'s usual HS [hour of sleep] routine, and relaxation when preparing for bed." There was no more detail provided for this vague intervention, and no documentation of effectiveness. When interviewed on 5/8/14, at 10:30 a.m. registered nurse (RN)-D, was asked if there was documentation of detailed non-pharmacological sleep interventions in the record. She stated that those interventions should be listed on the care plan. Sleep monitoring was not being completed on a	F 329		

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	245295	A. BUILDING _____ B. WING _____	05/08/2014

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F 329	Continued From page 13	F 329		

routine basis for R74 after Remeron was restarted during a hospital stay from 1/29 - 1/31/14.

A review of the most current physician orders revealed that R74 had been on Remeron 15 mg (milligrams) at bedtime for insomnia prior to 1/27/14; and on 1/27/14 the physician had discontinued the Remeron. According to a history and physical from the hospital R74 was admitted to the hospital on 1/29/14 and discharged on 1/31/14, with a physician's order for Remeron 7.5 mg at bedtime. [Remeron is an anti-depressant medication, also used for difficulty sleeping.]

A review of nursing notes from 2/1 to 5/7/14 did not indicate R74 was having difficulty sleeping and did not indicate sleep monitoring was completed. A review of the medical record, with registered nurse (RN)-B on 5/8/14 at 12:47 p.m. revealed no sleep monitoring had been conducted since the Remeron was restarted. RN - B stated she would add the sleep monitoring to the treatment administration record, which according to RN - B was where sleep monitoring documentation was to be completed.

A revised care plan dated 3/27/14, addressed R74's history of difficulty sleeping; that the resident's normal pattern of sleep was 6-8 hrs per night; that R74 would nap frequently during the day based on needs, but "as of late have not experienced difficulties with sleep. Non-pharmacological interventions that help me are exercising during the day. I am able to report to staff if I am having trouble sleeping."

R74 stated on 5/8/14 at 12:35 p.m. that 8:00 p.m. was the usual bedtime for him and there were no

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F 329	Continued From page 14 problems sleeping, unless his roommate had the TV on. R74 stated he was not taking any sleep medication and was exercising on a daily basis.	F 329		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate dental services were provided or offered related to malodorous mouth and possible pain for 1 of 2 residents (R76) reviewed for dental services. Findings include: R76 was not provided with dental care services. Interview on 5/8/14 at 8:50 with the nurse manager, (RN)-A revealed R76 was admitted in September 2011 and had diagnoses including unspecified cerebrovascular disease. Resident was nonverbal and unable to communicate her needs other than with her eyes or facial expressions.	F 412	Immediate corrective action: Resident R76 received initial dental services on 5/13/14. Action as it applies to other residents: All residents will be reviewed to ensure their dental needs have been met. The Policy and Procedure for providing Dental Services was reviewed and remains current. All Nursing, Social Service and Medical Records staff will be re-educated on the policy for Dental Services by 6/16/14. Date of Completion: 6/16/14 Recurrence will be prevented by: Random weekly audits will be conducted	6/16/14

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F 412	Continued From page 15 Observation of oral cares on 5/7/14 at 9:23 a.m. revealed nursing assistant (NA)-B performed oral care using toothettes. R76's teeth were done on all sides along with the gum lines. It was unclear if R76 experienced discomfort during oral care. R76's forehead was wrinkled during procedure. The resident did not open her mouth so staff could clean her tongue and get the upper inner sides of the teeth. The teeth appeared to have yellowish debris on them. The quarterly minimum data set (MDS) dated 2/18/14 indicated no concerns, under the oral/dental section. The nursing completed oral/dental assessment dated 4/28/14, indicated the resident had her own teeth, in fair condition, No signs or symptoms of oral pain or discomfort noted. The oral mucosa was moist and pink. The resident needed total assist with oral care twice a day (bid). The section about dental care was left blank. The oral/dental assessment form completed 2/18/14 under the dental care section indicated, "does resident need/want a dental exam." The form was marked with a "yes" response. That was never followed up on. The plan of care (CP) dated 3/17/14, indicated the resident needed assist with oral care, had her own teeth in fair condition, and breathe was malodorous which required frequent oral cares. The staff was directed to provide daily oral care twice a shift due to bad breath and to monitor for mouth irritation or pain. Arrange routine and emergent dental treatment. The CP also indicated the family, (F)-A originally declined dental services because she would have to pay for it. It was unclear what F-A's preferences were for dental appointments since R76 enrolled in medical assistance (MA) in July 2013.	F 412	on each unit to ensure residents receive dental services according to facility policy. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing and/or designee	

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F 412	Continued From page 16 Interview with family on 5/6/14 at 3:17 p.m. revealed that R76 had not seen a dentist and it was unclear if R76 was in pain, as she was not able to communicate verbally. F-A was concerned about teeth not getting cleaned all the time and possible odors at times. Interview on 5/8/14 at 8:50 with the social worker, (LSW)-A revealed R76 had not been seen by the dentist. When R76 had her insurance benefits switched to medical assistance (MA) in 7/2013, the dental consent was not signed by F-A. LSW-A indicated she usually had the resident/family sign dental consents when they go onto MA. However she did not do that for R76. LSW-A filled out the consent, dated, 5/8/14. LSW-A later reported she called F-A on 5/8/14 and discovered she would like R76 to have a dental appointment scheduled. LSW-A agreed the care plan should have reflected the dental needs of R76.	F 412		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428		6/16/14

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F 428	Continued From page 17 by: Based on interview and document review, the facility consultant pharmacist [CP] failed to identify and notify the facility of irregularities in the medication regimen for 3 of 5 residents reviewed for unnecessary medications; monitoring of heart rate and blood pressure for R96, non-pharmacological interventions for sleep for R26 and R96 and sleep monitoring for R74. The facility consultant pharmacist failed to identify and notify the facility of the lack of monitoring of pulse and heart rate as ordered by the physician related to administration of a hypertension medication, and lack of documentation of non-pharmacological interventions for sleep to complement the use of a medication prescribed for insomnia for R96 The Order Summary Report, dated 3/31/14 and 4/30/14, directed staff "Metoprolol Tartrate Tablet Give 25 mg [milligrams] two times a day related to unspecified essential hypertension (401.9) Hold for systolic BP [blood pressure] less than 100 or heart rate less than 60." [Metoprolol Tartrate is a medication for hypertension. Systolic blood pressure measures the pressure in the arteries when the heart beats ,when the heart muscle contract. Heart rate is the number of times your heart beats per minute.] A review of the medication and treatment administration records for April and May indicated R96's heart rate and blood pressure were documented five times in April and once in May. A review of the weights and vitals summaries for both heart and blood pressure indicated the heart rate and blood pressure were documented	F 428	Immediate corrective action: Monitoring of Systolic blood pressure and heart rate were implemented for resident R96 on 5/21/14; Non-pharmacological interventions for sleep were implemented for residents R96 on 5/22/14and R26 on 5/20/14; and sleep monitoring was implemented for resident R74 5/21/14. Action as it applies to other residents: All residents receiving antihypertensive or medications to induce sleep will have their medication regimens reviewed by the consultant pharmacist to ensure monitoring is in place according to facility policy and acceptable standards of nursing practice. The policy and procedure for Medication Regimen Review was reviewed and remains current. All nursing staff and the Consultant Pharmacist will be re-educated on the policy for Medication Regimen Review. Date of Completion: 6/16/14 Recurrence will be prevented by: Monthly meetings will be held with Nursing, Administration and the Consultant Pharmacist to ensure medication regimen reviews are completed and any noted irregularities are identified by the pharmacist. Random weekly audits will be conducted on each unit to ensure residents who receive antihypertensive medications and/or medications to induce sleep have appropriate medication monitoring in	

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F 428	Continued From page 18 on the same five days in April and one day in May as the medication and treatment administration records. On 4/10/14 R42's systolic blood pressure was 95. The Metoprolol Tartrate was marked on the medication administration record as administered for both doses that day. A review of consultant pharmacist [CP] reports and monthly medication regimen reviews dated 4/1/13 through 4/10/14 for R96 do not provide direction related to monitoring of blood pressure and heart rate. On 5/7/14 at 10:15 a.m., a floor nurse (LPN)-A reported there were not spaces to record heart rate and blood pressure in the electronic medication administration record to enter vitals for each administration of Metoprolol Tartrate. On 5/7/14 at 10:17 a.m. a floor nurse (RN)-B reported staff should be monitoring heart rate and blood pressure before each administration of Metoprolol Tartrate. RN-B reported she would add an order and space to record heart rate and blood pressure in the electronic medication administration record. On 5/7/14 at 10:20 a.m. the nurse manager, (RN)-A explained she thought the order was to monitor but not document blood pressure and heart rate. She believed staff were monitoring heart rate and blood pressure prior to each administration of Metoprolol Tartrate. On 5/8/14 at noon, the consultant pharmacist (CP) explained the facility should be documenting heart rate and blood pressure prior to each dose of Metoprolol Tartrate administered to R96. CP was not sure if she had addressed the lack of	F 428	place according to facility policy and procedure. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing and/or designee	

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F 428	Continued From page 19	F 428		

heart rate and blood pressure monitoring with the facility. CP reported she would review her documentation and provide any further information she had to the survey team. No additional information was provided.

R96's Order Summary Report, dated 3/31/14 and 4/30/14 directed staff to administer "Trazodone HCL Tablet 75 mg by mouth at bedtime related to insomnia unspecified." [Trazodone is an anti-depressant medication, also used for difficulty sleeping, insomnia.]

A review of R96's current care plan, last reviewed 3/28/14 directed staff "I do usually take a short nap during the day and am able to sleep well at night when I take my sleeping medication. I do have a diagnosis of insomnia" Interventions included : "Staff administer sleeping medications per NP/MD [nurse practitioner/medical doctor] order." No non-pharmacological interventions for sleep were on the care plan.

On 5/8/14 at 12:10 p.m., RN-A explained the facility tried to create a peaceful environment conducive to sleep by offering snacks, dimming the lights and keeping the noise level low. RN-A confirmed no non-pharmacological interventions specific to R96 were on his care plan.

A review of consultant pharmacist [CP] reports and monthly medication regimen reviews dated 4/1/13 through 4/10/14 for R96 do not provide direction related to non-pharmacological interventions related to sleep.

The facility's consulting pharmacist did not advise the facility of a lack of specific,

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F 428	Continued From page 20 non-pharmacological sleep interventions in the plan of care for R26, who was receiving medication for sleep. Record review on 5/7/14 revealed a physician's order for trazodone (an anti-depressant also used to treat insomnia) 75 milligrams by mouth at bedtime for insomnia, dated 4/3/14. The medication administration record for this resident showed that this medication was given every day since it was ordered. The current care plan, dated 5/7/14, contained a focus that read, "I do have difficulties sleeping at night sometimes..." The non-pharmacological interventions for evening sleep for this resident read, "Staff promote [R26]'s usual HS [hour of sleep] routine, and relaxation when preparing for bed." There was no more detail provided for this vague intervention, and no documentation of effectiveness. When interviewed on 5/8/14, at 10:30 a.m. registered nurse (RN)-D, was asked if there was documentation of detailed non-pharmacological sleep interventions in the record. She stated that those interventions should be listed on the care plan. During interview on 5/8/14, at 11:25 a.m. the consulting pharmacist was asked if she looks for non-pharmacological sleep interventions for residents taking sleep medication when reviewing resident records. She stated that she generally looks more carefully at residents receiving prn (as needed) sleep medication to be sure that everything is being done with non-pharmacological interventions before the resident is started on a scheduled sleep medication. She went on to explain that	F 428		

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F 428	Continued From page 21 once a resident is started on a scheduled sleep medication, she is more concerned with dose reduction. Sleep monitoring was not being completed on a routine basis for R74 after Remeron was restarted during a hospital stay from 1/29 - 1/31/14. A review of the most current physician orders revealed that R74 had been on Remeron 15 mg (milligrams) at bedtime for insomnia prior to 1/27/14; and on 1/27/14 the physician had discontinued the Remeron. According to a history and physical from the hospital R74 was admitted to the hospital on 1/29/14 and discharged on 1/31/14, with a physician's order for Remeron 7.5 mg at bedtime. [Remeron is an anti-depressant medication, also used for difficulty sleeping.] A review of nursing notes from 2/1 to 5/7/14 did not indicate R74 was having difficulty sleeping and did not indicate sleep monitoring was completed. A review of the medical record, with registered nurse - B (RN)-B on 5/8/14 at 12:47 p.m. revealed no sleep monitoring had been conducted since the Remeron was restarted. RN - B stated she would add the sleep monitoring to the treatment administration record, which according to RN - B was where sleep monitoring documentation was to be completed. A revised care plan dated 3/27/14, addressed R74's history of difficulty sleeping; that the resident's normal pattern of sleep was 6-8 hrs per night; that R74 would nap frequently during the day based on needs, but "as of late have not experienced difficulties with sleep.	F 428		

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F 428	Continued From page 22 Non-pharmacological interviews that help me are exercising during the day. I am able to report to staff if I am having trouble sleeping." R74 stated at 12:35 p.m. on 5/8/14 that 8:00 p.m. was the usual bedtime for him and there were no problems sleeping, unless the roommate had the TV on. R74 stated he was not taking any sleep medication and was exercising on a daily basis. A review monthly pharmacy reviews, from 1/14 to 4/14 revealed the pharmacist had not noted the lack of sleep monitoring since the medication was restarted. On 5/8/14 at 1:10 p.m. the consulting pharmacist (CP) was interviewed regarding the lack of sleep monitoring to support the continued use of the Remeron. The consulting pharmacist stated a review of physician progress notes revealed that the Remeron was also being used for depression, but the according to the pharmacy the medication use was for insomnia. The consulting pharmacist stated that with a diagnosis of insomnia there should be some monitoring for sleep. When asked why the lack of sleep monitoring had not been completed, the consulting pharmacist stated the facility had identified areas that needed to be addressed and the pharmacist was working on one at a time.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431		6/16/14

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F 431	Continued From page 23 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 policy review the facility failed to ensure medications were stored properly in 2 of 3 medication carts on third floor, insulins were not labeled and dated when open for 4 of 9 residents prescribed insulin on third floor (R24, R83, R76, R1); impacting 30 of 46 residents on third floor, 1 of 3 medication	F 431	Immediate corrective action: The insulin for residents R24, R76 and R83 were immediately removed from the medication cart on 3rd floor and reordered from the pharmacy. The Spiriva inhaler, Advair inhaler, Ventolin inhaler and Lovenox syringe were	

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F 431	Continued From page 24 carts on second floor contained improperly labeled medications, impacting 8 of 23 second floor residents; and expired stock medications and prescriptions for R38 were not removed from 1 of 3 medication carts on fourth floor, impacting 11 of 33 fourth floor residents. This errant practice had the potential to impact 53 of 102 residents residing at the facility, who could be administered a medication. Findings include: Insulins on third floor were not dated when opened, and medications were observed on second and third floor lying loose in the medication cart with no label or name. Observation on 5/5/14 at 5:22 p.m. on third floor revealed 7 of 22 insulin's were opened and not dated. All four of R24's and R83's Lantus pens had varying amounts left in the pens and were not properly dated. R83's Novolog bottle was opened the 25th with no month indicated. R76 Novolog and R1's Novolog were opened and not dated. [Lantus and Novolog are types of insulin used to treat diabetes] On 5/5/14 at 7:15 p.m. the medication carts on third floor revealed 2 of 3 medication carts had Spiriva inhaler, Advair inhaler, Ventolin inhaler, and a syringe of Luvenox lying loose in the medication cart without a name or pharmacy directions. [Spiriva, Advair and Ventolin are medications used to treat breathing and airway problems. Luvenox is a medication used to reduce the risk of developing DVT, or deep vein thrombosis.] When interviewed on 5/5/14 at 5:25 p.m. licensed	F 431	immediately removed from the medication carts on 3rd floor and reordered from the pharmacy. The Spiriva inhaler and novolog insulin were immediately removed from the medication cart on 2nd floor and reordered from the pharmacy. The medication for resident R38 was immediately removed from the 4th floor medication cart and reordered from the pharmacy. The bottle of stock calcium plus vitamin D and the bottle of stock supply of calcium citrate were removed from the medication cart and replaced. Action as it applies to other residents: All medication carts and medication storage rooms were inspected and all improperly labeled, undated, unlabeled, medications with illegible labels and expired stock and prescription medications were immediately removed on 5/8/14. The policy and procedure for the Storage of medications was reviewed and remains current. All Licensed Nursing staff and Trained Medication Aides will be re-educated on the policy and procedure for the Storage of Medications. Date of Completion: 6/16/14 Recurrence will be prevented by: Random weekly visual inspections of medication storage rooms and medication carts will be conducted on each unit to ensure all, unlabeled, undated, improperly labeled, expired medications and	

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F 431	Continued From page 25 practical nurse (LPN)-D indicated all insulins needed to be dated when opened. Registered nurse (RN)-A when interviewed at 5:30 p.m. said all insulins should be labeled and dated when opened and thrown out after 28 days. Interview on 5/5/14 at 7:25 p.m. RN-A said all medications need to be labeled. She did not know who the inhalers and Lovenox medications were for. They were removed from the cart. Second floor medication cart was checked on 5/7/14 at 11:40 a.m. and Spiriva inhaler and Novolog Insulin were found lying loose in the cart without a name or pharmacy label. Interview with RN-C at 11:50 a.m. indicated all medications need to be labeled with resident name and directions. The medications were removed from the cart. During a tour of the fourth floor medication carts on 5/8/14 at 9:30 a.m,. expired medications were noted in 1 of 3 carts checked. In the B-wing cart the expired medications were observed and verified with licensed practical nurse - (LPN)-B. The cart contained expired medications belonging to R38; 120 tablets or 4 cards of Oxcarbazepine 300 mg (milligrams) which expired on 4/30/14 and one card of 30 tablets of Oxcarbazepine which expired on 3/31/14. [Oxcarbazepine is an anticonvulsant and mood-stabilizing drug.] A bottle of stock supply calcium 600 mg plus vitamin D expired on 4/14; and a bottle of stock supply calcium citrate expired on 4/14. The policy and procedure titled, Storage of Medications, dated 9/10, indicated all medications are to be labeled according to federal requirements. Insulin vials and pens are to dated	F 431	medications with illegible labels are removed from current use according to facility policy and procedure and acceptable standards of nursing practice. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing and/or designee	

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F 431	Continued From page 26 when opened, and all outdated medications are removed from stock immediately.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		6/16/14

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F 441	Continued From page 27 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure potentially contaminated laundry was handled in a manner to prevent cross contamination, which the potential to affect all residents currently residing in the facility; cleaning practices were consistently implemented for R71 to prevent the spread of infection within the facility; proper cleaning of the universal blood glucose monitoring machine on third floor, which had the potential to affect 9 of 9 residents who could use the blood glucose machine; and failed to administer eye medications in a sanitary manner for 1 of 2 residents (R54) observed receiving eye medications. All residents could potentially be impacted by these errant practices. The facility failed to implement infection control procedures to prevent the possible spread of infection from using the universal blood glucose machine and for eye medication administration. Observation of blood glucose monitoring on 5/5/14 at 7:30 p.m. revealed licensed practical nurse (LPN)-D performed a blood glucose check and put the machine away in the carrying caddy. She then took the machine out and took a bleach wipe and did a quick wipe once over of the machine and put it away. LPN-D reported "I always wipe it off just in case others don't do it." LPN-D said the blood glucose machine should be cleaned before and after use, but was unsure how long to sanitize the machine.	F 441	Immediate corrective action: LPN-B and LPN-D were re-educated on the policy and procedure for Blood Glucose Monitor Disinfection. TMA-B was re-educated on the policy and procedure for the Administration of Eye Drops. The Foam cushion for Resident R71 was removed and replaced. The room for Resident R71 was cleaned, the bed was cleaned, the bed linens changed, all soiled surfaces were cleaned and the floor was mopped on 5/6/14. The tape and tape residue were removed from the clean linen table and cupboards on 5/8/14. The light fixtures, overhead fan and water pipes have been cleaned of all dust, the boxes of linen storage have been permanently removed from the clean linen area, the soiled linen bins were cleaned and the floor was cleaned on 5/19/14. The soiled linen chute was cleaned on 5/19/14. The stored containers of liquid wax, floor scrubber brushes and floor cleaning machine were removed from the soiled linen room on 5/8/14. Action as it applies to other residents: The missing formica on the edge of the folding table will be repaired by 6/16/14 Clean linen stored in the lower cupboards	

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F 441	Continued From page 28 LPN-B was orientating LPN-C on 5/7/14. At 7:18 a.m. LPN-C was observed at the medication cart with the blood glucose machine. LPN-C indicated a blood glucose check had just been done. LPN-C took a sani wipe and wiped the machine off going around the machine once. LPN-C then put the machine back down in the container from where it came. When asked, LPN-C said you should let the machine dry for 2 minutes, but was unsure of how long to actually clean it. LPN-B indicated the machine needed to be sanitized for 2 minutes and both LPN-B and LPN-C said that was not done. On 5/6/14 at 11:32 a.m. observation of eye drops for R54 was observed by trained medication aide (TMA)-B. After TMA-B gave the eye drops she took the tissue she had in her hands and wiped off the tip of the eye drop bottle with it. When interviewed, TMA-B agreed she should not have done that as she possibly could contaminate the tip of the eye drop bottle. When interviewed on 5/8/14 at 9:14 a.m. registered nurse (RN)-A, indicated the policy stated the blood glucose machine needs to be sanitized for 2 minutes. She also indicated staff should not wipe off the tip of the eye drop bottle, because of possible contamination. The policy and procedure titled, Blood Glucose Monitor Disinfection, dated 2/14 indicated, directed staff to disinfect the monitor by continually wiping or wrapping monitor with a second wipe to ensure contact time of 2 minutes. The policy and procedure titled, Medication	F 441	will be stored in covered bins by 6/16/14. Covers will be provided for the soiled linen to transport soiled linen within the laundry area by 16/14. The soiled linen bins will be lined with plastic to prevent the bins from becoming soiled by 6/16/14. A policy and Procedure was developed for the cleaning of the linen chute and soiled linen bins. A Policy and Procedure was developed for Cleaning the Laundry area. The Policy and procedure for Blood Glucose Monitor Disinfection was reviewed and remains current. The Policy and Procedure for Eye Drop Administration was reviewed and remains current. The Policy and Procedure for Handling Soiled Linen was reviewed and remains current. The Policy and Procedure for Daily Patient Room Cleaning was reviewed and remains current. All Licensed Nursing staff and Trained Medication Aides will be re-educated on the policy and procedures for Blood Glucose Monitoring Disinfection and Eye Drop Administration by 6/16/14. All nursing and Laundry staff will be re-educated on the Handling of Soiled Linen Policy and Procedure by 6/16/14. Housekeeping staff will be educated/re-educated on the policy and procedures for Daily Patient Room Cleaning, Cleaning of the Linen Chute, Cleaning of the Soiled Linen Bins and Cleaning the Laundry Area. Date of Completion: 6/16/14.	

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F 441	Continued From page 29 Administration Eye Drops, dated 10/07 to administer solution into the eye in a safe and accurate manner take care to avoid touching the dropper tip. The facility failed to ensure cleaning practices were consistently implemented for R71 to prevent the spread of infection within the facility. This had the potential to affect all residents in the facility. During an observation on 5/5/14, at 7:00 p.m. R71's bed linens were observed to have large plate size yellow stains in multiple areas of the linens. The tray table and bedside stand were sticky and mutiple different colored stains were clearly visible on the table surfaces. The bed frame was soiled with dried on substances and dust. The personalized mechanical wheelchair was dusty with stains in numerous and various areas of the chair. There was a 4 inch foam cushion on a chair in the room which did not have a cleanable surface. The bedroom floor had multiple pieces of paper, dust and debris scatterred around the floor and there were red and dark brown droplet and spatter stains. The floor in the bedroom was sticky. R71 came out of the bathroom and without washing hands reached for a handshake and hands were sticky to the touch. Review of the physician start of care documentation revealed R71 had diagnosis of uncontrolled diabetes, peripheral vascular disease with multiple open wounds, stasis ulcers to the feet, legs and knees, history of MRSA (Methicillin-resistant Staphylococcus aureus) in sputum, tracheostomy, history of hepatitis C. R71 is ambulatory in the bedroom and able to take	F 441	Recurrence will be prevented by: Random weekly visual audits will be conducted on each unit to ensure resident rooms and the laundry area including soiled linen bins, and the laundry chute are cleaned according to policy and procedure and all clean linen surfaces . Random weekly audits will be conducted to ensure staff administer eye drops and clean the blood glucose meter per facility policies. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing/Director of Housekeeping and/or designee.	

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F 441	Continued From page 30 self to the bathroom. [MRSA infection is caused by a strain of staph bacteria that's become resistant to the antibiotics commonly used to treat ordinary staph infections.] During an interview on 5/7/14, at 8:30 am, housekeeping aide (HA)-A, who worked full time on the wing R71 resided, verified the room goes many days and weeks where it is not cleaned because the resident refused to allow the housekeeper to clean the room. HA-A had reported to her supervisor of environmental services that the resident would not allow housekeeping to clean his room. Interview with the director of environmental services (DES) on 5/7/14, at 8:45 a.m. confirmed the resident refused to allow his room to be cleaned. Interview with the registered nurse RN-E verified the resident refused to have his room cleaned. RN-E validated the infection control concerns because of R71 having a tracheostomy and wounds which could be a source of the dried red and brown splatters on the resident room flooring. RN-E did not belive the infection control practices with this resident had been discussed at the quality assurance meetings. [A tracheostomy is a surgically made hole that goes through the front of the neck and into the trachea, or windpipe. The hole is made to help one breathe.] The Healthcare Services Group, Inc 5-Step Daily Patient Room Cleaning procedure, dated 1/1/2000, directed staff: "1. Empty trash", "2. Horizontal Surfaces-disinfected", "3 Spot Clean Walls" ,"4. Dust Mop", and "5. Damp Mop" The Healthcare Services Group, Inc Complete Room Cleaning procedure, dated 1/1/2000, directed staff "The Complete Room Cleaning Schedule insures that each resident room is discharge-cleaned on a monthly basis." "1 Check	F 441		

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F 441	Continued From page 31 Complete Room Schedule daily and inform Nursing supervisor of appropriate room numbers." "2 Clean the scheduled Complete Room. By this time, the room should be emptied and ready for cleaning. If it is not, contact the Nursing supervisor to assist in the situation." "Starting in a clockwise rotation from patient room door: clean, polish, scrape, dust, disinfect, sweep, wipe and mp everything in the room..." The facility failed to ensure potentially contaminated laundry was handled in a manner to prevent cross contamination. This had the potential to affect all residents currently residing in the facility. During infection control observation for the handling of the facility linen on 5/8/14, at 9:15 a.m. with the laundry aide (LA)-A who worked full time, and the director of environmental services (DES), several areas were discussed and verified. The clean linen folding table had partial areas of masking tape residue which prevented the clean table from having a cleanable surface because of the tape residue. The cupboards overhead of this table had hundreds of pieces of masking tape and residue from the masking tape from hanging paper items, over the years, according to LA-A. The formica was missing on the edge of the folding table exposing rough and uncleanable surfaces. Linen was stored in the lower cupboards but there was no door or covering to protect the clean linen. An overhead fan was blowing onto the clean linen and the fan was laden with heavy accumulation of dust. The water pipes, chains holding up the lights, and ceiling lights were heavy with dust. According to LA-A, they had never been cleaned. Multiple medium sized boxes were on the floor under the	F 441		

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F 441	Continued From page 32	F 441		

clean folding table and there was sand, dust and paper particles around these boxes. According to LA-A, the boxes were storing linen and not moved when the floor was mopped.

The soiled linen was sent to the dirty linen room from the nursing stations on second, third and fourth floors through a chute. The linen should be in plastic bags. According to LA-A often linen and trash come through the chute not in plastic bags. During observation at 10:00 a.m. with the director of environmental services, the director of nursing, and the administrator, the bin to catch soiled linen contained linen that was sent through the chute not bagged and bowel movement was smeared throughout this unbagged linen. The process to get this soiled linen to the washing machines involved moving the bin through a small 15 foot corridor which was 5 feet wide. On the south wall of this hallway stored the uncovered clean personal linen, clean hangers, extra clean linens in bins along this narrow hallway.

Interview with LA-A revealed there was not a system to wash the dirty linen bins, they were not lined with plastic, and the bins did bump into the personal clothing several times a day when the dirty linen had to be brought to the washing machines, past the clean linen because of the lack of space in the laundry department.

Interview on 5/8/14, at 10:00 a.m. with the DES verified the eye wash station should not be stored in the dirty linen room, the open containers of liquid wax for floor scrubbing, the floor scrubber brushes and the floor cleaning machine should not be stored in the dirty linen room. The DES validated there was not a consistent system to clean the laundry chute and it was not

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F 441	Continued From page 33 documented when cleaned. The DES verified the dirty linen bins were dirty and there was not a system for cleaning of the laundry bins. Interview on 5/8/14, at 11:00 a.m. with the LA-A verified the dirty linen bins were not cleaned, there was not a system to clean the dirty linen bins and the LA-A verified the linen bins were dirty, stained and soiled with body fluids.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3rd floor was free of unpleasant odors, resident rooms and common areas were maintained in good clean repair and the carpeting in the common area on fourth floor was clean. This had the potential to impact a total of 80 out of 100 residents residing at the facility: all 46 3rd floor residents, including those who expressed concerns or had concerns expressed on their behalf regarding odors (R32, R107, R76); 9 of 35 residents reviewed for room maintenance (R2, R96, R116, R22, R53, R4, R65, R107, R39); and all 33 residents on the fourth floor. Findings include: The facility failed to maintain an environment free	F 465	Immediate corrective action: The shower room on third floor was cleaned on 5/8/14. Action as it applies to other residents: The ventilation system was inspected and found to be in need of repair. It will be repaired by 6/16/14. The countertop area in resident R2□s room will be repaired by 6/16/14. The plastic door trim on the door to resident R65□x room will be repaired by 6/16/14. The door into resident R96□s room will be repaired by 6/16/14. The toilet in resident R116□s room will be repaired by 6/16/14. The door into resident R22□s room will be	6/16/14

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F 465	Continued From page 34 of odors on the 3rd floor. There was a pervasive strong urine odor detected in the shower/toilet room on third floor on 5/5/14, 5/6/14, 5/7/14 and 5/8/14. This room was used to give showers, store lifts and to toilet some residents. The odor appeared at various times throughout different times of the day. On 5/5/14 at 5:39 licensed practical nurse (LPN)-D agreed the shower room had an odor of urine but was unsure where the smell originated. On 5/6/14 at 8:50 a.m. the shower room again had a strong odor of urine. LPN-E agreed there was an odor. There were also strong odors of urine and body odor in the hallways and common areas of the 3rd floor, noted on the evening of 5/5/14 and during the days on 5/6/14, 5/7/14 and 5/8/14. During interview on 5/5/14 at 4:15 p.m. about facility odors and R32 stated, "oh yes, sometimes it smells bad , but we just spray." On 5/5/14 at 6:30 p.m. R107 was interviewed about facility cleanliness. She responded, "it is not clean, it smells bad." On 5/6/14 at 1:22 p.m. a family member (FA)-A of 3rd floor resident, R76. F-A was interviewed about the cleanliness of the facility and responded with, "sometimes it doesn't smell good." On 5/8/14 at 2:00 p.m. nurse manager, RN-A reported she sometimes noticed an overwhelming odor, but did not think it was	F 465	repaired by 6/16/14. The wall in resident R53 room was cleaned on 5/23/14. The doors on the rooms of residents R4. R53, and R65 will be repaired by 6/16/14. The wall in resident R107□s room will be repaired by 6/16/14. The ceiling in resident R39□s room will be painted by 6/16/14. The carpet in the fourth floor common area was cleaned on 5/23/14. Maintenance will perform a house wide inspection of doors, walls, ceilings, countertops, and toilets in resident areas and ensure any noted concerns are repaired by 6/16/14. The policy and procedure for Patient room cleaning was reviewed and remains current. The policy and procedure for Carpet Cleaning was reviewed and remains current. The policy and procedure for Routine Maintenance Inspection was reviewed and remains current. Housekeeping and Maintenance staff will be re-educated on the policies by 6/16/14. Date of Completion: 6/16/14. Recurrence will be prevented by: Weekly Random audits will be conducted on each unit to inspect resident and common areas for odors, chipped doors or door trim, countertops in need of repair, toilets in need of repair, soiled carpeting, walls in need of repair and ceilings in need of repair. Audits will be completed for a period of 90	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 35 noticeable all the time. During observation on 5/8/14 at 2:15 p.m., the administrator confirmed she noticed an odor of urine upon exiting the elevator onto 3rd floor. She was unable to detect an odor of urine in the shower room or elsewhere on the floor. On 5/8/14 at 2:30 p.m. the housekeeping/laundry manager was interviewed and a cleaning schedule along with ventilation checks was requested. Nothing was provided. The Healthcare Services Group, Inc 7-Step Daily Washroom Cleaning procedure, dated 11/1/2000, directed staff "1. Check supplies" "2. Empty trash" "3. Dust mop floor" 4. Clean and sanitize sink and tub" "5. Clean and sanitize commode." "6. Spot clean walls and/or partitions" "7. Damp mop floor" The facility failed to maintain fixtures, doors and walls in resident rooms and common areas in good clean repair. During observation on 5/6/14 at 11:03 a.m., R2's room was noted to have plastic peeling off from the countertop near the sink. During observation on 5/6/14 at 10:38 a.m. of R65' room , plastic trim on the door to the room was noted to be chipping away in several spots. On 5/6/14 at 10:35 a.m. R96's room to his door was noted to be difficult to open. On 5/6/14 at 10:32 a.m. a hole was noted in R116's bathroom door. The bathroom toilet was chipping around the edges.	F 465	days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Ongoing compliance will be monitored by the Director of Nursing/Director of Housekeeping /Maintenance Director and/or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	05/08/2014

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F 465	Continued From page 36 The door on R22's room was extremely chipped of wood and very splintered near the bottom. On 5/6/14 at 10:52 a.m. the wall behind the bed of R53 had stains running down the wall. On 5/8/14 at 9:30 a.m., during tour, the plastic covering and the wood of the doors were noted to be peeling and chipped on the rooms of R4, R53 and R65 and on the door for the 3rd floor tub room. The wall at the head of the bed and on the south wall in R107's room was gouged. The northwest corner of the ceiling in R39's room was gouged. The area had been primed, but not painted. All concerns were confirmed with the administrator and housekeeping/laundry manager during environmental tour on 5/8/14 at 9:45 a.m. The Healthcare Services Group, Inc 5 Step Daily Patient Room Cleaning policy, dated 11/1/2000, directed staff "3. Spot clean walls" The facility failed to ensure carpeting in the common area on the 4th floor was clean. During observation on 5/5/14, at 7 p.m. the carpeting in the fourth floor common area near the elevators was darkened and soiled in an area approximately three feet by five feet. This soiled carpeting was in the area where food was served at meal times. During the tour on 5/8/14 at 9:30 a.m. the	F 465		

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F 465	Continued From page 37 carpeting in the lounge/dining area was noted to be soiled. The soiled area was along the west wall, by a countertop. The housekeeping/laundry manager stated on 5/8/14 at 9:45 a.m. that the carpeting was generally cleaned after the noon meal, and that each floor was done on either Tuesday, Wednesday or Thursday. The administrator also stated at this time that daily spot cleaning throughout the facility was completed as needed. The administrator also stated she completed a weekly walk through of the facility and did daily spot checks.	F 465		

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	245295	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/07/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE 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, Bethel 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 STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/26/2014

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Bethel Care Center is a 4-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1982, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 131 beds and had a census of 101 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 025	Continued From page 2	K 025		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observationand and interview, the facility failed to maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.3, 8.3, 8.3.2 and 8.3.6. This deficient practice could affect all residents, staff and visitors. Findings include: On facility tour between 09:00 AM and 01:00 PM on 05/07/2014, it was observed that the Smoke Barrier doors did not fully close when tested in the following areas: 4th floor smoke barrier doors by rooms 410 & 420. 3rd floor smoke barrier doors by room 310 2nd floor smoke barrier doors by rooms 210 & 220. This deficient practice was verified by Plant Operations Director (MF).	K 025	Corrective Action: Maintenance will be educated on maintaining smoke barrier doors in accordance with the requirements of NFPA 101 -2000 edition, Sections 19.3.7, 19.3.7.3, 8.3, 8.3.2 and 8.3.6 4th floor smoke barrier doors by rooms 410 & 420 will be repaired. 3rd floor smoke barrier doors by room 310 will be repaired. 2nd floor smoke barrier doors by rooms 210 & 220 will be repaired. Smoke barrier doors will be audited Monthly to ensure all doors close properly. Date of completion: 6/16/14 Reoccurrence will be prevented by: The Administrator/Maintenance will complete monthly audits to ensure compliance. Audits will be ongoing and reported to QA	6/16/14

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K 025	Continued From page 3	K 025	monthly. The correction will be monitored by: Administrator/Maintenance	
K 033 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5 .This deficient practice could affect 30 of 131 residents. Findings include: On facility tour between 09:00 AM and 01:00 PM on 05/07/2014, it was observed that the Lower Level Stairwell Door by room Central Supply Storage Room did not fully close and latch when tested. This deficient practice was verified by Plant Operations Director (MF).	K 033	Corrective Action: Maintenance will be educated on providing and maintaining the vertical opening protection in accordance with the requirements of NFPA 101 -2000 edition, Sections 19.3.1.1, 8.2.5. Lower Level Stairwell Door by room Central Supply Storage Room has been repaired to fully close and latch. All exit components will be audited monthly to ensure all doors fully close and latch. Date of completion: 6/16/14 Reoccurrence will be prevented by: The Administrator/Maintenance will complete monthly audits to ensure compliance. Audits will be ongoing and reported to QA monthly.	6/16/14

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K 033	Continued From page 4	K 033	Corrections will be monitored by: Administrator/Maintenance	